

TRENDS IN MIDWIFERY IN THE UNITED STATES

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Research Proposal

Midwives are becoming more popular in recent years, and a rising percentage of women have been choosing midwives over doctors. Originally midwives were mostly used by minority women, but now more caucasian women are finding midwives to be a natural and preferable way to give birth. Due to this change in trend, midwives are becoming more accepted in society. The intent of this project is to research and define the reasons behind the changing trends of midwifery in the United States. Specifically, if this changing trend has to deal with interventions, such as pitocin or cesarean sections, by doctors to speed up the delivery process. This will be achieved through the review of the literature on midwives and hospital births, as well as viewing documentaries pertaining to home births and hospital births. I hope to find a pattern among my research that will bring to light the reasons for this changing trend in birth.

Annotated Bibliographies

Rochman, B. (2012, June 25). Midwife mania? more u.s. babies than ever are being delivered by midwives. *Time Magazine*, Retrieved from <http://healthland.time.com/2012/06/25/midwife-mania-more-u-s-babies-than-ever-are-delivered-by-midwives/>

Bonnie Rochman describes in her article that midwives are becoming more popular in the United States when it comes to delivering babies. She states that 8.1% of the country's babies in 2009 were delivered by midwives. Rochman suggests that part of the reason for midwives becoming more popular is due to white mothers accepting midwives as a more organic way to deliver. Rochman elaborates by explaining that midwives are less likely to induce labor and have more patience in the delivery process. Instead of using a c-section to speed up the birth, midwives try to comfort the mother and have her try various positions to try to get labor going. Rochman references Declercq's study about midwife use pointing out that in 1990 midwives were mainly used by non-white mothers, but by 2009 the numbers evened out. She also explains that there are regional variations in the numbers of midwife use with higher concentrations in the West Coast and Northeast areas of the United States. She proposes that the reason for midwives not being as embraced in other parts of the country is because of the lack of understanding by expectant mothers of their qualifications. There are three types of midwives each with different background and training, which can have an expectant mother debate whether a midwife or obstetrician is a better choice. This article backs up my theory that midwives are becoming more popular due to the medical interventions used by doctors in hospitals.

Declercq, E. (2012). Trends in midwife-attended births in the united states, 1989-2009.

JOURNAL OF MIDWIFERY & WOMENS HEALTH, 57(4), 321-326. doi: 10.1111/j.

1542-2011.2012.00198.x

Eugene Declercq's study of midwife trends in the United States focuses mostly on certified-nurse midwife (CNM) attended births. Declercq found that the race/ethnicity of mothers attended by CNMs has changed over recent years. In 1990, there was a high number of non-white mothers who were attended by a CNM. In 2009, the numbers evened out and 1 in 9 vaginal births were attended by CNMs in the United States. The state with the highest proportion of CNM attended births is New Mexico with 23.9% of all births in 2009. Declercq points out a regional pattern of CNM attended births; the Northeast and both coasts have higher rates of CNM attended births, and the midwest and deep south, with the exception of Georgia, have the lowest rates. While examining these patterns, Declercq notes that between 1990 and 2009 CNM attended births has increased in every state, except for Alabama, the District of Columbia, and Nevada which had declines. Although Declercq study focuses mostly on CNM attended births, he brings up "other midwives" as well. He states that births attended by "other midwives" in the United States reached a high average of 21,787 in 2009. When combining all midwives in the United States, the total comes out to 335,303 midwife attended births in 2009, making it the highest percentage of midwife attended births since 2002. This journal article supports my paper by providing statistical information portraying the increase of midwife attended births in the United States.

Wiley, A. S., & Allen, J. S. (2013). *Medical anthropology: A biocultural approach*. (2nd ed., pp. 178-185). New York: Oxford University Press.

According to Wiley and Allen, “The birth process for humans is unusual compared to that of other mammals.... and may have given rise to the need for social support during the birth event” (p. 178). They explain that for most four-legged animals, their pelvis is pretty flat and it is easier for them to give birth. Humans, however, are bipedal, meaning they walk on two legs, and in order to support their upright frame the pelvis is bowl-shaped. To add to this, we have larger brains, which means bigger heads, making the birthing process a bit more complicated. This is why babies are born before their brains are fully developed, but it is still a tight fit between the fetus’s head and the pelvic bone during birth. Wiley and Allen reference anthropologist Wenda Trevathan’s argument about a women in labor needing assistance during the birthing process to guide the baby out of the birth canal. They explain that Trevathan suggest this was the reason midwives appeared around five million years ago, to help the mother in delivering the baby along with emotional support during this painful and anxious process. Wiley and Allen continue to explain that hospital births have women laying on their backs strapped to the bed to deliver, which makes giving birth more difficult. This increases the pain and more drugs are administered which in turn makes the delivery process longer. This then leads to more drugs being administered to speed up the delivery process. This section from Wiley and Allen’s book will also strengthen my argument about medical interventions during the birthing process leading to women choosing midwives to have a more natural birth.

Shaw, S. M., & Lee, J. (2012). *Women's voices feminist visions: Classical and contemporary readings*. (5th ed., pp. 292-293). New York: The McGraw-Hill Companies.

Shaw and Lee states, “As the medical profession gained power and status and developed various technologies, women’s traditional authority associated with birthing was eclipsed by an increasing medicalization of birthing” (p. 293). They explain how childbirth is seen less as natural and more of an “irregular” situation that must be administered medically. This includes “invasive forms of treatment” such as pitocin or anesthesia. As hospitals became more popular, women who could afford medical care decided to chose doctors over delivering at home with a midwife. During the time when hospitals were becoming more popular, sanitation was not the greatest and doctors did not know anything about childbirth. As time passed, new medical technologies were invented and women were strapped down to the bed while given drugs and episiotomies, which is an incisions from the vagina to the anus to prevent tearing during child birth. In more recent times, women are not forced to the same drugs as those administered in the early twentieth century and incisions are only made when it is necessary, but healthcare services are still inadequate when it comes to women who cannot afford it, especially women of color. This becomes a problem when unhealthy babies are being born along with complications during the birthing process for the mother. This section of Shaw and Lee’s book will help give a bit of background to my paper about medical practices during the birth process.

Zeidenstein, L. (2007). Midwifery and gender equality. *Journal of Midwifery & Women's Health*, 52(1), 1-2.

