EXECUTIVE SUMMARY*

Listening to Mothers II: Report of the Second National U.S. Survey of Women's Childbearing Experiences

Conducted January–February 2006 for Childbirth Connection by Harris Interactive® in partnership with Lamaze International

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ABSTRACT

With permission from Childbirth Connection, the "Executive Summary" for the *Listening to Mothers II* survey is reprinted, here. The landmark *Listening to Mothers I* report, published in 2002, described the first national U.S. survey of women's maternity experiences. It offered an unprecedented opportunity to understand attitudes, feelings, knowledge, use of obstetric practices, outcomes, and other dimensions of the maternity experience. *Listening to Mothers II*, a national survey of U.S. women who gave birth in 2005 that was published in 2006, continues to break new ground. Although continuing to document many core items measured in the first survey, the second survey includes much new content, exploring earlier topics in greater depth, as well as some new and timely topics.

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Childbirth Connection's ongoing *Listening to Mothers*® Initiative is devoted to understanding experiences and perspectives of childbearing women and using this knowledge to improve maternity policy, practice, education, and research. *Listening to Mothers* surveys enable us to compare actual experiences of childbearing women and newborns to mothers' preferences, as well as to evidence-based care, optimal outcomes, and protections granted by law. Identified gaps present opportunities to improve conditions for this large and important population during this crucial period.

The landmark *Listening to Mothers I* report (2002) described the first national United States

Lamaze members can view the entire report of the Listening to Mothers II *survey by logging in to the Lamaze Web site (www.lamaze.org). Others can purchase the full report from the Childbirth Connection Web site (www.childbirthconnection.org), where the Executive Summary of the report is also available to the public.*

survey of women's maternity experiences. It offered an unprecedented opportunity to understand attitudes, feelings, knowledge, use of obstetric practices, outcomes, and other dimensions of the maternity experience. *Listening to Mothers II*, a national survey of U.S. women who gave birth in 2005, continues to break new ground. While continuing to document many core items measured in the first survey, the second survey included much new content, exploring earlier topics in greater depth, as well as some new and timely topics. Most mothers who participated in *Listening to Mothers II* also participated in a follow-up survey that focused on their postpartum experiences. The *Listening to Mothers II* survey report presents results of *Listening to Mothers II* and the few items from the follow-up survey about pregnancy and birth experiences. A future report will focus on postpartum experiences explored in the follow-up survey.

THE SURVEY

The *Listening to Mothers II* survey was developed through collaborative efforts of core teams from Childbirth Connection, Boston University School of Public Health, and Harris Interactive®, with the support of the *Listening to Mothers II* National Advisory Council and in partnership with Lamaze International. Harris Interactive administered the survey.

For *Listening to Mothers II*, 200 mothers were interviewed by telephone, and 1,373 completed an online version of the survey. All 1,573 survey participants had given birth to a single baby (mothers with multiple births were excluded) in a hospital in 2005. The interviews, averaging approximately 30 minutes in length, were conducted in January–February 2006. There were many indications that the mothers were exceptionally engaged in the survey and interested in having their voices heard, including their willingness to take more time answering questions than typical survey respondents and to provide detailed responses to open-ended questions that asked about best and worst aspects of their experiences while giving birth. We made special efforts to ensure a representative national sample through oversampling of mothers who were ethnic minorities in the telephone portion of the survey. To develop a national profile of childbearing women, the data were adjusted with demographic and propensity score weightings using methodology developed and validated by Harris Interactive. The resulting survey population is representative of U.S. mothers aged 18–45 who gave birth to a single infant in a hospital in 2005. The respondents are generally comparable to published national data for U.S. birthing mothers on critical factors such as age, race/ethnicity, parity, birth attendant, and method of birth.

A total of 903 of the original mothers participated in the postpartum survey, either online or by phone, in July–August 2006, and those data were likewise weighted to obtain a nationally representative view of the target population.

