Citizens *for* Midwifery news

VOLUME 9, ISSUE 2, FALL/WINTER 2004

Inside this Issue

Midwives Model of Care™ SUPPORTER

Changing Birthing Practices at Hospitals

By Sheri Menelli

Hospitals are corporate machines. They care about the bottom line. They study how to draw in more patients. Money walking away makes a big impact on them.

Hospital administrators know that for every letter they receive, there are hundreds of people who aren't speaking up. When they get hundreds of letters, it makes an impact.

I am pregnant with my second child. I had a decent first birth although it could have been better with the knowledge that I have now. I actually had one of the least invasive and most empowering OBs in San Diego. I could have done without the nurses and the sterile atmosphere at the hospital, but live and learn. My second birth will be at home. How will that affect the hospital that doesn't even know that I'm pregnant? I'm money that they will never see!

Now that I'm four months pregnant, I plan on writing all of my local hospitals. There are five of them. I plan on telling them why I'm not giving birth at that facility. My favorite of the local hospitals is mother-baby friendly which I plan on giving them kudos for, but they don't allow waterbirth. They don't even have tubs for laboring in. They are not set up to be able to handle my three year old. There aren't any private postpartum rooms. (Not likely that I'd be talked into staying more than one hour after birth this time, but that is beside the point). I know from an insider that they don't allow waterbirth because the anesthesiologists don't want it. It causes them to lose money. If the hospital knew that they were losing patients because of what they don't offer, they may have more incentive to offer it.

The hospital I gave birth at the first time has a very high cesarean section rate. They gave me formula for my way home, and had some very unpleasant nurses.

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Are VBACs "Safe" in Birth Centers?

Reviewed by Susan Hodges

The long-awaited VBAC study from the National Association of Childbearing Centers (NACC) was published in the November issue *of Obstetrics & Gynecology* (Vol. 104, No. 5, Part 1, November 2004). "Results of the National Study of Vaginal Birth After Cesarean in Birth Centers" by Lieberman, Ernst, Rooks, Stapleton & Flamm is worth reading, and worth the exercise of some critical thinking.

Unfortunately, and overshadowing important and positive findings of the study, the authors concluded that "out-of-hospital birth is not a safe choice for women with prior cesarean deliveries," and they "advise both birth centers and women with prior cesarean deliveries against attempting VBACs in any non-hospital setting." This recommendation has already been endorsed by NACC ("Background Information on VBAC and Birth Centers" <http://www2.birthcenters.org/booksresources/vbacbackground.shtml>). We also know that competing maternity care providers (i.e., OBs and hospitals) have the power to enforce this recommendation, and it is likely also to be used to block home VBACs by CNMs and licensed midwives alike, in the few states where this is "allowed."

The critical reader should ask: are the conclusion and recommendation supported by the data reported in the study?

The carefully carried out study was based on prospectively collected data for 1,453 women who came to birth centers in labor. The investigators found that 87% had vaginal births. Twenty-four percent (347) were transferred to hospitals during

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Citizens *for* Midwifery

Who Are We?

CITIZENS FOR MIDWIFERY, INC. is a non-profit, grassroots organization of midwifery advocates in North America, founded by seven mothers in 1996. CfM's purposes are to:

- *promote the Midwives Model of Care.*
- *provide information about midwifery, the Midwives Model of Care, and related issues.*
- *encourage and provide practical guidance for effective grassroots actions for midwifery.*
- *represent consumer interests regarding midwifery and maternity care.*

CfM facilitates networking and provides information and educational materials to midwifery advocates and groups. CfM supports the efforts of all who promote or put into practice this woman-centered, respectful way of being with women during childbirth, whatever their title.

CfM News welcomes submissions of articles, reviews, opinions and humor. Please contact us for editorial guidelines and deadlines. We plan to publish our newsletter quarterly.

If you have questions about the group, feel free to drop us a line: Citizens for Midwifery, Inc., PO Box 82227, Athens,GA 30608-2227. You can also reach us at (888) CfM-4880 (ET) (toll free), or e-mail <info@cfmidwifery.org>.

Be sure to check out our web site: <http://www.cfmidwifery.org>.

As always, we want to hear your comments and suggestions!

CfM News Credits:
Editor: Susan Hodges
Editorial Review: Susan Hodges and Paula Mandell
Design & Composition: Paula Mandell
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Positive Giving!

By Sheri Menelli

I read a book recently that changed my life and changed my business practices. The book was *The One Minute Millionaire* by Mark Victor Hanson and Robert G. Allen. In the book they talk about becoming an Enlightened Millionaire. They recommend giving 10% of your pre-tax income to charity. I suppose in the past I had a rather negative view about giving away money especially when I was hardly making enough to pay my bills. My thoughts were "Well, I'll give when I'm a millionaire." This book changed my mind. I decided that 10% of any money coming in now through my hypnotherapy business and with the sales of my books and CDs was going to go to charitable organizations. These organizations are carefully chosen because my passion is about educating women so that they can have a more fulfilling birth experience. I want to support charities that are supporting this passion. I have chosen three, and every few weeks I rotate who I send a check to. My first check was to Citizens for Midwifery.

I'll know one day if giving to charitable organization really is good for business as they say. I don't care if it is or isn't because I'm so satisfied with the feeling I have of sending that check. Contributing supports a concept that I wrote about in my book. The concept is that if we really want to create a better birth experience for every woman in this country, we need to start by supporting the organizations that are set up to do this. The more members each organization has, the more powerful they are politically. The more money they have, the more they can reach out and educate those in need. Go join three or four great organizations today. Give beyond what the membership dues are. Encourage others to become members if they don't like what they see with birth today. We can make a big impact quickly just by doing this. Be the change you wish to see in the world.

Sheri Menelli is the author or Journey into Motherhood: Inspirational Stories of Natural Birth, *due out October 2004. <http://www.whiteheartpublishing.com>*

CfM Annual Board & Membership Meetings

By Carolyn Keefe

I had the privilege of hosting the CfM Annual Board Meeting here in Albany, NY, this year (October 1-3, 2004). Unfortunately Paula was called home, and Willa needed to stay with her family. We missed them, and were sad for the trouble that kept them home.

Once we packed my family off on their camping trip, Susan and I were pretty productive. We drafted materials for a strategic framework and for leadership development. We've become much more aware of our need to divide up the work of CfM and bring more people into the process of getting it done. We also drafted a letter to Michael Moore, who is working on a film about health care in the US.

Our Annual Membership meeting was also held in Albany. We discussed what CfM has done over the past year – our accomplishments despite numerous "life" issues for our Board – as well as looking forward to the coming year and to our 10th anniversary in 2006. Maureen Murphy counted ballots and the Board was unanimously re-elected with a final count of 72 votes for Susan Hodges and 70 each for remaining Board members Paula Mandell, Willa Powell, and me.

The officers of the Citizens for Midwifery 2004-2005 Board of Directors are:

President: Susan Hodges
Vice-President: Paula Mandell
Secretary: Carolyn Keefe
Treasurer: Willa Powell

After the "official" meeting was done, we spent time eating and chatting. Tisha Graham and Maureen Murphy of New York Friends of Midwives put together a lovely dinner and social gathering. We came back together after dinner to go over what is happening in the various regions of New York and in the other states that were represented. Attendees came from the Capital Region of New York, Central New York, New York City, New Jersey, and Rhode Island – and, of course, Susan from Georgia.

We've laid some good ground work to grow and build for the future. We can only hope that next year will bring us more help, more prosperity, and happier times for all.

President's Letter

Dear Friends,

I am writing this as holiday cookies are baking, and it will likely be nearly New Year's by the time you receive this "Fall" issue of the *Citizens for Midwifery News*. Once again, I apologize for the lateness of this issue. Out of town trips (midwifery meetings and conferences), on top of my part-time job and my family, have been very challenging this fall.

As you will read (see page 2), the CfM Board realizes we need more midwifery advocates, more of you!, to be more involved with the work of CfM for this organization to continue growing and making an impact for birthing women. We are working on a Strategic Plan, and know already that an important part will be to further develop the Board and have clearly defined volunteer opportunities to make it easy and inviting for more of you to get involved. It will take some time to put the plan into action, and in the mean time, all of the Board members ask your patience. We will do our best to get newsletters out, but some future issues may still be late or combined.

