International Cesarean Awareness Network

Support. Education. Advocacy.

Clarion

A call to action

November 2026 Issue

Greetings from the ICAN board! As we reflected on our upcoming Cesarean Awareness Month (CAM 2027) theme, *Stitched Together*, we wanted to focus on this idea of connection and communication through the Clarion Newsletter as we seek to further our mission of support, education, and advocacy. Within this re-established quarterly newsletter you can expect to find resources and new research, a celebration of our members and chapters, and ways in which we can advocate for greater options within the birthing community.

To continue your subscription to this newsletter, be sure your membership with ICAN is active by emailing board@ican-online.org.

This month's newsletter includes:

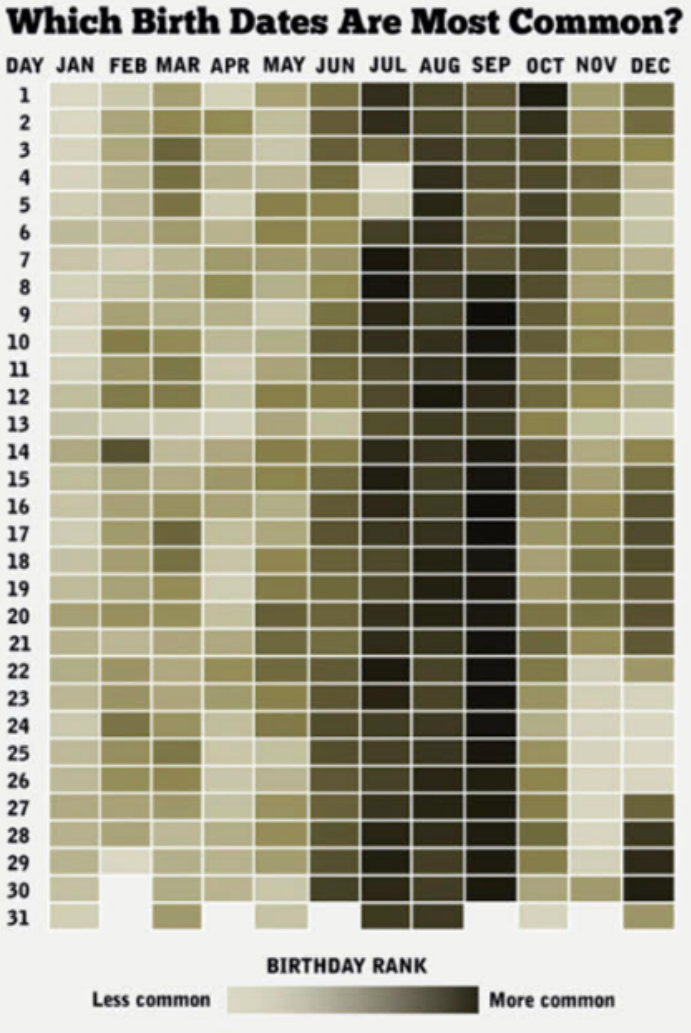
- Inductions, the Holidays, and Limitations of the ARRIVE Trial
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- Giving Day Information
- Thank You to Our Lifetime, Ten Year, and Five Year Members

Inductions, The Holidays, And Limitations of the ARRIVE Trial

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The Holiday Induction Phenomenon

Around this time of year, we are accustomed to seeing holiday decorations coming out, warm pumpkin pie, and cute gingerbread cookies. But along with the glittering lights and yummy treats, comes a less welcome trend in prenatal healthcare: holiday inductions. How many of us have heard, “I’m going on vacation over Thanksgiving, so we had better schedule your induction before then! You wouldn’t want to go into labor without me there!” Some practitioners won’t even be that honest about scheduling; some will just say, “We had better get your induction on the books. You wouldn’t want to go past 39 (40 or 41) weeks!” Data from a study in California show 18% fewer births on holidays and the day after (1). What we see instead is an increase in births during the 11 days before the holiday. Providers’ schedules may influence these holiday birth shifts.



The graphic above was originally created by Matt Stiles for the New York Times and it uses U.S. National Center for Health Statistics data from 1994-2014 to map popularity of birthdays. You don't have to work hard to find the very light blocks near Thanksgiving and Christmas on the graphic above. Notice also that fewer births occur on the July 4th U.S holiday as well. Meanwhile December 28-30th are extremely common birthdays, dropping noticeably lighter for the 31st and then extremely light though the first half of January. How popular is your birthday?