According to Zeidenstein, “Midwives have a unique Philosophy of care; we treat each woman as if she is a sister or a peer; not an object” (P. 1). She explains that midwives make women an active participant during their pregnancy and child birth by educating them and letting the mother make her own decisions. There is an emphasis on “listening to women” and being “women-centered”. Zeidenstein also brings up how maternal mortality has not improved even though there has been efforts to decrease the number. Medical interventions during birth do not help women, especially in places where women are not as highly regarded as men. There are about 500,000 women per year, globally, who die during childbirth. Zeidenstein suggests that in order to start improving in the prevention of maternal deaths during child birth, midwives must continue to “listen to women” by educating themselves through peer pelvic examinations. This practice will make sure women are no longer objectified. She describes pelvic examinations in a medical setting as putting women in a vulnerable position that makes them feel objectified and also hesitant to make appointments for pelvic exams during their pregnancy. She hopes to use peer pelvic examinations as a way to educate other future midwives to be sensitive while examining mothers to be during their pregnancy. This article will help me expand on the reasons why midwives are so sought after by pregnant women today.

Vanderbilt, A. , & Wright, M. (2013). Infant mortality: A call to action overcoming health disparities in the united states.*Medical Education Online*, 18, 22503-22502.

Vanderbilt and Wright's (2013) article on infant mortality proclaims that the United States has the highest infant mortality rate, with ethnic and racial disparities. Compared to caucasian infants, African American infants have more than doubled in infant mortality rates. Vanderbilt and Wright indicate that these ethnic and racial health disparities continue to grow, and are different across the United States. They reference Tyler et al. in arguing that the differences across the country is due to under reporting about fetal death, infant and neonatal mortality rates, and racial disparities. Vanderbilt and Wright propose that health disparities should be included in the medical school curriculum, so future doctors have a foundation and an idea of what to expect when it comes to risks in infant mortality when they enter the workforce. This will also help expand my reasons for the changing trend of midwives being more preferred over doctors.

Johantgen, M. , Fountain, L. , Zangaro, G. , Newhouse, R. , Stanik-Hutt, J. , et al. (2012).

Comparison of labor and delivery care provided by certified nurse-midwives and physicians: A systematic review, 1990 to 2008. *Women's Health Issues : Official Publication of the Jacobs Institute of Women's Health*,22(1), e73-e72.

Johantgen et al.'s article is based on a study that compared the outcomes of certified-nurse midwives and physicians care during labor and delivery. In 2006, Facility charges for hospital births in the United States costs about \$86-billion. Hospital births tend to use enhanced medical technology ,drug interventions, and other “invasive procedures” during the delivery process. Also practices that will benefit the mother and baby are not used much, such as vaginal birth after cesarean delivery or fetal auscultation, which is pretty much monitoring the babies heart with the ear itself or stethoscope. Johantgen et al. claim that midwives view birth as natural and use more organic ways to deliver. A review of 11 non-U.S. controlled trials of midwives versus physicians care showed that midwife deliveries had more benefits compared to physicians. Outside the United States, midwives are usually the ones who deliver babies for women who do not have complicated pregnancies. In the United States, doctors are the primary caregivers to pregnant women, with only about 7.9% of births attended by nurse midwives. In their study, Johantgen et al. found that certified-nurse midwives, without using any technological interventions during delivery, were able to achieve similar or even better outcomes than physicians. This showed that care by certified-nurse midwives is more safe and effective, and could lead to better outcomes and maternity care practices. This article provides great quantitative and qualitative information on midwives and physicians to expand my paper.

McDonagh Hull, P. , Bedwell, C. , & Lavender, T. (2011). Why do some women prefer birth by caesarean? an internet survey.*British Journal of Midwifery*,19(11), 708-716.

In this article about caesarean births, McDonagh and colleagues conducted an internet survey asking women about their reasons for wanting a caesarean birth instead of giving birth vaginally. Three of the usual main reasons for caesarean births are fear of pain, the convenience of a planned birth, and fear of ruining the pelvic floor. There were 359 women from 16 different countries who were included in the survey. Overall, these women were afraid of the birth experience, especially of maternal and infant mortality. They felt it was safer to just have a caesarean that was planned than giving birth vaginally, which they felt was unpredictable. These women's opinions came from either their own previous experiences with birth, or experiences of others, leading McDonagh et al. to consider that birth experiences were really important to expectant mothers. Although this study was done in the United Kingdom and involves 16 different countries, I feel this article is important to my research in finding out why midwifery is becoming more popular in the United States. This article will also help give me insight into the reasons why caesarean sections are so popular in the United States, and maybe why they are also leading more women to consider midwives.

Wolf, J. H. (2009). *Deliver me from pain: Anesthesia and birth in america*. Baltimore: The Johns Hopkins University Press.

Jacqueline Wolf's book *Deliver Me from Pain*, describes the medical market of drugs during childbirth. She describes a medical doctor from the 1980s who admits that medical intervention is the norm. The doctor gives an example of the 1940s when caesarean sections needed to be approved by the staff and carefully reviewed, and now vaginal births have to be justified. Wolf suggests that increases in medical interventions is due to the print culture promoting a possible pain free childbirth to women, which then created a competitive market among the medical world. There was more business in providing women gasses, drugs and any other treatments that would lessen the pain of childbirth. This also lead to the decline of home births and the replacement of midwives with medical doctors. Women became more disconnected with the process of their pregnancy and childbirth, relying on doctors to tell them what to do. Early in the 20th c., hospital births only made up 5% of the population, by the mid 20th c. it made up 95%. In the 1990s women began booking their caesarean sections because they were too busy working and managing the household to let nature take it's course. This book gives great insight into how cultural norms can affect the way we view birth. This book will provide great background information on the history of medical interventions.

Boucher, D. , Bennett, C. , McFarlin, B. , & Freeze, R. (2009). Staying home to give birth: Why women in the united states choose home birth. *Journal of Midwifery and Women's Health*, 54(2), 119-126.

This article is based on a study done by Boucher et al. on reasons why women in the United States choose home births. According to Boucher et al. “Approximately 1% of American women give birth at home and face substantial obstacles when they make this choice” (p. 119). They conducted an online survey asking 160 American women why they chose a home birth. The participants of the survey were mostly college educated at 61%, married at 91% and white at 87%. The most common reasons for home births given were safety, avoiding medical interventions deemed as unnecessary, and previous negative hospital experiences. Women felt safe and comfortable in their own home environment. Also they felt they had more control over the birthing process as well as trusting their own bodies without any interference from doctors. Unfortunately, planned home births are not supported in the United States by the government, professional organizations, insurance companies and society itself. Only 23 states allow certified midwives to attend home births, and licenses for home births are limited. This article points out that most of the people in the survey were white, educated, and married women. Some of these women had full-time jobs, indicating that most of these women in the survey were not using midwives for lack of finances for a doctor.