Volunteering

Do you like to surf the Internet? Do you like to write or edit? Do you enjoy calling people up to get information? Could you volunteer even a bit of your time? Even before our Strategic Plan is in place, there are a number of straightforward tasks that you could do to help CfM and be more involved, with the newsletter and with our website. For example, a good website needs regular systematic checking to catch out-of-date information and dead links, and then follow up to obtain new information and current web site addresses. In particular, many of our state pages are either undeveloped or have out-of-date information. For the newsletter, we could use reporters for the state by state section, and we welcome thoughtful articles on birth- and midwifery-relevant topics, as well as reviews of books, articles, useful websites, etc. Many thanks to contributors to this issue: Carolyn Keefe, Sheri Minelli, Karen Wallace, Kathi Mulder, Christa Craven (and anyone else I may have missed).

Please contact me if you are interested in any of these opportunities or have any questions about them.

Citizens for Midwifery at Conferences

In mid-October Carolyn Keefe and I represented CfM at the annual conference of the Midwives Alliance of North America (MANA) in Portland, Oregon. We had a table in the exhibit hall, talked with many people, and distributed CfM literature. In addition, I met briefly with Katherine Camacho Carr, President of the American College of Nurse-Midwives (ACNM), as well as a number of other midwives and leaders.

On Saturday evening Carolyn and I, along with a number of MANA members, attended a banquet held by the International Center for Traditional Childbearing (ICTC), an event that was part of the Third Annual Black Midwives and Healers Conference taking place in Portland the same weekend. In addition to enjoying good food and inspiring entertainment and speakers, this afforded a wonderful opportunity to make new connections and let more people know about Citizens for Midwifery.

Carolyn Keefe at the CfM booth at MANA2004.

At the conference the MANA Board also announced the newly organized Division of Research. The important work of this part of MANA includes coordinating data collection from direct entry midwives for statistics projects, planning research projects and publications, and responding to published scientific papers. Members of the division have been working hard for months on a project to improve the data collection process for midwives, including the creation of an online data entry program for participating midwives that is now in place. Having this improved system (where midwives can enter their own data online) should encourage more midwives to participate as well as cut down the total time and work involved for midwives and researchers.

The weekend following the MANA conference I traveled to New York City as an invited presenter at the Art of Birthing conference put on by the Open Center. The two-day conference explored many dimensions of natural birthing; presenters included Marshall and Phyllis Klaus, Eugene deClercq, Nancy Wainer, Shafia Monroe, Jeanine Parvati Baker, and others. My presentation was about the Economics of Maternity Care; the information was new to many people and was well-received. I was also invited to be part of the panel that was the final session. New York City has many dynamic and dedicated birth advocates. On Saturday evening I spent time with founders of Choices in Childbirth, a new advocacy group in New York City, as well as some Friends of the Birth Center, working to establish a new free-standing birth center.

The American Public Health Association annual convention began first weekend of November. I traveled to Washington DC where I helped with the MANA/MEAC/NARM booth, and presented a poster session. The poster was titled, "Economic Disincentives for Evidence-Based Maternity Care," and it attracted a steady stream of interested people during the two hours it was up. The APHA convention is huge, attracting more than 14,000 people! Most members are health professionals or involved in some way in public health policy or education. Citizens for Midwifery is one of the few consumer-based organizations at this convention.

Participating in conferences and conventions is an important way to gain recognition for the "consumer voice" in maternity care and to build friendships and alliances that will help increase our effectiveness in the future.

May we all have a peaceful and productive year in 2005!

Susan

(VBAC... continued from page 1)

labor, of which only 37 (11% of the transports) were considered emergencies, and about half of the transports still gave birth vaginally. There were six uterine ruptures (0.4%), one hysterectomy, and 15 infants with five-minute Apgar scores less than seven. Seven fetal/neonatal deaths were reported, two of which appear to be unrelated to a prior cesarean, and only two of which occurred for women who had uterine ruptures. Longer stays in the birth center (i.e., longer labors) were not associated with increased incidence of adverse outcomes, and, contrary to widespread medical belief, the frequency of serious outcomes (including uterine rupture) was not significantly related to newborn weights. The data did show that in birth centers, women with more than one prior cesarean section and women with a gestational age of 42 weeks or more were at higher risk for both uterine ruptures and for perinatal death, with half or more of these adverse outcomes occurring for women with at least one of these characteristics. Among the reported 1271 women who were both less than 42 weeks and had had only one cesarean section, there was only one death probably attributable to the cesarean scar, for a perinatal mortality rate of about 0.8/1000.

In the discussion, the authors compared their observations, especially for perinatal mortality, with several hospital VBAC studies that appeared to be selected for some degree of similarity to birth centers in their VBAC management practices and where the latest ACOG guidelines were met (obstetricians and anesthesiologists immediately available). Each hospital study cited had one or more of the following: extensive midwifery program, VBAC policy of no induction, no augmentation and/or no restrictions on gestational age. Neither VBAC success rates nor percent that ended in cesarean sections in these studies were noted, although it is generally established that hospitals have lower success rates for VBACs than was found for birth centers in this study. The authors reported that in every case the perinatal death rate was lower in the hospital studies. However, because no statistical data was provided, we cannot tell from the paper if the perinatal mortality rate in birth center VBACs was statistically significantly different from the various rates reported in the hospital studies; this is an important question for events occurring at very low frequency.

The authors did not address the fact that most hospitals, if they even allow VBACs, have stringent protocols and policies that do not resemble those of the hospitals in the studies. This means that most women would have access only to hospitals that might not have neonatal mortality rates like those cited in this paper. In addition, the authors did not take into account all the other "safety" issues, including the risks and complications that would result from more cesarean sections (see the Maternity Center Association's "What Every Pregnant Woman Should Know about Cesarean Section" <http://www.maternitywise.org/mw/topics/cesarean/booklet.html>, given the lower vaginal birth rate for hospital VBACs and the increasing lack of access to any "trial of labor" at all. Is a hospital that does not allow any VBACs "safer" for mother or baby than a birth center?

Based on the assertion that "out-of-hospital birth is not a safe choice for women with prior cesarean deliveries," the paper "advises" that no VBACs should take place in birth centers. The validity of this advice depends on two other statements being true, although neither is explicitly stated. One is: For babies of mothers with prior cesarean sections, any hospital in the country is safer than any birth center. The data reported in the study clearly do not support this statement, since the perinatal mortality comparison only looked at hospitals with generous VBAC policies, not at "any" hospitals. The second assertion is the value judgement: ANY risk to the fetus or baby is always more important than any risk to the mother. This is neither acknowledged as a value judgement nor supported in any way by the data presented in the paper, nor is it legally valid. Furthermore, focusing only on risks to the baby in essence demotes the mother to a baby-container whose present and future health and well-being, let alone her judgement, are not valued. The serious problems with these two assertions undermine the validity of the paper's conclusion and recommendation.

What is "safe" enough? The paper did not compare the risks purportedly found in this study with other risks frequently taken in maternity care. Looking only at perinatal deaths that are or might be associated with the scarred uterus for all women in the study, data showed five in 1453, or 3/1000, a rate the same as the risk of fetal demise for amniocentesis, a procedure routinely recommended to all women over 35 (eOb.Gyn.News. July 1 2002 • Volume 37 • Number 13). If we leave out the women who had the risk factors of more than 42 weeks and more than one prior cesarean section, we find, in fact, only one death probably attributable to the cesarean scar, for a much lower risk of about 0.8/1000. Many women deciding to undergo amniocentesis are balancing the risk to the fetus with other risks and their own fears. What is different about women who have had a prior cesarean section, especially when they fall into the "lower risk" group reported on in this paper? Should they not be permitted to weigh the risks and benefits of birth center vs. their local hospital options – including access to VBAC and outcomes for women with a prior cesarean section? The paper's recommendation undermines the very idea of "informed consent," since it effectively eliminates the possibility for a mother to weigh the various risks and potential benefits of having a VBAC birth in one setting or the other. Similarly, it removes from women the opportunity for making their own decision based on their values, their circumstances and the care options available to them; the authors of the paper have effectively made the judgement for them.

Given the risk data reported in this paper, the broad advice for "no VBACs in birth centers" begs the question of how much "risk" does it take for "authorities" (birth centers, hospitals) to supercede the mother's rights to bodily integrity and autonomy and to exercise informed consent and refusal? Is it ethical, or health-promoting, for either hospitals or birth centers to essentially condemn most (eventually all) women with prior cesarean sections to major abdominal surgery? ACOG's own Code of Professional Ethics states: "The respect for the right of individual patients to make their own choices about their health care (autonomy) is fundamental." and "Conflicts of interest should be resolved in accordance with the best interest of the patient, respecting a woman's autonomy to make health care decisions." <http://www.acog.org/from_home/acogcode.pdf> If a birth center refuses VBACs (on the basis of this study), and the mother's only other option is scheduled cesarean section in the hospital, what has happened to responsibility? Autonomy? Informed consent? Safety?

