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When maternity care, which is run by doctors, is absent or not at its best, higher CS rates are found. Many studies have shown lower intervention rates when midwives attend low risk birth than when doctors are the primary care providers to low risk women. Is it just a coincidence that the U.S., Canada and Brazil, where doctors attend most births and there are few midwives attending births, have the highest CS rates in the world?

Sue Trezona feels having a highly trained gynecologcal surgeon attend a normal birth is similar to having a pediatric surgeon babysit a normal 2 year old child. She believes it would be a waste of the pediatric surgeon's time and skills, and when the young child gets tired and fussy the surgeon might be tempted to use drugs where a properly trained babysitter would soothe the child with a variety of non-medical techniques. This allegorical medicalization of normal childhood is similar to that of normal birth. High cesarean section rates are indeed a symbol of the lack of naturalization of birth.

So far it seems that we have not been smart enough, in developed or developing countries, to take advantages of medicalized birth care while avoiding the disadvantages of its use in excess. Naturalizing birth has the possibility to combine the advantages of Western medicalized birth with the advantages of redirecting the care in a way to honor the biological, social, cultural and spiritual nature of birth.

There are several strategies for naturalizing birth. These strategies will put the woman and the family back in control of the birth of their own child while empowering the woman to believe in herself through experiencing what her own body can accomplish.

The first strategy is education. Those who control the information hold the power. In the past the medical profession often maintained control of medical care through protecting and withholding information. Today there is no excuse for limiting this data. Full information on the good and bad results of medicalized birth must be given to healthcare providers, public health officials, politicians and to the public. In other words, everyone must begin to see the ideas many doctors and hospitals "preach" and realize that in many instances they are not entirely true.

The need to broaden the horizon of doctors concerning maternity care is not a new problem. This statement was found in a medical book published in the year 1657: "Doctors who have never seen a home birth and yet feel competent to argue against it resemble those geographers who give us the description of many countries which they have never seen." It just makes sense for doctors to be required to look at the space in which modern maternity care exists in order to get a proper standard against which they can measure all of their experiences. An anonymous source from the Philippines said every doctor in their country must attend a minimum number of planned home births. Maybe it would be beneficial for us if every obstetric training program for doctors, midwives and nurses required visits of planned out-of-hospital births, including birth centers and home births.

The education of women, especially pregnant women, is most important. But what women are told is quite an issue. From my experience, doctors and nurses who insist on giving only "doctor-friendly" information to pregnant women control prenatal education programs. Also, many anesthesiologists in the U.S. have managed to gain access to prenatal classes where they preach the wonders of epidural block to eliminate pain, and usually say nothing about the considerable risks of this invasive procedure. Some doctors promoting women to choose cesarean sections for which there are no medical indications find it necessary to provide limited, highly selective information.

It is highly unlikely women would ever consider choosing elective CS if they were given full scientific evidence on the risks for themselves and their babies. Maybe the key issue is not the right to choose or demand a major surgical procedure for which there is no medical indication but the right to receive and discuss full, unbiased information prior to any medical or surgical procedure. Sue Trezona speculates, "A liberated woman strives not to be controlled by men, an effort that can be extremely difficult if she lives in a male chauvinist society."

There are many ways in which women giving birth in hospitals in male dominated cultures are oppressed and given the message they are not important and not free but controlled by an often pushy opinionated staff. For example, women are told not to scream or cry and to be quiet labor contractions. If a woman accepts the medicalized, male dominated obstetric model of care with its selected information, she gives up any chance to control her own body and make true choices.

Volumes have been written about how liberating and empowering it is for a woman to give birth when she controls what happens. Without fully informed choices, she will give up any control and conform to the wishes of the doctors and hospitals. Women who demand choice but get only selected "doctor-friendly" information innocently buy into the medical position. According to Sue Trezona few feminists who fight for women's rights have confronted biased doctor-based information "and as a result have unwittingly promoted...obstetric procedures, which are dangerous to them and their babies."