Your Birth, Your Decisions: Informed Consent

While it may be fun to see how "popular" your birthday is compared to the general population, let's consider for a moment what this data means for birth. Underlying this data are more elective inductions (inductions performed without a clear medical indication) occurring at certain times of the year based on holidays and other events. In ACOG Committee Opinion 819, "*Informed Consent and Shared Decision Making*", the organization states that people should be provided with the benefits and risks of each intervention so they can make a fully informed decision, including the right of informed refusal. In reality, there is a spectrum of education practitioners provide around the risks of induction or cesarean and, as a result of differing counsel, induction and cesarean rates vary considerably between practitioners and hospital systems.

Would you want an induction just because your provider is on vacation around your baby's estimated due date? Most providers will not share that their vacation plans are the reason for their recommendation to induce around the holidays; however, they will often point to the ARRIVE trial (A Randomized Trial of Induction Versus Expectant Management) from the New England Journal of Medicine (Grobman et al., 2018) (3) that claimed that 39 week inductions decrease the cesarean rate.

What Did the ARRIVE Study Actually Show?

The ARRIVE study was conducted as researchers wanted to determine if elective inductions reduced complications or stillbirths for babies and the impact of elective inductions on cesarean rates. The researchers designed the study to assign individuals into either an "elective induction group" where patients had their labor induced between 39 weeks 0 days and 39 weeks 4 days, or an "expectant management group" where patients were expected to continue their pregnancy until at least 40 weeks and 5 days, unless there was a medical reason to have an induction earlier.

The ARRIVE trial found:

- Elective induction had no impact on serious newborn complications or death

- Elective induction at 39 weeks led to a lower rate of Cesareans. The Cesarean rate was 18.6% in the elective induction group compared to 22.2% in the expectant management group.

The researchers also concluded other differences resulting from the study related to pregnancy-related blood pressure and time in the hospital in labor as well as postpartum. However, experts have highlighted several issues with the ARRIVE study and therefore caution reliance on the study's results.

What Are the ARRIVE Study's Limitations?

Most eligible people chose not to be in the study. The ARRIVE trial enrolled 6,106 participants, and approximately 72-73% of eligible people declined participation. That raises a reasonable question about whether the participants were representative of the broader population. Further, participants in the study were younger than average; only 4% of people who participated in the trial were 35 years or older, compared to about 19% of birthing people in the U.S. People self-identifying as Black were more likely to consent, and those identifying as Asian less likely to consent than White women. According to Mallett et al. (2020) (7) the people who chose not to be studied cited several reasons for not wanting to participate. Of those who declined participation, 85% stated that they preferred expectant management over being randomly assigned to a group.

Why did so many people decline participation? Some likely reasons are: wanting some semblance of control over their birth outcome, fear of not being able to cope with the pain of induced contractions, and/or not wanting unnecessary medications (amongst a myriad of other possibilities). All of these factors contribute to selection bias in the ARRIVE Trial. The people left in the study may not represent the entire population in physical or psychological readiness or coping skills. In fact, Henci Goer (Goer, n.d.)[4] (read more here and here) pointed out that a larger percentage of the expectant management group developed hypertension or pre-eclampsia than in the general population. Goer came to the conclusion that the sample was not actually low-risk and/or providers justified inductions by using hypertension diagnoses.

The study inductions were handled differently than many regular inductions. Induction protocols in the study required extreme patience that is often not seen in inductions:

- All patients had either sure Last Menstrual Period (LMP) dates and ultrasound before 21 weeks, or if unsure of their LMP, a first trimester ultrasound was required to confirm dating was accurate.

- Induction required cervical ripening if the patient's Bishop score (a tool healthcare providers often use to check if a cervix is "ready" for labor) was less than 5 out of 13.

- Cesarean could not be suggested until 12 hours after cervical ripening, rupture of membranes, AND use of synthetic oxytocin had all been completed.

- There were strict active labor protocols, including that active labor arrest could not be diagnosed until the cervix was 6cm AND four hours of adequate contractions or six hours of pitocin-induced contractions produced no cervical change.

In real-world clinical practice, however, providers vary widely in induction protocols. The overall cesarean rates in both groups were much lower than the average cesarean rate in the U.S. (18% and 22%, respectively, compared to approximately 32% in the U.S. overall). Many experts point out that this could partly be due to the strict induction protocol. Will you have a provider who is as patient as the ones in this study were?

The study focused primarily on physician-led care.