The authors do make the point that initial cesarean sections should be avoided and that "Hospitals should increase access to in-hospital care provided by midwife/obstetrician teams during VBACs." However, the authors do not address the reality of today's maternity care world, where, CNMs are "let go" and increasing numbers of hospitals are refusing to "allow" VBACs at all, leaving women without options. Nor do they attempt to balance the possibly slightly increased risks for the

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(VBAC ... continued from previous page)

baby with birth center VBACs with the well documented short- and long-term risks associated with additional cesarean sections that would be performed on women in hospitals that have, at best, a lower success rate for VBACs, and, at worst, a policy of repeat cesarean sections for all women with a uterine scar.

The study overall appears to have been carefully undertaken and the results provide useful information that women with a prior cesarean should know. The stated conclusion and recommendation, however, have the potential to harm mothers and babies by effectively restricting VBACs to hospitals regardless of their protocols, policies or outcomes for mothers and babies.

(Changing Birth Practices ... cont. from page 1)

They also don't have waterbirth. If you do have a cesarean section, they separate you and your baby for over an hour. I'll be writing them about what I didn't like about my birth experience and why I won't be back.

The point is, I want to let all the local hospitals know which policies and procedures I don't like as well as let them know what I want and expect. I won't bother telling them that I'm giving birth at home because they may just dismiss the letter as "We'll never get her business anyway." My goal is to encourage these changes so that the majority of women who do give birth at hospitals will have better experiences and hopefully fewer cesarean sections. We need to start raising the bar in this country. We can influence the mainstream by getting hospitals to start making changes.

What would happen if every midwifery client wrote a letter to the hospital? How much sooner would we start seeing changes? Soon, other women across the country would start expecting more from care providers and hospitals. This means we would once again empower ourselves which is what we should have been doing during the last 100 years!

Sheri Menelli is the author of Journey into Motherhood: Inspirational Stories of Natural Birth, *due out October 2004. <http://www.whiteheartpublishing.com>*

Cesarean Section Rate for 2003 Highest Ever at 27.6%

The National Center for Health Statistics released their report "Births: Preliminary Data for 2003" two days before Thanksgiving, to little fanfare (neither ACOG nor ACNM posted press releases). Among other things, the report shows the highest rate yet for cesarean sections, a dramatic decrease in VBACs, and continued small increases in preterm births and babies born at low birth weight.

The Cesarean section rate for 2003 is reported as 27.6% overall (29.3% for non-Hispanic blacks). Data regarding preterm and low birth weight was also reported: "The percent of babies born preterm (less than 37 weeks of gestation) rose from 12.1 in 2002 to 12.3 in 2003, continuing its steady increase since the mid-1990s." "The percent of babies born at low birth weight (under 2,500 grams) rose from 7.8 percent in 2002 to 7.9 percent in 2003. Low birth weight has gradually increased since the mid-1980s." It should be noted that many low birth weight and pre-term births are preventable, and some are associated with "elective" cesarean sections when gestational age is determined inaccurately, while at least some are attributed to the increase in births to women 40-44 years of age and to the increase in multiple births.

You can find the press release at <http://www.cdc.gov/nchs/pressroom/04facts/birthrates.htm> and a pdf file of the complete report at <http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09.pdf>. "Births: Preliminary Data For 2003" was prepared by CDC's National Center for Health Statistics. The data were based on over 95% of birth records reported to vital statistics offices in all 50 states as part of the National Vital Statistics System.

A separate report of State-specific data can be found at: <http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09tables.pdf>. These tables show that seven states have a Cesarean rate over 30%: FL, KY, LA, MS, NJ, TX, WV. New Jersey had the highest rate at 33.1% among states, but Puerto Rico hit 46%.

The Preliminary Data report usually comes out in June or July; the report for 2003 was unusually late, reportedly due to changes in the birth certificates of some states. The Final Report usually includes additional information, such as place of birth, birth attendant, complications, etc. For example, the Final Data report for 2002, released in mid-December 2003, included: "The proportion of births with induced labor has more than doubled since 1989. More than one in five births was induced in 2001." With the Preliminary Data report delayed by months, we do not yet know when the Final Data report for 2003 will be made available.

The International Cesarean Awareness Network prepared a press release, endorsed by Citizens for Midwifery and several other organizations, which is posted on their website <www.ican-online.org>. The press release notes that the increase in hospital policies to not "allow" VBACs (ICAN has documented more than 300 such hospitals) coincides with this report of an all-time high rate of cesarean sections and decreased VBACs.

CDC Releases US Birth Data for 2003

Total Cesarean Rate: 27.6%
(up 6% from 2002)

Primary Cesarean Rate: 19.1%
(up 6% from 2002)

VBAC Rate: 10.6%
(down 16% from 2002)

ICAN also notes that "In 1970, the U.S. cesarean rate was 5.5 percent. The rising cesarean rate has not resulted in improved outcomes for mothers and babies." Tonya Jamois, President of ICAN, states, "This is more than a women's health issue; it is a civil rights issue with thousands of women denied VBAC and forced into risky major surgery each year under the guise of 'patient safety,'" said Tonya Jamois, ICAN president. "Dwindling support for normal birth has much more to do with concern over lawsuits and liability insurance. Women and babies are caught in the crossfire between doctors, lawyers and insurers."

You can respond to reports of this birth data in your local newspapers, which may appear when the Final Report is published (January or February?). One point that can be made is that these increasing numbers of cesarean sections, and the decreasing opportunities for VBACs, have not resulted in any improvements in outcomes, and fly in the face of research evidence regarding safe and effective birth practices. "Tips for writing letters to the editor" can be found at <http://www.cfmidwifery.org/Citizens/Resources/item.aspx?ID=2>.

State by State

In addition to the reports here, a number of states are at various stages of thinking about or working on legislation aimed at legal recognition of direct entry midwives, specifically of Certified Professional Midwives. Is there news to report from your state? Inspire others by sharing your stories of advocacy and public education!

CALIFORNIA

The California Association of Midwives (CAM) has continued ongoing efforts to improve the situation for licensed midwives in California. Licenses became available in 1996 under the auspices of the Medical Board (MBC), but there have been a number of challenges, some of which relate to statutory language or its interpretation. Ongoing efforts have sought to resolve those challenges.

Perhaps the most notable development was the Licensing Committee of the MBC voting to adopt regulations for LM standards of practice, in November. While not perfect, the regulations do officially acknowledge the Midwives Model of Care as the LM standard of care, recognizing that the standards should be those of midwives, not of doctors – a very important step forward for LMs in California. In the process of getting these regulations adopted, excellent language regarding twins and breeches also was developed and included. However, language that is clearly objectionable involves practice protocols, since the statute calls for only the adoption of Standards. The MBC will have a 45-day comment period which will begin around the end of December, with a formal public hearing at the MBC meeting in mid-February. CAM will be working hard to have the objectionable language removed while getting the "good stuff" passed.

New regulations adopted by the Department of Health Services allow LMs to apply for and receive a Medi-Cal number, but only physicians and clinics can bill for their reimbursement, so many LMs will not be able to get reimbursed. CAM worked hard to avoid this problem, and will continue to work hard to get necessary changes made so all LMs can get Medi-Cal reimbursements directly.

Information provided by Carrie Sparrevohn, President, California Association of Midwives <carrielm@sbcglobal.net>, <http://www.californiamidwives.org/>.

MARYLAND

Rally to Support Women's Birth Choices

Last October Frederick Memorial Hospital (FMH)in Frederick, Maryland, decided to join the list of 300 hospitals nation-wide that now ban vaginal birth after cesarean (VBACs). In response, doula Barbara Stratton (who had a preventable cesarean in 1999) and the Birthing Circle of Frederick organized a rally held on November 9 in support of women's birth choices. The rally was endorsed by a coalition of childbirth-related organizations. In addition to the rally, supporters wrote letters and e-mails to the hospital and signed a petition.

At least 50 women from four states and the District of Columbia rallied despite the cold weather. Many had babies and children with them, and they all carried signs and balloons with slogans such as "Surgeries for Emergencies" and "Choosy Moms Choose VBAC." Speakers at the rally included a birth center midwife, a doula whose client nearly died over the summer from a cesarean, the President of the Association of Nurse Advocates for Childbirth Solutions, Stratton, and the chapter leader of the International Cesarean Awareness Network of Northern Virginia. Chanting, the group marched to the hospital, where the entire hospital Board of Directors was meeting at the time.

This rally achieved considerable media coverage. There were five TV stories, coverage in two local Frederick newspapers and several radio stations. Baltimore Public Radio did a follow up story as well as the *Baltimore City Paper*. Most impressive, the event sparked an article in the *New York Times:* "Repeat Caesareans Becoming Harder to Avoid" Nov. 29, 2004 <http://www.nytimes.com/2004/11/29/health/29birth.html?pagewanted=3&oref=login>.