A second strategy for naturalization of birth is promotion of evidence-based maternity care practices. There continues to be a gap between present obstetric practices and the evidence-based care. In many places public health agencies have failed to aggressively pursue closing the gap between obstetric practices and evidence-based practices, often out of fear of the power of the medical establishment.

It has been an interesting and educational experiment for me to go to a hospital labor and delivery unit and share with the staff a simple table displaying their own rates of interventions — such as induction, episiotomy (cutting of perineum), lithotomy, suction and cesarean section on one side, and the evidence-based rates on the other. The resulting discussion is often quite heated but always with at least a few people who are as concerned as I am about the gap between their practices and the evidence.

As we enter the era of post-modern medical care, the old clinical guidelines must be replaced and approved by the community in order for proper progressive practices to evolve.

Another essential strategy in naturalizing birth lies with whom the primary care giver for women during pregnancy and birth should be. Midwifery has a long tradition of placing the birthing woman in the center with all the control in the woman's hands and with the midwife providing the kind of support that will empower the woman and strengthen the family. For this reason, having primary maternity care in the hands of midwives is a huge strategy in naturalization of birth.

It is important to look at the maternity care in other countries that are much further along the road to naturalization than the U.S. such as New Zealand, The Netherlands and the Scandinavian countries. In these countries more than 80% of women see only midwives during pregnancy and birth (in or out of the hospital) and they have some of the lowest maternal and perinatal mortality rates in the world.

Considerable scientific research has demonstrated four major advantages to independent midwifery: midwives are safer for low risk birth, midwives use less unnecessary interventions, midwives are less expensive and they provide more satisfaction.

First, there can no longer be any doubt that midwives are the safest birth attendants for low risk birth. A study published in 1998 on the safety of midwife-attended birth looked at all the births in one year in the U.S., more than 4 million. Selecting only single, vaginal births and removing cases of social or medical risk factors, they compared outcomes between midwife-attended births and physician-attended births. Compared with physician-attended births, midwife-attended births had 19% lower infant mortality rates, 33% lower neonatal mortality, and 31% lower low-birth weight rates.

After his review of the extensive evidence for the safety of midwives in his article "Midwifery in the Industrialized World" in the *Journal Society of Obstetrical Gynecology* (1998) Marsden Wagner concludes, "A search of the scientific literature fails to uncover a single study demonstrating poorer outcomes with midwives than with physicians for low risk women. Evidence shows primary care by midwives to be as safe or safer than care by physicians."

The second advantage of midwives over doctors as primary birth attendants is a drastic reduction in rates of unnecessary interventions. Scientific evidence shows that compared to physician-attended birth, a midwife-attended birth has a significantly less use of the following: IV fluids, IV medications, routing electronic fetal monitoring, use of narcotics, use of anesthesia including epidural block for pain, forceps and vacuum extraction and cesarean section. They also have more vaginal birth after CS.

The third advantage of using midwives as the primary birth attendant is that they cost less. While it varies from country to country, midwives' salaries are almost always considerably less than doctors' salaries. In addition, the lower intervention rates with midwives mean major cost savings. The data on cost savings is reviewed in Marsden Wagner's article "Midwifery in the Industrialized World" in countries where, for example, one study found cost savings of at least $500 U.S. for every case where a midwife is the birth attendant.

Another advantage of midwifery care is the pregnant and birthing woman's satisfaction. The evidence in Wagner's article supports that midwifery is statistically more satisfying to the woman and her family.

Since hospitals are doctor territory and no woman has even been in control of her own care in a hospital setting, another important strategy for naturalization of birth is to move birth out of the hospital.

There have always been and will be women everywhere who choose planned home birth and need a midwife to attend the birth. But today, as a result of years of insincerity about the hazards of birth, there are many women who have bought into the myth that home birth is dangerous. This is often due to the stories told by doctors who are themselves afraid of birth and believe hospital birth is the only safe way and who themselves need the security of hospitals.