PLANNING FOR PREGNANCY AND THE PREGNANCY EXPERIENCE

Survey topics relating to planning for pregnancy and being pregnant were designed to increase understanding of mothers' readiness for pregnancy, their experiences with prenatal care, and various influences on their knowledge, attitudes, and feelings at this time.

Our results identified areas for improvement relating to readiness for pregnancy: more than 4 out of 10 mothers did not intend to be pregnant, either by that time or at all; about half had a body mass index considered to be ''overweight'' or ''obese'' when they became pregnant; and most did not have a visit to plan for a healthy pregnancy.

On the plus side, most mothers learned of their pregnancies in the early weeks of pregnancy, started prenatal care well within the first trimester and when they wanted to, and saw the same provider throughout pregnancy. However, just a small proportion of mothers visited multiple providers before selecting their own or sought a provider or hospital matching their own philosophy. Most obtained care from obstetricians as opposed to family physicians and midwives. Virtually all women had ultrasounds, and most had several. Though most mothers reported that caregivers did not ask about abuse or depression during pregnancy, most were informed during prenatal visits about signs of prematurity and were confident of being able to recognize them.

First-time mothers identified books as their most important source of information about pregnancy and childbirth, and those who had given birth before relied most on their own prior experiences. Far more mothers were exposed to childbirth through TV shows than through childbirth education classes. As they neared the end of pregnancy, most women felt confident and a majority also felt fearful about their upcoming birth.

WOMEN'S EXPERIENCES GIVING BIRTH

In the United States, the great majority of pregnant women are healthy and have good reason to anticipate uncomplicated childbirth, so we wanted to understand who provided care for the women and what their experiences were at this time.

When giving birth, most mothers again received care from obstetricians (79%), with a minority having family physicians or midwives as birth attendants. Most had, as their birth attendant, the person who had been their primary prenatal caregiver, but a large minority had never or only briefly met their birth attendant. Nearly all mothers (96%) reported receiving supportive care (comfort, emotional support, information) for some period while in labor from at least one person, most often husbands/partners or the nursing staff. Mothers generally rated sources of support highly, with doulas receiving more favorable ratings than others.

Despite the primarily healthy population and the fact that birth is not intrinsically pathologic, technology-intensive childbirth care was the norm. Each of the following interventions was experienced by most mothers: continuous electronic fetal monitoring, one or more vaginal exams, intravenous drip, epidural or spinal analgesia, and urinary catheter. Half of the mothers experienced one or more methods of inducing labor (attempted medical and/or self-inductions), and a notable minority experienced each of the following: labor that was induced, synthetic oxytocin (Pitocin) during labor, artificially ruptured membranes during labor, narcotics, cesarean section, episiotomy, perineal stitches, staff-directed pushing, and a staff member pressing on the mother's belly to help push the baby out. The combination of interventions depended to a large degree on whether the birth was vaginal or cesarean.

About 1 mother in 3 (32%) gave birth by major abdominal surgery, evenly divided between first-time and repeat cesareans. Although the media and some health professionals have given much attention to the phenomenon of "maternal request" cesareans, just 1 mother among the 252 survey participants with an initial (primary) cesarean reported having had a planned cesarean at her own request with no medical reason. Similarly, just 1 mother (in a repeat cesarean) reported having a cesarean in the belief that it would help avoid incontinence later in life, despite extensive media and professional focus on cesarean as a purported preventive measure for long-term pelvic floor problems. A small proportion of mothers with a previous cesarean (11%) had a VBAC (vaginal birth after cesarean), though quite a few would have liked to have had the choice but had providers or hospitals unwilling to support their vaginal births.

Small proportions of women experienced numerous forms of care that are especially appropriate for healthy low-risk women, including use of several highly rated drug-free methods of pain relief (e.g., immersion in a tub, shower, use of large "birth ball"), monitoring the baby with handheld devices, drinking fluids or eating during labor, moving about during labor, giving birth in nonsupine positions, and pushing guided only by their own reflexes.