Additionally, Evidence Based Birth has a great signature article: *Evidence on: The ARRIVE Trial and Elective Induction at 39 Weeks*, in which they point out that, "Most study participants received care from a physician versus a midwife, and the midwifery perspective was missing from the study" [6]. Evidence Based Birth also notes the following:

- 94% of participants received care from a physician, while only 6% received care from a midwife. Recent data suggests that as many as 12% of births in the U.S. are now attended by midwives.

- Midwifery-led care has been shown to lower the risk of Cesareans and midwives are experts in normal, spontaneous labor (James-Conterelli and Kennedy 2023; Sandall et al. 2024).

- If midwives had been better represented in the study, Cesarean rates might have been lower in the expectant management group.

- Midwives were not included among study authorship.

The study design left room for unconscious provider bias. Another critique of the ARRIVE trial is that it is not a double-blind trial. Providers knew which patients were there for their elective 39-week inductions and which patients were in the expectant management group. As a result, providers may have exercised performance or management bias in their clinical decision-making, hoping to confirm their hypothesis that 39-week induction would result in better outcomes. Simply knowing their decisions were being monitored could have led to a change in their care. For instance, were these providers more patient with the people in the induction group, and more likely to veer from recommended protocols in the expectant management group during the study period than they would have been in a real-world setting? Many experts critique the ARRIVE trial for these possibilities.

Early induction is so widely accepted in the obstetric community that it was called a "nondebate" topic at the ACOG annual meeting of 2016 by Christopher Glantz. Although the ARRIVE trial demonstrated a lower cesarean rate among its selected study population, questions remain about how consistently those findings translate into everyday clinical practice. Differences in patient populations, provider practices, hospital protocols, and labor-management decisions can influence outcomes.You can read about Dr. Sara Wickham's review of this and see how application of study recommendations to different patients, providers, and settings can change outcomes in real-world populations here. Each person's medical condition during pregnancy and labor is different. Because so much of labor management is also subjective, determining when to induce, when to move on to the next intervention, when the decision is made to proceed from induction to cesarean, or even the minutia of fetal monitoring and when to recommend a cesarean on this basis is all open to provider discretion. Each individual's experience cannot be decided by a study's statistical findings. We must use caution when evaluating our own choices against statistical data.

Individualized Care Starts with You

Perhaps Christopher Glantz said it best, "Counseling all pregnant women that the safest choice for their baby is to be delivered at 39 weeks does not account for women's preferences, inappropriately extends conclusions that are tentative at best to many women, and may

“guilt” large numbers of susceptible women into agreeing to have unnecessary interventions and procedures. Who wants to take risks with one’s baby, even when the actual risks are very small or based on convoluted mathematical models? An individual woman is not a statistical mean, and women should not be coerced into interventions by directive use of modeled statistics.” (Glantz 2017) [5]

If your provider suggests induction this holiday season, we recommend looking at the research for yourself. Don’t just read the conclusions, because the real juicy portions are often glossed over or not even mentioned in that small excerpt, especially when study authors stand to gain from supporting their own conclusions.

Modern obstetrics providers are often governed by hospital policies, which are designed not just to prioritize patient outcomes but also minimize business and facility risk and liability. Individuals and families often find themselves in positions where they have a responsibility to inform themselves in ways beyond what their providers are sharing, and to ultimately make the choice that is best for them and their specific situation.

Looking for Support? Check out ICAN’s offerings

ICAN provides educational information and support, not individualized medical advice. Induction can be an appropriate and empowering birth option when chosen or medically recommended with appropriate counseling and support. While we talk about the drawbacks of elective induction here, we recognize that every pregnancy and birth is different and an induction may be the best choice for one person and not the best choice for another. What matters is that you receive accurate information, understand the benefits and risks of your options, and have the opportunity to make decisions that reflect your individual circumstances and preferences.

ICAN believes that every family deserves respectful, evidence-informed perinatal care and support throughout their birth experience. Whether you are considering induction, preparing for a VBAC, or recovering from a cesarean, you do not have to navigate this alone. Connect with a local chapter, view a replay of our April 2026 Cesarean Awareness Month (CAM) webinar “*All About Informed Consent with Dr. Stu Fischbein*”, or join our monthly National virtual meeting for individualized support and information.