Following the *New York Times* article, the president of ICAN was invited onto *The Today Show* to debate VBAC bans with the chief of obstetrics from FMH. The two were then asked to write opposing op-ed pieces for the December 12 *New York Daily News*. Several regional newspapers across the US have recently covered the issue as well.

The hospital has claimed that the VBAC ban is in the interest of "patient safety" due to the increased risks of uterine rupture. Protesters pointed out that the risk of uterine rupture is less than one percent. They claim that doctors magnify the potential complications and play down the risks associated with repeat cesarean sections because repeat cesarean sections reduce their liability and increase profit.

According to November newspaper reports, the hospital administration might reconsider the ban, but only if initiated by the physicians. The head of obstetrics has no plans to rescind the ban. Stratton and Robin O'Brien, President of Birthing Circle of Frederick, have made several requests for a meeting with hospital administrators but so far have not received a response. The women are currently investigating possible legal means to force FMH to reverse the policy.

The rally was funded out of pocket by just a few individuals and included a large long distance phone bill for Stratton. Donations have totaled $40 so far. Please consider sending a check of any amount payable to the Birthing Circle of Frederick and mailed to Robin O'Brien, 1193 Codorus St., Frederick, MD 21702.

For more information contact Barbara Stratton, Chapter Leader of ICAN of Baltimore at <WomanCareDoula@comcast.net>.

NORTH CAROLINA

Editor's Note: We apologize that this article was inadvertently omitted from the Spring/Summer issue.

Midwifery advocates around the state have been busy getting the word out about all the wonderful things midwives do for birthing women. In Greenville, Eastern Carolina Childbirth Options hosted a film showing of *Gentle Birth Choices* in the main branch of Greenville Library on May 5, 2004, International Midwives Day. Midwives, mothers and expectant women attended. The event was first publicized by passing out fliers about the event at the local Maternity Fair. The town was

International Midwives Day!

It's not too early to start making plans for May 5!

Find information and ideas for celebrating at the MANA website.

http://www.mana.org/IntMidDay.html!

Family Wisdom in Michigan

by Kathi Mulder, CPM

Midwife supporters of Traverse City, Michigan, will once again host the day long Family Wisdom Conference on the campus of Northwestern Michigan Community College, March 5, 2005. After hosting a Childbirth Choices film night for a few years at the public library, the group decided to expand their horizons. An idea was born to gather together healthcare providers, educators, community resource leaders, and others involved with families in our small town community.

The 2004 event drew 180 attendees for an incredible day of networking, sharing of ideas and learning. The day began with a slide presentation set to live music by Kat Burke, a home born, 21-year old local singer-songwriter. People then chose different sessions to attend. Topics included: Midwives Care Home or Hospital, Preparing an Herbal First Aid Kit, Turning Green Alternatives to Common Household Toxins in Cleaning and Healthcare Products, Newborn Options, Healthy Foods for Fussy Toddlers, A Chiropractic Approach to Family Wellness, Postpartum Depression, Alternatives to Antibiotics, and many more. During each of the three breakout sessions, a workshop was also offered for parents and children to do together such as Yoga for Kids or Music and Movement. In addition, over 25 educational booths lined a large classroom and several door prizes were awarded.

Of course an event such as this requires many hands. A committee of 10 hardworking and dedicated women volunteered their time, each one heading up a specific aspect of the "making it happen." One of the largest hurdles was raising money to cover the expenses of the event. We were just a group of parents who wanted to share what we'd learned about birthing and parenting and to learn more ourselves.

Two women in charge of fundraising planned a pre-conference extravaganza. Dubbed an evening of "Wine, Women & Chocolate," they orchestrated a silent auction. It was held at a fancy New York style apartment, with lavish hor d'vourz, desserts and wine. Women came out in droves to mingle, relax and bid on over 50 great items. It was a lovely mix of older women with purses and young women with babies in slings. All items were donated. We raised over $2500, enough to put on Family Wisdom.

We feel strongly that Family Wisdom should be affordable and available to anyone in our community who wants to attend. Our very successful fundraising event allowed us to keep fees nominal and also offer scholarships to teen and low income families.

If you would like more information about how to make this happen in your community, contact me at <kathi@tcmidwife.com> or (231) 929-3563.

also plastered with our fliers, and invitations were mailed to local midwives. We had a good sized crowd of 20 in attendance. Activities were set up for children. A midwifery professor from East Carolina University attended and encouraged us in our grassroots efforts. The feeling was that these efforts truly make a difference. As Margaret Mead said, "Never doubt that a small group of thoughtful committed citizens can change the world. Indeed, it's the only thing that ever has."

Across-the-state supporters gathered at the North Carolina Zoo in Asheboro to celebrate International Midwives Day. Although it was raining, the dedicated and true-at-heart braved the weather and showed their support for and belief in midwifery. The event was such a success that we are planning to make it an annual event. First on the agenda was a pot luck picnic where families gathered to share a meal and conversation. It was a great time for putting faces with names and getting to know each other. After the meal our new director for North Carolina Friends of Midwifery (NCFOM), Alice Webb, gave a talk about her vision and strategies for our organization. Then it was off to tour the zoo. Before it was all over even the sun peaked out to see what a great time we were having.

Contributed by Victoria Brown <NCFOM@aol.com>.

SOUTH CAROLINA

Midwifery Council Backs Secondary VBAC

On November 10, 2004 the Midwifery Advisory Council (MAC) voted unanimously to recommend classification of secondary vaginal birth after cesarean (VBAC) as low-risk. If state officials agree, then licensed midwives will be allowed to attend pregnant women at home whose previous deliveries were VBAC.

It is unclear how long it will take officials from the Department of Health and Environmental Control (DHEC) to review and respond to the MAC recommendation. The next scheduled bi-annual MAC meeting is May 11, 2005, and is open to the public.

The issue of licensed midwives attending home VBAC deliveries was discussed at length at the Council's May meeting with research supporting VBAC presented. Following the discussion, DHEC officials announced classification of VBAC as high-risk, based on the previously obtained recommendation by a paid obstetrician consultant. South Carolina regulations restrict licensed midwives from attending high-risk women in labor.

Critics of VBAC often cite the risk of uterine rupture as a reason for forcing women who have had a prior cesarean into the operating room. But the risk of rupture with spontaneous labor after a cesarean is 0.5 percent, according to a 2001 study published in the New England Journal of Medicine, significantly lower than the 1.3 percent risk of respiratory distress to infants as a result of scheduled cesareans.

South Carolina has the seventh highest cesarean rate in the nation at 29.7 percent, according to 2003 figures from the Centers for Disease Control. Consumers opposed to the home VBAC ban on licensed midwives are encouraged to mail short letters (less than one page) to DHEC, Attn: Randy Clark, 2600 Bull St., Columbia, SC, 29201.

Information provided by Sally Hebert, Publicity Director, International Cesarean Awareness Network, Inc. (ICAN) <http://www.ican-online.org> and Chapter Leader of ICAN of Charleston <http://health.groups.yahoo.com/group/ICANcharleston> (843) 871-4708. *(ICAN is a nonprofit organization whose mission is to improve maternal-child health by preventing unnecessary cesareans through education, providing support for cesarean recovery and promoting vaginal birth after cesarean.)*

National Association on Childbearing Centers Meeting

Amy Chamberlain of Texans for Midwifery-Austin and her midwife, Mary Barnett, CNM, spoke in September at the National Association on Childbearing Centers on "Mobilizing your clients for advocacy." With a national audience of about 100 midwives, Amy and Mary talked up the work of "consumer" advocacy groups and the resources of Citizens for Midwifery, especially in areas where there are no local groups.

Mary's message to midwives was that "just as midwives have a responsibility to empower their clients in their own pregnancies and birth, we also have the responsibility to empower them as advocates for their own health care and for The Midwives Model of Care."

With awareness and encouragement, consumers become powerful allies in preserving and promoting the best type of maternity care. One hundred midwives left the meeting with CfM's newsletter for their birth center's waiting room, "free issue" postcards for clients to get a free sample of *CfM News*, CfM membership brochures, Midwives Model of Care brochures, and order forms for more of each. Local advocacy groups should do the same with their membership materials!

(States ... continued from previous page)

TEXAS

Sunset Review

The Texas Sunset Commission held its final testimony hearing on November 16-17. The job of the Sunset Commission was to review the authorizing legislation for each of the six licensing boards attached to the Department of Health Services, to assess what changes might be needed to improve regulation. The Texas Midwifery Board is one of those boards. Members of Texans for Midwifery and the Association of Texas Midwives worked hard to make sure that their voices were heard in the process. In October the Sunset Commission published its Preliminary Report. To the relief of midwives and advocates this report was relatively favorable. According to the TfM website: "The umbrella health organization the Sunset Commission recommends is a favorable, non-medical solution for the Texas Midwifery Board, and as it is currently written, it preserves the autonomy that the Midwifery Board currently exercises." TfM had few issues with the preliminary report.