Outline

- I. A brief history of midwifery in the United States.
 - A. During colonial times, midwives delivered babies from their own homes.
 - 1. They brought the skills of delivering babies from England.
 - 2. They passed the skills from one woman to another.
 - 3. African-American midwives delivered babies for both black and white women in the south and were referred to as “Granny Midwives.”
 - 4. Native American tribes had their own midwife traditions.
 - B. In early America, midwifery laws varied locally.
 - 1. There were not many doctors who were willing to attend the births of poor women, so outlawing midwives was not possible.
 - 2. In most states, midwives practiced without government intervention until the 1920s.
 - a) In the early 1900s doctors, mostly in eastern and southern America, went on a very effective smear campaign against midwives.
 - b) Doctors portrayed midwives as ignorant, dirty, illiterate, and from the “old country”.
 - c) Hospitals were seen as clean and safer to give birth.
- II. A brief history of medical interventions.

III. Medicine in the U.S. did not become truly professionalized until the second half of the nineteenth century.

1. In the early 1900s, midwives only attended about half of the births in the U.S.
 - a) In 1900, ninety-five percent of births in the U.S. took place at home.
 - b) In 1930, only half of all births took place at home.
 2. The other half were attended by medical doctors.
 - a) By 1955, less than one percent of births took place at home.
- B. The option of a painless childbirth made hospital births more popular in the U.S.
1. Ether and chloroform were used as a way to alleviate pain during labor in the late 1840s.
 - a) Social births use to be popular during the 1800s.
 - (1) Women attended each others births and helped each other during the labor process.
 - (2) As doctors replaced midwives, social births became less popular.
 - b) “In the absence of social birth, women searched for other comforts” (Wolf, 2009).
 - (1) Women became more conservative in their conversations about childbirth and reproduction.

- (2) “Reluctance to discuss reproduction crossed class and racial lines...” (Wolf, 2009).
 - (3) Women’s fear of birth intensified when it came to doctors taking over childbirth and delivery.
 - (a) “With so many women uninformed about even the most fundamental aspects of reproduction, deprived of the support and companionship of cohorts during birth, and prevented from observing other women giving birth, birth became shrouded in mystery,” (Wolf, 2009).
2. Twilight sleep, or Dammerschlaf, was invented in Germany in the early 1900s.
- a) “...the prospect of painless childbirth had become a topic of conversation in upper-class American social circles...” (Wolf, 2009).
 - b) Only privileged women had access to this treatment.
 - c) Twilight sleep just erased the memory of the harsh labor from the mother’s mind.
 - d) Twilight sleep lasted a little more than a year.
 - e) “With the advent of twilight sleep, not only indigent and single women but also for the first time upper-and middle-class

- f) women had compelling reason to give birth in the hospital” (Wolf, 2009).
- g) The 1920s was a turning point for hospital births.

IV. Midwifery and hospital births today in the U.S.

- A. In 2009, one percent of births in the U.S. were at home and eight percent of births were attended by midwives.
 - 1. Midwives attended over seventy percent of births in Europe and Japan in 2008.
 - a) Reasons why women in other countries choose home birth was due to fewer interventions, able to be more in control, more freedom to move around, and more comfort in the own home.
 - 2. In 1990, most midwife deliveries in the U.S. were to non-white mothers.
 - 3. In 2009, the percentage of midwife deliveries in the U.S. to non-white mothers and white mothers evened out.
 - a) In 2009, New Mexico had the highest proportion of midwife attended births at a little over twenty-three percent.
 - (1) In the 2010 Census, Non-Hispanic whites represented about forty-one percent of the population of New Mexico.
 - (2) In the 2012 Census, they represented about forty percent.
 - b) Vermont was the second highest state with midwife attended births in 2009 at about nineteen percent.

c) Vermont has a smaller population base and it is a smaller state.

(1) Their Non-Hispanic white population in the 2012 census was at ninety-four percent.

d) Maine was third with about eighteen percent, New Hampshire fourth with about seventeen percent, and Oregon fifth with about sixteen percent.

(1) These states have a high white population.

(2) The percentage of their population that is white is between seventy-eight to ninety-five percent.

4. Women in the United States who have chosen to be attended by midwives agreed “that they desire a natural birth experience without medical interventions, and that they wish to feel that they are in control of their birth” (Boucher et al., 2009).

B. The U.S. has the second worst infant death rate and one of the highest maternal mortality rates in the developed world.

1. More than two woman a day die of pregnancy related causes in the U.S.

2. There has been a twenty-five percent increase between 1998 and 2005 in women nearly dying because of severe complications during childbirth.

C. Childbirth has been highly medicalized.

- D. “Hospitalization related to pregnancy and childbirth costs some US\$86 billion a year; the highest hospitalization costs of any area of medicine” (Amnesty International, 2010).
1. Hospitals use medical interventions to speed up the delivery process to get hospital beds empty and filled quickly.
 2. A cascade of interventions usually comes into play in hospital births.
 - a) Pitocin makes contractions longer and stronger and closer together.
 - b) An epidural is then given because the pain is much worse from the contractions caused by pitocin.
 - (1) This makes labor slow down, so more Pitocin is used.
 - (2) The baby is then suffering due to the harsh contractions caused by the pitocin and goes into distress which then leads to an emergency caesarean section.
 3. Lying down is not the most logical position to give birth.
 - a) Humans are bipedal, and the pelvis has a unique bowl shape to support the upper body.
 - b) Humans also have larger brains, which makes the birth process a bit more difficult.
 - c) There is a tighter fit between the baby’s head and the pelvic bone.

- d) Laying on your back makes the pelvis smaller and more difficult for women to use their stomach muscles to push.
 - e) It is also more likely for a women to get an episiotomy, vacuum extraction, or forceps used to help deliver the baby, if she is on her back.
4. Since 1996, the caesarean rate in the U.S. has risen to forty-six percent.
- a) In 2005, it was one out of every three births.
 - b) Caesareans are more doctor friendly.
 - c) “The cesarean rate decreased from 2009 for non-Hispanic white women (32.8 percent in 2009), but increased for Hispanic women (31.6 percent in 2009). The rates were essentially unchanged from 2009 to 2010 for non-Hispanic black women,” (CDC, 2012).

V. Conclusion

- A. There is a rising number of midwife attended births, especially in the white population.
 - 1. “Affluent people contribute to what is trendy in birth” (Business of Being Born, 2008).
- B. The medicalization of birth and cascade of interventions has led women to seek out midwives.

- C. “Midwives are more patient” (Declercq referenced by Rochman, 2012).
- D. Women feel that having a midwife gives them more control over their pregnancy.

