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CATCHING SATISFACTION: PERSONAL AND POLITICAL FRAMING IN THE HOMEBIRTH MOVEMENT

by

NASIMA OONA PFAFFL
B.A. University of Central Florida, 1999

A thesis submitted in partial
fulfillment of the requirements
for the degree of Master of Arts
in the Department of Sociology
in the College of Arts and Sciences
at the University of Central Florida
Orlando, Florida

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ABSTRACT

This study illuminates the experiences, motives, and organizational process of a cohort of homebirthing women in Tucson, Arizona who embody the holistic reframings of the national homebirth movement. It also provides a detailed presentation of the development of the homebirth movement's diagnostic, prognostic, and motivational collective action frames. It details the communities or "submerged networks" of women where these ideas were taking shape across America. This provides information on the personal micro-level experiences of selected birth pioneers that would be translated into collective action frames of the movement itself. It presents their processes of "cognitive liberation;" from these articulations in books and other media presented by national actors the details of the movement's framings can be analyzed. It presents detailed information on what diagnostic, prognostic, and motivational frames have emerged, diffused, and evolved through the thirty-odd years the movement has existed; and their arguments for and against common aspects of maternity care. It also presents the counter-framing efforts of the medical establishment to curb these collective action frames. It also provides details on the evolution of midwifery and homebirth in Tucson Arizona, which provides the structural background to the narratives under study.

To study home birthing women and the homebirth movement, I conducted 36 in-depth interviews in Tucson, Arizona with homebirth midwives, and homebirthing women who gave birth between 1969 and 2000. This produced 70 birth stories. These accounts were transcribed and analyzed. Grounded theory was employed as a means to develop categories and themes from the data.

From the data emerged a birth frame construction, alignment, and adoption model, composed of five stages: Frame Foundations, Frame Bridging, Frame Negotiations, Testing the Frame, and Frame Transformations. Each stage has multiple components important in developing women's birth models. The concluding chapter summarizes the links between the national collective action frames and the individual-level birth experiences. It also presents how maternity care has been changed by the homebirth movement's reframings of birth and where the future of policy is heading. It brings the reader from the micro-experience of movement pioneers, to the macro articulations of movement leaders, back to the micro-level of my respondents' processes of birth model construction, alignment, and adoption; and then backup again to how social policy and "life politics" are changing birth culture in America.

For my mother and her birth choices that have forever impacted my interest in birth and my expression of my sociological imagination.

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LIST OF NOMENCLATURE

Apgar Score	A test to determine a newborn baby's physical health. It is done at 1 minute and 5 minutes after birth. Scoring is based on a rating of 0 to 2 for each of five factors: heart rate, respiratory effort, muscle tone, reflexes, and color. Adding the values together gives the score. Scores of 7-10 indicate a normal response to birth, 4 to 7 means moderate distress, and 0-3 is severe distress.
Amniotic fluid	A liquid made by the amnion of the placenta that surrounds the fetus during pregnancy providing it protection
Amniotic-Fluid Embolism	Dangerous, often fatal maternal complication around the time of labor, in which amniotic fluid is forced into the mother's bloodstream.
Augmentation of Labor	The administration of synthetic oxytocin (usually Pitocin) to increase the strength and intensity of uterine contractions in labor.
Braxton-Hicks Contractions	Generally painless contractions that occur during pregnancy to prepare the uterus for labor
Breech presentation	When the baby's bottom or feet are the presenting part in the birth canal
Cervical Dilation	The opening of the cervix or entrance to the uterus usually during labor. Dilation ranges from 1cm to 10cm.
Certified Nurse-Midwife (CNM)	A licensed healthcare practitioner who provides well woman and maternity care services. CNMs are usually trained as nurses and then receive advanced training in midwifery. CNMs are legal and licensed in all 50 states and primarily attend births in hospitals, although some practice in out-of-hospital settings.
Certified Professional Midwife (CPM)	A type of Direct-Entry Midwife who is knowledgeable and skilled practitioner in providing the midwives model of care in out-of-hospital settings. A CPM has met the standards for certification set by the North

	American Registry of Midwives and has demonstrated knowledge and competency in clinical skills in out-of-hospital settings, continuity of care, and risk assessment skills.
Direct-Entry Midwife (DEM)	An independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college- or university-based program distinct from the discipline of nursing. A direct-entry midwife is trained to provide the Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings. Their licensing and legal status varies by state.
Doula	An experienced woman who helps other women around the time of birth.
Eclampsia	Serious metabolic illness of pregnancy, which is associated with poor nutrition and inadequate expansion of maternal blood volume. It is often fatal.
Endorphins	Nuero-hormones that numb pain and produce euphoria
Epidural	Local anesthetic injected into the dura mater of the spinal column in the lower back. Used to numb labor pain. Reduces movement and can cause a drop in maternal blood pressure.
Episiotomy	A surgical cut in the perineal muscles to enlarge the birth canal measured in one to fourth degrees of severity
Fetal heart tones	The fetal heart beat as identified through listening with a fetoscope, doopler transducer, or electronic fetal monitor. Fetal heart tones are monitored in labor and delivery to identify distress in the neonate.
Forceps	Large spoon shaped metal instruments inserted into the vagina and placed around the baby's head. Traction is applied to the forceps, pulling the baby's head from the vagina.
Grad multipara	Woman who has more than five babies
Induction of Labor	The use of drugs or techniques to bring on the initiation of labor before it has begun naturally on its own. Most

often this involves administration of synthetic prostaglandins and/or oxytocin.

Lay midwife	An uncertified or unlicensed midwife who was educated through informal routes such as self-study or apprenticeship rather than through a formal program. Some lay midwives have considerable experience and knowledge. A term that is historically appropriate to homebirth midwives in the 1970s and early 1980s. Other similar terms are traditional midwife, traditional birth attendant, granny midwife and independent midwife.
Malpresentation	Presentations other than vertex (head down) at birth
Meconium	The dark green/yellow intestinal contents formed before birth and present in a newborn child. Meconium present in amniotic fluid at varying levels of severity (also called meconium “stained” amniotic fluid) is indicative of fetal hypoxia and is a sign of fetal distress.
Multipara	Woman who is giving birth to her second or subsequent child
Oxytocin	Hormone secreted during labor that causes uterine contractions. Synthetic oxytocin is given intravenously to stimulate labor or by injection to stop a postpartum hemorrhage
Parity	A system for labeling the number of live and dead children a woman has given birth to.
Perineum	The band of muscles between the vagina and the anus
Perineal massage	Massage of the vaginal tissues during pregnancy or during labor to help increase awareness of tension, stretch, soften and relax these tissues and help prevent perineal tears during delivery.
Pitocin	Synthetic Oxytocin (sometimes referred to as Pit)
Placenta	a blood rich structure through which the fetus takes in oxygen, food, and other substances and gets rid of carbon dioxide and other wastes. Often referred to as the afterbirth during delivery. Contains a tree like pattern of veins and arteries on the fetal side which

some refer to as the “tree of life.”

Placental abruption	Premature separation of the placenta from the uterine wall causing bleeding and a potentially life threatening situation for mother and child.
Placenta Accreta	The placenta implants too deeply into the uterine wall, possibly growing into the muscle tissues or beyond and as such does not separate properly from the uterus causing severe bleeding. A life threatening complication. Placenta percreta indicates the placenta has grown through the uterus possibly into surrounding organs, associated with previous damage to the uterus such as cesarean sections.
Placenta Previa	The placenta implants partially or completely over the cervical opening, exposing mother and child to grave risk of bleeding as the cervix dilates. Previas diagnosed early with ultrasound do sometimes migrate up and away from the cervix as the uterus grows.
Preeclampsia	Milder form of eclampsia a metabolic disease of pregnancy marked by hypertension, edema, and protein in the urine
Primiparas	Women giving birth for the first time
Prostaglandins	Substances that stimulate smooth muscles such as those in the cervix. (Artificial prostaglandins can be used in inducing labor, such as misoprostol (cytotec)).
Relaxin	Hormone of pregnancy which relaxes ligaments
Rooming-in	Hospital practice of keeping mother and baby together
Shoulder dystocia	During delivery a complication that occurs when the baby’s shoulders become stuck behind the pubic bone after the head emerges, causing a delay in delivery and potential fetal distress
Stadol	Narcotic-like analgesic used to dull labor pain

Station	Used to measure descent of a baby's presenting part (usually the head) in the pelvis. Measured in relationship to the ischial spines of the pelvis. +5 is high in the pelvis, 0 is level with the ischial spines, +4 or +5 is crowning.
Toxemis	Eclampsia and preeclampsia
Vacuum extractor	Device that attaches to the head of the fetus with suction used during delivery to pull the fetus, speeding the delivery of the baby from the birth canal
Vertex	Baby that is presenting with its headfirst in the birth canal

(Definitions partially derived from Baldwin 1986; Citizens for Midwifery 2006; Davis 1987; Dox, B. John Melloni, and Gilbert M. Eisner 1993; Gaskin 2003; Glanze, Anderson, and Anderson 1992; Midwives Alliance of North America 2006b)

CHAPTER ONE: INTRODUCTION

Damiana: "I think they were just ready to change their life, and they met somebody at the right time... They were just exposed to a different way of thinking, or books, or just a different way of life, so,...I mean, those are always... kind of my greatest joys, that feeling like Wow, all I did was turn somebody on to a different path..."

Kathy: " I mean, you know women, a lot of women are all about being empowered in our culture right now and, hey, you want to be empowered, you have a homebirth,. You get to choose what your doing, how its going to be, what its going to look like."

This thesis is about women, their births, their babies and their desire to see change in America's maternity care. It is about social forces that shape the birthing options available to women and how women individually and in groups have worked to change birthing in America, both for themselves and for others.

The birth of a child can reconstruct or reinforce a woman's sense of self and the world she lives in. Women's definitions, expectations, meanings, interpretations, and frames of birth are greatly affected by the ideologies of the predominant cultural system. Today, physicians hold the predominant role in defining birth for American women. The medical framing of birth has only strengthened as medical technology has increased. This model holds birth to be "risky," and hence all birth should be the purview of medical science. Early alternate birth paradigms that challenged the medical model, such as Lamaze, were designed to work within the medical system, not to challenge its tenets. In the 1970s, the homebirth movement, and midwives as the movement's practitioners, grew up as a direct challenge to the medical control of birth. The homebirth movement argued

for a reframing of birth. These reframings have been constrained by a multiorganizational field, including the counter arguments of the American Medical Association, American College of Gynecologists and Obstetricians, and parts of the media, which have sought to discredit and disavow the lived experiences of homebirthing women and their advocates. Despite this opposition, the homebirth movement has made slow but significant strides in making homebirth midwifery available and legal to more women across America.

In 1986, homebirth midwifery was legal in eleven states, illegal in ten states, essentially illegal due to lack of means to licensure in another twelve states, and lacking any statutory standing in the remainder (Sullivan and Weitz 1988). Today, in 2006, homebirth midwifery is regulated in twenty states and unregulated but not explicitly illegal in sixteen states. Of these thirty-six states, ten provide Medicaid reimbursement for homebirths. For details see APPENDIX C: DIRECT-ENTRY MIDWIFERY STATE-BY-STATE page 456. Today twelve midwifery education programs are approved by the Department of Education through the Midwifery Education and Accreditation Council (MEAC) (Citizens for Midwifery 2005a). Interestingly, the number of homebirths nationally has remained around 1% of birthing women or about 40,000 a year in 1994 (Klassen 2001).

This small group of homebirthers and homebirth midwives work to keep open a “conceptual space” around birth, providing a radical flank to influence general maternity care. Hence, homebirth advocates have not only worked to improve the legal status of homebirth, but have also sought to change maternity care in general. These changes have found their expression in the lived experiences of birthing women and their midwives. One example of these shifts in maternity care would be “rooming-in.” Today it is

common for women to keep their babies with them most of the time after they are born-- whereas in the seventies this was a rarity (Edwards and Waldorf 1984). This practice has been influenced by the family-centered orientations of homebirth and research on the importance of bonding. The homebirth movement provides fertile ground to explore the connections between micro-level social constructions and larger macro-level framing efforts by national “actors.” This connection illuminates the collective action frames developed by movement actors, and how these collective action frames were internalized and tested in the birthing experiences of individual women.

This work is theoretically grounded in the framing perspective of social movement theory (see Snow et al. 1986). It is further informed by aspects of new social movements theory, most particularly collective identity as a goal and a motivator of micro-mobilization (Melucci 1988). Lastly, cognitive liberation (Nepstad 1997), as a social-structural component of framing is also employed.

The framing perspective grows out of Goffman’s (1974) work on frames and frameworks. Snow et al. (1986) elaborate on Goffman’s (1974:464) term and define it as “‘schemata of interpretation’ that enable individuals ‘to locate, perceive, identify, and label’ occurrences within their life space and the world at large. By rendering events or occurrences meaningful, frames function to organize experience and guide action, whether individual or collective.” The term frame is employed as a verb, to denote “framing” (Gamson, Fireman, and Rytina 1982; Snow et al. 1986; Snow and Benford 1988), an active, process-oriented phenomenon that implies agency and contention on the level of reality construction. Hence, frames and framings provide a means to understanding birth and making choices about how one wants to birth. These frames

provide “footings” to make choices and interpretations both individually and collectively. The results of these framing activities are referred to as collective action frames (Snow and Benford 1992).

Collective action frames perform an interpretive function by simplifying and condensing aspects of the “world out there” and mobilizing potential adherents. As defined by Benford and Snow (2000:614), “Collective action frames are action-oriented sets of beliefs and meanings that inspire and legitimate the activities of a social movement organization.” The development, evolution, and maintenance of the homebirth movement’s collective action frames provides insights into both the utility of these frames conceptually, but also the manner in which they have been constructed and maintained within this specific movement. The aspects, characteristics, and variable features of these collective action frames are at the heart of the research conducted within this vein of social movement research.

As Benford and Snow (2000:615) state, “Collective action frames are constructed in part as movement adherents negotiate a shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge others to act in concert to affect change.” As such, researchers (Benford 1993; Benford and Snow 2000; Snow and Benford 1988, 1992) have identified three component parts of these framing tasks: diagnostic framing, prognostic framing, and motivational framing.

Diagnostic framing involves diagnosing some aspect of social life as problematic and in need of change. For the homebirth movement this involved a clear indictment of the treatment of women and babies in standard maternity care. It also diagnosed the

dangers of technological interference in the majority of normal healthy births. Lastly, it emphasized the problems of medicine treating pregnancy as pathology instead of a natural healthy function (see Rothman 1982). Prognostic frames involve proposed solutions to the diagnosed problems. For the homebirth movement, this meant moving normal birth out of the purview of hospitals and doctors and into the hands of trained midwives at home. Lastly, motivational frames provide a call to arms or rationale for action (Snow and Benford 1988). Women's birth accounts and an ideological model of holistic birth provided this call to create change individually and collectively.

These women's experiences, motives, and organizational process also represent micro-mobilization and movement participation dependent on a frame alignment process as defined by Snow et al. (1986). This alignment process refers to the linkages of individual and social movement organizations (SMO) such that "some set of individual interests, values, and beliefs and SMO activities, goals, and ideology are congruent and complementary" (Snow et al. 1986:464). Part of these shared individual interests and values have come to be referred to as collective identity, a shared set of ideas, beliefs, and values based on some shared understanding of identity. Collective identity in New Social Movements (NSMs) is both a means and a goal of micromobilization. I build conceptually on Taylor's (1996; Taylor and Van Willigen 1996) work on the postpartum support movement, the breast cancer support movement, and women's liberation, as well as, Brown et al.'s (2004) work on embodied health movements in the argument that "life politics" is politics. Part of how this is expressed is through the adoption of a collective identity associated with a movement. I explore different levels of movement participation

from leader activists, to women who simply have chosen to birth at home and identify with the movement's collective action frames by their birthing choices.

Cognitive liberation (McAdam 1982), which was further linked with framing by Nepstad (1997), involves a three-part process of cognitive liberation: first, individuals no longer perceive the system as legitimate or just; second, those who once saw the system as inevitable begin to demand change; and third, those who normally considered themselves powerless come to believe that they can alter their lot in life. When individuals have moved through all three stages, they are “cognitively liberated” and able to organize, act on political opportunities, and instigate change (McAdam 1982; Nepstad 1997). I detail how these steps are incorporated into the collective action frames of the early pioneers and later as part of the frame alignment process model of birth choices I present. Nepstad (1997) developed this concept to describe how individuals become “cognitively liberated” through the effects of framing.