About one-quarter or more of mothers said that they had felt "weak," "overwhelmed," and other negative feelings while giving birth, and about one-fifth or more chose "powerful," "unafraid," and other positive feelings.

Despite the importance of early contact for attachment and breastfeeding, most babies were not in their mothers' arms during the first hour after birth, with a troubling proportion with staff for routine, nonurgent care (39%). For the rest of the hospital stay, most mothers and babies experienced rooming in. Although 61% of the mothers wanted to breastfeed exclusively as they neared the end of their pregnancy, just 51% of all mothers were doing so 1 week after birth, a troubling missed opportunity. Babies of many mothers who intended to breastfeed exclusively were given formula or water "supplements" (38%) and a pacifier (44%), and most of their mothers received formula samples or offers (66%). Over one-third of mothers perceived that the staff was neutral about feeding method or preferred formula. A very tiny minority (2%) experienced all of the care practices that promote normal birth and are endorsed by Lamaze International.

HOME WITH A NEW BABY

Being pregnant, giving birth, and becoming a new parent present challenges to many women. As described in the previous section, most women experience a range of consequential surgical and other interventions while in labor and giving birth. We developed a series of questions to understand how the mothers were doing physically and emotionally in the postpartum period as they recovered from birth experiences, continued to undergo physical changes, and took on new responsibilities.

Nearly all mothers had at least one maternity-care office visit from 3 to 8 weeks after giving birth. Only

a small proportion of providers asked about verbal or physical abuse, while most asked about depression.

Among mothers who had given birth at least 7 months earlier, 27% met the international standard of exclusive breastfeeding for at least 6 months.

Nearly all mothers gave high ratings to the health of their infants, but many indicated that they themselves experienced various new-onset health problems in the first 2 months after birth. Most mothers identified physical exhaustion (62%) and sore nipples/breast tenderness (59%) as problems, and most mothers with cesareans identified pain at their incision site as a problem (79%). Notable minorities experienced numerous other problems. In the first 2 months, several problems were significantly more likely among women who had had cesareans or episiotomies, and urinary problems were more common among women with vaginal births. More so than other conditions, physical exhaustion (25% of all mothers) and pain at the cesarean incision site (18% of cesarean mothers) persisted to 6 months or more. Many mothers, and especially cesarean mothers, reported that pain had interfered with everyday activities in the first 2 months after birth. At the time of the survey, most mothers had a body mass index considered to be ''overweight'' or ''obese,'' with little change in the distribution between 3 and 12 months postpartum.

The Postpartum Depression Screening Scale (PDSS) Short Version, with items measuring symptoms that are common features of postpartum depression, revealed that almost 2 out of 3 mothers (63%) were suffering some degree of depressive symptoms in the 2 weeks before the survey. The most common symptoms were shifting emotions and difficulty sleeping even when the baby was sleeping. About 1 in 5 mothers had consulted a professional with concerns about her mental health since giving birth, and those with higher PDSS scores were more likely to have done so.

MOTHERS' EXPERIENCE WITH EMPLOYMENT AND HEALTH INSURANCE

Many new mothers face challenges in taking time off from employment to care for their babies and themselves and in balancing family responsibilities and employment. We developed a series of questions to better understand the transition of mothers from and to employment or their decision to stay home with the baby. We also asked mothers about maternity leave benefits and sources of payment for their maternity care.

Most mothers who were employed during pregnancy worked at their jobs until very shortly before their due dates. Most survey participants received no financial support at all for maternity leave. Most who did receive paid maternity leave received 8 weeks or less and at least half of their salary. Fully 84% of mothers who had been employed during pregnancy and had returned to paid work had done so within 12 weeks of giving birth. Overall, 36% of mothers had assumed responsibility for paid work by 12 weeks postpartum.

Most mothers who had returned to paid work by the time of the survey reported that they had not been able to stay home with their babies as long as they liked. The most common challenge in their transition to employment was being apart from their babies, followed by making child-care arrangements and breastfeeding issues. Most mothers who were not employed at the time of the survey and had given birth at least 3 months earlier reported that they were not employed because they chose to stay home with their babies.