According to TfM the testimony hearing went well. "The key points were agreeing with the placement in the umbrella organization, suggesting a majority of midwives on the Midwifery Board, and change of 'documented' to 'licensed' in wording."

The Sunset process has gone smoothly so far, with little action from the obstetricians. However, Texas midwifery advocates are anticipating that the obstetricians who would like to see the midwives governed under the Medical Board are saving their energy for the legislative session.

Information derived from the Texans for Midwifery website <www.tfmidwifery.org>.

Midwifery Advocates Prepare for Legislative Session

Join us on Monday, January 24, 2005, in Austin to talk with our elected officials about the importance of midwifery care! Texans for Midwifery and the Association of Texas Midwives will join forces to organize a "Visiting Day at the Capitol" for all midwives and consumers. Why?

The board regulating direct-entry midwives is up for renewal by the Texas Legislature in 2005. Although the anticipated bill looks positive for midwifery, a powerful physicians' lobby has publicly declared its opposition to out-of-hospital birth and may lobby for restrictions on midwifery, as it has in the past. Bring your friends and family! For more information, visit <http://www.texansformidwifery.org/austin> or <http://www.texasmidwives.com> or call Emily at (512) 452-2705. For more info about the Sunset Review, go to <http://www.sunset.state.tx.us/79.htm>. Scroll down to "Midwifery Board" and click on "Self-evaluation Report." The staff report is relative too.

Texans for Midwifery also has a private "Alert and Newslist." Visit <http://www.tfmidwifery.org> to join; you will receive updates and Action Alerts throughout the legislative session to mobilize thousands of citizens to call or email their legislators when necessary. Visit tfmidwifery.org to join.

Birth Fair

On November 13, Texans for Midwifery-Austin hosted its first Birth Fair to provide birthing families with information and resources for a healthy pregnancy and birth, breastfeeding, and healthy living. Based on the successful Houston BIRTH Fair, the Austin fair attracted 250 people eager to meet vendors providing information on the Midwives Model of Care, doula care, breastfeeding support, childbirth educators, medicinal herbs, acupuncture, massage, hydrotherapy and water birth, banking breastmilk for premature and sick infants, yoga, cleaning with non-toxic products, and more. The fair also featured live music, a fun raffle, and discussions on water birth, teen parents, nutrition, and more! To help plan the next birth fair, contact Mikisha at (512) 467-2357.

Information provided by Amy Chamberlain, Texans for Midwifery-Austin, <amychamberlain@speedpost.net>.

UTAH

We are trying for the fourth time to get our voluntary licensure bill through the legislature. We have been working with the CNMs in the state to iron out differences so they will not oppose it as they did last year. Of course, the Utah Medical Association will continue to oppose, and there are some DEMs in the state who oppose. We had a great committee meeting in October, and we expect to have a committee vote on November 11, 2004. The legislative session begins in January of 2005, so by the time it is over in March we should know whether we succeeded or if we'll be working on it for another year. We've not had any prosecutions since 2000, which is what started this whole adventure.

Information provided by Suzanne Smith, CPM <midwife@qwest.net>.

Making Our Voices Heard: Highlighting Midwifery in Health Care Policy Debates

by Christa Craven, Ph.D.

Midwives and midwifery advocates found new ways to highlight the importance of the Midwives Model of Care in Virginia this year. In response to a call for nominations for a Governor's Work Group on Rural Obstetrical Care, midwifery groups mobilized to have two midwives appointed to the Rural Work Group, and citizens spoke about the difficulty of accessing midwives throughout the state during a public commentary period.

The Rural Work Group's Interim Report drew attention to the challenges that midwives – both CNMs and DEMs – face as they provide care for families throughout the state. Preliminary recommendations included licensing Certified Professional Midwives and removing physician supervision requirements for Certified Nurse Midwives.

In the Final Report,[1] the Work Group voted to support the initiation of a pilot program for CNMs, including the directive that in medically underserved areas, CNMs would work "collaboratively" with physicians (not under "supervision," as their current regulations stipulate). Unfortunately, after heated debate, the Work Group voted 13-9 against recommending the licensure of CPMs in Virginia. Virginia midwives and their supporters hope that this report, and particularly the publicity gained for both CNMs and DEMs as a result of this study, will be influential in efforts to change state laws and regulations regarding midwives.

I am writing this article for *Citizens for Midwifery News* in hopes that what Virginia midwives and their supporters have learned through becoming involved in health policy debates can be helpful to those supporting midwives in other states. Although the specifics of state-appointed committees will undoubtedly vary, and the outcomes of these studies are always affected by many internal variables, Virginia's Rural Work Group provides an important example of how midwives and citizens can and do contribute to health care policy decisions.

The Purpose of Virginia's Rural Work Group

In March 2004, Virginia Governor Mark Warner signed an Executive Directive directing the Secretary of Health and Human Resources to convene and chair a Rural Obstetrical Services Work Group. This came in response to growing problems with access to obstetric care in rural Virginia. Problems with Medicaid reimbursement, increasing costs for professional liability insurance, and a growing number of uninsured patients have caused several hospitals to close their obstetrical care units during the past year. Several others are facing closure, and many obstetrical providers are refusing to see Medicaid patients or are leaving the Commonwealth for states with more favorable environments.

To address this problem, the Rural Work Group was appointed to review "policies that may serve as an impediment to providing needed care in rural areas of the Commonwealth" and make policy recommendations to remove these impediments. Members include officials in the Virginia General Assembly, physicians (obstetricians, family practitioners, pediatricians, and neonatologists), trial attorneys, representatives from local governments, health plans, health insurance companies, non-profit organizations, academic health centers, and (as I highlight in this article) a Certified Nurse-Midwife (CNM) and a Certified Professional Midwife (CPM).

How Midwives Were Appointed to the Work Group

The Governor appointed two Virginia midwives – Deren Bader, CPM and Juliana van Olphen-Fehr, CNM – to the Rural Work Group. First, both Deren and Juliana sent their own letters to the Secretary of the Rural Work Group outlining their credentials. In addition to practicing as a CPM in Virginia and several other states, Deren has her MPH, and now her PhD in Public Health. Juliana has her PhD in Nursing and Health Sciences and she served on Virginia's Work Group on the Study of Obstetric Access and Certified Nurse-Midwives in 1992. She is also the Coordinator of the Nurse-Midwifery Program at Shenandoah University in Virginia.

In addition, the Commonwealth Midwives Alliance (CMA), asked midwifery-friendly legislators (those who had supported pro-midwifery legislation in previous years) to nominate Deren and Juliana. CMA also encouraged grassroots organizations that support midwives to write follow-up letters to the Secretary in support of these recommendations. Both Deren and Juliana were appointed to the Rural Work Group!

The Initial Report of the Work Group

The Rural Work Group released an Interim Report on July 1, 2004. With regard to midwives, the Work Group reported:

> *Licensure and regulatory requirements limit access to certain types of providers.*
>
> Currently in Virginia, certified nurse midwives may provide obstetrical care to women under the supervision of a physician. CNMs are nationally certified to provide well woman gynecological care as well as prenatal, delivery, and prenatal care in hospital, birthing centers, and home environments. Typically, certified nurse midwives in Virginia provide delivery care in a hospital setting. Certified professional midwives (CPM) are not licensed to provide prenatal, delivery, or postnatal care in Virginia. CPMs are nationally certified with the ability to provide prenatal, delivery, and postnatal services in the home environment. (Page 10 of report.)

How Citizens Became Involved

Midwifery groups and citizens supporting midwifery were excited to see this initial mention of midwives in the report, but were also quick to point out that there was more to say AND that recommendations to fix these problems in access to care were strikingly absent. As the Work Group held town meetings throughout the state to elicit public comments about the report and access to obstetrical care in rural areas, midwives and midwifery advocates offered their own perspectives about the issues that restrict rural (and all) families' access to midwives in Virginia.

In particular, most rural areas of Virginia do not have access to CNMs. Virginia law mandates physician supervision for CNMs, but physicians' risk of vicarious liability creates a strong disincentive, and in most cases prohibits physicians from entering into supervisory agreements with CNMs.

And although legislation to license CPMs has been gaining support in the legislature for the past five years, it has yet to pass. This has left Virginia CPMs in the awkward

(continued on next page ...)