Homebirth as a movement is informed both by ideas of self-help, feminism, and popular health (O'Connor 1993). This self-help component lends itself to an analysis based on Taylor (1996). Her work emphasizes the importance of personal change in the post-modern world. She states, “Self-help participants frequently enact their social and political commitments more as empowered individuals than as members of formal groups” (Taylor 1996:103). New social movement theorists also emphasize how contemporary movements are primarily concerned with aspects of the body, self, and identity (Melucci 1994). Taylor also emphasizes this aspect of self-help movements as a New Social Movement. According to Taylor (1996:104) “Self-help takes matters of health, mental health, the body, problems of everyday life, and self-definition to be

problematic, which makes the individual and the self the locus of change.” I discuss both levels: the lived experience of pioneers which facilitates the creation of the movements’ CAFs and the frame alignment and collective identity process experienced by birthing women in their adoption and testing of these CAFs.

This study illuminates the frame construction process of women considering homebirth. I provide a discussion of these frame construction processes for two waves of the homebirth movement: The Pioneers (late 1960s- 1970s) and Contemporary Birthers (1980s-2000). I provide their individual-level experiences, motives, and homebirth frame construction processes, while weaving them together with the emergence and evolution of the homebirth movement nationally and temporally.

Historically birth has undergone major shifts; the most significant occurring in the last one hundred and fifty years. In colonial America, birth was primarily a family and women-centered event, a focus which remained in place until doctors began to replace midwives in the 1800s. By the early 1900s, midwives had been all but displaced except for in poor, rural, or immigrant enclaves (Wertz and Wertz 1989). As doctors were displacing midwives, births remained primarily at home, but as technology increased and society “modernized” births began to move from home to the hospital. In 1900, 5% of births occurred in hospitals. In 1930, it was up to 30%, and by 1970, 99.5 % of births occurred in the hospital (Wertz and Wertz 1989). Socially the advances of science and medicine were viewed as improving birth. After women obtained the right to vote, a group of early feminists sought “twilight sleep,” for a birth that would “liberate” them from the biological realities of birth pain. This led to two decades of women experiencing birth as a “black void.” They were routinely given morphine to dull the pain and

scopolomine to erase the experience from their memories, and then forceps were used to extract the babies from their bodies. Slowly dissent from natural birth advocates started to shift birth practices toward less drugged births. A slow shift toward spinal anesthesia also contributed to this social change as did the 1950s focus on birth as a culmination of femininity not to be missed. From this initial groundwork by natural birth advocates the homebirth movement emerged.

Out of the political hot bed of the 1960s, the emerging feminism of the 1970s, and the emergence of a naturally minded counterculture coupled with the dissatisfaction of many women with their childbirth experiences, the homebirth movement was born and took shape. Homebirth had always remained in small enclaves such as isolated rural populations. In these settings homebirth was simply a matter of necessity but in the activism of the 1960s and 1970s homebirths and lay midwifery re-emerged as a political matter. “Political” homebirthing grew out of communities of women.

One such community in Tennessee brought forth Ina May Gaskin, who is now touted as the mother of modern midwifery (Granju 1999). It was through her experiences as midwife to thousands of births on the communal living arrangement known as The Farm that she helped develop an articulated set of motives, rationales, and practices of homebirth midwifery which she shared with the world through her books *Spiritual Midwifery* (Gaskin 1977) and *Ina May's Guide to Childbirth* (Gaskin 2003), her newsletters and other publications, and her teaching and lecturing opportunities. Other midwives and activists also wrote books and added to the discourse on homebirthing and lay midwifery in the early days (Arms 1975; Baldwin 1986; Davis 1987; Johnston 1995; Lang 1972; Stewart and Stewart 1977a; Wellish and Root 1987) to name just a few. As

other women picked up these ideas, new homebirth enclaves were born. One such place was in Tucson Arizona, where out of a Sufi group, a homebirthing community was born that eventually would lead to changes in state licensing of homebirth midwives and the opening of a school of midwifery. This pattern occurred in other areas as well such as Washington state and Texas.

Through the last three decades lay¹ midwives and homebirthers were gaining experience and important political lessons. In consort with researchers the homebirth movement has produced solid research documenting the safety of homebirth as well as the positive experiences of women (Anderson and Murphy 1995; Declercq, Paine, and Winter 1995; Gaskin 2003; Johnson and Daviss 2005; Lang 1972; Mehl et al. 1977; Stewart and Stewart 1977a). Into the 1980s and 90s homebirth midwifery advocacy began to operate on a more national-level. Organizations such as the Midwives Alliance of North America (MANA) were founded to unite lay and nurse midwives under one national organization that supported out-of-hospital birth. Later as greater concerns were raised regarding midwives levels of experience and credentials, Midwives Education and Accreditation Council (MEAC) and North American Registry of Midwives (NARM)

¹ ¹ The term lay midwife is historically appropriate to the early days of the homebirth movement. In the late 1980s, midwives began working toward greater standards for practice and education. One way they began to redefine themselves was by slowly replacing the term “lay midwife” with the term Direct-Entry midwife (DEM), as a reflection of their ever increasing levels of knowledge, experience, professionalization, and more in-line with European non-nurse paths into midwifery I use the term “lay” when referring to homebirth midwifery before this shift occurred.

were developed to administer a national certification test and provide accreditation to midwifery schools.

In the midst of these national-level organizational efforts were the meso-level organizing of many state midwifery organizations, midwifery schools, and consumer groups, as well as legal cases that were brought against midwives accused of practicing medicine without a license. On the more individual level, the homebirth movement sought to create birth experiences that allowed women to take control and responsibility for their births; to create environments that fostered respect and acknowledged women's embodied knowledge as authoritative; and to reincorporate into birth a holistic approach that considered the mind, body, and spirit as all important to each woman's life, pregnancy, and birth. As individual women embraced this philosophy and experienced their own births, they generally became aligned with the movement. Many added their experiences to the movement's accounts, and by so doing, modified the movement, its rhetoric and goals. It is within these accounts of homebirthing parents that I have come to see not only the life histories of the women themselves but also of the homebirth movement.

The homebirth movement provides fertile ground to explore the connections between micro-level social constructions and larger macro-level framing efforts by national "actors." This connection illuminates the collective action frames developed by movement actors, and how these collective action frames were internalized and tested in the birthing experiences of individual women. This study presents the frame construction process of women considering homebirth. I provide a discussion of these frame construction processes for two waves of the homebirth movement: The Pioneers (late

1960s-1970s) and Contemporary Birthers (1980s-2000). I provide their individual-level experiences, motives, and homebirth frame construction processes, while weaving them together with the emergence and evolution of the homebirth movement nationally and temporally.

We will explore the homebirth movement from the inside out and from the outside in. I will present individual narratives to explicate the themes that were salient to homebirthing. I provide patterns of women's choices, details on their motives and experiences. I describe the process of frame bridging, frame negotiation, and frame testing to explain women's processes of choices and experiences around homebirthing. I take all these micro-level data and link them with the bigger picture and explain how they influenced each other. Each woman created the movement just as the movement influenced them; therefore I explain the reflexive nature of the homebirth movement. I provide analysis and scope to provide a big picture of what the emergence and maintenance of the homebirth movement has meant for midwives, birthing parents, and society as a whole. To elucidate the reflexive evolution of the homebirth movement, I conducted 36 in-depth interviews in Tucson, Arizona with homebirth midwives and homebirthing women who gave birth primarily at home between 1969 and 2000. This produced 70 birth stories. These accounts were transcribed and analyzed using ANSWER a text analysis software program. Grounded theory was employed as a means to develop categories and themes from the data.

It is through these accounts and experiences that we can begin to understand the homebirth movement and individual women's motives. This research builds on previously conducted field research (Pfaffl 1999) in which each woman described a

process of frame alignment, that was instrumental in her micromobilization and movement participation. Homebirthing in Arizona has undergone great organizational shifts as the local homebirth movement evolved from a few women helping each other in the 1970s with their own homebirths to an organized school for midwifery by the 1980s, and an established group of midwives practicing from that point on. These early pioneers in Arizona were also instrumental in helping a state task force establish licensing and practice guidelines for direct-entry midwives practicing in Arizona making Arizona one of the only legal and regulated states in the US in the late 1970s. Arizona is an interesting place to study homebirthing partly because of this history, and partly because I was born at home in Tucson, and named after one of the central figures in the Arizona homebirth movement there, Nasima Lomax. As such this research has a personal nature that motivates and guides my interest in this topic. I have tried to balance this personal aspect with a sense of objectivity and reflection. My respect and desire to understand these radical homebirthing women, some of whom were my childhood baby sitters, has helped me to develop my guiding research questions and purpose.

The central research purpose of my thesis is to illuminate the experiences, motives, and organizational process of a cohort of homebirthing women in Tucson, Arizona who embody the holistic reframings of the national homebirth movement. In so doing, I will also discuss the national homebirth movement's framing of an alternative paradigm of holistic birth that developed in opposition to the medical model of birth; and the frame alignment processes, micromobilization, movement participation and growth of the homebirth movement. This thesis will further elaborate the link between micro and

macro-levels of social movements; detailing how movement processes are reflexive at both the individual and group level.

To the task of answering these research purposes I provide the following organization of material. Chapter Two: Sociological Research on Birth and Social Movements discusses the background of the theories that underpin this research. I present theoretical components of the framing, new social movement, collective identity and cognitive liberation literature and the ways in which this current research builds on these traditions. I also present sociological research on birth, and discuss how this research and the social movement literature are related. In Chapter Three: Research Methods, I detail the way I conducted the research and analysis. I then move on to Chapter Four: Historical Antecedents to Today's Birth Culture. This chapter covers the history of American birth culture from colonial days through the 1960s. This chapter focuses on the changing social trends that increased doctors roles in birth, increased the use of technology and eventually hospitals, and how these trends resulted in the decline and almost abolition of homebirth midwives. This chapter also presents the development of the medical model of birth. At the end of this chapter we see the beginnings of protest against fully medicalized birth in America. The natural birth movement that began in earnest in the 1950s began to influence America's birth culture. I then discuss how new birth pioneers in the late 1960s and 70s sought to change America's birth culture, and in the end took the radical step of removing the hospital all together. Chapter Five: Birth of a Movement- Collective Action Frame Emergence and Diffusion presents the building of the collective action frames that some of the national actors built from their lived experiences. I detail the communities or "submerged networks" of women where these ideas were taking shape across America.

This provides information on the personal micro-level experiences of the birth pioneers that would be translated into collective action frames of the movement itself. I present their processes of “cognitive liberation.” From these articulations in books and other media presented by national actors the details of the movement’s framings can be analyzed. I present detailed information on what diagnostic, prognostic, and motivational frames have emerged, diffused, and evolved through the thirty-odd years the movement has existed; and the arguments for and against common aspects of maternity care. I also present the counter-framing efforts of the medical establishment to curb these collective action frames. In Chapter Six: The History of the Homebirth Movement in Tucson, Arizona I provide details on the history of the movement in Arizona specifically and how the pioneer women in my research were either part of that history, or where their stories fit within this historical context. I also discuss the evolution of alternative maternity care providers in Arizona and the changing legal statutes which were institutional backdrops to the homebirths in my sample. In Chapter Seven: Birth Frame Construction Process I present my model of micro-level framing, involving cognitive liberation, and the adoption of collective identity, that emerged from the data I collected from 36 women (70 birth stories) who gave birth, mostly at home. Through the analysis of this qualitative data, a birth frame construction, alignment, and adoption model was developed. The remaining seven chapters are devoted to describing this frame alignment model and linking this model to the movement’s CAFs. These chapters include: Frame Foundations, Frame Bridging, three chapters on Frame Negotiations, Testing the Frame, and Frame Transformations. Lastly, the concluding chapter summarizes the links between the national collective action frames and the individual level birth experiences. I also present

how maternity care has been changed by the homebirth movement's reframings of birth and where the future of policy is heading. In the totality of this thesis I hope I have succeeded in bringing the reader from the micro experience of movement pioneers, to the macro articulations of movement leaders, back to the micro-level of my respondents' processes of birth model construction, alignment, and adoption; and then back up again to how social policy and "life politics" is changing birth culture in America.

CHAPTER TWO: SOCIOLOGICAL RESEARCH ON BIRTH AND SOCIAL MOVEMENTS

Two divergent bodies of literature inform this thesis: the sociology of birth and the sociology of social movements. The later perspectives are applicable in part to the analysis of the former; with the writings of several sociologists and anthropologists who have focused their scholarship on the issue of birth, becoming important parts of the homebirth movement's collective action frames (Davis-Floyd 1992, 1998; Jordan 1997; Kitzinger 1972; Martin 1987; Oakley 1980; Rothman 1983a, 1998).

Social science research has predominantly focused on critiquing the medical or technocratic model, explaining the midwifery/ holistic model, and elaborating on the effects of these models on birthing women. Oakley (1979; 1980), a British sociologist, provided an initial critique of the social organization of women's experiences of pregnancy, childbirth, and the early maternal period. Later, Rothman (1983b; 1989; 1996) provided the first macro-level conceptualization of the differing models of maternity care that emerged in the late 1970s. She was the first (Rothman 1982) to conceptualize the differences between the emerging midwifery model and the medical model of American maternity care. Her work is a scathing indictment of patriarchal medical systems and their effect on women's birth experiences. Her models have become incorporated into the homebirth movement's main articulations of the movement's goals and strategies. She continues to research patriarchy and its effects on women's reproduction, as well as the continuing evolution of midwives in America (Rothman 1983b, 1989; Rothman and Caschetta 1996).

Like Rothman, Davis-Floyd (1987; 1992), an anthropologist, studies women who gave birth in a variety of birth settings and finds that most women undergo a ritual rite of passage that reinforces the central axioms of American culture (ie. technology and patriarchy). She advocates for women's greater control of the birth process and encourages changes and challenges to medical hegemony of birth. Davis-Floyd also explores the education of midwives and obstetricians, elaborating on the training of obstetricians and how this training process creates doctors who focus on birth complications in comparison to the training of midwives (both direct-entry and certified nurse-midwives), which creates trust in normal natural birth (Davis-Floyd 1987; Davis-Floyd and Davis 1996). Both Rothman and Davis-Floyd continue to write and guest lecture about social and cultural aspects of birth (Davis-Floyd 1998; Rothman 1983b, 1998).

Recent scholarship has begun to question components of these critiques of birth as presented by Rothman (1982) and Davis-Floyd(1992). Fox (1999) has criticized Rothman and Davis-Floyd as presenting women as victims, who are seen as empowered only if they choose to step outside the medical system and have a homebirth. Fox (1999) has raised the proposition that some women use the medical model to achieve their own goals and as such are empowered women, not victims of a medical system. Her emphasis on women's agency in various birth settings is an important step in the sociological birth research, and an important reminder to researchers to focus on women's agency not just the effect of macro social systems. Her research highlights the importance of social support on birth choices and how social support during birth negates negative aspects of women's medical birth experiences and leads to higher childbirth satisfaction. Nelson

(1983) also found feminist sociological/anthropological critiques of medical childbirth as incompatible with the needs of nonwhite, non-middle class birthers. There is a need for further scholarship to explore these issues.

Scholarship has also focused on several other areas. Howell-White (1997) explored how women's adherence to the medical or midwifery models of birth affected the choice of birth practitioners and the course of their birth experiences. Other sociological studies of birth have focused on homebirth midwifery's legality (Tjaden 1983) and the evolution and history of the homebirth movement (Mathews and Zadak 1991; O'Connor 1993; Sullivan and Weitz 1988). A recent study on the interactions of religion, spirituality, and homebirth has illustrated the religious diversity of the movement, and the importance of spirituality to homebirthers in the understanding of birth and their choices of homebirthing (Klassen 2001). Sociologists who have studied birth issues have added to our understanding of the differing models of birth that predominate in our culture, the effect of socioeconomic, racial, and attitudinal variables on birth choices, and women's experiences with various birth settings. However, there are still more avenues to explore. Scholarship that focuses on women's agency and decision-making processes will add to our understanding also. Linking these decision-making processes with the creation and diffusion of social movements will further our understanding of the effects of these movements on women's lives. To this end, I now shift my discussion from the sociological study of birth to the sociological study of social movements.

The sociological literature on birth is rather sparse, with questions of women's agency and decision-making processes in regards to birth setting still in need of further

scholarship. Further research is also needed on the articulation of collective action frames within the homebirth movement, and how these collective action frames translate into collective identity as well as individuals' vocabularies of motives for homebirthing. The model of women's frame alignment process I present in this body of research will elaborate on women's motives, collective identity, and social factors, which affect these choices. My analysis illustrates women's agency in creation and adoption of birth frames on both the micro-and macro-levels. To explore birthing women's agency I utilize theories of social movement framing.