Abstract

Midwives have become more popular in recent years, and a rising percentage of women have been choosing midwives over doctors. Originally midwives were mostly used by minority women, but now more caucasian women are finding midwives to be a natural and preferable way to give birth. Due to this change in trend, midwives are becoming more accepted in society. This paper examines and defines the reasons behind the changing trends of midwifery in the United States. Specifically, if this changing trend has to deal with interventions, such as pitocin or cesarean sections, by doctors to speed up the delivery process. In 1900, ninety-five percent of births took place at home, in 1930 only half of births took place at home, and by 1955 less than one percent of births took place at home (Lake & Epstein, 2008). Now the trend seems to be changing, in 2009 eight percent of midwives attended births (MacDorman et al., 2012). In 1990, there was a high number of minority women that were attended by certified nurse midwives. In 2009, the numbers changed and evened out suggesting that more white women were using midwives (Declercq, 2012). From reviewing the literature and documentaries on midwifery and hospital births, there is a pattern shown throughout history that portrays social class, status, and ethnicity determining what is popular in birth.

Introduction

During colonial times in the United States, midwives delivered babies in the home and were widely used by everyone. These skills of midwifery were brought over from European countries and passed on to the next generation (Rooks, 2014). In the 1800s, “social births” were popular, women would gather at the expectant mother’s home while she delivered her baby at the hands of a midwife (Wolf, 2009). In the late 1800s/early 1900s, doctors realized delivering babies can become a lucrative business and began an effective smear campaign against midwives. They portrayed midwives as ignorant, dirty, and illiterate women from the “old country”, while at the same time portraying hospital births as safe and clean (Lake & Epstein, 2008). What really made hospital births popular was the introduction of medical interventions, which promoted pain free child birth. In the early days of medical interventions, only the rich, and usually white, women of society could afford it. Pain-free child birth was new and wanted by every expectant mother, making medical interventions a normal part of childbirth (Wolf, 2009). What added to the popularity of medical interventions was the women’s rights movement during the early 1900s. During this time, women grew up with the story that pain from childbirth was the curse of Eve, because of Eve’s sin from the Garden of Eden women had to suffer during childbirth. Feminist during that time period saw medical interventions as a statement of the modern women no longer having to suffer. By 1955 less than one percent of births took place at home (Lake & Epstein, 2008). Today midwives are becoming more popular again, and a rising percentage of women have been choosing midwives over doctors, especially caucasian women. In 1990, there were more midwife attended births to minority mothers compared to white mothers. In 2009, the numbers balanced out indicating a rise in midwife attended births to white

mothers (Declercq, 2012). It is believed that the new popularity of the midwife is due to the acceptance of midwives by white mothers who no longer see medical interventions as a need, and prefer a more natural way of giving birth (Rochman, 2012). This paper explores the reasons behind the resurgence of midwives in the United States through taking a closer look at the history of midwifery and hospital births. As well as reviewing the present literature on child birth, and comparing historical and contemporary data to find a pattern that will explain the rising use of midwives today.

A Brief History of Midwifery in the United States

The Navajo of the southwestern United States secure a rope or woven sash on a log used as a pole that is brought into their home. They also can secure a rope or sash from the rafters on the ceiling if there are no logs available. The floor was usually made of dirt and the attendant or husband will dig out a shallow hole so sand from the stream bed may be put in. The sand is then covered with comfortable padding made of sheepskin and clean cloth and sheets. The husband or attendee then stands behind the pregnant mother and holds her tightly against them with their hands held tightly together under her breast and over her pregnant belly. During intense contractions, the pregnant mother pulls tightly on the rope or sash while the husband or attendant tightens their hold on her. By the attendant or husband holding her and the pregnant mother pulling on the rope or sash, the woman giving birth is able to hold an upright supported position during her labor (Begay, 2009).

Midwives were widely used during the colonial era in the United States. They delivered babies from their own homes and passed the skills down from woman to woman. In the southern states, before the civil war, West African midwives, who were brought over to America as slaves, delivered babies for both black and white women. After emancipation, African-American midwives were referred to as “Granny Midwives”, and continued to help deliver babies for both black and white women in poor rural areas in the south. Native-Americans had their own practices of midwifery within their respective tribes. (Rooks, 2014).

In early America, midwifery laws varied locally, compared to Europe where midwifery laws were national. There were not many doctors who were willing to attend the births of poor women, so outlawing midwives was not possible. Also, with few midwifery

schools available, laws that required an education in order practice was not plausible. In most states, midwives practiced without government intervention until the 1920s. When medicine became a profession in the mid to late 1800s, there was competition among midwives and doctors (Rooks, 2014). “With the rise of medical obstetrics at the turn of the twentieth century, efforts to improve maternal and child healthcare brought childbirth practices-particularly those of poor women and African Americans-under increasing public scrutiny” (Craven & Glatzel, 2010, p. 336). In the early 1900s, doctors, mostly in eastern and southern America, went on a very effective smear campaign against midwives. Doctors portrayed midwives as ignorant, dirty, illiterate, and from the “old country” (Lake & Epstein, 2008). There were training programs that were required by both the federal and local directives for midwives. They also must obtain a license and registration in order to keep practicing midwifery. This was used to drive midwives out of practice, and at the same time discredit elderly midwives in African American communities. Medical officials preferred younger midwives who were more compliant with the new federal and local mandates. Midwives had to learn to be careful with what they shared with doctors about their practices, such as using herbs or other childbirth practices that were restricted among the professional medical community. Midwives started carrying two bags with them, one was for their actual use and the other was just for “show” among doctors and other medical professionals. Unfortunately midwives, especially African-American midwives, during this time of change did not have much political influence. White midwives were able to at least get their foot in some doors for political change, but African-American midwives unfortunately expected doors to be shut in their face before they can even get their foot in (Craven & Glatzel, 2010).

Hospitals were seen as clean and safer to give birth, even though at the time obstetricians were more dangerous than midwives at giving birth. Doctors graduating from medical school did not witness a live birth before they set out to practice. Obstetricians started burgeoning in society and business took over as the concept of normal changed (Lake & Epstein, 2008).

A Brief History of Medical Interventions

Medicine in the United States did not become truly professionalized until the second half of the nineteenth century. In the early 1900s, midwives only attended about half of the births in the United States. In 1900, ninety-five percent of births in the United States took place at home. In 1930, only half of all births took place at home, the other half were attended by medical doctors. By 1955, less than one percent of births took place at home (Lake & Epstein, 2008).

The option of a painless childbirth made hospital births more popular in the United States. Ether and chloroform were used as a way to alleviate pain during labor in the late 1840s. The first woman recorded to use this type of medical intervention was Fanny Appleton Longfellow from Cambridge, Massachusetts. When her husband, Henry Wadsworth Longfellow, went out to seek more information from doctors, they denied his request to administer the substance to his wife. The doctors reasoning for denying Longfellow's request was that it was inessential and risky. In the end it was a dentist by the name of Nathan Cooley Keep who agreed to administer the drug and reported a successful delivery (Wolf, 2009). Fanny Appleton Longfellow was reported to have said that she was, "proud to be the pioneer to less suffering for poor weak womankind" (as cited by Wolf, 2009, p.13).