Private insurance paid for all or some of the maternity care bills for most (60%) mothers. More than 4 in 10 (41%) received Medicaid or similar government benefits for all or some of their care. Over one-third (37%) paid for some maternity care bills out of pocket, and the median expense for those mothers was $1,000. One percent of mothers were responsible for the entire bill.

CHOICE, CONTROL, KNOWLEDGE, AND DECISION-MAKING

In addition to exploring women's experiences over the course of the childbearing period, we wanted to understand their views about the birth process, maternity decision-making, and the care to which they had access.

Despite experiencing high rates of a broad range of interventions while giving birth, half felt that giving birth is a process that should not be interfered with unless medically necessary, while others were divided evenly between feeling uncertain and disagreeing.

Mothers generally gave high ratings to the quality of the United States health care system and even higher ratings to the quality of maternity care in the U.S. Their opinions about the impact of the malpractice environment on maternity care, however, recognized concerns. Large proportions felt that malpractice pressures led to increased charges and unnecessary tests and cesareans, and caused providers to stop offering maternity services. On the other hand, most felt that the malpractice environment caused providers to take better care of their patients.

By law and through ethics statements of leading professional organizations, women are entitled to full informed consent or informed refusal before experiencing any test or treatment. Most mothers stated that they had fully understood that they had a right to full and complete information about any care that was offered and to accept or refuse any offered care. A similar understanding was reflected in their views of a woman's right to choose her mode of birth: Nearly all felt a woman with no previous cesarean should be able to have a vaginal birth if she wanted, and the great majority (85%) supported the right to choose a VBAC (vaginal birth after cesarean); fewer than half, however, supported the right to choose an initial cesarean.

A small proportion of mothers reported experiencing pressure from a health professional to have labor induction (11%), epidural analgesia (7%), and cesarean section (9%). We asked mothers whether they had declined any forms of care for themselves or their babies during their hospital stay. Despite the very broad array of interventions presented and experienced, widespread belief in the value of avoiding unnecessary interference, and a high degree of understanding about the right to informed refusal, just a small proportion (10%) had refused anything during this period. Of concern, the great majority of mothers who had experienced episiotomy (73%) stated that they had not had a choice in this decision.

We asked mothers about knowledge needed about side effects of labor induction, epidural analgesia, and cesarean before deciding to have these interventions. In every case, virtually everyone felt that all (78–81%) or most (17–19%) complications should be disclosed. However, whether mothers had had the specific intervention or not, they were poorly informed about a series of complications of labor induction and cesarean section: most had an incorrect understanding or were not sure.

Finally, we asked mothers whether in a future birth they would be inclined to choose a cesarean for no medical reason if they had the option. Despite their support for a woman's choice and their limited understanding of adverse effects of cesareans, nearly all women who had given birth vaginally would not be inclined to choose a cesarean, while those who had had a cesarean were evenly divided.

LOOKING AT SOME IMPORTANT VARIATIONS IN EXPERIENCE

Women's childbearing experiences can vary considerably depending on their circumstances. It is important to go beyond overall responses to understand the experiences of key subgroups.

For some matters, there are little or no differences between cesarean and vaginal mothers, between experienced and first-time mothers, and across three race/ethnicity groupings. However, we found many areas where experiences varied markedly through the course of the maternity period.

In comparison with first-time mothers with a vaginal birth, those with a cesarean had different personal traits (less confident as they approached labor), care arrangements (less likely to have a midwife), feelings while giving birth (less capable and powerful), and interaction with newborns (less contact in hospital).

In comparison with experienced mothers with a vaginal birth, those with a cesarean had different personal traits (less confident as they approached labor), care arrangements (less likely to have a midwife), birth interventions (less medical induction and epidural analgesia), feelings while giving birth (less capable and powerful, more frightened and overwhelmed), interaction with newborns (less contact in hospital), and infant feeding experiences (less breastfeeding at 1 week).