Beginning in the 1980s, a gradual interest in social psychological, agency, and meaning construction processes began to be seen in social movement theorizing in the United States (e.g. Gamson et al. 1982; Snow et al. 1986). The study of social movements has evolved to give greater consideration and scholarship to movements and research that focuses on framing, collective identity, and new social movement theory. These three areas of theoretical grounding underpin the frame construction model I present within this thesis, and the analysis I provide.

With the publication of Snow et al.'s (1986) seminal piece on framing, a new perspective emphasizing interpretive issues began to develop popularity. This social constructionist approach put meaning at the center of answering research questions (Benford and Hunt 1992). As Benford (1993:199) states,

From this perspective, movement mobilization not only requires that the structural conditions be ripe for collective action to occur, it also requires that a critical mass of persons collectively define the situation as ripe and persuade others on an on going basis that their version of reality rings true. This reality construction process entails, among other things, the employment of framing activity and the development of vocabularies of movement motives and micromobilization.

Today the framing perspective has great utility, especially when used in conjunction with more structurally oriented perspectives to illuminate the core characteristics of social movements (Brown et al. 2004; Kebede, Shriver, and Knottnerus 2000). I utilize framing, new social movement theory, and collective identity in combination to produce the theoretical base for the analysis of this current research.

The framing perspective grows out of Goffman's (1974) work on frames and frameworks. Snow et al. (1986) elaborate on Goffman's (1974:464) term and define it as "'schemata of interpretation' that enable individuals 'to locate, perceive, identify, and label' occurrences within their life space and the world at large. By rendering events or occurrences meaningful, frames function to organize experience and guide action, whether individual or collective." The term frame is employed as a verb, to denote "framing" (Gamson et al. 1982; Snow et al. 1986; Snow and Benford 1988) ; an active, process-oriented phenomenon that implies agency and contention on the level of reality construction. The results of these framing activities are referred to as collective action frames (Snow and Benford 1992). Collective action frames perform an interpretive function by simplifying and condensing aspects of the 'world out there' and mobilizing potential adherents. As defined by Benford and Snow (2000:614), "Collective action frames are action-oriented sets of beliefs and meanings that inspire and legitimate the activities of a social movement organization." The development, evolution, and maintenance of the homebirth movement's collective action frames provide insights into both the utility of collective action frames conceptually, and the specific manner in which collective action frames have been constructed and maintained within the homebirth movement. The homebirth movement's collective action frames which provide "a

schemata of interpretation” for individual women and the movement as a whole will be explored in depth in the chapters to come. The aspects, characteristics, and variable features of these collective action frames are at the heart of the research conducted within this vein of social movement research.

As Benford and Snow (2000:615) state, “Collective action frames are constructed in part as movement adherents negotiate a shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge others to act in concert to affect change.” As such, researchers (Benford 1993; Benford and Snow 2000; Snow and Benford 1988, 1992) have identified three component parts of these framing tasks: diagnostic framing, prognostic framing, and motivational framing.

Diagnostic Framing involves “the diagnosis of some situation or aspect of social life as problematic and in need of change. It entails problem identification as well as the attribution of blame or causality” (Benford 1993:199). For the homebirth movement this involved a clear indictment of the treatment of women and babies in standard maternity care. It also diagnosed the dangers of technological interference in the majority of normal healthy births. Lastly, the movement’s diagnostic collective action frames emphasized the problems of medicine treating pregnancy as pathology instead of a natural healthy function (see Rothman 1982). Diagnostic framing is central to both consensus and action mobilization; without an identified problem what need is there for a social movement? Within the homebirth movement, consensus and action mobilization occur on two levels. At the individual level these diagnostic collective action frames provide schemata of interpretation of standard medical birth that enable the individual to define an experience

or situation within the confines of an “injustice,” which if they are convinced, may motivate them to make alternate birthing choices, hence building both a consensus and the potential for the expression of action mobilization through the “life politics” of individual women. At the group level, these articulated diagnostic collective action frames also provide reasons to mobilize and create change. After a problem is identified, the movement can place blame or responsibility for the identified problem on culpable agents—such as obstetricians and the hospital administrators. In the case of the homebirth movement, both structural and cultural attitudes and agents are identified as problematic. The development of an injustice frame is part of this diagnostic framing.

Snow et al. (1986:466), summarizing Goffman (1975) states, “Rebellion against authorities is partly contingent on the generation and adoption of an injustice frame, a mode of interpretation that defines the actions of an authority system as unjust and simultaneously legitimates non-compliance.” The homebirth movement as part of its collective action frames has accused standard medical birth of creating injustices for both mothers and babies and has readily encouraged non-compliance through seeking the alternative of birthing at home.

Gamson (1992) states that all movements must involve an injustice frame; however, Benford and Snow (2000) refute this claim. I concur with Benford and Snow’s (2000) assertion. All movements must identify areas that require change, but not all areas of social life that require change are framed as injustices. For example, self-help, health, identity, and religious movements may not need to contain an injustice frame. The diagnosis of the problem area may be defined as residing in the individual’s thinking, belief system or behavior, not in the “social system” itself. Thus far, however, research

on self-help (Taylor 1996; 1999; 2000; Taylor and Van Willigen 1996), and Rastafari (a political/religious movement) (Kebede et al. 2000) have all identified injustice frames as a component of these movements' framing efforts. The assertion that all movements require an injustice frame further highlights the need for further research in self-help, health, religious, and identity movements. With the exception of self-help, health, religious, and identity movements, research on diagnostic frames has been extensive (Benford and Snow 2000). I acknowledge that considerable research has been conducted on diagnostic framing, but I feel that exploring the homebirth movement's diagnostic frames is critical to accomplishing a complete picture of how these movement-specific diagnostic frames were created and maintained and how they have "played out" in the lived experiences of homebirthing families. Once movements have provided a diagnosis of a problematic aspect of social life, solutions to these problems are often formulated and articulated.

Prognostic Framing involves the articulation of a proposed solution to an identified problem. It may also involve a plan of attack and strategies for carrying out this plan (Benford and Snow 2000). For the homebirth movement, this meant moving normal birth out of the purview of hospitals and doctors and into the hands of trained midwives at home. The creation of these solution frames is limited by two factors: diagnostic framing and outside forces.

These prognostic framings are bound to a movement's diagnostic frames, and these act to constrain the movement's options for action. For an extreme example, a peace movement would not bomb a nuclear power plant. The nature and character of movements are defined by these framings, and as such, prognostic frames help to

differentiate Social Movement Organizations (SMOs). Benford and Snow (2000) note that prognostic framing is constrained and occurs under the varying forces of SMO constituents, opponents, targets of influence, the media, and bystanders. Due to these outside influences, certain solutions may not be “viable or reasonable” for the movement. For example, for the homebirth movement, advocating that high-risk mothers birth at home, which has a higher risk of neonatal mortality, is unreasonable. This frame would lack what has been referred to as cultural resonance (Klandermans 1992; Snow and Benford 1988) since neonatal deaths are generally unacceptable, whereas identifying treatment styles and specific technologies as problematic is less culturally unacceptable. Movements can be judged successful or not partially on how culturally resonant their framings are with adherents and bystanders (Babb 1996; Berbrier 1998; Snow and Benford 1992). This is a problematic area for the homebirth movement. It currently has limited resonance with the majority of birthing women today. Once culturally resonant solutions are framed, a movement must motivate actors to action.

Motivational Framing provides a call to arms or rationale for engaging in ameliorative collective action (Benford and Snow 2000). This includes the construction of appropriate vocabularies of motives. The principle of vocabularies of motives is built on Mills’ (1940) work. Vocabularies of motive provide participants with reasons for identifying with the goals and values of a movement and for taking action on its behalf (Benford 1993). Vocabularies of motive are most often invoked when one’s behavior is called into question by oneself or by significant others; they can be both past-oriented accounts or future-oriented disclaimers and rationales, and these can become part and parcel to a social movement. According to Benford (1993:200), “As movement actors

impute and avow motives, their vocabularies of motive become part of the everyday discourse of movement actors and thus an aspect of the movement's culture." I utilize this concept to detail the motives espoused by homebirthers and how they use these motives as a defense against the stigmatized nature of homebirthing. These motives are also incorporated into the model of frame negotiation with which I discuss the decision-making process homebirthers utilize. The combination of framing activities and the construction of vocabularies of motives represents the primary micro-mobilization process by which movement actors give meaning to their participation and continued support. At the individual birthing woman's level, I describe how birthing at home can be seen as micro-mobilization and how this process makes her part and parcel to the movement's growth and maintenance.

Benford and Snow (2000:617-618) point out that, "Further research needs to specify the conditions that affect the construction and adoption of various vocabularies of motive as well as assess their relative impact on social movement participation, collective identity processes, and other movement framing activities." My study will help fill in this gap in the research. Through eliciting the stories of homebirthing parents, I have accessed their "accounts" of their actions and their "rationale" for their choices. Through their accounts, I have identified what affected the construction of these vocabularies of motive, why they were adopted, how they impacted participants, and what effect these had on framing activities. I use this concept of vocabulary of motives both for the macro-level production of public media and at the individual level of disclaimers and rationale. I will identify vocabularies of motives and their subsequent framing activities on both levels.

Vocabularies of motives as well as a movement's collective action frames are negotiated and subject to competing interpretations. They do not arise and remain unchanged. In a multiorganizational field and a complex social system saturated with media outlets, a movement's message must be continually maintained (Benford and Snow 2000). These competing interpretations have been an ongoing challenge for the homebirth movement. In addition, the movement must also have cultural resonance to survive. Berbrier's (1998) work on new white supremacists illustrated how extremist groups frame their claims-making in a way that is more culturally acceptable. She found white supremacists framing racism as white pride. She found this packaging made the message more resonant and less radical. The homebirth movement's contemporary focus on birth "choices" represents a shift toward "packaging" their message in a similar fashion. Frame resonance involves four factors: empirical credibility, experiential commensurability, frame consistency and credibility of the frame articulators or claimsmakers (Benford and Snow 2000). Although each of these factors impacts the homebirth movement, empirical credibility and experiential commensurability are of particular importance.

Empirical credibility refers to the apparent fit between the "framings" and "events" in the world. Often this fit is related to "evidence" claimed by the movement. Benford and Snow (2000:620) state, "Hypothetically the more culturally believable the claimed evidence, the greater the number of slices of such evidence the more credible the framing and the broader its appeal." Generally in our culture medical studies and research are considered "resonant evidence." This is a conundrum for the homebirth movement. Despite the publication of numerous medical articles and books detailing the

safety of planned homebirth with trained attendants and the dangers and risks of hospital procedures and interventions such as epidurals, fetal heart monitors, and cesarean sections for the majority of normal birthing women (see Chapter Five for details on these risks)(see also Declercq et al. 1995; Durand 1992; Gaskin 2003; Goer 1995; Mehl et al. 1977), the homebirth movement has had minimal resonance with the majority of American women. In 1994, approximately 40,000 women, less than 1% of women giving birth, gave birth at home (Klassen 2001). This percentage of homebirths has nationally stayed about the same for decades. For those who are receptive to the movement, these research articles, as well as published personal accounts (e.g. Davis 1983; Gaskin 1990) comprise evidence of the movement's claims-makings and are resonant for them. Building on my previous research (Pfaffl 1999), these claims-making efforts are integrated into the accounts and rationale espoused by homebirthers. Accounts and statistics from books are commonly quoted for explaining individuals' choices to birth at home. These espoused claims are representative of the resonance these claims had with adherents in that they were incorporated into their personal vocabularies of motive for their actions. Benford (1997), in a critique of framing literature, called for more research on both the resonance of claims-making as well as its impact on individuals. My research speaks to the way movements can survive and impact cultural constructions while having a relatively low level of frame resonance with the larger culture. My research also attends to another aspect of cultural resonance of frames: experiential commensurability.

Experiential Commensurability refers to how congruent or resonant a collective action frame is with a person's everyday life. Benford and Snow (2000:621) state, "Hypothetically, the more experientially commensurate the framings, the greater their

saliency, and the greater the probability of mobilization.” For homebirthers, claims-making may not have been resonant until they were pregnant, but once they entered into this “liminal” phase (Pfaffl 1999) their claims-making became much more experientially commensurate with their everyday lives. This link is further reinforced in this analysis. The link between everyday experience and movement claims-making, and the further evolution of claims arising from lived experience, is an essential finding of this thesis.

Beyond the diagnostic, prognostic, and motivational components of framing efforts and the related issues of frame resonance and vocabularies of motive, framing efforts involve four strategic processes. Snow et al. (1986) identified these four strategic processes employed by movements during framing efforts as: frame bridging, frame amplification, frame extension, and frame transformation. Frame bridging and frame transformation are of particular importance to my homebirth research.

Frame bridging refers to, “the linkage of two or more ideologically congruent but structurally unconnected frames regarding a particular issue or problem” (Snow et al. 1986: 467). Frame bridging is another area of research that Benford and Snow (2000) highlight as an area in need of further research. I provide detailed evidence of the homebirth movement’s frame bridging process both at the national level and at the individual level. Frame bridging was a central component in my previous research (Pfaffl 1999) and is a critical component of the frame alignment model I present in this thesis. I discuss how the homebirth movement is linked with the women’s movement, alternative health, and new age spirituality movements; as well as how “spill over” of collective identity and organizational experience has helped the homebirth movement. They also share common principles and concepts that act as a bridge between these movements. For

example, the alternative health movement and homebirth movement share a common interest in personal responsibility for health care. This bridging of ideas and interests helps to bring more prospective adherents to the movement. For example, a woman's interest in alternative health care may act as a bridge to learning about and becoming interested in the homebirth movement. I will provide a number of women's accounts that illustrate this process of frame bridging.

Frame transformation refers to changing old understandings and meanings and/or generating new ones (Snow et al. 1986). Few studies have looked at this frame alignment process, with the exception of White's (1999) work on a Black feminist collective's attempts to reframe and overturn racist and sexist myths regarding rape. White (1999) detailed Black feminists' efforts to transform the public's understanding of the seriousness of rape especially within the African-American community. My research on homebirth also adds to this understanding, as well as details how homebirthers have attempted to transform the public's ideas of homebirth's safety, and changed public opinions regarding birth options and homebirth practitioners.

A great deal has been learned about framing dynamics, including how movements create diagnostic, prognostic and motivational collective action frames; how they resonate with adherents and the public; as well as the strategies employed through frame bridging and frame transformation. Beyond these framing strategies, networks and the development of collective identities have an important role in social movements' framing attempts and the lived experience of adherents.

Networks are of critical importance to social movement scholars. McAdam and Paulsen (1993) illustrated the importance of networks for the recruitment of activists for

the 1964 Mississippi Freedom Summer Project. Benford (1987) also found the number of friendships and connections one had to a social movement member, the greater the likelihood that one would participate in that social movement. I found a similar trend among homebirthers (Pfaffl 1999). Networks are also critical to social movement framing techniques because collective action frames are created through the interaction of participants, helping other participants further incorporate these beliefs into their vocabulary of motives. This process will be explored in detail within the homebirth movement in Tucson. Klandermans (1997) notes that interpersonal interaction is an important factor in the creation of consensus formation and the appropriation of collective beliefs. Klandermans (1997:20) states,

People tend to validate information by comparing and discussing their interpretations with significant others...especially when the information involved is complex- as is always the case with social and political issues.... As a rule, the set of individuals interacting in one's social networks- especially friendship networks- is relatively homogeneous and composed of people not too different from oneself. The processes of comparison that take place inside a social network produce collective definitions of a situation.

I found a similar process among my homebirth sample. These collective definitions become part of both the individual-level vocabularies of motives that individuals espouse and the collective action frames produced from movement participation that become part of the larger social movement culture.

Network forces are equally important for members of the homebirth movement. In my previous research (Pfaffl 1999), networks served to provide information from a woman who had had a homebirth to someone who was considering this possibility. This process included information regarding personal experiences, access to practitioners, statistics and pro-homebirth rationales, support for one's choices, and simply an example

that someone else had done this radical thing called a homebirth and perhaps “you could do it too.” This current cycle of research confirms and elaborates the importance these networks played in individuals’ motives and experiences, as well as the homebirth movement’s framing of collective action frames.