During the mid 1800s, women of middle and upper-class societies were seen as weak and unhealthy. Medical drugs, such as chloroform and ether, were administered during labour and childbirth to relieve these "weak and unhealthy" women from the pain they probably could not handle while giving birth (Wolf, 2009). In 1886, a medical doctor by the name of Turner described that there were two types of pelvic shapes, the anthropoid and the platypelloid. Turner explains that non-European women usually have an anthropoid (Figure 1) pelvis which allows

them to give birth easily since the anthropoid pelvis is the one most suited for childbirth.

Turner's reasoning was that non-European women had pelvic shapes that were "degraded or animalized arrangement as seen in the lower races" (as cited by Stone, 2009, p.43). According to Turner, the Platypelloid (Figure 2), which was considered to be a more flattened pelvis, "was characteristic of the more civilized and advanced races of mankind" (as cited by Stone, 2009, p. 43). For this reason, Turner claims that this type of pelvis is seen in more white women and is the reason why white women have a more difficult time giving birth (Stone, 2009).

Another reason contributing to middle and upper-class women's frailty had to deal with the fact that during the Victorian era, proper women were delicate and did not work. In order to present themselves this way women during this time ate very little to keep their figures small. This cause malnutrition among the women of the Victoria era along with fainting spells due to lack of nutrients. The use of corsets also did not help matters much. Corsets were used to keep women's figures small and also shrink the size of a woman's pregnant belly since pregnancy was a sign of sex during an era where matters such as sexual reproduction was not openly discussed. Working and lower-class women were also not free of the moral codes of the Victorian era. Although they might not strictly follow the codes, they still cared about society's judgement and also wore corsets to hide pregnancy because it could mean losing one's job. These social practices cause women of these times to have a harder time at birth since not only were they malnourished, but also their skeletal structure was changed through the use of corsets. These women, especially middle and upper-class women, had flattened pelvises as a result making birth more difficult (Stone, 2009).

The rapid urbanization in Northern America during the late 1800s, was thought to have contributed to women not being able to handle the nature of birth since city life was unnatural. Along with the connection of rapid urbanization and intense childbirth, the fear of dying during childbirth was great due to high numbers of maternal mortality rates at the time. This anxiety of painful and deadly childbirth thought to have contributed to the dropped fertility rates in the 1800s from 7.04 children to 3.56. This drop in fertility rates is also thought to have instigated the need for medical interventions such as ether and chloroform. Those who could not afford the use of ether or chloroform to have a painless childbirth, stuck to the old tradition of “social births” (Wolf, 2009).

During the 1800s, women attended each others births and helped each other during the labor process, usually under the guidance of a midwife. These “social births” were ways for women not only to help the pregnant mother deliver her baby safely, but also as a way to socialize with other women. As doctors replaced midwives, social births became less popular. Some scholars claimed that male medical physicians changed the ambience of the birthing room, and contributed to women’s increase of unbearable labor pain. The birth experience then became more of a formal medical practice that produced more anxiety among the pregnant mother (Wolf, 2009). “In the absence of social birth, women searched for other comforts” (Wolf, 2009, p.19).

Women became more conservative in their conversations about childbirth and reproduction. The growing number of physician attended births contributed to the mystery of birth. Mothers became more reluctant to discuss reproduction and childbirth with their daughters (Wolf, 2009). During the Victorian era, medicine was at the center of care and reflected status.

This era was marked by propriety, and male physicians had to objectify the female reproductive system as a tool that produces offspring in order to be able to work without the feeling of immorality. The objectification of the female reproductive system promoted the medicalization of birth in which there was only one norm and anything outside the defined norm was considered deviant (Stone, 2009). Childbirth is seen less as natural and more of an “irregular” situation that must be administered medically (Shaw & Lee, 2012). This then provided more fuel to the fire of fear of childbirth since many were ignorant about the process of giving birth. Women had to rely on outside sources in order to find information about childbirth and reproduction. Usually middle and upper class women sought their information from magazines that were not the greatest source of reference. This ignorance of birth and reproduction were not only among the middle and upper-class white women, but also “crossed class and racial lines.” It was known that daughters of slaves did not know much about conception and birth even after they were married (Wolf, 2009). As hospitals became more popular, women who could afford medical care decided to choose doctors over delivering at home with a midwife (Shaw & Lee, 2012).

Twilight sleep, or Dammerschalf, was invented in Germany in the early 1900s. “... the prospect of painless childbirth had become a topic of conversation on upper-class American social circles...” (Wolf, 2009, p.44). Only privileged women had access to this treatment, and had the money to travel to Germany to receive Dammerschalf when the drug was becoming more popular and more public. Magazines and newspapers advocated twilight sleep as good for the mother and baby, insisting that the drug produced “better babies.” The public media promoted the drug as one used by the modern Gibson Girl, and that mothers were seen getting up from

their beds only twenty-four hours after giving birth. “Natural mothers”, as they were called, took ten days to get out of bed and are barely able to walk when they do (Wolf, 2009).

Twilight sleep did not necessarily take the pain away from the women in labor, but just erased the memory of the harsh labor from the mother’s mind. There were also some nasty side effects from the drug that included a slow pulse, decreased respiration, reddened face, dilated pupils, dry throat, restlessness, and delirium. Some women had to be tied down or wear something similar to a straight jacket (Figure 3&4) to keep them from running off or scratching and attacking the nurses and doctors. The pregnant mothers were also blindfolded and kept in canvas cages, which were medical beds with screens placed around them and a canvas cover that was tied to the tops of the screens that surrounded the bed (Wolf, 2009).

It was thought that the semiconsciousness of the women on Dammerschalf was extraordinary because it prevented mental trauma from the pain of mothers’ child birthing experiences. Of course they were talking about mothers who were considered more “civilized” and usually from the upperclass who could not handle childbirth unless they had attentive medical care. In the early 1900s, theories about the difficulty of child birth still revolved around class and ethnicity (Wolf, 2009). A man by the name of Bernhard Kronig theorized that “...the mental preoccupations of sophisticated, modern women impeded their ability to submit to labor; their lack of abandon, in turn, exacerbated labor pain” (Wolf, 2009, p.49).