(Making Our Voices Heard ... cont. from page 9)

position of practicing without a license (which, of course, is unavailable to them). In turn, families who desire CPMs to attend homebirths are often unable to find practitioners.

Influencing Health Care Policy Decisions

Midwives and midwifery advocates made their voices heard throughout Virginia on this issue – and Juliana van Olphen-Fehr and Deren Bader in particular deserve the gratitude of midwifery supporters throughout the U.S. for their patient, thoughtful, and persistent support of midwives and the recommendation of midwifery-friendly policies in the face of quite difficult odds. The public testimony of homebirthers, midwives, and representatives of professional midwifery organizations, childbirth education organizations, and groups supporting midwifery also encouraged the Rural Work Group to consider midwifery care as one solution to Virginia's growing problems with access to rural obstetrical care.

Despite the mixed success of midwifery advocates' specific recommendations to the Work Group, the volume and passion of the midwives and citizens at these meetings also gained the attention – and, in some cases, the unexpected support – of physicians, medical officials, and legislators on the committees. Positive press coverage also reinforced women and families' strong desire for midwives:

> Health care planners are going to have to produce better, more creative and more realistic care models of service delivery. The era when the dominant model for prenatal, delivery and postnatal care is an obstetrician working at a physician practice, may be ending. In 2002, for instance, seven percent of women received prenatal care from the local health department, and a certified nurse midwife attended 7 percent of births. Those statistics must evolve. ("OB Shortage Should Sounds Alarm" in *The Virginian-Pilot*, July 15, 2004)
>
> Virginia's regulations for midwives are unclear. In fact, the American College of Nurse-Midwives and the American College of Obstetricians and Gynecologists have jointly called for a collegial relationship, not a supervisory one [between nurse-midwives and physicians]…. Nurse-midwives have a proven track record, they are already in Southwest Virginia, they want to work, and women need maternity care. The logical solution to the maternity-care shortage – certified nurse-midwives. (Karen Winstead, "Let Nurse-Midwives Work in Virginia," a Letter to the Editor in *The Roanoke Times*, July 25, 2004)
>
> Governor Warner's task force demonstrates the need for more maternity options. The consumers of Virginia will continue to push for CPM legislation in the General Assembly. We know that midwives are a benefit to maternity care and should be an option for women. (Dawn Kubik, a Letter to the Editor in *The Roanoke Times*, July 27, 2004)

Several TV stations also ran stories that gave positive coverage to midwifery issues at the public hearings.

How This Strategy Can Be Adapted for Use in Other States

Even though some of this information is state-specific, state-appointed committees to review malpractice insurance issues, efforts to improve maternal and infant outcomes, etc. are forming in many states. Here are some points from Virginia midwives and advocates about becoming involved in health care policy decision-making:

- *Keep in mind that opportunities to highlight midwifery issues may come up in unexpected places.* Although the Governor's Executive Directive for the Rural Work Group in Virginia never mentioned midwives specifically, this turned out to be an important venue for midwives and midwifery advocates to raise concerns about access to midwives throughout the state. Also, keep in mind that even if the recommendations of the state committee don't reflect all of your goals for midwifery, educating legislators, medical officials, and the public are quite admirable goals in and of themselves – and potentially useful in the future!
- *Keep alert for opportunities.* Delegate a person in your state organization to monitor government & news outlets for opportunities. Look on your state government website & add yourself to their mailing list (sometimes you can also find specific mailing lists for agencies, such as the Department of Health). Also search past and present legislation and state studies by using keywords, such as "maternity" or "obstetrics." Have members of your group look for articles in their local newspapers & have a central contact person in your state midwifery organization to alert.
- *Before nominating candidates to serve on state committees, consider the current political climate of your state.* In Virginia, the Governor is a Democrat. Since the Governor was appointing the members of the Rural Work Group, Virginia midwives opted to have Democrats in the legislature write nominations for midwifery-supportive candidates (even though Republicans have historically been the most vocal supporters of pro-midwifery legislation in Virginia).
- *When citizens (and midwives) present at public hearings, it is important to be brief and to the point.* Speakers were allowed between 3-5 minutes of testimony in most cases. Several speakers mentioned that they hadn't prepared commentary beforehand, but wished they had ... Remember that 3-5 minutes is a really short amount of time to make your point(s) and many of us tend to get nervous speaking in front of large groups (especially with lawmakers). Take time to make an outline of your points and practice with a friend (or even with your kids in the car) beforehand.

[1] For more information on Virginia's legislative efforts for midwives see <www.vfom.org> (particularly, "Important Dates in Virginia Midwifery History" in the "Legislation" section, and for a more in-depth historical account, see the updated chapter from my dissertation that appears on the website, "Educated, Eliminated, Criminalized & Rediscovered: A History of Midwives in Virginia").

A big thank you to Leslie Payne for sending out a detailed update on the Final Report before it was made available to the public on the Virginia Department of Health's website. The full report is available by the time you are reading this article in the Fall Citizens for Midwifery News *at <http://vdh.virginia.gov/>.*

A Thanksgiving Dinner to Remember

By Carolyn Keefe

Welcome to our humble establishment. We hope you enjoy sharing your special Thanksgiving Dinner with us. We'll do our best to make your dinner a unique and memorable experience.

Our highly trained professional staff is among the best in business and will work to ensure your comfort, privacy, and safety while dining in our establishment's state of the art facility. The home-like ambience will help you relax, and you'll appreciate the comfort of knowing that the operating room is right down the hall, should the need arise.

Thanksgiving is coming up, and I thought this would be a great opportunity to think about the normality of birth. We often say that birth is a normal physiological process, but it's hard for most people to understand what that means. Comparisons to other normal physiological functions are valuable. Although some others more closely resemble birth, eating will work to illustrate how a normal function can be spoiled by over-zealous attempts to control it.

Of course, birth is a far more profound and rare experience. Also, in both cases, sometimes some people need help – when eating people can choke, have allergic reactions, have digestive disorders, and even need to bypass the whole process. But in both cases, most of the time, our bodies can perform the function more or less as designed.

Let's imagine, then, consuming our Thanksgiving dinner under the same circumstances that most women in the US give birth:

- First, you make the decision to leave home and go out to the "best" restaurant in town with the "best" chefs. This means leaving behind your children and most of your family, but you agree anyway.
- When you make your reservations, you are informed that consuming the meal will very likely be dangerous and difficult, so a surgeon will be supervising in case it becomes necessary to insert a tube.
- The restaurant insists that you arrive before Thanksgiving and get started on the meal early, so as not to miss the holiday.
- You are shown to a small, cold, dark room that smells awful, but is good and sterile. You are encouraged to change into appropriate clothes for eating, though they may be uncomfortable and make you feel self-conscious.
- Before you can sit down to eat, you're hooked up to an IV and wires to monitor your progress with swallowing and digestion, just in case emergency surgery is needed.
- As you eat, various medical personnel hover, looking in your mouth periodically – sometimes in mid-chew – to make sure you're progressing well.
- At the first sign of displeasure or difficulty, you're offered seasonings to mask the flavor and the meal is pureed to make it easier to swallow.
- If you aren't eating quickly enough, the surgeon comes in to give you something to improve your appetite and tells you that the tube will need to be inserted if you don't finish soon.
- When the moment you've been waiting for finally comes, the surgeon performs a procedure to expedite the process.
- When the meal is all over, everyone tells you that are lucky to have finished it alive, with your entire family intact. After all, such unpleasantness is the price we pay for eating safely.
- Even if you are able to complete the meal under these circumstances, any complaints you might have are dismissed as ingratitude. You learn to not discuss it and accept that you will be expected to undergo exactly the same experience for each Thanksgiving dinner.

Of course, birthing women are in a far more heightened state of awareness. They are extremely vulnerable to stimuli, which can have a profound effect on their ability to function well under such circumstances and on their perceptions of the experience later.

If the meal described above seems unpleasant, imagine how difficult giving birth under such circumstances must be. That so many women do it successfully with a minimum of negative effects is remarkable. Then again, many do not. Small wonder.

We hope you have enjoyed sharing this very special meal with us. Please remember us for all your dining needs, and tell your friends and family about your wonderful experience. We look forward to serving you again!

Happy Thanksgiving and Bon Appétit!

Midwives Model of Care™

The Midwives Model of Care is based on the fact that pregnancy and birth are normal life processes. The Midwives Model of Care includes:

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

The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section.

Resources

Review: Bringin' in Da Spirit

By Carolyn Keefe

I have had the privilege of seeing *Bringin' in Da Spirit* by Rhonda L. Haynes twice now, and both times I've found it breath-taking in its grace and scope. Rhonda tells the often-overlooked story of African-American midwives – past and present – with archival footage, interviews, and compelling first-person narratives.