Moving somewhat beyond the theoretical camp of social movement framing, personal networks and collective identity have emerged as areas of utility for social movement scholars. The concept of collective identity has received a good deal of scholarship in the last few years (Benford and Snow 2000; Johnston, Larana, and Gusfield 1994; Kebede et al. 2000; Poletta and Jasper 2001; Rupp and Taylor 1999; Taylor 1996, 2000; Taylor and Whittier 1992). According to Klandermans (1997), collective identity is important to social movements when movement participation and causal attributions create a “they” and “we” feeling. Taylor and Whittier’s (1992) research on lesbian feminist mobilization explored how collective identity is constructed through three main processes of boundaries, consciousness, and negotiation. Boundaries are social, psychological, and physical structures that establish differences between a challenging group and dominant groups. Consciousness involves the interpretive frameworks that emerge out of a challenging group’s struggle to define and realize its interests. Negotiation involves the symbols and everyday actions subordinate groups use to resist and restructure existing systems of domination (Taylor and Whittier 1992:111). Collective identity is also coming to be seen as a very effective concept for understanding movement participation in our postmodern world and is considered especially important for issues of birth, death, and the biological body (Giddens 1991; Taylor 1996), and as such is very applicable to the study of homebirthing.

Taylor's (1996; 2000; Taylor and Van Willigen 1996) work on the postpartum depression (PPD) movement has brought to light important aspects of collective identity. Collective identity has also been used to explore developing a wider theoretical base for describing health social movements (Brown et al. 2004). Issues of collective identity are further elaborated within this body of research. For homebirth, individuals often come from a wide variety of socio-economic, racial, political, and spiritual backgrounds. Homebirthers have also been demonstrated to come to homebirth from a wide range of ideological backgrounds. In fact, the stereotype of a "hippie homebirther" is often rejected by homebirthers as too stereotypical (Davis-Floyd 1992). However, after having said that, my research (Pfaffl 1999) did find that homebirthers share common motives and rationales for having homebirths and hold an affection for other homebirthers. The fact I even use the label "homebirther" demonstrates a boundary demarcation--a distinction between a "we" (homebirthers) and a "them" (hospital birthers) (Taylor and Van Willigen 1996). This label implies a shared consciousness and identity. This research further explores this topic in regards to a health-based movement where further scholarship is needed.

Various schools of thought often claim collective identity, but it is most commonly associated with the school of new social movements from Europe. Melucci (1989; 1994) and those who have utilized his ideas of submerged networks (Mueller 1994) have popularized these theories within the United States. New Social Movement theory is helpful to our understanding of the homebirth movement because it is useful for identifying and describing movements that are not bound by class or other structural

boundaries. This theory has proven useful in exploring identity movements such as the gay rights and women's movements.

Johnston et al. (1994) summarized eight components of new social movements (NSM). First, NSMs transcend class structure and are associated with a diffuse social status. Second, NSMs are characterized by a pluralism of ideas and values. Third, NSMs are associated with a new form or set of identities that are associated with a set of beliefs, symbols, values, and meaning related to sentiments of belonging to a differentiated social group (e.g. ethnic, gender, separatist movements). Fourth, NSMs have blurred lines between the individual and the collective. Movements are acted out in individual actions rather than through or among mobilized groups. The American "hippie" movement is a prime example of this phenomenon. Fifth, NSMs involve personal and intimate aspects of human life, such as alternative medicine, new age spirituality, and the women's movements. These affect the intimate aspects of our lives through sexuality, the physical body, behavior, daily life, eating habits, making love, and personal problems. Sixth, NSMs are characterized by mobilization via civil disobedience, resistance, and disruption. Seventh, NSMs have gained popularity due to a credibility crisis of the conventional channels in western democracies. Lastly, NSMs produce organizations that are segmented, diffuse, and decentralized. Melucci argues that these NSMs create collective identities and collective identities are created in submerged networks. The homebirth movement clearly falls within the rubric of NSMs since its organizations tend to be decentralized and it deals with intimate and personal aspects of reproduction, transcending class structure and other social statuses to appeal to a wide variety of people. Thus the lines between the individual and the collective are blurred. Birthing at

home itself becomes a political act. The homebirth movement is also characterized by the creation of a new collective identity of “homebirther” and builds on pluralist ideas and values as seen through the amalgamation of its collective action frames.

The emphasis on the emergence of collective identities through submerged networks is of critical importance to the homebirth movement. Submerged networks are defined as hidden networks of individuals that are diffuse through the social landscape and provide a means of engaging in cultural experimentation and free exchange of information and people. They are cultural laboratories submerged within civil society (Melucci 1989). These networks become visible only when actors confront public policy. This process is a perfect illustration of what has occurred in the homebirth movement. The movement developed within the cultural laboratories of the 1960s counter-culture, such as The Farm in Tennessee, and still exists within diffuse groups of women freely exchanging information and ideas. This creation of collective identity brings home the importance of recognizing private and public actions and identities in a new light. In our postmodern age it is important to see the effect of “life politics” not just the traditional forms of “emancipatory politics”(Giddens 1991). Taylor (1996:104) has illustrated how personal and public issues become redefined as a collective identity; “The insistence that the construction and expression of new identities is politics, which leads activists to contest traditional distinctions between the private and the public and between the personal and the political, is, to a large extent what new social movement scholars see as the core of what is ‘new’ about the new social movements.” I reinforce this point and my research further elaborates this link between private and public, personal and political--treating the private personal act of giving birth as an act of public political consequence.

In conclusion, the framing approach, the concepts of new social movements, and collective identity are useful to elucidate the central premises of my research. These social-psychological and meso-level theories have helped sociologists recognize the importance of the interpretive processes at work in collective action. It has helped to illuminate the micro-level processes involved in movements and how these interpretive processes take place in different movements, providing a link to macro-level processes. However there is still considerable ground to cover under this perspective. Research has focused on a wide range of movements. There has been a focus on environmental (Cable and Shiver 1995; Capek 1993; Krogman 1996; Kubal 1998), peace (Benford 1987, 1993; Benford and Hunt 1992; Gamson and Modigliani 1989), gender and abortion rights (Evans 1997; Jenness and Broad 1994; Taylor and Whittier 1992; White 1999), civil rights (McAdam, John D, and Zald 1996; Platt and Fraser 1998), hate groups (Berbrier 1998; Jessup 1997), and public policy movements such as Mothers Against Drunk Driving (McCarthy 1994), with relatively little work on health and self-help movements with the important exceptions of Taylor (1996; 1999; Taylor and Van Willigen 1996); Brown et al. (2004); and Shiver, White, and Kebede (1998). Benford and Snow (2000) have called for further research on self-help and health movements. Research is needed to further explore the dynamics and processes of these types of movements.

Health and self-help movements have not been more common foci of social movement research partly because the discipline tends to treat these movements as apolitical. I argue that in a postmodern world it is these very types of movements that deal with everyday life and life transitions that are critical to our understanding of social movements and political, cultural change; hence the homebirth movement is an area

worthy of studying as a “social movement.” These arguments are based on Taylor’s (1996) work on postpartum depression and Brown et al.’s (2004) work on embodied health movements, which clearly demonstrated that health issues are worthy of “social movement” analysis because these movements have created important changes in the larger society and played important roles in individuals’ lives; the same holds true for the homebirth movement. I place homebirth squarely within the analysis of both these sociologists’ works.

Theoretically I am building on Della Porta and Diani’s (1999) definition of social movements as informal networks based on shared beliefs and solidarity, which mobilize around conflictual issues and deploy frequent and varying forms of protest, and Brown et al.’s (2004:52), assertion that embodied health movements (HSMs) are “collective challenges to medical policy and politics, belief systems, research and practice that include an array of formal and informal organizations, supporters, networks of co-operation, and the media.” Health and self-help movements represent challenges to political power, professional authority, and personal and collective identity. Utilizing these definitions, it will be clear in the following chapters how the homebirth movement has presented a challenge to dominant medical knowledge, authority, practice and research. Homebirth midwifery has provided a way for individual women to express their political discontent with the current maternity system and a means to achieve an alternative route to practice. Homebirthers, although very divergent in characteristics, do hold the central collective action frames of the movement as important; their collective identity can be identified through these shared beliefs, attitudes, and behavior. They share

a “definition of the situation” that reflects their shared understanding of the movement’s collective action frames (Owens and Aronson 2000).

The homebirth movement exists in the constellation of social movements and social movement organizations focused on holistic health, self-help, women’s rights, and natural childbirth. It has been advantaged by the “spill over” (Meyer and Whittier 1994) effect of these movements both in regards to ideational components and also activist experience and organizational elements. Both Taylor (1996) and Brown et al. (2004) found women’s previous experience in other movements gave them organizational experience that helped them organize within both the postpartum depression movement and the breast cancer awareness movement. Meyer and Whittier (1994:277), who coined the spillover term, illustrated the importance of not seeing movements as isolated islands unto themselves. They view social movements as a,

...collection of formal organizations, informal networks, and unaffiliated individuals engaged in a more or less coherent struggle for change...because social movements aspire to change not only specific policies , but also broad cultural and institutional structures , they have effects far beyond their explicitly articulated goals. The ideas, tactics, style, participants and organizations of one movement spills over its boundaries to affect other social movements.

The homebirth movement has worked to create social change. It is a political effort to legalize direct-entry midwifery, achieve third party payer equity, and protect parents’ rights to choose in what setting their childbirths take place. It is also a movement to provide a different cultural conceptualization that espouses the health, safety, and capability of the birthing process and women’s bodies. To this end, practitioners, consumers, and advocacy groups have made efforts at both the personal, the

political, and the cultural level to create changes that favor homebirth, making it a valuable area to research.

CHAPTER THREE: RESEARCH METHODS AND ANALYSIS

In this thesis I focus on the national homebirth movement's development, evolution, and diffusion as well as individual parents' experiences and motives for homebirthing. My primary focus is on Tucson, Arizona, where a group of women in the early 1970s went from helping each other birth at home, to an organized school of midwifery in the late 70s to early 80s, followed by the school's demise, and subsequent midwives' struggle to continue midwifery in the 1990s. The history of the Tucson homebirth scene parallels other areas in the country and provides a good place to explore issues relevant to homebirthing parents and the homebirth movement as a whole. I do not claim that my respondents are representative of all homebirthers everywhere, but as I will demonstrate these homebirthing parents' experiences and motives are congruent with the ideologies of the homebirth movement and the motives and experiences espoused by homebirth leaders. Hence they illustrate their part in the homebirth movement.

Their experiences are also valid on their own, as individual processes. In fact, these individual processes illuminate the building blocks of the collective action frames espoused by homebirth leaders. Collective action frames are internalized and provide individual interpretive schema which serve as determinants of how a situation is defined and therefore acted upon. Studying the actions, decisions, and espoused rationales of homebirthing women illuminates their internalized schema, their framing processes, and subsequently the collective action frames of the movement (Johnston 1995). Social movement research deals with multiple layers of experiences, motives, interactions, and

organizations occurring through time and place. The greatest understanding of this sociological phenomenon can be found in the in-depth accounts of participants. This understanding can then be added to by historical documents (meeting notes, state statistics, written accounts, photos, and video recordings) (Berg 1995). Research that focuses on the micro-, meso-, and macro-levels is appropriate to a subject matter as reflexive and evolving as social movement participation and development. This multilevel emphasis is consistent with the majority of framing research conducted on social movements. Another aspect consistent with many social movement researchers is a personal interest in the material under study.

The Emic Researcher

My interest in the homebirth movement, midwives and homebirthing parents is both academic and personal. Academically, my research on the homebirth movement adds to our understanding of health related social movements and their growth, maintenance and diffusion. It also elaborates on individual women's participation in their own birth choices and subsequently the movement itself by the application of an adopted collective identity and the expression of "life politics." The movement may also be supported by the structural and political efforts of activists. Personally, homebirthing has been part of my life since I was born. In 1974, in the early days of the homebirth movement, my mother chose to birth at home. In fact, I am named after Nasima Lomax, who was pivotal in the development of homebirth in Tucson during the 70s and who is a close friend of my mother. Both Nasima and my mother, Sue, are included in the first

group of study respondents in Tucson. My mother's involvement with homebirthing led her to have continuing connections with other homebirthing families in the Tucson area for the last 30 years. I have known many of these women since I was a baby. Eight of these women, including Nasima and my mother Sue, were among the first wave of my research (Pfaffl 1999). Additionally, since the second phase of research was conducted in 2000, I have subsequently become pregnant and delivered my own child at home. This has given me a new level of insight I didn't know I would need. Having my own homebirth clarified points respondents told me and redefined some of the ways I looked at the birth experience. Most interestingly, I think what has been gained by having my own homebirth is true insider status. At the time of the interviews some of the respondents conveyed that I'd "understand" once I had a baby, and in some ways they were correct. I now very much hold an insider's point of view and I am certain that this affects the way I have conducted my research.

Many scholars have grappled with the insider/outsider debate, some advocating research that is objective, positivistic, and conducted by an outsider (e.g. Horowitz 1983; Sanchez-Jankowski 1991); while others suggest that only insiders can really "know" the complexities of a community (Kremer 1990; Oakley 1980, 1981; Riessman 1987; Segura 1989). Others such as Pierce (1995) have called for a more balanced approach to this dichotomy. "By virtue of her academic training, the fieldworker has been trained to look at the world in a way that is different from the perspective utilized by people with no such academic background. In this sense, even an insider will be 'estranged' from any community or group she studies" (Pierce 1995:193). Patricia Hill Collins (1986)

advocates the idea of an “outsider within.” The outsider within status has produced many illuminating pieces of research.

In the social movement vein, insiders have conducted a good deal of the research. For example, Benford (1987) illustrates how in his process of studying the nuclear disarmament movement he became a movement actor himself. Taylor’s (1996) study of postpartum depression was affected by her own clinical depression in the midst of her study. Rothman’s (1991) sociological work on birth issues was also assisted by her own homebirths and participating in a community of midwives. All these studies reflect the value of balancing the insider and outsider perspectives. I personally seek to provide insight into an arena of women’s lives. I have seen the evolution of homebirth midwives, witnessed the politics of birth in America, grappled with insurance companies trying to get them to cover my homebirth, and seen the process of frame construction in the lives of my friends and myself. I hope this provides this project with a sense of depth and first-hand knowledge perhaps not available to an “outsider.” Yet utilizing my capacity as an “outsider within” I hope to bring to light sociological issues of relevance to the study of social movements and elaborate on important themes and processes in the lives of birthing women. I have looked at these materials with a trained eye, one searching for questions, patterns, and activities perhaps not readily visible from a different vantage point.

Subjects

Two groups of informants have been used in this study. The first consists of eight women who were interviewed in December 1997 and July 1998 as part of my undergraduate honors thesis research (Pfaffl 1999). The interview format is almost identical to the current interview approach and as such is appropriate for inclusion in this research as well. The second sample is composed of twenty-seven contacts, and involved a second level of snowball sampling identified during the initial fieldwork, as well as new leads and contact networks. This field research was conducted during three weeks in Tucson, Arizona, in July and August of 2000. Most interviews were conducted in the respondents' homes or friends' homes, with a few conducted in respondent's offices or at restaurants. Although the interviews were collected at different times in the field, let me be specific that the sets of interviews are connected.

The total sample size is thirty-five women who provided seventy-five birth stories. These seventy-five birth stories provide scope and an immense quantity of data about the women's birth experiences, the impact of the homebirth movement on their lives, and the emergence, maintenance, and evolution of the homebirth movement. These seventy-five birth stories are composed of the following birth settings. They include forty-eight successful homebirths and seven births that were planned to be homebirths but were transferred to the hospital; of these, one was a transport while in labor, one was a breech baby, and the other five were transferred to doctors due to premature labors and deliveries that were out of the scope of care provided by lay midwives. Also included in the seventy-five birth stories are thirteen planned hospital births and seven birth center births (one of which was transported to hospital for an in-labor complication). I sought

out information on birth center births due to the importance of the Women's Center in Tucson. This birth center is a place of employment for several of the midwives included in my sample; it is an "alternative" to home and hospital birth and as such provides data on why people *don't* choose to homebirth; and it has been important to the birth politics in Tucson. I, however, have not provided detailed analysis of the birth center parents and have omitted five of these births from the total number of birth accounts. This omission is due to a restriction in transcription capacity and funding. I do hope to analyze these accounts further in the future. Of the total sample population, thirteen respondents are midwives and three have worked as doulas or midwives' assistants. Three of the midwives have never had children; some became midwives before their children's births and some after. These midwives provided data on their own birth experiences as well as data on midwifery, the homebirth movement, and the politics of obstetrics.

The respondents have also provided a wide cross section of birth stories across time, since I have included stories from 1968 through 2000. This date range has provided data on the changing practices of obstetrics and midwifery. It has illuminated the emergence and evolution of the homebirth movement in the U.S. for over thirty-five years. For example, one woman's account of her homebirths provided information on the rapidly changing nature of birth politics. Her first child was born in the early 1970s with an unlicensed and minimally trained lay midwife, and her second was "delivered" five years later by a midwife who had graduated from the Arizona School of Midwifery and who was legal and state licensed. I have data on twenty-two births in the 1970s, nineteen in the 1980s and twenty-seven between 1990-2001.