The twilight sleep movement ended after a little more than a year with the death of Francis Carmody in 1915. Carmody died in childbirth in a New York hospital only a year and three months after all the publicity about the miracle of twilight sleep began. Carmody was a widely known advocate for twilight sleep and so her death brought about an intense focus around

the drug and its side effects, ending the fascination with the drug. Although the movement and public promotion of twilight sleep ended, the drug was still used well into the 1960s. (Wolf, 2009). “With the advent of twilight sleep, not only indigent and single women but also for the first time upper-middle-class women had compelling reason to give birth in the hospital” (Wolf, 2009, p.47).

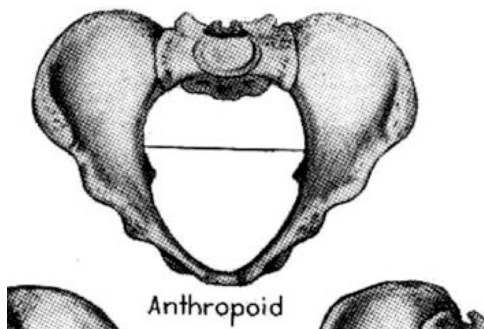


Figure 1. Example of an anthropoid pelvis which Turner considered to be only seen among non-European women. (Stone, 2009, p.44).

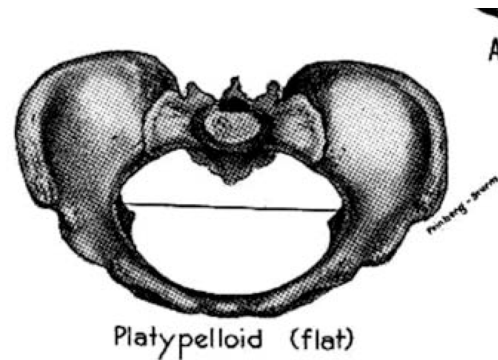


Figure 2. Example of a platypelloid, or flat, pelvis which Turner claims is seen among “civilized” white women, making birth more difficult. (Stone, 2009, p.44).



Figure 3. An example of a patient being blindfolded and put into a gown with a continuous sleeve. (Wolf, 2009, p.52).



Figure 4. Patient's hands are then tied back with the continuous sleeve. (Wolf, 2009, p.52).

Midwifery and Hospital Births Today in the United States

In 2009, one percent of births in the United States were at home, and eight percent of births were attended by midwives (MacDorman et al., 2012. Figure 5). Midwives attended over seventy percent of births in Europe and Japan in 2008. Reasons why women in other countries choose home birth was due to fewer interventions, more control, more freedom to move around, and more comfort in their own home (Lake & Epstein, 2008).

Eugene Declercq's (2012) study of midwife trends in the United States focuses mostly on certified-nurse midwife (CNM) attended births. Declercq (2012) found that the race/ethnicity of mothers attended by CNMs has changed over recent years (Figure 6). In 1990, there was a high number of non-white mothers who were attended by a CNM. In 2009, the numbers evened out and 1 in 9 vaginal births were attended by CNMs in the United States. The state with the highest proportion of CNM attended births is New Mexico with a little over twenty-three percent of all births in 2009 (Declercq, 2012). In the 2010 census, non-hispanic whites represented about forty-one percent of the population in New Mexico. In the 2012 census, they represented about forty percent (Centers for Disease Control and Prevention [CDC], 2014). Declercq (2012) points out a regional pattern of CNM attended births; the Northeast and both coasts have higher rates of CNM attended births, and the midwest and deep south, with the exception of Georgia, have the lowest rates. Vermont was the second highest state with midwife attended births in 2009 at about nineteen percent. Although, Vermont has a smaller population base and it is a smaller state. Their non-hispanic white population in the 2012 census was at ninety-four percent (CDC, 2014). Maine was the third highest with about eighteen percent, New Hampshire is fourth with about seventeen percent, and Oregon fifth with about sixteen percent (Declercq, 2012). These states

have a high white population, with the percentage between seventy-eight to ninety-five percent among the three states. Maine and New Hampshire fall in the ninety percentile and Oregon falls towards the lower eighty percentile (CDC, 2014).

While examining these patterns, Declercq (2012) notes that between 1990 and 2009 CNM attended births has increased in every state, except for Alabama, the District of Columbia, and Nevada which had declines. Although Declercq's (2012) study focuses mostly on CNM attended births, he brings up "other midwives" as well. He states that births attended by "other midwives" in the United States reached a high average of 21,787 in 2009. When combining all midwives in the United States, the total comes out to 335,303 midwife attended births in 2009, making it the highest percentage of midwife attended births since 2002 (Declercq, 2012).

A study done by Boucher et al. (2009) on reasons why women in the United States choose home births shows that, "...they desire a natural birth experience without medical interventions, and that they wish to feel that they are in control of their birth" (p.125). Boucher et al. (2009) conducted an online survey asking 160 American women why they chose a home birth. The participants of the survey were mostly college educated at sixty-one percent, married at ninety-one percent, and white at eighty-seven percent. The most common reasons for home births given were safety, avoiding medical interventions deemed as unnecessary, and previous negative hospital experiences. Women felt safe and comfortable in their own home environment. Also they felt they had more control over the birthing process as well as trusting their own bodies without any interference from doctors. Unfortunately, planned home births are not supported in the United States by the government, professional organizations, insurance companies and society itself. Only 23 states allow certified midwives to attend home births, and

licenses for home births are limited (Boucher et al., 2009). Some of these women had full-time jobs, indicating that most of these women in the survey were not using midwives for lack of finances for a doctor.

The United States has the second worst infant death rate and one of the highest maternal mortality rates in the developed world (Lake & Epstein, 2008). More than two women a day die of pregnancy related causes in the United States. There has been a twenty-five percent increase between 1998 and 2005 in women nearly dying because of severe complications during childbirth. Just between 2004 and 2005 alone, 68,433 women were near death during childbirth, and 1.7 million women each year experience some type of complication in birth. In the United States, there are five main causes of maternal death: Embolism, hemorrhage, pre-eclampsia and eclampsia, infection, and cardiomyopathy. Embolism is at the top with twenty percent. Embolism happens when there is a blood clot that blocks a vital blood vessel. Hemorrhaging, or severe blood loss, is second at seventeen percent. Pre-eclampsia and eclampsia is third at sixteen percent, and are disorders that are related to extremely high blood pressure. Any kind of infection is fourth at thirteen percent. Fifth is cardiomyopathy at eight percent, which is a heart disease (Amnesty International, 2010).

Vanderbilt and Wright's (2013) article on infant mortality proclaims that the United States has the highest infant mortality rate, with ethnic and racial disparities. Compared to caucasian infants, African American infants have more than doubled in infant mortality rates. Vanderbilt and Wright (2013) indicate that these ethnic and racial health disparities continue to grow, and are different across the United States. They argue that the differences across the country is due to under reporting about fetal death, infant and neonatal mortality rates, and racial disparities.