Comparing first-time and experienced mothers overall, experienced mothers had different childbirth education experiences (less likely to take a class), personal traits (more confident as they approached labor), birth interventions (less likely to use pain medications), attitudes (more likely to support avoiding medically unnecessary intervention), infant feeding experiences (less likely to intend to breastfeed, more likely to achieve goal of breastfeeding).

Comparing the major race/ethnicity groupings of white non-Hispanic, black non-Hispanic, and Hispanic mothers identified notable differences. White non-Hispanic mothers were least likely to have an unplanned birth, have their birth paid for by Medicaid or another government program, report feeling powerful during birth, and support unnecessary intervention in the birth process. They were most likely to experience a medical induction, intend to exclusively breastfeed and be breastfeeding at 1 week, and support the right to choose a VBAC. Black non-Hispanic mothers were least likely to have a midwife or family physician, have met their birth attendant prior to the birth, be married or have a partner at the time of birth, and rate the U.S. maternity care system positively. They were most likely to have a provider discuss prematurity

with them and to have experienced a cesarean. Hispanic mothers were least likely to experience a primary cesarean and support a mother's right to choose a VBAC, while they were most likely to want to know the sex of their baby before it was born, feel capable and overwhelmed, and have the baby in their arms immediately after birth.

CONCLUSION

What happens to childbearing women, infants and families matters deeply. A vast body of evidence is accumulating about lifelong implications for babies of the medical, physical, and social environment during this crucial period. Growing evidence also supports the long-term impact on maternal well-being of conditions at this time—for example, whether mothers have a cesarean or breastfeed. The *Listening to Mothers II* survey results allow us to identify opportunities to improve these conditions by comparing actual experiences of mothers and their infants to their preferred experiences, to care to which they are legally entitled, to care supported by best evidence, and to optimal outcomes. Some survey results indicate that U.S. maternity experiences are generally on track. The predominant picture that emerges from our data, however, is of large segments of this population experiencing clearly inappropriate care that does not reflect the best evidence, as well as other undesirable circumstances and adverse outcomes. It is reasonable to project that concerns involving a majority of mothers impact millions of mothers or babies annually. With 4 million U.S. births annually, a single percentage point represents about 40,000 mothers and babies per year.

Concerns were documented through the entire childbearing cycle, beginning with high levels of unplanned pregnancies, entering pregnancy with excess weight, and low levels of prenatal screening for abuse and depression. Women's typical experiences during labor and birth were especially troubling. Many women did not have the childbirth choices or knowledge they wanted. Support for women's intrinsic capacity for physiologic childbirth appeared to be extremely limited. Large proportions experienced numerous labor and birth interventions that would be of benefit for mothers with specific risk conditions, but are inappropriate as routine measures. These interventions left healthy women immobilized, vulnerable to high levels of surgery, and burdened with health concerns while caring for their newborns. Most mothers did not have paid maternity leave, and many assumed employment responsibilities within weeks of giving birth. Most who had been employed during pregnancy reported being unable to stay home with their babies as long as they liked. Just about 1 in 4 met the international standard for duration of exclusive breastfeeding.

Our survey results identify many opportunities to close gaps between actual and more optimal experiences through policy, practice, education, and research. It is important to implement strategic clinical, public health, payment, and family support policies at national, state, local, and corporate levels. In clinical and health systems practice, there is a critical need to ensure access to safe, effective care that is appropriate for childbearing women and to honor women's legal right to truly informed choice. Education priorities include strengthening all phases of health professionals' education and improving the knowledge and skills of childbearing women. Knowledge of evidence-based maternity care and skills for achieving safe vaginal birth are urgent priorities for education in health professions. Greater transparency about health system options (including performance at provider and hospital levels) and responsible high-quality mass media content can play major roles in helping women make wise choices. We have growing and extensive knowledge about safe and effective maternity practice, so research priorities must focus on filling in gaps and better understanding how to translate our knowledge into practice. With the will and the skill, we can seize these opportunities to enhance the well-being of mothers, babies, and families.

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