The accounts also provide data on birth in multiple states. The focus of my thesis is on the homebirth movement in Tucson, Arizona, and how this is linked with the national homebirth movement, but where appropriate I have presented information from other areas around the country. People move around, and it is not uncommon for a woman to give birth in different states over the course of her childbearing cycle, and so my sample includes information from various states. In sections of the thesis where geography is central to the data or theoretical concepts, I will clarify the geographic region I am discussing.

The women in the sample come from a wide range of backgrounds. They vary in age from their early twenties to their mid-sixties. They represent a cross section of educational backgrounds from high school graduates to holders of master's degrees. They also come from a cross section of financial backgrounds. Some are poor by choice, making lifestyle choices that do not emphasize financial gain. Some have professional careers or husbands who are professionals, such as engineers, doctors, or chiropractors.

They also represent a wide ideological cross section. Many could be labeled as "hippies" with a liberal political background, with a few respondents self-identifying as Republicans. I have also included members of a network of women who are part of a missionary church in the Tucson area and as such could be labeled as religious fundamentalists. Informants critical to the emergence of homebirth and lay midwifery in Tucson were also included. All of these women were connected through various networks. One important network was a Sufi community active in Tucson during the 1970s. This community was pivotal in connecting all the women who gave birth as part of this early group. This group was lead by Nasima, and can be seen as a central nexus to

the homebirth movement in Tucson, Arizona. Nasima was instrumental in participating in the revision of state regulations regarding lay midwives and homebirth, as well as opening The Arizona School of Midwifery with her husband. The two other homebirthers who became midwives also attended this school. These structural and network connections provided the beginning of the second sample of homebirthers that are central to this thesis.

This variety in respondents is explained by two factors. First, the homebirth movement as a “new social movement” is characterized by diversity of constituents. These new social movements are not characterized by the older forms of collectivities characterized by class and political ideologies (Melucci 1994). Instead, NSMs are characterized by individuals who share common interests, experiences, and solidarity. These characteristics are also often associated with issues of health, the body, and identity (Taylor 1996). Second, the diversity of the sample is also illustrative of how the motives and ideas of homebirth cut across the population. However, with that said, the women do tend to have common motives and foundations for choosing homebirth and these characteristics will be further explored in the thesis.

Sampling

Snowball sampling was utilized to identify new informants, and new participants were sought through several sources. First, two midwives were included who were part of the early pioneering group, and were identified during the previous research, but not interviewed. Second, students who graduated from the Arizona School of Midwifery

were contacted. Third, contacts were made with individuals who gave birth at the Tucson Birth Center. Fourth, midwives were asked to provide names of clients who would be interested in being interviewed. If or when patient privilege was a concern, the midwives were asked to contact clients and request these clients contact me. This self-selecting of clients could raise concerns about bias in the research, but this concern must be balanced by both feasibility and careful research design (Berg 1995). In many respects homebirthers are hard to identify without using a practitioner as a connecting source. To limit some bias, I requested that midwives suggest people who have had both positive and negative homebirth experiences (such as transport to the hospital). This has produced a broad range of narrative data in the study. I also asked the midwives to select clients over several years, when possible, to help illuminate a broader time frame. Despite this request I have more stories (twenty-four) from the 1990s than one would anticipate given a general leveling off of homebirths occurring at this time. I suspect this is due to the ease of contacting people who had births within the last few years. Despite this fact, I still have considerable data from both midwives and homebirthers for all three decades under study. I also asked the midwives to provide a list of names to help reduce attrition effects. Out of forty-one contacts given to me by midwives, I was unable to set up meetings with sixteen. This attrition seemed mostly due to scheduling difficulties, such as people being out of town on summer vacation during the duration of the field research. Most contacts seemed enthusiastic to share their birth stories with a researcher.

When studying homebirth, snowball and purposive sampling with in-depth interviewing are most appropriate due to the rarity of homebirth; only about 1% of the population gives birth at home (Anderson and Murphy 1995). This sampling limited the

research to a descriptive level of analysis, but given the lack of research done on the homebirth movement within sociology, it is appropriate to begin with this level of analysis. Populations of homebirthers are dispersed and difficult to identify for randomized survey type research. There are also potential legal constraints (since being a midwife is illegal in several states), as well as the social stigma attached to homebirthing. In-depth interviewing and purposive sampling is consistent with a tradition of qualitative research on stigmatized and/or rare populations, such as delinquent youths or street gangs (Babbie 1998; Berg 1995). It is also logical to use snowball or purposive sampling when a collective is being identified, and these methods are how the majority of research on social movements within the framing perspective has been conducted (Benford 1997). Through these networks of key informants, the boundaries of the group are delineated, additional research subjects are identified, and group development can be traced.

In-depth interviewing is also consistent with the frame analytic approach. In-depth interviewing allows subjects to more clearly express vocabularies of motive, as well as what meaning and interpretations situations and experiences have for them. The interviews were conducted in a semistructured fashion. The interviews varied in length from 1 ½ to 4 hours long. The interviews with the midwives tended to be the longest since they provided data on both their own birthing experiences, their evolution as midwives, and the politics of birth in America. All subjects were asked the following guiding research questions:

- Describe your experiences, impressions, and feelings about your pregnancy, labor, and birth?
- How did you become interested in homebirth?

- Why did you become interested in homebirth?
- Describe how you dealt with questions of risk associated with the birthing experience?
- What books, groups, or networks facilitated your interest in homebirth?
- For the midwives additional questions were asked regarding their entrance into midwifery, how they were trained, their professional experiences, and career evolutions.
- During the interviews with all subjects, additional probative questions were asked.

Participation was voluntary and all human subject guidelines were followed.

Participants were asked to sign a consent form (see APPENDIX A: CONSENT FORM on page 452.) They were given a choice of audio and/or video tape recording. Most choose both options, with thirteen respondents choosing audio only. (Additionally, I also had difficulties with my video equipment which contributed to a reduced number of videos). Respondents also had the option of confidentiality when the audio-only option was their preference. For the video option clearly confidentiality is not possible. Confidentiality was offered in the first study, but declined by all participants, so for that subgroup, real names will be used as appropriate. In the second wave of research all respondents except one did not wish to remain anonymous in the thesis.

The rationale for using subjects' real names is twofold. First, confidentiality is difficult to maintain when many members of a group are aware of intimate details of others' lives. This is especially true for the early homebirthers who existed as part of a community who knew each other. In fact these details are part of the group's process that

is critical to movement development. Even if pseudonyms were employed, it would be obvious from the details of their birth experiences and others involved who was being referred to. This was fairly obvious to me when reading Rose Weitz and Deborah Sullivan's book Labor Pains: Modern Midwives and Home Birth (1988), which discusses midwifery in Arizona. A group of the individuals I have studied are included in this book. The authors used pseudonyms, but it was fairly obvious to me, in most cases, who the authors were referencing and it was probably obvious to others associated with the movement as well. Many of these women are part of official written accounts, as well as a history of a network of people who know each other; therefore true confidentiality is difficult.

This historical component is directly related to the second rationale for using real names. Many of the women interviewed are proud of their part in the history of the homebirth movement. Due to their pride, they want direct credit for their actions. They want their roles to be accurately portrayed in the written accounts (such as my thesis) of the development and process of the homebirth movement in Arizona. Therefore, I have allowed them to choose if they want their names used in my text.

I will, however, protect my subjects from undue harm. To this end, I have included real first names and used real last names only for women on the "record" such as midwives who were licensed with the state and who appeared in newspaper articles, etc. This is in an effort to strike a balance between historical credit and privacy. Additionally, if information from an account seems to shed light on an issue that could bring a subject harm, then her name has been withheld and every effort taken to disguise her identity. This is particularly the case with midwives who may have stretched or

broken state regulations in the course of their careers and could be subject to legal ramifications. This concern has been balanced by an effort to construct an accurate picture of the homebirth movement in Tucson, its core collective action frames, and the experiences of the homebirthing parents.

The interview data has been supplemented with additional historical data. These include items such as newspaper accounts, Committee for Arizona Midwifery (COFAM) meeting notes, Arizona School of Midwifery documents, written birth accounts, photos and videos, and state statistics and regulations. Data from websites from national organizations such as Midwives Alliance of North America, American College of Nurse Midwives, Lamaze International, Coalition for Improving Maternity Services, Citizens for Midwifery and midwifery schools across the country have also been utilized. I use these additional data sources to elaborate points not fully explained by the interviews, provide a more national scope, and to provide further historical support for the details contained in the interviews. Memories can be faulty on details, and the addition of “concrete” data can help to offset this effect in historical research (Berg 1995). Information from other published works such as Rose Weitz and Deborah Sullivan’s book, Labor Pains: Modern Midwives and Home Birth, (1988), that describes the structural aspects of the homebirth movement in Arizona were also utilized. I also examined additional birth accounts not only for comparison of experiences but also as data on the development of collective action frames and the frame bridging that occurred through these published materials. Specifically, I looked at 103 published birth accounts in Lang (1972), Zimmer (1997), Gaskin (1977), and Wellish and Root (1987) as a comparison to seventy-five birth accounts I collected. These published accounts are

mostly homebirth narratives, although hospital transfers and others who ended up in the hospital were also included.

Methods of Analysis

All interviews were transcribed utilizing the following shareware software programs: MusicMatch Jukebox from www.musicmatch.com and Talkscribe from www.metabien.com. Audio interviews were transferred from microcassette analog tapes to digital MP3 format files. This facilitates both the utilization of the above software programs and the long-term storage and protection of the data files. This process resulted in forty hours and fifty minutes of interviews and over 1200 pages of transcription. Due to the number and length of the interviews, several people were employed to transcribe the data files. The MP3 format allowed for electronic passing of both the audio files and transcription text files between transcribers and myself. Transcribers were asked to sign a confidentiality form (see APPENDIX B: TRANSCRIPTION CONFIDENTIALITY FORM page 454) to ensure the protection of subjects.

Content analysis was used to analyze the interview data and provide the method for developing grounded theory. The shareware software program ANSWR from the Centers for Disease Control and Prevention was employed to conduct the data analysis. The content analysis primarily focused on a thematic level of analysis. Additionally, content analysis provided a means for developing a historical picture of the homebirth movement through these accounts. An initial reading of the interviews provided a first step for becoming immersed in the data. Immersion in the data allowed sensitizing

concepts and patterns to become evident. In line with suggestions made by Strauss (1987) and Berg (1995), both natural terms used by participants, as well as sociological constructs were formulated. In line with developing grounded theory, this process is both inductive and deductive (Berg 1995). By building on my previous research, I applied deductive categories identified during that research cycle, while simultaneously staying open to new concepts and inductively developing new categories. Some of the categories previously identified in the first wave of research (Pfaffl 1999) are: Networking, Historical Sequence, Attitudes about Birth and Motives for Birth Choices, Books, Fear and Risk, Intuition, Social Setting, Frame Transformation or Seeking out a Provider, Experiences with the Medical Community, and Nature. I developed over 100 codes that were nested within each category in the process of code development; which was a helpful feature of ANSWR. For example within Frame Negotiations is contained Seeking a Provider, Risk, Fear, Family Concerns, Books, and Networks. This facilitated the theoretical organization of the data. In the end, the following global categories were utilized: Frame Foundations, Frame Negotiations, Testing the Frame, Frame Bridging, Collective Action Frame Creation and Diffusion, and Evolution of the Homebirth Movement. These contain many subcategory codes that will be explored in detail in the Findings chapters as I weave together the narrative data, the supplemental data, and social movement analysis.

I followed Berg's (1995) suggestion that grounded theory requires both inductive and deductive approaches but should have a greater emphasis on the inductive approach. After an initial grounding in the data, the list of coding categories was developed and the second phase of content analysis commenced. This process is what Glaser and Strauss

(1967) have referred to as analytic induction. It is inductive in that it primarily begins with observations, but is analytic because it goes beyond description to find patterns and relationships among variables. As the researcher examines the data, initial hypotheses or theoretical positions begin to take form, and then a more rigorous test of the data takes place (Babbie 1998). At this juncture a criterion of selection was developed to increase the study's reliability and validity.

Following some of Berg's (1995) criteria for increasing reliability and validity in content analysis, three techniques were utilized. First, selecting items from each category randomly helps to avoid picking the cases that best supports your position. I have attempted to do this whenever possible; however, I have chosen to use a different similar narrative if the randomly chosen narrative is unclear or too wordy. Second, at least three examples are provided to support assertions. Last, any inconsistencies are reported. These steps help to ensure a greater reliability and validity of the findings of the study.

These issues, however, point out the weaknesses and strengths of the content analysis approach. Not only do steps need to be taken to increase reliability and validity, but also one is restricted to examining already recorded materials. However, content analysis is exactly suited to the analysis of processes that occur over time and produce both oral and written histories. In fact, Berg (1995:193-194) has pointed out that content analysis is most appropriate for "processes that occur over long periods of time or that may reflect trends in a society." This is reflected in the majority of work on new social movements that incorporate content analysis into the research design (Marx and McAdam 1994). It is also cost-effective and provides the means for developing grounded theory. Grounded theory is consistent with a frame analytic approach that provides

subjects with the ability to convey the meanings, understandings, and interpretations of situations that they hold and espouse. These natural understandings then reflect through the quotation and assessments as the end data that emerges out of the content analysis. All in all, content analysis is the most appropriate research design for the subject matter under study.

CHAPTER FOUR: HISTORICAL ANTECEDENTS TO TODAY'S BIRTH CULTURE

This chapter covers the history of American birth culture from colonial days up through the 1960s, and focuses on the changing social trends that increased doctors' roles in birth, increased the use of technology, and led to the advent and increase in hospital births. It also explains how these trends resulted in the decline and almost abolition of homebirth midwives. This chapter also presents contrasts between the medical model and midwifery model of birth. At the end of this chapter, we see the beginnings of protest against fully medicalized birth in America, including the natural birth movement that began in earnest in the 1950s. The resulting changes in maternity care that followed from early natural birth advocates provided a foundation for the emergence of "political" homebirthing and the homebirth movement.

The Two Predominant Models of Birth

Two very different and antithetical models for framing the world and birth in particular exist within our culture. The first, and essentially predominant model, emphasizes separation and mechanicity. The second emphasizes integration and consciousness. I will refer to the historically predominant view of birth as the "technocratic" (Davis-Floyd 1992) or "medical" (Rothman 1983a) model of childbirth. I will refer to the second model as the "holistic" (Davis-Floyd 1992) or "midwifery" model (Rothman 1982). The central premises are summarized in Table 1: Comparative Table of

the Technocratic and Holistic Birth Models. . These models “are ways of constructing reality, of imposing meaning on the chaos of the phenomenal world,” and “once in place, models act to generate their own verification by excluding phenomena outside the frame of reference the user employs” (Helman 1990:87). The importance of these models will be elaborated throughout this thesis. It should be noted, however, that although these models represent the general trends and attitudes of practitioners, it is important to remember that actual individuals may draw from aspects of both models, tending toward one or the other.

Technocratic-Medical Model, Patriarchy, and the One-Two Punch

The medical model is based in Cartesian mind body dualism as developed in the 17th century (Davis-Floyd 1992; Helman 1990). Descartes divided man [sic] into a “body” to be studied by science, and the “mind” or “soul” to be studied by philosophy and religion. This dualism remains today. In medicine this is, “a way of thinking which focuses on identifying physical abnormalities, while often ignoring, the patient and his [sic] attributes as a person, a human being, reducing him [sic], to a set of abnormal physiological parameters” (Helman 1990:89).

This separation in medicine was further developed by the western cultural separation of nature and culture; it was deepened as “nature” came to be associated with women and their sexuality. As Helman (1990:128) makes clear, patriarchy in the western 19th century equated women as “less cultural, and equated with ‘nature’ (uncontrolled, dangerous, polluting), rather than with ‘culture’ (controlled, creative, ordered) of the male world.” This was due to women’s physiological functions of reproduction, nurture,

and childrearing, which were viewed as closer to nature; hence, women's social roles were lower on the cultural scale than that of males (Merchant 1980). This division was used as a justification for the superiority of men, with "'nature' as something to be conquered, transformed, and then made productive by the forces of 'male' culture" (Helman 1990:128). Peter Reynolds (1991) describes this process as the "One-Two Punch." Take a highly successful natural process (such as salmon swimming upstream to spawn). Punch One: render it dysfunctional with technology (such as a dam). Punch Two: fix it with technology (take the salmon out of the water with machines, make them spawn artificially and grow the eggs in trays, then release the baby salmon down stream). This "One-Two Punch" acts to destroy a natural process, then rebuild it as a cultural process; a process integral to a society that highly values science and technology over nature.