Beginning with the earliest slaves, African-American women brought their practices of healing and birthing to America. At first helping each other to give birth, these wise women passed down their skills and their knowledge to those who would eventually be referred to as "granny" or grand midwives.

Grand midwives caught the vast majority of babies, black and white, born in the South for centuries and brought thousands of spirits across the threshold safely. Though highly skilled and experienced, grand midwives were slowly regulated out of existence during the 20th century, a slow and painful process that these remarkable women quietly fought with pride and ingenuity.

In addition to providing this extraordinary history, *Bringin' in Da Spirit* illustrates current efforts to reclaim that heritage and bring this wisdom back, particularly to African-American women and their families. Showing contemporary African-American midwives and healers working with clients in urban and rural settings, the film illustrates how out-of-hospital birth in particular can benefit all women and their babies. Rhonda also includes footage of the first Black Midwives and Healers Conference in Portland, Oregon in 2002.

At 60 minutes, *Bringin' in Da Spirit* is appropriate for high school or college classes or community forums. The inclusion of some images of medical procedures might not be appropriate for younger children – though mine (ages five and eight) didn't seem to mind (then again, they've seen some of this before). This would also be an excellent program for a public or community television station.

Bringing together exceptional visual images with beautiful music and poignant narration by Phylicia Rashad, *Bringin' in Da Spirit* gives all of us who support midwives and midwifery a wonderful tool to educate our communities and ourselves, as well as a way to come together around this shared goal.

Bringin' in Da Spirit will be available for rental ($75) or purchase ($225). For more information, go to the Third World Newsreel Online Catalog at <http://www.twn.org/record.cgi?recno=453>. (Note: Special rates available for individuals and special groups. See website for details.)

Review: Midwifery Today Website

By Karen E. Wallace

A full service website supporting consumers of birth and parenting, midwives and aspiring midwives can be found at <www.midwiferytoday.com>. This website is chock full of information. For example it has publications, articles, forums, conference information, birth market, and advertising information. It contains publications, community, shop online, and resources about the print magazine *Midwifery Today*. The channels section includes becoming a midwife, international midwifery, homebirth, waterbirth, and information for parents. The center of the home page contains an ever changing array of current articles; during the fall CfM's own Susan Hodges' "Effects of Hospital Economics on Maternity Care" was linked from this page.

Midwifery Today's website – a wealth of information.

Search for archived articles and reviews by topic, title, or author's name.

Find articles by authors such as Michel Odent, Henci Goer, Marsden Wagner, and Robbie Davis-Floyd.

The bottom line is that all CfM members who have access to the internet should click on <www.midwiferytoday.com> and browse the site. This is truly a worthwhile site for all!

Mortality Statistics and U.S. World Ranking

By Susan Hodges

Midwifery advocates often like to cite the relatively poor standing of the United States compared to the rest of the world regarding infant mortality and maternal mortality. Thanks to Steve Cochran for bringing the following resources to our attention.

Infant Mortality

One place to find such information is in the World Fact Book – information published on-line by the CIA. The rank order of countries for infant mortality can be found at: <http://www.cia.gov/cia/publications/factbook/rankorder/2091rank.html>.

According to this list, 40 other countries have better outcomes for infant mortality than the U.S. However, the list includes very small countries, islands and principalities. For example, the Faroe Islands, with a population of 46,662, is on the list, as are the Falkland Islands with a population of only 2,967! In comparison, the United States population is 293,027,571. One more or one less infant death in a country with a small total population can dramatically change the standing, because one infant mortality event is a larger percentage of the whole population compared to countries with a large population. If one leaves out the small islands etc., what remains is primarily "western industrialized" countries, and the U.S. ranks about 30th, with 6.63 infant deaths per 1,000 live births. We should be embarrassed that despite all our wealth and resources, we do not even do as well as Cuba when it comes to infant mortality.

Maternal Mortality

A good resource for maternal mortality is the United Nations Statistics Division - Millennium Indicators at <http://unstats.un.org/unsd/mi/mi_series_results.asp?rowId=553>. If you download the file and open it with Microsoft Excel, you can "select all" and sort the data by Column L (the number of deaths). That will put us on line 29 with 12/100,000 (along with five other nations that we fall behind alphabetically). However, the CDC estimates the actual U.S. number is 2-3 times

greater than reported. (To understand some of the reasons why, read on the CDC website "Pregnancy-Related Mortality Surveillance – United States, 1991-1999" at <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5202a1.htm>). Therefore, if you conservatively multiply by two you get a maternal mortality rate of 24/100,000; the U.S would be tied with Cuba in 52nd place. If our rate was actually 36/100,000 we'd be slightly worse than Chili and Costa Rica which occupy lines 62 and 63. Of course this list also includes many very small countries, so the same considerations mentioned above for infant mortality also apply for maternal mortality, in general a rare event. It is safe to say that the U.S. ranks 30th, at best, for maternal mortality.

It is important to note that infant mortality may be defined differently by different countries, but is expressed as deaths per 1000 live births, in contrast to maternal mortality, a much rarer event, which is expressed as maternal deaths per 100,000 births.

Midwifery Today E-News 6:20
September 29, 2004

Biophysical Profiling and Suspect Diagnoses

Studies have shown a correlation between breastfeeding and significantly lower rates of child abuse and abandonment. When Leningrad Maternity Hospital instituted the Baby-Friendly Hospital Initiative, which supports breastfeeding, abandonment of babies was reduced by one-half. A Costa Rica study followed the progress of 78,000 babies for seven years. For those who had had early mother-infant contact, rooming in, and breastfeeding support, the rate of weaning before six months was reduced by half. The rate of child abandonment was also significantly reduced. A 1995 study found that children of women who did not breastfeed their babies were 38 times more likely to have suffered abuse than were those who had been breastfed.

The above information was posted on the Midwifery Today e-news, September 29, 2004. <www.parentsplace.com>.

Networking Opportunities!

Now midwifery advocates who are at any stage of working on legislation have two great resources! Separate but complementary, e-mail vs. live voices on the phone. Now you can easily network with other people, learn from others' mistakes, share what your state is doing, get help with difficult challenges, and build on what others have found out can work. Either or both, do make use of these resources!

BirthPolicy E-list

The BirthPolicy e-list is a forum for discussing strategies for instituting maternal infant health policy reforms, including passing legislation to license Certified Professional Midwives and raising public awareness of related issues, such as decreasing access to VBAC and Certified Nurse Midwives and the need for better informed choice in healthcare generally. We hope to have childbirth reform activists from all 50 states represented on the list, so please spread the word! People interested in subscribing should send an email to <BirthPolicy-subscribe@yahoogroups.com> and include a brief summary of their specific interests and background.

This e-group was started by Katherine Prown and Steve Cochran, both of whom contributed to the on-line book *From Calling to Courtroom* < http://www.fromcallingtocourtroom.net/>, and both of whom have been active midwifery advocates in Virginia for years. Prown, who has worked with groups in several states on getting balanced media coverage when a midwife is under investigation or on trial, now lives in Wisconsin where she has been working with CPMs for a regulatory bill.

Consider ordering your books online from Amazon.com through the CfM website <www.cfmidwifery.com>.

(Scroll to the bottom of the homepage and look for the Amazon icon.)

Every item you order generates a small donation to CfM!

Legislative Strategy Calls

Is your state working on legislation? Never drafted a bill before? Maybe you are considering legislation? Do you know where to start? Do you have questions on how to proceed? We might have some answers for you.

The Joint Boards of MANA, MEAC, NARM, and CfM invite all midwives and midwifery activists in states considering or pursuing legislation to a conference call. Representatives of the Joint Boards will join a call to discuss midwifery legislative issues with two or three midwives and activists from a state working on legislation. They can discuss current progress (or lack thereof) or any other issues surrounding the development of a bill and/or the process of obtaining support within the midwifery community, the consumer community, and the legislative community. Local midwives will share information about what is happening in their state and receive constructive feedback and new ideas from people who have been involved with midwifery legislation on state and national levels. This will be a good starting point for those considering legislation in the next year or two, or a call could serve as a strategy session for those who have a bill currently in the legislative process.

If midwives and/or midwifery advocates in your state are considering legislation and would like to talk with members of the above boards (and other key people this group feels may be able to provide helpful contributions to the conversation), please call Debbie Pulley, MANA Legislative Chair, at (888) 842-4784. Please be prepared with the names and phone numbers of two or three midwives (or activists) on your legislative committee and several possible dates for the phone call. The legislative calls are usually on Sunday night, but other arrangements may be possible.

Special!

Join CfM for only $20

when you join *Your State Organization* at the same time!

YES, Count me in!