Vanderbilt and Wright (2013) propose that health disparities should be included in the medical school curriculum, so future doctors have a foundation and an idea of what to expect when it comes to risks in infant mortality when they enter the workforce.

Childbirth has been highly medicalized, “Hospitalization related to pregnancy and childbirth costs some US \$86 billion a year; the highest hospitalization costs of any area of medicine” (Amnesty International, 2010, p.1). Hospitals use medical interventions to speed up the delivery process to get hospital beds empty and filled quickly. A cascade of interventions usually comes into play among hospital births. First the pregnant mother is given pitocin which makes the contractions longer and stronger and closer together. An epidural is then given because the pain is much worse from the contractions caused by pitocin. The epidural then slows down the labor and so more pitocin is used. The baby is then suffering due to the harsh contractions caused by the pitocin, and goes into distress, which then leads to an emergency caesarean section. Hospitals only handle one kind of birth, and it is a fight not to get put through that system. Media portray women giving birth as scary and painful, so women expect to have traumatic experiences during the birthing process. It does not help that doctors do this sort of power play where they make the pregnant mother feel like they should listen to them because they are the experts (Lake & Epstein, 2008).

In hospitals, the pregnant mother is usually lying down, which is not the greatest position to give birth. Lying down makes the pelvis smaller and more difficult for women to use their stomach muscles to push. Also, it is more likely that an episiotomy will be performed. An episiotomy is when a surgical cut is made at the opening of the vagina to make it easier for the

baby to come out during birth. If not an episiotomy, then a vacuum or forceps may be used as well to aid in a difficult birth (Lake & Epstein, 2008).

According to Wiley and Allen “The birth process for humans is unusual compared to that of other mammals.... and may have given rise to the need for social support during the birth event” (2013, p.178). They explain that for most four-legged animals, their pelvis is pretty flat and it is easier for them to give birth. Humans, however, are bipedal, meaning they walk on two legs, and in order to support their upright frame the pelvis is bowl-shaped. To add to this, we have larger brains, which means bigger heads, making the birthing process a bit more complicated. This is why babies are born before their brains are fully developed, but it is still a tight fit between the fetus’s head and the pelvic bone during birth. Wiley and Allen (2013) reference anthropologist Wenda Trevathan’s argument about a women in labor needing assistance during the birthing process to guide the baby out of the birth canal. They explain that Trevathan suggest this was the reason midwives appeared around five million years ago, to help the mother in delivering the baby along with emotional support during this painful and anxious process.

Since 1996, the caesarean rate in the United States has risen to forty-six percent. In 2005, it was one out of every three births (Lake & Epstein, 2008). In 2009, the total caesarean rate in the United States reached and all time high of about thirty-three percent. There seem to be a decrease of caesarean rates of more than five percent among women who were thirty-eight weeks, but an increase of four percent for those who were thirty-nine weeks (Osterman et al., 2013). McDonagh and colleagues (2011) conducted an internet survey asking women about their reasons for wanting a caesarean birth instead of giving birth vaginally. Three of the usual main

reasons for caesarean births are fear of pain, the convenience of a planned birth, and fear of ruining the pelvic floor. There were 359 women from 16 different countries who were included in the survey. Overall, these women were afraid of the birth experience, especially of maternal and infant mortality. They felt it was safer to just have a caesarean that was planned than giving birth vaginally, which they felt was unpredictable. These women's opinions came from either their own previous experiences with birth, or experiences of others, leading McDonagh et al. (2011) to consider that birth experiences were really important to expectant mothers. Although this study was done in the United Kingdom, it gives some insight into the reasons why caesarean sections are so popular in the United States, and maybe why they are also leading more women to consider midwives.

Bonnie Rochman (2012) describes in her article, "Midwife Mania?", that midwives are becoming more popular in the United States when it comes to delivering babies. Rochman (2012) suggests that part of the reason for midwives becoming more popular is due to white mothers accepting midwives as a more organic way to deliver. Rochman (2012) elaborates by explaining that midwives are less likely to induce labor and have more patience in the delivery process. Instead of using a c-section to speed up the birth, midwives try to comfort the mother and have her try various positions to try to get labor going. She proposes that the reason for midwives not being as embraced in other parts of the country is because of the lack of understanding by expectant mothers of their qualifications. There are three types of midwives each with different background and training, which can have an expectant mother debate whether a midwife or obstetrician is a better choice.

According to certified nurse midwife Laura Zeidenstein, “Midwives have a unique Philosophy of care; we treat each woman as if she is a sister or a peer; not an object” (2007, P.1). She explains that midwives make women an active participant during their pregnancy and child birth by educating them and letting the mother make her own decisions. There is an emphasis on “listening to women” and being “women-centered”. Zeidenstein (2007) also brings up how maternal mortality has not improved even though there has been efforts to decrease the number. Medical interventions during birth do not help women, especially in places where women are not as highly regarded as men. There are about 500,000 women per year, globally, who die during childbirth. Zeidenstein (2007) suggests that in order to start improving in the prevention of maternal deaths during child birth, midwives must continue to “listen to women” by educating themselves through peer pelvic examinations. This practice will make sure women are no longer objectified. She describes pelvic examinations in a medical setting as putting women in a vulnerable position that makes them feel objectified and also hesitant to make appointments for pelvic exams during their pregnancy. She hopes to use peer pelvic examinations as a way to educate other future midwives to be sensitive while examining mothers to be during their pregnancy.

Johantgen et al.’s (2012) article is based on a study that compared the outcomes of certified-nurse midwives and physicians care during labor and delivery. Hospital births tend to use enhanced medical technology, drug interventions, and other “invasive procedures” during the delivery process. Also practices that will benefit the mother and baby are not used much, such as vaginal birth after cesarean delivery or fetal auscultation, which is pretty much monitoring the babies heart with the ear itself or stethoscope. Johantgen et al. (2012) claim that midwives view

birth as natural and use more organic ways to deliver. A review of eleven non-U.S. controlled trials of midwives versus physicians care showed that midwife deliveries had more benefits compared to physicians. Outside the United States, midwives are usually the ones who deliver babies for women who do not have complicated pregnancies. In the United States, doctors are the primary caregivers to pregnant women, with only about eight percent of births attended by nurse midwives. In their study, Johantgen et al. (2012) found that certified-nurse midwives, without using any technological interventions during delivery, were able to achieve similar or even better outcomes than physicians. This showed that care by certified-nurse midwives is more safe and effective, and could lead to better outcomes and maternity care practices.