Davis-Floyd (1994) suggests that this "One-Two Punch" is a perfect example of the cultural management of American birth: Punch One: dissect birth into stages with standardized measurements and rules that say how long each stage should last (e.g. Friedman's curve), use diagnostic technology to monitor the progress of these designated stages (e.g. external and internal fetal heart monitors). Punch Two: provide "fixing" technology to remedy variations from the model (pitocin, episiotomies, cesarean sections), offering technocratic solutions to a deconstructed labor process. A successful natural process now appears to "need" man's assistance.

Holistic-Midwifery Model

The holistic or midwifery model is based in very different ideas. It is essentially an extension of systems theory, which emphasizes the interconnectedness of all things. As described by Davis-Floyd (1992) and Dorsey (1982), systems theory blends cultural hierarchies and oppositions (e.g., man/woman, good/bad) into a boundless “biodance.” This lack of dualism makes it difficult to organize individuals in concrete ways. It has provided the backbone for many movements, from underground women healers in the Middle Ages to modern social movements. Movements such as the holistic health, environmental, transpsychological, home schooling, and homebirth all intersect in systems theory (Davis-Floyd 1992). These movements emphasize a holistic worldview. No parts are separate. The environment is linked to humans and vice versa. Health is a matter of the mind, soul, and body. Where modern technocratic ideologies emphasize the separation of parts of society, systems theory encourages the opposite. Table 1: Comparative Table of the Technocratic and Holistic Birth Models presents these two opposing models. The historical development of this model will be further developed in the next chapter. I now turn to the socio-historical trends that were instrumental in the decline of midwives and the rise of medicalized birth in America.

Table 1: Comparative Table of the Technocratic and Holistic Birth Models

<u>The “Technocratic” Model</u>	<u>The “Holistic” Model</u>
Based upon the male norm the female body is seen as defective.	The female body is healthy and capable of pregnancy and birth.
Birth is inherently pathological, dangerous, and “risky.”	Pregnancy and birth are inherently healthy. Nature is seen as sufficient.
The mind and body are separate.	The mind, body, and spirit are interconnected.
The best interests of the mother and fetus are antagonistic.	The mother and child’s emotional needs and safety are one.
The significant “social unit” is the institution and the supremacy of technology is at the forefront.	The family is the essential “social unit.”
Actions are based on facts, measurements, and timetables.	Actions are based on body knowledge and intuition.
Technical knowledge is valued.	Experiential and emotional knowledge are valued as highly as or more than technical knowledge.
The doctor is seen as a technician who “delivers” the baby	The mother “births” the baby and an attendant “catches” the baby
Naturally occurring labor pain is problematic and unacceptable, but iatrogenic pain (caused by practitioner) is acceptable.	Labor pain is acceptable and normal. Through mind-body integration and labor support, pain is lessened. The practitioner must strive not to cause the woman pain.

Figure #1 based on Arms (1975; 1996); Davis (1983; 1987); Davis-Floyd (1992); Gaskin (1977); Kitzinger (1979); O’Connor (1993); Rothman (1982); Stewart and Stewart (1977a; 1977c); Sullivan and Weitz (1988).

The Decline of Midwives and the Rise of Medicalized Birth

The medical model has evolved out of several historic developments. The following sections detail midwives' early practice and their eventual decline. As American society began to change and obstetrics began to assert itself as a profession, lay midwives largely disappeared. The increased use of technology, specifically forceps and anesthesia, also changed birth culture and increased the perception of obstetrical skills.

The Early History of Midwifery in America

When the English settled in America, they brought with them traditional customs of childbirth to the New World. Most notably, the practices made birth the exclusive province of women, and this was to be true during most of the colonial period. Women attended and aided each other during birth itself and during several weeks of "lying-in" that followed. Not till the revolutionary period did doctors seek to attend births. For more than 150 years, therefore, expectant women looked to female friends and kin for aid and comfort-- to a social childbirth. They turned to midwives for skillful attendance (Wertz and Wertz 1989). According to Wertz and Wertz (1989:5), "The laboring woman must have gained confidence from being surrounded by women who had themselves suffered and survived, often to an old age." At this time midwives were seen as having a quasi-religious and social function separate from medicine or the professions. Midwives did not train formally, did not organize in guilds, and did not train by formal apprenticeships. Wertz and Wertz (1989:6) explain how midwives emerged to serve their communities,

...Midwives succeeded one another by selecting themselves, or being selected by other women, to attend births. The fund of knowledge about birth practices was widely shared among women who had given birth themselves and aided others to do so. A midwife had to satisfy the expectations of such groups of women. Many midwives probably came from networks of women who aided one another in birth and were distinguished by such intangibles as manual dexterity, sensitivity and luck. Many may have been older women, themselves past childbearing age, who were available for the sometimes time consuming work and possessed of certain admired moral qualities as well as physical abilities.

These qualities may have helped midwives hold high social standing. This high social standing may be due in part to the fact that childbirth was largely successful during this period compared to other points in history. It is unfortunate that midwifery began to decline, because maternal mortality increased with the increased use of interventions by male midwives, and eventually doctors.

Few records exist to provide conclusive evidence of the maternal and infant mortality rates, but the evidence that does exist in the form of women's diaries, Bibles, and town records shows that birth was mostly successful. The evidence suggests that midwives prior to 1800 had good rates of maternal mortality, given the lack of antibiotics, blood transfusions, or prenatal care. Historians have calculated that birth was successful about 95% of the time (Wertz and Wertz 1989). Several examples exist as evidence of early midwives' records. A Long Island midwife who practiced from 1745 to 1774 was reported to have delivered 1,300 children and of that number lost but two (Wertz and Wertz 1989). Another midwife, Lydia Baldwin, an eighteenth-century Vermont midwife, claimed only one maternal death in 926 deliveries. Mrs. Schrader, a midwife from the Netherlands who practiced between 1693 until 1745, recorded in her diary her attendance at 3,017 births, and that in 94.5 percent of the cases birth was normal and spontaneous. "There were just fourteen maternal deaths in the 3,017 deliveries (4.6 in

one thousand births) for which she had direct responsibility” (Gaskin 2003:267). To put these statistics in perspective, in 1935², in the US, the maternal mortality rate was 5.9 in one thousand births, even when doctors, forceps, cesarean sections, and hospitals were available to most women who needed them by that time (Gaskin 2003:267). Mrs. Schrader’s diary is even more incredible because she handled complicated cases. She amazingly handled cases of placenta previa--where the placenta covers the cervix and death by hemorrhage is a grave complication. Remarkably, of the ten cases of placenta previa she encountered, she was able to save seven out of ten cases by delivering the placenta first and then turning the child and pulling it out feet first (Gaskin 2003). Martha Ballard was another midwife who kept records in her diary of every birth she attended. She practiced in Maine from 1785 until 1812. She attended 814 births with only five maternal deaths (Ulrich 1990). “This meant there was one maternal death for every 198 births. As late as 1930 (when we had doctors, hospitals and cesarean sections), there was one maternal death for every 150 births in the United States” (Gaskin 2003:268).

In comparison to the recorded rates of these midwives, early doctors had rates that were considerably worse: “In some eighteenth-century London and Dublin hospitals, maternal mortality ranged from 30 to 200 (!) per thousand, compared with 5 per 1,000 for Martha [Ballard],” (Ulrich 1990:172). The horrible number of women who died in

² In 1935, 70% of the urban population and 20% of the rural population gave birth in the hospital Thomasson, Melissa A. and Jaret Treber. 2004, "From Home to Hospital: The Evolution of Childbirth in the United States, 1927-1940" *National Bureau of Economic Research: Working Papers*, National Bureau of Economic Research, Retrieved 8/21/05, (http://www.nber.org/cgi-bin/author_papers.pl?author=melissa_thomasson).

hospitals was due to epidemics of child-bed fever, which killed 10-20 percent of women in these institutions (Markel 2003).

Neonatal mortality seems to have been better with early midwives as well. Martha Ballard's stillbirth rate was fourteen stillbirths in 814 deliveries and an additional five infant deaths within an hour or two of delivery, for a neonatal mortality rate of 1.8/100. In comparison a physician during the same time period, James Farrington, had a neonatal mortality rate of 36 per thousand or 3.0/100 (Ulrich 1990:170-171). Table 2: Historical Rates of Maternal Mortality by Caregiver provides additional information and comparison.

Table 2: Historical Rates of Maternal Mortality by Caregiver

History of Maternal Mortality		
Year	Doctors/National Average	Lay Midwives
1693-1745 (A)	na	4.6/1000 or 14 out of 3,017
1785-1812 (B)	na	6.1/1000 or 5/814
1943-1981 (C)	See F	0.0/1000 or 0/3000
1930 (F)	6.67/1000	See D and E
1925-1954 (D) 1931-1951 (E)	See G and F	.91/1000 .88/1000
1935 (G)	5.9/1000	Lay Midwives in serious decline
1941	3.17/1000	*
1982-1996 (F)	7.5/100,000	*
1999 (G)	9.9/100,000	*

A= Vrouw Schrader – Netherlands (Gaskin 2003)
B=Martha Ballard- Maine (Ulrich 1990)
C=Margaret Charles Smith a grand midwife from Alabama (Gaskin 2003)-includes all her cases
D=Frontier Nursing Service served a very poor and higher risk group of women in their homes (Rooks 1997)
E=Maternity Center Association Midwives in the Northeastern US (87% at home) (Rooks 1997)
F= no change in rate between 1982 and 1996 (Division of Reproductive Health 1999; Gaskin 2003)
G=(Gaskin 2003) Some estimates place this number even higher
***= I could find no specific recent data detailing maternal mortality rates by care provider. I believe this is due to midwives only caring for women who are considered low risk as well as timely transports to hospitals for emergency treatment. There were no maternal mortalities reported in recent studies (Anderson and Murphy 1995; Gaskin 2003; Johnson and Daviss 2005; Rooks et al. 1989).**

Women of the 18th and 19th centuries spent most of their lives childrearing with up to twenty or more children possible in a woman's childbearing life. Their diaries reflect the mundane nature of birth. It is a perplexing question why a mundane and mostly normal process would become medicalized and traditional midwives would become replaced. Why American midwives were displaced, when their English counterparts remained, may in part be due to America's religious culture.

...Historians have said that Protestantism bred a cultural acceptance of new science and a particular willingness to intervene technically in nature. Many American women, whether urban or rural, were more ready than the majority of English women to look positively on doctor's new knowledge and technical skills. Doctors therefore inherited a cultural process that had demystified birth and rationalized it before doctors appeared (Wertz and Wertz 1977:25)

Additionally, a medical tradition built on Descartes's division of man into a "body" to be studied by science, and the "mind" or "soul" to be studied by philosophy and religion, further fostered control of the body and women's bodies in particular. Eventually the medical model would become the reigning paradigm of birth in American culture.

The Rise of Medicalized Birth

Medicine's authority over birth is intrinsically intertwined with its development into a modern institution. Paul Starr (1982) details the decline of midwives beginning in the late 1700s. He explains the professionalization of American medicine and how this professionalization was intertwined with the practice of obstetrics. In the 18th century, as medical knowledge and technologies increased and became available, birth interventions also increased. Wertz and Wertz (1990:154) explain the effect greater technologies had on the practice of obstetrics. American doctors originally held nature to be sufficient; however, "this view conflicted with the exigencies of their practice, which called upon them to demonstrate skills. Gradually, more births seemed to require aid." Women themselves began to change the practice of medicine as they urged the doctor to "do something." "If doctors believed that they had to perform in order to appear useful and to win approval, it is very likely that women, on the other hand, began to expect that more might go wrong with the birth processes than they previously believed" (Wertz and

Wertz 1990:154). This imperative to “do something” has been called the “technological imperative” by Freund and McGuire (1995) and has continued as medicine has developed more and more technologies to aid the physical body. “The technological imperative implies that action in the form of the use of available technology is always preferable to inaction” (Freund and McGuire 1995:243). Midwives had a tradition of noninterference and this disinterest in “action” may have partially led to their decline. So then several factors began to play into the decline of midwives in the United State, including a protestant ethic that made women more open to scientific solutions, and the technological imperative that encouraged patients and physicians that actions were preferable to inaction.

Also during this time the French began to study birth for its regularities, finding its mechanicity. This new anatomical knowledge became part of medical training in Europe. This view of mechanicity was further encouraged by Descarte’s dualism. After about 1750 American “doctors” who were trained abroad, under French influence, began to practice in colonial towns and cities. They also called their skills midwifery, but they sought to set themselves above “midwives” by demonstrating new skills (Wertz and Wertz 1977). Midwives of the same era in both England and America continued to be noninterventionist in nature and in their writings spoke of the dangers of the “man instruments and their midwifery beliefs that their hands served them better” (Wertz and Wertz 1977:39). From approximately 1750 to 1810, American doctors conceived of the new (scientific) midwifery as an enterprise to be shared between themselves and trained midwives much as was the case in Europe (Wertz and Wertz 1977). However, this shared enterprise never came to be because of a combination of social, financial, and ideological

differences. In Europe, governments provided financial support for medical training including the training of midwives. In the US no such financial support existed and as such most women could not afford training in schools. Instead, schools that had opened to teach men and women, trained mostly male midwives and eventually doctors (Wertz and Wertz 1977).

After 1810, a gradual decline in midwives was seen. This decline occurred for several reasons. First, attitudes concerning women's roles were changing and it became unthinkable to train midwives alongside men, even for birth. Victorian culture found certain roles unsuitable for women. It was written that women were both unfit for midwifery and that midwifery was socially unacceptable for a "lady" (Wertz and Wertz 1989). Second, male midwives, who would in 1828 rename themselves "obstetricians," had begun to carve out medical societies and professional organizations. Midwives, on the other hand, never moved to organize or become part of a system where they were subservient to doctors (Wertz and Wertz 1989). In Europe, midwives were trained as doctor's helpers. European midwives remained the main attendants of normal birth while doctors became experts in abnormal birth. American midwives served a community of women and did not see the value in organizing in guilds. This eventually led to their decline due to economic competition with better-organized doctors. Lastly, upper and middle class women's tastes began to change. In the desire for a perceived sense of "safety" and "respectability," these women turned to physicians to aid them in delivery. Classism clearly played a part in midwifery's decline. Upper to middle class men had the resources to become doctors and women sought "professionals" of their own social standing to attend them. Women's roles also became more constricted in the upper

classes and fewer and fewer upper class midwives existed. Midwives therefore largely ceased to attend the middle classes in America during the nineteenth century. Except among ethnic immigrants, among poor, isolated whites, and among blacks, there is little significant evidence of midwifery (Wertz and Wertz 1989).

The Beginnings of Nurse Midwifery

As allopathic medicine became the dominant model in health care in America, and midwives were quickly disappearing, nurses began to take on ever more important roles. By the late 1800s, American schools existed to teach nurses, and what would become their national professional organization, the American College of Nurse-Midwives, was begun in 1896. Early nursing leaders discouraged nursing from becoming “mixed up” with midwifery (in comparison to nurse-midwifery which was the norm in Europe.) They advocated that maternity care should be under the auspices of obstetricians, either at home or in the new maternity hospitals (Rooks 1997). Despite this initial discouragement, in 1911, Bellevue Hospital opened the first publicly funded American midwifery program. In 1912 the Children’s Bureau undertook a study on maternal and infant health. The results were not good, and it led to the enactment of the Sheppard-Towner Maternity and Infant Protection Act, a federal law that encouraged states to make their own plans to improve maternal and child health and provided funds to train people to implement these plans (Edwards and Waldorf 1984; Rooks 1997). Several Southern states proposed plans in which public health nurses would educate and supervise granny midwives. Rooks (1997:36) states, “Articles published in several respected journals during this period went a step further by advocating the actual training

of nurses to be midwives.” In 1914, Dr Taussig coined the term nurse-midwives and encouraged the development of midwifery schools as a graduate program for nurses (Rooks 1997).

In 1925, Mary Breckinridge implemented Dr. Taussig’s suggestion and opened the Frontier Nursing Service (FNS) in poor rural Leslie County, Kentucky. Mary Breckenridge was an experienced and very capable leader ³. She went to England and became trained as a midwife; she then hired and brought back to Kentucky two other British trained midwives. The FNS developed protocols, worked with physicians to develop directives, and established physician backup for the nurse-midwives. FNS grew and established two outposts and a small maternity hospital by 1928. By 1933, they had eleven district nursing centers. The nurse-midwives at these centers provided midwifery and nursing care to people of the area, traveling by horseback to attend births and provide care. For the FNS centers, homebirth was the norm until the 1950s when a belated but expected shift to hospital birth occurred, following the national trend (Rooks 1997).