For more than 80% of women who have had no serious medical complications during pregnancy, planned home birth is a perfectly safe choice.

Any doctor, hospital or medical organization attempting to discourage a low risk woman from choosing home birth is denying basic human rights by withholding unbiased information and limiting a woman's freedom of choice of birth. The birth of a baby is one of the most important events in the life of the family and when the family chooses a planned home birth, what is best for the family must be honored.

Many in the obstetrical profession support the scare propaganda about how dangerous birth is. Because of this misinformation, women want the freedom to control their own birthing but need the security of some sort of institution. Women today can be in control of giving birth, be empowered by birth, be assisted by a midwife and still feel confortable and protected by an institution if they choose to give birth in a birth center.

The first essential characteristic of a birth center is that it is free standing of any control of a hospital. A hospital that claims to have a birth center is similar to Nabisco claiming to sell "homemade" cookies in a bag at the supermarket. To be a birth center the birthing woman must be in control of everything that happiness to her and her baby. This means the birth center should be staffed by midwives who use protocols (practices) devised by midwives.

The type of care provided in the birth center is quite different from a hospital. In a hospital the doctor is always in absolute control. In the hospital emphasis is on routines while in the birth center it focuses on individuality and informed choice. Hospital protocols are designed with all the possible complications in mind while the birth center protocols focus on normality, screening and observation. In hospitals pain is defined as an evil to be stamped out with drugs while in the birth center it is relieved with scientifically proven non-pharmacological methods such as immersion in water, changing position and moving about, massage, presence of family and continuous presence of the same birth attendant.

In the hospital, inductions are frequent and are often done with the use of powerful drugs. These drugs increase the pain and carry many risks, some of which are not FDA approved for the purpose of induction.In the birth center labor is stimulated with non-pharmacological methods including walking and sexual stimulation such as massage to the nipples to produce oxytocin, a natural hormone that induces labor. In the hospital, staff are not always present and change every eight hours. In the birth center there is continuous presence of one midwife throughout the labor. In the hospital the new baby is commonly taken from the mother for various reasons, such as doing newborn assessments. In the birth center the new baby is never taken from the mother.

The only way to determine whether birth centers are safe is to turn to the scientific evidence. In 1995 an important paper on birth centers was published: "The National Birth Center Study" by J. Rooks (*et al*) in *The New England Journal of Medicine*. The study compared hospital birth and birth in a birth center. The outcomes were in favor of birth centers. The results are as follows:

~99% of the women preferred a birth center to hospital birthing.

~Increased rates of successful breast-feeding.

~99% spontaneous vaginal births compared to 55% in the hospital.

~Less than 4% use of anesthesia compared to 42% in the hospital.

~Less than 1% use of forceps or vacuum extraction compared to 10% in the hospital.

~Less than 5% cesarean section compared to 21% in the hospital.

Looking at these comparisons, clearly the logical question is not if "birth center" birth is safe but if "hospital" birth is safe. Compared to hospital births, home births and births in the birth center are safe, much cheaper, use far less unnecessary interventions and are more satisfying to the woman and family. In other words, out-of-hospital birth is an important strategy in naturalizing birth care.

If the growing trend towards the medicalization of birth is to be stopped and the naturalization of birth is to recommence, then childbirth without fear should become a reality for women, midwives and obstetricians. This is a matter of teamwork, a shared philosophy of care and mutual respect. Women-centered services must be developed. Visits to units or countries with less medicalized approaches should be encouraged for all medical/health students. As well as attending at least one planned home birth. There is a need for straightforward birth with guaranteed continual support throughout labor, low intervention rate, low mother-infant mortality rate and good postnatal and breast-feeding support.

Why, if this is what we see in other countries such as The Netherlands and New Zealand, do we not see this in our own country? We must *trust* birth to *give* birth naturally!

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