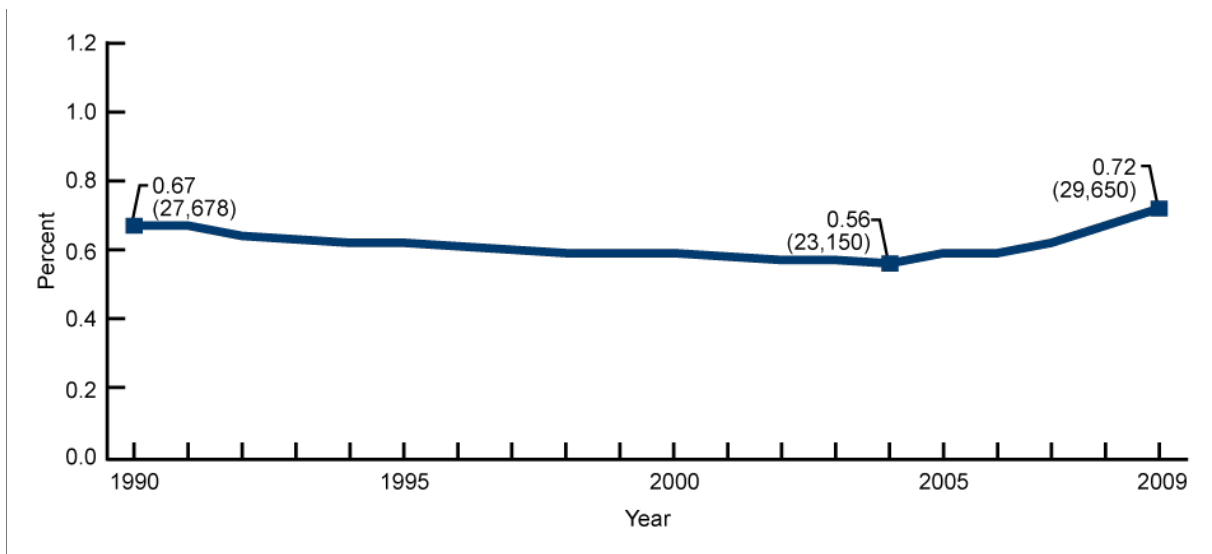


Figure 5. This graph shows the percentage of home births in the United States between 1990-2009. (MacDorman, 2012).

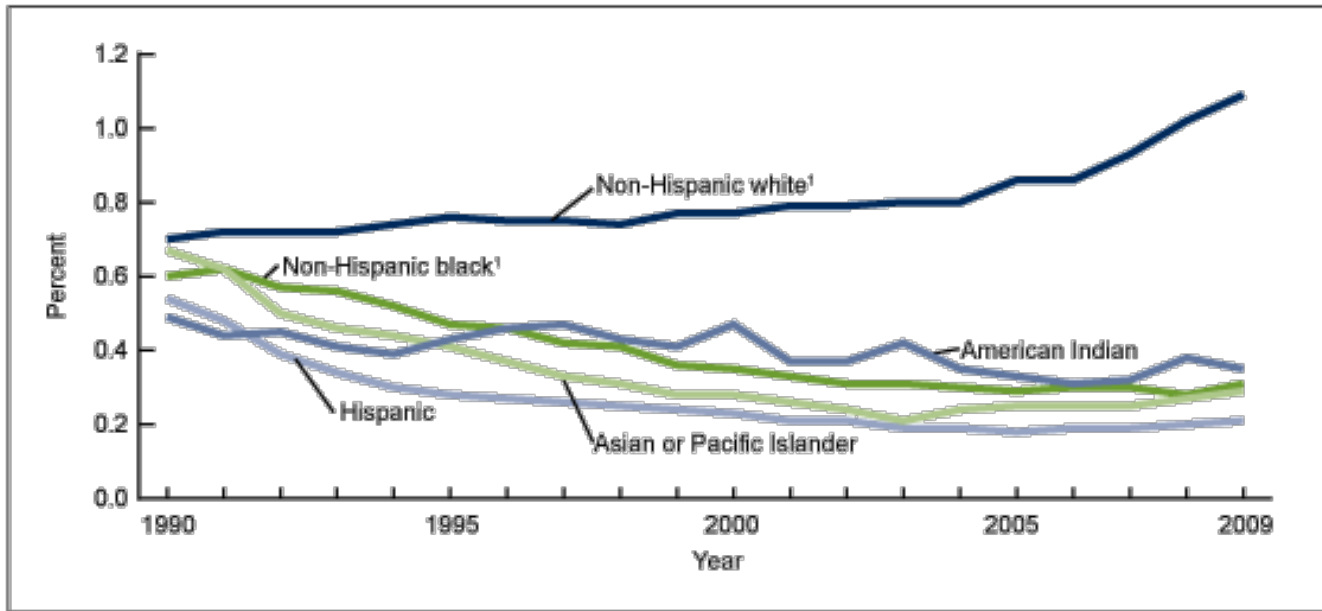


Figure 6. This graph shows the percentage of home births by race in the United States between 1990-2009. (MacDorman, 2012).

Conclusion

Midwives were widely used during colonial times in the United States. Skills of midwifery were brought over from Europe (Rooks, 2014), a continent that still has a great percentage of births attended by midwives today (Lake & Epstein, 2008). Then doctors and hospitals became more popular when the option of a painless childbirth was available (Wolf, 2009). Through out history there is a pattern of caucasian women in middle-upper social class societies that determine what is popular in birthing practices. During the Victoria era women were seen as weak and fragile, and to keep their appearance of frailty women often ate very little and wore constricting corsets, because it was what proper ladies did. This led to difficult births and the popularity of medical interventions to relieve the excruciating pain of childbirth (Stone, 2009). Now, there is a rising number of midwife attended births, especially in the white population. In the early 1990s more minority women used midwives, then in 2009 non-hispanic white women evened out in numbers in midwife attended births suggesting more caucasian women were using midwives (Declercq, 2012). Midwives have become more popular since more white mothers are using midwives to give birth in a more natural setting (Rochman, 2012). Usually, “Affluent people contribute to what is trendy in birth” (Lake & Epstein, 2008). In more recent times, women are not forced to the same drugs as those administered in the early twentieth century and incisions are only made when it is necessary, but healthcare services are still inadequate when it comes to women who cannot afford it, especially women of color. This becomes a problem when unhealthy babies are being born along with complications during the birthing process for the mother (Shaw & Lee, 2012).

The medicalization of birth and the cascade of interventions has led women to seek out midwives. Women feel that having midwives gives them more control over their pregnancy and health. Midwives have shown themselves capable of delivering healthy babies into the world with out the need of interventions or extreme measures that are not necessary. Women are now more educated compared to the past, and are able to decide for themselves what kind of birth they want. They are able to research on their own the benefits of giving birth with a midwife and do not have to rely on a doctor telling them what is best for them.

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