The FNS kept meticulous records which clearly documented the centers’ good outcomes for both mothers and babies. A life insurance audit of the services provided by FNS stated, “The type of service rendered by the Frontier nurses safeguards the life of mother and babe. If such a service were available to the women of the country generally, there would be a saving of 10,000 mothers’ lives a year in the United States. There would be 30,000 less stillbirths and 30,000 more children alive at the end of the first month of life” (Tom (1982) quoted in Rooks 1997:37). Prior to the initiation of the FNS program,

³ See Rooks, Judith Pence. 1997. *Midwifery and Childbirth in America*. Philadelphia: Temple University Press. for a more thorough discussion of Mary Breckenridge and her contributions to nurse-midwifery.

Leslie County had one of the highest levels of perinatal and infant mortality in the US. After the initiation of FNS, Leslie County's perinatal and infant mortality rate dropped considerably. This is even more remarkable because FNS served a low-income, poorly nourished and thus higher risk population. The funding provided by the Sheppard-Towner Act succeeded with the FNS in improving maternal and infant health; however, obstetricians lobbied against this Act and succeeded in cutting the Act's funding. Despite this loss of funding the FNS program continued, as did other nurse-midwifery programs.

In 1931, the Lobenstine Clinic in New York opened as the second nurse-midwifery service in the US and the nation's first nurse-midwifery educational program. The Maternity Center Association had been working to improve maternity care in New York and realized its public health nurses needed further training to provide better services. The Lobenstine Clinic was an outgrowth of this need for better training. Mary Breckenridge sent a FNS midwife to help set up the school. This clinic served poor underserved populations and existed for twenty-six years. They attended 7,099 births, mostly in women's homes, and the maternal mortality rate was 0.9 per 1,000 live births, compared to the national average of 10.4 per 1,000 (Rooks 1997).

Several further developments occurred. In 1939, FNS opened its own nurse-midwifery education program. In the following years three other nurse-midwifery educational programs would also open, all designed to serve special populations in need. Not until 1955, at Columbia-Presbyterian-Sloan Hospital in New York City, would nurse-midwives enter mainstream hospital care. In 1955, out of precursor organizations, the American College of Nurse Midwifery⁴ was begun. It published its first volume of its

⁴ Merged with other organizations and was renamed to American College of Nurse-Midwives

professional journal *Nurse-Midwifery Bulletin*⁵ the same year (Rooks 1997). Slowly, despite opposition from a majority of obstetricians, nurse-midwives began to make inroads in hospitals, but nurse-midwifery was changed as this transition occurred. In the hospital nurse-midwives were more strictly under the control and policies of the doctors and institutions, and these restrictions changed the way they practiced and their profession.

Nurse-midwifery's growth has been slow. In a national survey, in 1963, only 535 nurse-midwives were identified and of these only 34 were providing direct labor and delivery maternity care, mostly in New York, Kentucky, and New Mexico--where it was clearly legal. In the 1970s, nurse-midwifery underwent increased growth. By 1976, nurse-midwifery was legal in all but a few Midwestern states, nineteen educational programs existed, and the number of hospital deliveries by certified nurse midwives (CNMs) doubled. Once CNMs were in hospitals, they became firmly entrenched as part of the health care team, under physician control. This led to an ACNM position stating that births should occur in hospitals and that the organization discouraged members from attending homebirths. Rooks (1997) notes nurse-midwives associated their slow growth in part to a connotation of untaught, unprofessional, midwifery. This attitude exists to some degree to the present day; with some nurse-midwives accusing lay or direct-entry midwives of hampering CNM's efforts to establish professional midwifery in America (Rooks 1997; Rothman 1998).

Since midwives have traditionally served only a small proportion of clients, who are mostly poor, rural, or underserved, few women experienced the advantages their care

⁵ This publication became the *Journal of Nurse-Midwifery* in 1974

provided. The majority of American women were cared for by doctors who had risen to become the main practitioners of birth. A central difference between midwives and doctors was physicians' increasing use of interventions.

New Skills, New Problems in Medical Birth

Forceps

Within the emerging profession of medicine the need to demonstrate skill mounted. Hence, forceps became the tools of the emerging male midwifery and eventually doctors as well. Peter Chamberlin invented forceps in the early seventeenth century, but his family did not share his invention till about 100 years later.

By the early eighteenth century the forceps had become widely known to English doctors, who experimented with various shapes that would fit both the angles of the birth canal and the baby's head. The forceps was able to do what other tools and manual skills could not, but it was a dangerous instrument when used hastily or clumsily, for it could damage the mother or crush the child (Wertz and Wertz 1977:35).

One serious but not uncommon complication of forceps injuries was a fistula that developed between the bladder or rectum and the birth canal. This fistula allowed urine or feces to drain into the vagina causing constant odor, tissue damage, and invalidism. The increased use forceps did not make birth safer. It did however create a perception of increased skill and capabilities for physicians.

Childbed Fever

The tragedy of childbed fever illuminates the dangers of obstetrics, increased interventions, and the dangers in the developing hospitals. Childbed or puerperal fever reached epidemic proportions in the 1800s in America. This epidemic was directly tied to the practice of physicians and the common use of forceps, although this link would take some years to be recognized. In one Boston lying-in hospital as many as 75% of the maternity patients contracted childbed fever, with 20% dying of the disease. In New York, in 1885, it was estimated that the mortality from puerperal fever was 40 per 1000 (Wertz and Wertz 1989:126). In as late as 1914, 4,664 women died of puerperal fever in the US, and as recently as 1929, 405 maternal deaths were associated with puerperal fever. For every one that died three were stricken with the disease (Lang 1972).

Childbed fever is caused by a staphylococcus bacterium, which causes raging fevers, putrid pus emanating from the birth canal, painful abscesses in the abdomen and chest, and an irreversible descent into an absolute hell of sepsis and death- all within twenty-four hours of delivering a baby (Markel 2003). This tragedy was a great mystery to physicians. In 1843, and again in 1855, Dr. Oliver Wendell Holmes was the first American physician to identify puerperal fever as caused by a contagion spread by physicians. Dr. Semmelweis of Vienna was the first in the same year (1855) to publish a statistical study, revealing the role of doctors in the spread of the disease. It was discovered that physicians, who knew nothing of the importance of washing their hands, spread the disease from dead women whom they performed autopsies on, to healthy women in labor. Doctors objected to this theory strongly saying they were gentlemen and gentlemen have clean hands. It took considerable time before it was widely recognized

that they were spreading the staphylococcal disease from diseased autopsy tissues to women in labor (Markel 2003). Pasteur's 1860 discovery of microbes and Lister's advances in antiseptic technique helped guide physicians to eventual acceptance of their role in the disease.

Physicians also did not accept the role their interventions such as forceps played in the epidemic. This incidence of childbed fever was further exacerbated by the use of forceps, which tended to cause vaginal injuries that created a prime environment for the introduction of the bacterium into a woman's bloodstream. Hospitals, which were simultaneously being promoted as "safer and modern," were in fact creating environments where a woman was at much greater risk of dying from childbed fever. Interestingly, there were no reported cases of epidemics of puerperal fever among the disappearing midwives and their mortality rates remained considerably lower than that of physicians. Physicians, whether they delivered a woman at home or in the hospital, continued to spread the disease on their hands and/or instruments. Even with antiseptic protocols, childbed fever remained a serious problem until the advent of sulfa and penicillin in the thirties. In the 1920s, research conducted by Dorothy Mendenhall, a doctor for the Children's Bureau, demonstrated that, "more than three times as many women died during childbirth in Washington, DC hospitals as those who gave birth at home" (Edwards and Waldorf 1984:4). Also in the late 1920s in New York the nurse-midwifery program at The Maternity Center Association (MCA), that primarily served at-risk, poor, malnourished communities and delivered women at home, had remarkably good maternal mortality rates. From 1932-1958, the MCA midwives attended 7,099

births with a maternal mortality rate of 0.9 per 1,000 live births. The national average for the same time period was 10.4 per 1000, more than ten times higher (Rooks 1997:39).

Anesthesia

The next major intervention introduced into childbearing came in the form of anesthesia. Victorian culture spent a good deal of time discussing the pains and ills of ladies, and doctors responded with ether and chloroform. It is possible that Victorian ladies were generally unhealthier than their colonial forebears, due to inactivity, ideas of ladies' delicate nature and ill health, city crowding, scurvy, and corsets which deformed the torso and created difficulties in the reproductive organs. Pain of reproduction seems to have reached new levels in the Victorian era. "The relief of female suffering was a prominent feature of nineteenth-century medicine, and this humanitarian concern encouraged doctors to apply the new anesthesia--chloroform and ether--to the relief of birth pain in the 1840s"(Wertz and Wertz 1989:116). In 1847, James Y. Simpson first used chloroform in childbirth (Lang 1972). In 1850, Queen Victoria had her seventh child under chloroform, hence beginning the popularity of anesthesia in birth. Women began demanding that pain be removed from birth and slowly physicians began to use anesthesia more liberally. Dr. Rudolph Holmes of Chicago introduced twilight sleep (a combination of scopolamine and morphine) to American labor rooms. Later he stated, "I didn't know what I was doing. I have found out since.... We must protest vigorously against making the human mother an animated mass without any mentality" (Edwards and Waldorf 1984:2). By 1936, twilight sleep was the norm and women felt that being modern and independent included freedom from the childbed suffering of their mothers.

Early feminists had contributed to this shift in birth attitudes. After women obtained the right to vote, a group of early feminists fought for “twilight sleep,” a birth they argued “liberated” them from the biological realities of birth pain (Wertz and Wertz 1989).

Around the same time in the 1920s, the very influential Dr. Joseph DeLee popularized the active management of birth in the first volume of *Obstetrics and Gynecology*. Previously, in an influential AMA paper (DeLee 1920), he painted birth in harsh images. He equated crowning to having the infants head squeezed in a slowly closing door and the damage to the mother as equivalent to her landing on a pitchfork. He believed the repeated thrusts down the birth canal, as the baby “pounded against the rigid perineum,” were responsible for some cases of brain damage, epilepsy, and cerebral palsy. DeLee proposed the following universal protocols to avert the dangers of birth-- deep sedation during the first stage of labor, ether during delivery, large episiotomies, and pulling the baby out with low forceps. By the end of the 1930s this protocol became the norm in American hospitals and still has an effect on obstetrics today.

Thus, in conclusion, by the early 1900s, midwives had been all but displaced except for in poor, rural, or immigrant enclaves (Wertz and Wertz 1989). As doctors were displacing midwives, births remained primarily at home, but as technology increased and society “modernized,” births began to move from home to the hospital. In 1900, 5% of births occurred in hospitals. In 1930, it was up to 30%, and by 1970, 99.5 % of births occurred in the hospital (Wertz and Wertz 1989). Thus began the era of highly medicalized childbirth. By the early 1900s, the technocratic model was the predominant social construction of birth. Women in labor received scopolamine and anesthetic; many births were augmented and forcep delivered (Rothman 1982). In fact between 1959 and

1965, 92% of white women and 74% of black women were anesthetized during delivery (Rooks 1997). This “black void” of birth was the status quo and few lay voices of dissent were heard, but by 1957 an outpouring of grievances regarding the majority of women’s birthing experiences bubbled to the surface in the pages of *The Ladies Home Journal*. The magazine ran an article from a registered nurse detailing cruelties on the maternity wards. These complaints included women being bound with leather straps and with metal bars across their chests; being left alone for many frightening hours without any support; being left in the lithotomy delivery position for hours at a time and lastly having their babies held back if the doctor was not present when the baby began to crown (Arms 1996; Edwards and Waldorf 1984; Sullivan and Weitz 1988). A flood of letters was sent to the *Journal* following this letter. One letter illustrates the cruelty women were experiencing:

My Obstetrician wanted to get home for dinner. When I was taken to the delivery room my legs were tied way up in the air and spread as far apart as they would go.... when I was securely tied down I was left alone...My baby arrived after I had lain on the delivery table for nearly four hours” (Edwards and Waldorf 1984).

Nurses and doctors responded by saying the policies and procedures that were generating complaints were all done for the “comfort and safety” of the woman and child (Edwards and Waldorf 1984). Many others believed these practices needed to be changed.

Rise of the Natural Childbirth Movement

In the 1930s, as a response to fully medicalized birth, alternative birth movements began to develop. Organizations such as The Maternity Center Association (MCA)

provided important research and advocacy opportunities to nascent natural childbirth advocates. In 1947, the MCA sponsored Grantly Dick-Read to provide lectures based on his book *Childbirth without Fear*. His theory, developed in the 1930s, was based on the idea that fear produces tension, and tension produces pain in childbirth (Edwards and Waldorf 1984). He advocated prenatal education and relaxation methods to reduce fear and tension, hence reducing birth pain. Although not the first to describe this relationship, he is the most well known for this theory. He was ostracized for his work, and accused of promoting cruelty to women (Edwards and Waldorf 1984).

In 1946, Margret Gamper, an obstetric nurse, used Dick-Read's ideas to have her own natural childbirth. From this point on she set out to educate other women about Dick-Read and natural childbirth. She began teaching classes and published her own book *Relax, Here's Your Baby* in 1951. Her book remained for years one of the only publications by a childbirth educator and nurse to bravely discuss a subject, from a woman's point of view, that was largely taboo. Edwards and Waldorf (1984:25) commenting on Margret Gamper, state, "She stood alone in the unique position of a nurse turned childbirth educator. In addition to the classes in the Gamper methods, the books, films, and seminars, she trained dozens of nurses to become childbirth teachers on their own and encouraged many people."

One such person was Robert Bradley. He modified Dick-Read's principles with exercises developed by a nurse to develop the Bradley Method of Natural Childbirth (Edwards and Waldorf 1984). This method involves active participation by the husband or coach and is sometimes referred to as "Husband-Coached Childbirth." He has become nationally known for his work. Bradley teachers exist across the US today.

Also building on Read's principle's, Elisabeth Bing set forth as a strong advocate for natural childbirth in the 1950s; she would later advocate the Lamaze method which seemed more suited to Americans (Edwards and Waldorf 1984). An eventual colleague of Elisabeth's was Marjorie Karmel. She was instrumental in bringing the Pavlovian derived breathing techniques of the *Lamaze Method* to the US. Her publication of *Thank You Doctor Lamaze* (Karmel 1965) propelled this method of psychoprophylaxis into the American spotlight. In 1960, Elisabeth and Marjorie eventually teamed up and created the American Society for Psychoprophylaxis in Obstetrics (ASPO). This organization actively sought out physician participation, which aided its eventual acceptance with hospitals and doctors. Today, Lamaze based classes are often referred to as "Prepared Childbirth classes."

These advocates and pioneers, promoting Lamaze's "prepared childbirth" and Dick-Read's and Bradley's forms of "natural and husband coached childbirth" began to shift American society toward less drugged births (Davis-Floyd 1992; O'Connor 1993; Rothman 1982). During the period of 1950 to 1970 the principles of Lamaze and Grantly Dick-Read made progress in encouraging natural childbirth⁶. Concerns over the respiratory depressive effects of narcotics also began to shift medical attitudes about natural childbirth. A slow shift toward spinal anesthesia also contributed to this social change as did the 1950s focus on birth as a culmination of femininity not to be missed. Other organizations such as International Childbirth Education Association, Inc. (ICEA)

⁶ See Edwards, Margot and Mary Waldorf. 1984. *Reclaiming Birth: History and Heroines of American Childbirth*. Trumansburg, New York: The Crossing Press. for a history of childbirth education in America

were begun, which advocated for natural birth⁷. Le Leche League was also begun in the 1950s to support and encourage breastfeeding.

Natural birth advocates added to the cultural stock of knowledge and slowly Lamaze with its controlled breathing patterns began to be adopted in the hospital setting. Some later critics noted this took root because Lamaze always encouraged the supremacy of the doctor and the breathing gave women something to do that kept them quiet (Rothman 1991). This may be why Lamaze made progress in hospitals, but it is also clear that women benefited from a sense of control and knowledge that came with Lamaze training. From this initial groundwork by natural birth advocates, the homebirth movement emerged.

Out of the political hot bed of the 1960s, the emerging feminism of the 1970s, and the emergence of a naturally minded counterculture coupled with the dissatisfaction of many women with their childbirth experiences, the homebirth movement was born and took shape. Homebirth midwifery took natural birth to a new level by advocating removal of the hospital. Homebirth and midwifery had always remained in small enclaves such as isolated rural populations. In these settings homebirth was simply a matter of necessity, but in the activism of the 1960s and 1970s homebirths and lay midwifery reemerged as a political matter. “Political” homebirthing grew out of communities of women. The following chapter will detail this development, and the collective action frames that have come to characterize the movement.