Name _____

Renewals: Please include membership number (6 digit number from mailing label): _____

Street _____

City _____ ***State*** _____ ***Zip*** _____

Home Phone (_____) _____

Office Phone (_____) _____

FAX (_____) _____

E-mail _____

I originally learned about CfM from: _____

I am a (check all that apply):

[ ] concerned citizen [ ] parent

[ ] childbirth educator [ ] doula [ ] midwifery student

[ ] midwife (__CPM __CNM __LM __other)

[ ] other _____

CfM may occasionally make its list of members available to other reputable midwifery-related organizations.

(___ I do not want my name released.)

Special Annual Membership Rate: $20

(Regular: $30)

Additional donation **$_____**

Total amount enclosed **$_____**

Thank you!

Please give this form with your payment to a representative from your state organization!

When you join CfM, your will receive the quarterly *Citizens for Midwifery News*, keeping you informed on midwifery news and developments across the country. Your membership also helps to pay the costs of maintaining our toll-free hotline and supplying information and brochures to the public. Your contribution will be used responsibly for carrying out CfM's mission. A financial report is available on request. CfM is a grassroots, tax-exempt organization meeting IRS requirements under section 501(c)(3), and is composed of volunteers who want to promote the Midwives Model of Care™.

Citizens *for* Midwifery

PO Box 82227, Athens, GA 30608

(888) CfM-4880

info@midwifery.org ▼ *www.cfmidwifery.org*

SAVE MONEY!

When you join CfM *and* your state group at the same time!

CfM now offers a financial break for people who want to be members of both their state midwifery-related group and CfM. If you join or renew your CfM membership at the same time that you join or renew your membership with your state organization (midwifery or midwifery advocacy), your CfM membership will cost you only $20 (instead of $30).

This offer is only good when processed by your state midwifery advocacy group.

How it works:

- **Your state organization should use copies of the Special Membership Form** to the left , which may be personalized with your state organization name at the top and the name and mailing address at "Thank you!" box near the bottom.
- Fill out this form, in addition to whatever forms your organization uses for memberships, and **give these forms and the membership fees to your state organization**.
- **Your state organization must collect the CfM special membership forms and payments.** (Regular CfM membership forms may also be used, but must be labeled with your organization name and submitted by the state organization to take advantage of this special offer.)
- Your organization can collect a separate check for each CfM membership, or write one check to CfM for the collected CfM memberships.
- Your state organization forwards the CfM membership forms with payments to CfM.

CfM brochures are available at no cost (order forms are available).

State organizations may request a personalized digital file of this form by e-mail.

Please contact CfM if you have any questions about this Special Membership Deal!

We want to make it easier for people to belong both to their state organizations and to CfM!

Alphabet Soup Directory

Following is a brief listing of common terms and groups whose focus includes midwives and midwifery care. Time zones are listed, along with the telephone numbers for each organization.

***CfM* Citizens for Midwifery**
P.O. Box 82227, Athens, GA 30608-2227, (888) CfM-4880 (ET) (toll-free), <www.cfmidwifery.org> <info@cfmidwifery.org>

***CIMS* Coalition for Improving Maternity Services**
P.O. Box 2346, Ponte Verde, FL 32004, (888) 282-CIMS (ET) (toll-free), <www.motherfriendly.org> <cimshome@mediaone.net>

***MANA* Midwives Alliance of North America**
375 Rockbridge Rd, Suite 172-313, Lilburn, GA 30047, (888) 923-MANA (CT), <www.mana.org> <info@mana.org>

***MEAC* Midwifery Education Accreditation Council**
220 West Birch, Flagstaff, AZ 86001, (928) 214-0997 (MT), <www.meacschools.org> <info@meacschools.org>

***NARM* North American Registry of Midwives**
PO Box 140508, Anchorage, AK 99514, (888) 84BIRTH (888-842-4784) (CT), <www.narm.org> <info@narm.org>
***CPM* Certified Professional Midwife** (direct entry credential administered by NARM)

***ACNM* American College of Nurse-Midwives**
818 Connecticut Avenue NW, Suite 900, Washington, DC 20006, (202) 728-9860 (ET), <www.midwife.org> <info@acnm.org>
***CNM* Certified Nurse-Midwife** (advanced practice nursing credential administered by ACNM)
***CM* Certified Midwife** ("direct entry" credential administered by ACNM; also used to designate midwives certified through state midwifery organizations in some states)

***DEM* Direct Entry Midwife** (not a credential, designates midwives who came directly to midwifery, not through nursing)

Order *CfM brochures and packets!*

Use this form to order brochures in bulk.
• For a single brochure, please call toll-free or e-mail your request.
• The packets contain tips and "how to" information that you or your organization may find useful.
• You are welcome to reproduce packets for use in your area.

Send to (PLEASE PRINT):
Name _____
Street Address _____
City _____ State & Zip _____
Home Phone _____ Office Phone _____
Fax _____ E-mail address _____
CfM Member? _____ Yes _____ No

CfM brochures and packets are available to you free of charge. However, if you would like to help make CfM's funds go further (printing and postage do cost money), a donation to cover costs is always appreciated!
Contact CfM regarding prices for other quantities.

_____	Packet of 25 CfM brochures (Send SASE for sample copy)	(suggested donation $5)	$ _____
_____	Additional brochures, same order	(our cost $.10 each)	$ _____
_____	25 CfM brochures and 25 "Free Issue" postcards	(suggested donation $6)	$ _____
_____	25 CfM membership fliers (2-color flier – great alternative to brochure)	(suggested donation $3)	$ _____
_____	Organizing Packet, including legislative hearings and presenting testimony (approx 50 pp)	(suggested donation $5)	$ _____
_____	Public Education Packet (approx 25 pp)	(suggested donation $4)	$ _____
_____	Using the Media Packet	(suggested donation $4)	$ _____

FOR SALE:

_____	100 MMofC brochures (or .30 ea + shipping) [ ] English [ ] Spanish	($38 includes postage)	$ _____
_____	*Born In the USA* video ~ Special offer for CfM members only!	($89 ~ free shipping!)	$ _____
_____	*Midwives: A Living Tradition* video (1998, 68:30 min.)(see *CfM News* 4/99)	($30 includes postage)	$ _____
_____	"Liberty & Justice" advocacy buttons	($2 each or 10/$16)	$ _____
_____	Other advocacy buttons (call or e-mail for available selection)	($2 each or 10/$16)	$ _____

_____ **TOTAL ITEMS ORDERED / AMOUNT ENCLOSED** *(Check payable to Citizens for Midwifery)* $ _____

Please mail this form, with your check or money order to: Citizens for Midwifery, PO Box 82227, Athens, GA 30608-2227
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Members, have you moved?
Please let us know of any address corrections!

If your name is not followed by a six-digit number, you are not yet a member, and have received a complimentary issue.
Please join CfM today!

Citizens *for* Midwifery
Learn, Connect and Take Action

Yes!

I want to help promote the Midwives Model of Care.

Please mail this form,
with your check or money order to:
Citizens for Midwifery
PO Box 82227
Athens, GA 30608-2227

Name _____

Street Address _____

City _____ State & Zip _____

Home Phone _____ Office Phone _____

e-mail address _____ Fax _____

I originally learned about CfM from: _____

CfM may occasionally make its list of members available to other midwifery-related organizations. (___ I do NOT want my name released.)

Contact CfM regarding special rate when you join or renew CfM and state midwifery or midwifery advocacy group memberships at the same time.

___ Student	$20	*I am a (check all that apply):*
___ **Suggested**	**$30***	___ Concerned Citizen ___ Parent
___ Supporter	$50*	___ Childbirth Educator ___ Doula
___ Best Friend	$100*	___ Midwifery Student
___ Guardian Angel	$500*	___ Midwife (__ CPM __ CNM __ LM __ DEM)
___ For overseas addresses, add	$10	___ Other (_____)
___ Additional donation	$ _____ *	
TOTAL ENCLOSED	$ _____	

** Your contribution is tax deductible except for your newsletter subscription valued at $20 annually.*

Membership in Citizens for Midwifery: When you join CfM, you will receive the quarterly *CfM News*, keeping you informed on midwifery news and developments across the country. Your membership also helps to pay the costs of maintaining our toll-free hotline and supplying information and brochures to the public. Your contribution will be used responsibly for carrying out CfM's mission. A financial report is available on request. CfM is a grassroots, tax-exempt organization meeting IRS requirements under section 501(c)3, and is composed of volunteers who want to promote the Midwives Model of Care.

How can you help? Join today. Volunteer with CfM. Become informed!
By joining CfM you are helping to make a difference! Thank you for your support.

Getting in touch with CfM: Call: (888) CfM-4880 E-mail: info@cfmidwifery.org Visit our website: www.cfmidwifery.org