References:

1. Holiday, Just One Day Out of Life: Birth Timing and Postnatal Outcomes (Jacobson et al.) https://www.nber.org/system/files/working_papers/w27326/w27326.pdf

2. ACOG Committee Opinion No. 819: Informed Consent and Shared Decision Making - https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology

3. Grobman, W. A., Rice, M. M., Reddy, U. M., Tita, A. T., Silver, R. M., Mallett, G., Hill, K., Thom, E. A., El-Sayed, Y. Y., Perez-Delboy, A., Rouse, D. J., Saade, G. R., Boggess, K. A., Chauhan, S. P., Iams, J. D., Chien, E. K., Casey, B. M., Gibbs, R. S., Srinivas, S. K., . . . Macones, G. A. (2018). Labor Induction versus Expectant Management in Low-Risk Nulliparous Women. New England Journal of Medicine, 379(6), 513–523. https://doi.org/10.1056/nejmoa1800566

4. Goer, H. (n.d.). Routine 39-Week induction: Busting the ARRIVE Trial - Henci Goer. Henci Goer. https://hencigoer.com/routine-39-week-induction-busting-the-arrive-trial/

5. Glantz, J. C. (2017). Why not induce everyone at 39 weeks? Birth, 44(2), 97–100. https://doi.org/10.1111/birt.12275

Research Corner
New Research on VBA2C

Dr. Rixa Freeze of Breech Without Borders recently co-authored a new study on maternal and neonatal outcomes for women with a history of two cesarean deliveries undergoing Trial Of Labor After Cesarean (TOLAC) vs Elective Repeat Cesarean Section (ERCS). In summary:

- This retrospective cohort study covered the period from 2015 to 2025 in a large teaching hospital in Italy, which has one of the highest cesarean rates in the western world.
- From 2015 to 2020 (Period 1), a new protocol allowed a trial of labour after two previous cesareans (TOLA2C) in selected women.
- Starting in 2021 (Period 2), a revised protocol allowed induction of labour (either mechanical or pharmacological) and epidural pain control.
- The rate of TOLA2C rose from 9% in Period 1 to 23% in Period 2 ($p \leq 0.0001$).

This study compared two protocols for TOLA2C in women requesting a vaginal birth, and showed increased rates for TOLA2C and vaginal birth after two caesarean sections with a more liberal protocol. Results suggest that TOLA2C can be a reasonably safe option and should be offered to families.

At ICAN, we often support individuals seeking to labor after one or more cesareans. We often hear how hard it is to find a provider supportive of vaginal birth after one or more cesareans. ACOG's *Practice bulletin no. 115: Vaginal birth after previous cesarean delivery* states, "it is reasonable to consider women with two previous low-transverse cesarean deliveries to be candidates for TOLAC." This new study helps provide greater assurance to both patients and providers that TOLA2C can be a safe option for those who choose this plan for their delivery after 2 prior cesareans.

Giving Day
December 1st 2026

ICAN is preparing for our annual fundraiser - Giving Tuesday! What is Giving Tuesday? A day for giving thanks. On Tuesday, December 1st, 2026, charities, families, businesses, community centers, and students around the world will come together for one common purpose: to celebrate generosity and to give.

Our goal is to raise funds to expand our community outreach and to offer more resources to our U.S. and International chapters. With a Facebook following of over 62,000 and over 30 chapters in the states alone, if each follower donated just $1, we could raise more than $62,000… if half or our followers donated $5, we could raise over $150,000!

Our volunteers give so much of themselves all year long. Our chapter leaders work diligently to make change one parent at a time. We offer free support meetings throughout the year, countless hours reading through research and responding to social media, phone, or email requests for support. The personal and local advocacy efforts of our chapters help people to access VBAC or family-centered cesarean options where these are limited.

To thank you all for your generosity; we are offering gifts when you donate!



Here are the gifts for donating on Giving Tuesday (GT):

- Gift $5 or more, get an ICAN Sticker
- Gift $50 or more, get an ICAN Sticker + Magnet
- Gift $100 or more, get an ICAN Sticker + Magnet + Tote Bag

Here is the link for donating on Giving Tuesday.

For Those Who Can't Give Right Now
"I don't really have any money to give right now." There are so many more ways to be generous than through a financial donation. While money pays the bills, it is the dedication of our volunteers who give their time and talents to make ICAN a great organization - they make a difference!

- Share your story with us or share how ICAN has helped you, because we are always eager to hear from you. Letting others know about ICAN helps us help more women and families. Send your email to board@ican-online.org
- Share our cause with your friends and family. Ask them to give in your honor.
- Consider helping your local chapter or volunteering for smaller jobs within ICAN!

“Giving is not just about making a donation. It’s about making a difference.” - Kathy Calvin

We want to thank you in advance for your support. TOGETHER, we can make a difference!

Any questions can be directed to board@ican-online.org

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Thank you to our Lifetime Members!

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Thank You to our Ten Year Members!

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Thank You to our Five Year Members!

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