⁷ ICEA grew out of a 1959 meeting on childbirth reform convened by Maternity Center Association.

CHAPTER FIVE: BIRTH OF A MOVEMENT- COLLECTIVE ACTION FRAME EMERGENCE AND DIFFUSION

“This is a book about childbirth in America. It is neither a medical textbook, nor a political treatise...it is a statement that grew out of my need to understand and explain my own birth experience. It is my contribution to anyone interested in the American way of birth.”

- Suzanne Arms, Immaculate Deception (1975)

Many of the homebirth movement’s collective action frames and writings come out of the motivation of women to explain their birth experiences. In this chapter, the emergence and diffusion of the homebirth movement’s collective action frames are detailed. I use the lives and writings of three pivotal women, Raven Lang, Suzanne Arms, and Ina May Gaskin, to illustrate the production of the movement’s core prognostic, diagnostic, and motivational frames. These mothers of the homebirth movement went through a process of cognitive liberation. They applied their sociological imagination to American birth, which was essential to developing a new social construction of birth that brought birth back into women’s homes. I first provide a short explanation of framing and its role in social movements. I then move onto explaining how these pivotal women’s lived experiences and subsequent writings have been seminal in the articulation of the movement’s core collective action frames. I then detail the diagnostic, prognostic, and motivational collective action frames in the homebirth movement, including the framing of technology and risk. I provide considerable discussion on the arguments against common interventions and technologies used in birth. I attend to the medical

community's reaction to these framings and their subsequent counter-framing. Issues of empirical credibility and commensurability are also discussed.

The Theory of Collective Action Frames

As a means of understanding the emergence, evolution, and maintenance of the homebirth movement, I have employed the analytical tools and concepts of the social movement framing perspective. Snow et al. (1986:464) define frames as ,

‘schemata of interpretation’ that enable individuals ‘to locate, perceive, identify, and label’ occurrences within their life space and the world at large. By rendering events or occurrences meaningful, frames function to organize experience and guide action, whether individual or collective.

The term “frame” has been employed as a verb, to denote “framing” (Gamson et al. 1982; Snow et al. 1986; Snow and Benford 1988), as an active, process-oriented phenomenon that implies agency and contention on the level of reality construction. The results of these framing activities are referred to as collective action frames (Snow and Benford 1992). Collective action frames (CAF) perform an interpretive function by simplifying and condensing aspects of the “world out there” and mobilizing potential adherents. “Thus collective action frames are action-oriented sets of beliefs and meanings that inspire and legitimate the activities of a social movement organization” (Benford and Snow 2000:614). . As Benford and Snow (2000:615) state, “Collective action frames are constructed in part as movement adherents negotiate a shared understanding of some problematic condition or situation they define as in need of change, make attributions regarding who or what is to blame, articulate an alternative set of arrangements, and urge

others to act in concert to affect change.” Researchers (Benford 1993; Benford and Snow 2000; Snow and Benford 1988, 1992) have identified three core components of collective action frames: diagnostic framing, prognostic framing, and motivational framing.

Diagnostic framing involves an articulation of a problematic situation or aspect of social life in need of change (Benford 1993). By placing blame on culpable agents, diagnostic framing is essential to building both consensus and action mobilization. Prognostic framing involves an articulation of a proposed solution to the identified problem. This may also involve a plan of attack, strategies, and solutions (Benford and Snow 2000). Lastly, motivational frames provide a rationale or call to arms to engage in ameliorative collective action. This involves the articulation of vocabularies of motives (Benford and Snow 2000). All these framing components are affected by the existence of multiorganizational fields.

The presence of multiple actors in a social movement arena affects their articulated frames, actions, and outcomes. Such social actors as the state, counter movements, competing social movement organizations, bystanders, targets of influence, and the mass media (Benford and Snow 2000; Marx and McAdam 1994) all contribute to a movement’s development and evolution. As Klandermans (1997:10) has stated, “Such factors as the relationship between a social movement organization and its opponents, the presence of counter movements, the formation of coalitions, the movements’ relationship with sympathetic and opposing political parties, and its relationship with the mass media all shape the field of tension in which mobilization attempts evolve.” In the end mobilization is a struggle for the souls, hearts and actions of citizens (Klandermans 1997). For the homebirth movement and midwifery, the multiorganizational field specifically

involves such opposing groups as the AMA and the American College of Obstetricians and Gynecologists; such supportive groups as Citizens for Midwifery, Coalition for Improving Maternity Services (CIMS), NAPSAC, and MANA; pro-medical or alternative receptive political communities; the mass media which is both receptive and critical; and lastly midwives and birthing women themselves. Not only do movements emerge and evolve under the tensions of a multiorganizational field, but these are also created and constrained by the cultural context within which they emerge and function.

Cultural eras also contribute to the nature and rate of growth of various social movements. Different eras are associated with socio-cultural and political trends which flavor social movements that emerge during these eras. As Benford and Snow state (2000:629),

The cultural material most relevant to movement framing processes include the extant stock of meanings, beliefs, ideologies, practices, values, myths, narratives, and the like...which constitute the cultural resource base from which new cultural elements are fashioned, such as innovative collective action frames, as well as the lens through which framings are interpreted and evaluated.

The homebirth movement spans the last thirty-odd years, and the rhetoric and style of the movement has been affected during these different decades. The late 60s and early 70s gave rise to the homebirth movement. Later, as the movement matured through the late 1970s and early 80s, the movement was more affected by interests in self-care. In the conservative 80's and early 90s the homebirth movement underwent a decline, and many of the homebirth midwives "went medical" (became Labor and Delivery (L&D) nurses or CNMs) to sustain their families, and entered an "epidural" culture in the hospital. The late 1990s and 2000 have seen homebirth continuing to benefit from interests in holistic medicine and consumer "choice." Homebirth is often "sold" as one

choice on the table for birthing women today. However, the rate of homebirths has continued to remain nationally around 1% of births, with certain states having higher percentages than others (O'Connor 1993).

The homebirth movement emerged from a constellation of other social movements. The general activism of the 60s and 70s, the women's movement, "free clinic" and self-care groups, back-to-nature movements and a growing interest in "natural and alternative lifestyles," all combined to produce a rich environment for the emergence of the homebirth movement. The social milieu of the 1960s involved distrust of the "system" and active movements to change the status quo (Anderson 1995). This milieu developed in part from the effect of the civil rights movement. As McAdam (1989) comments, involvement with the civil rights movement in the 60s had a lasting effect on activists and their biographies. The civil rights movement led to a number of other movements that worked for rights for children, patients, and the handicapped, just to name a few (Starr 1982). This was coupled with a generally felt "crisis" in health care. Starr (1982) has noted that doctors had been given considerable power up to this point, but the public and governmental rhetoric of the times led to a call for a reformation of health care. This public rhetoric, which brought doctors down off their "pedestals," added to women wanting more control of their births and not blindly trusting their doctors. This was further fueled by feminist claims to decentralize medical knowledge, especially knowledge about women's bodies.

During this tumultuous time feminism and the women's movement provided frames for actively removing patriarchal aspects of society and finding more woman-centered alternatives. One such avenue is embodied in the work of the Boston Women's

Health Book Collective. The book Our Bodies, Our Selves, often referred to as the feminist bible on women's health, grew out of a women's group discussion on "women and their bodies" that was part of a 1969 women's conference held in Boston (Rooks 1997). These feminist health frames helped to lay a foundation on which homebirth frames were partially built. Also the feminist model of "conscious raising groups" was an important organizational model in the homebirth movement, often leading to schools and training of lay midwives.

All these movements and ideational components added to the cultural stock of knowledge and experience from which the homebirth movement emerged. The homebirth movement was distinct from earlier natural birth cycles in that it took the rhetoric of natural birth, feminism, holistic health, and self-care to a new level by advocating for removal of the hospital environment, advocating that most births were best achieved at home, away from technological intervention and the medical thinking of most doctors (O'Connor 1993). This innovation is an important component of the movement's collective action frames. As Benford (2000:138) states, "What gives a collective action frame its novelty is not so much its innovative ideational elements as the manner in which activists articulate or tie them together."

Advocates of homebirth primarily came to the movement through their own birthing experiences. Personal experience also provided a major source of evidence of the benefits of homebirth. To this day birth narratives are a major way homebirth advocates share important aspects of the movement's collective action frames. The very creation of the movement's core collective action frames has its roots in the lives of early radical women.

The Rise of New Radicals

The seeds of protest and change were germinated through the life experiences of birthing women. Some of these women were so radicalized by their experiences that they became movement leaders. It is rare to find an account of an early midwife that doesn't involve her own experiences as part of her activism. They are products of both social history and biography. They actively utilized their sociological imaginations and saw the linkages between their own experiences and the institutions in which they birthed. In the terminology of framing they became "cognitively liberated" (McAdam 1982; Nepstad 1997). They became cognitively liberated by first identifying care that was unjust and unnecessary; second they began to demand for change; and lastly, they became empowered to make decisions, find alternatives, and advocate for social change both as individuals and in groups. These women in the late 60s and early 70s were part of a social culture that encouraged activism, feminist thinking, and alternative life choices. They also were of childbearing age when birth had become "ultra-medicalized." It was unusual for husbands or other support people to be allowed in the delivery suites. Most women had episiotomies and were separated from their children right after birth for many hours. A number of different women's voices, energy, and activism, in various regions of the country, have fueled the homebirth movement over time; but I feel three "national" women warrant special attention since my respondents often mentioned their books. In addition they have played important parts in the "official" organizations and received

noteworthiness for their activities. Ina May Gaskin, Susanne Arms, and Raven Lang⁸ are all pivotal to the beginning of the homebirth movement and influential to the women in my study.

Raven Lang

Raven (Pat) Lang began as a self-taught childbirth educator in Santa Cruz after the birth of her first child in 1968. This birth occurred in the hospital, and although she had remained undrugged she had received a large episiotomy that had gone into the rectal sphincter causing considerable pain and a difficult recovery (Edwards and Waldorf 1984). In her book, *Birth Book*,(1972) she recounted the moment of her son's birth:

At the birth of my baby I was fully conscious. I remember a head rotating to my right leg and I saw a face in which I could recognize at least two generations of my past. A cry, forever imprinted in my mind, as clearly this minute as then. Heavy impressions. The baby was given to me for a minute and placed on my abdomen- then taken away to be wrapped and put in a plastic see-through box, far away and in back of me- so that I had to strain my neck to even see this little critter I had just parted from for the first time in his life. My perineum was stitched up and I was wheeled to maternity, my baby was sent to the nursery, my mate was sent home. I was to see my baby in several hours (Lang 1972:38)⁹

⁸ The information on Ina May Gaskin, Susanne Arms, and Raven Lang is drawn from various written sources. These three national actors were not part of the current interview respondents whom I interviewed for this thesis.

⁹ *Birth Book* (1972) does not contain page numbers, the numbers I am using while quoting I have assigned by numbering the book sequentially from the first page on.

After her birth and up until 1970 she believed birth should occur in hospitals. In 1970, she accompanied a woman in the hospital and the events of this birth radicalized her ideas about hospital birth.

She went to the hospital with a woman in active labor who had originally wanted a homebirth but whom Pat had encouraged to go to the hospital. At the hospital, the woman's labor was slowed with narcotics since the doctor was delayed. Then when he arrived hours later, she was given pitocin to "get the labor going." Then abnormal fetal heart tones were heard and the woman was whisked off for a hurried forceps delivery (Edwards and Waldorf 1984). Edwards and Waldorf (1984:160) stated, "To Pat, the pit drip was both a shock and a revelation. Now she knew that certain procedures like a hasty episiotomy or a labor stopped and started with drugs could be done for someone else's reasons and not solely to improve health in the baby or mother...Exposure to the pit drip transformed Pat Lang into Raven." This management of the birth processes was a radicalizing experience moving her toward identifying standard care as unjust and advocating for change. Previously Raven had thought education and advocacy in the hospital would be sufficient to ensure positive birth experiences, but this birth made her realize out-of-hospital birth was the only way to truly obtain that goal. She became a self-taught empiric and began attending births at home. She was one of eight "lay" midwives in Santa Cruz in 1970.

The doctors in the area called her a "health menace." At this time the doctors got together and agreed that no doctor would provide any prenatal care to any woman who was considering a home delivery. They hoped this would bring the women back into the

hospital. It had the opposite effect. The eight midwives organized and began providing prenatal care and deliveries at home.

The Birth Center in Santa Cruz was hence begun in 1971. It operated for five years with women receiving prenatal care at the birth center and having their births at home with the center's lay midwives. Lay midwifery was illegal in California, and as such an organized midwifery center was a daring choice. Raven states in *Birth Book*,

Some were scared because it wouldn't be legal and we'd be up for lots of criticism and a possible bust. But after reading Jerry Rubin's *Just Do It*, we decided it was the only solution open to us. We were already doing it, so there was no reason why we shouldn't organize and help each other out (Lang 1972:3).

In the spring of 1972 The Birth Center held a symposium inviting some medical personnel as well as homebirth parents. The parents recounted their experiences, and a large discussion ensued. They had large birth pictures on the walls of the dome building accompanied by the birth statistics that a young medical student, Lewis Mehl, had compiled of the "good" outcomes the birth center had achieved.

After the first year of the center's existence, Raven Lang published the *Birth Book* in 1972. This was a book of rationales for homebirth and narratives of the women who had had births with the Birth Center. The book contained thirty-four accounts of homebirthing experiences written by parents and midwives, chapters on maternal-infant bonding, an history of childbirth, female sexuality in parturition and lactation, issues on confronting fear, prenatal care, labor, delivery, and the newborn. It also included sections on herbs and the making of placenta stew for energy after the birth. Lastly it included accounts and information from the symposium the Birth Center had hosted and the statistics of the "good" outcomes of all the birth center births. This book could be called

a “call to arms” with a fairly radical tone. It was one of the first books published on the subject of lay midwifery and homebirths, and the Birth Center existed in an illegal environment that was tense and contentious. Within the pages of *Birth Book* Lang (1972) provided some of the first clear diagnostic, prognostic, and motivational collective action frames for the movement. These collective action frames are detailed in Table 8: Collective Action Frames in the Homebirth Movement on page 166.

The Birth Center and *Birth Book* were not well received by the medical world, even by medical people who favored natural birth. They were unaccustomed to being questioned in such a direct and radical fashion. On a trip to America, the natural birth advocate, Leboyer, was said to have picked up the *Birth Book* in a bookstore and after leafing through the pages dropped it and exclaimed that it was the work of the devil (Edwards and Waldorf 1984). In 1974, the California Board of Consumer Affairs investigated the Birth Center and three of the midwives were arrested and charged with practicing medicine without a license. In 1976, the Birth Center closed under the pressures of increasing popularity and a changing clientele.

This community and the publication of the *Birth Book* did contribute to the beginning waves of homebirth in the US. The importance of this book was stated by the early homebirthers in my sample. One respondent commented how important the information contained in *Birth Book* was to her having a successful homebirth in 1974. She stated, “It fueled my fire to have the birth I wanted.” Another book that was often mentioned by my respondents and holds importance in the politics of midwifery is Suzanne Arms’ *Immaculate Deception* (1975).

Suzanne Arms

Suzanne Arms' years of advocacy for natural birth began like so many other women's with the traumatic birth of her first and only child. She recounted this experience in her book *Immaculate Deception* (1975), and elaborated further on her birth in her 1996 edition:

I was terribly afraid and did not trust either the process of birth or my body...It was an all too typical birth, I found out later: admitted to the hospital too soon; put to bed instead of being encouraged to remain upright and active; given a shot of narcotic every few hours to sedate me, an artificial hormone to make contractions stronger, then shots of anesthetic to numb me, than more stimulant. Nurses came and went, but were too busy to stay; they told me I wasn't 'progressing' well enough and threatened me with a cesarean. And so it went for twenty-three hours, without my ever seeing the sun or moon or breathing in fresh air to remind me that all was well....[D]espite me pushing in every possible position, the baby did not move down the short distance of the birth canal. Finally a doctor pulled her out with forceps. I held her and cried. During Molly's birth, decision-making and control were taken from me. Trusting so little in my innate knowledge of this natural process, I bent to the authority of those who 'knew best.' They-the doctors and nurses-had ostensibly done everything they could to help me and make the birth safe. Why then was it such a difficult and traumatic experience? The overall effect was shattering. Molly's birth did not show me any strength, it made me question my abilities as a woman and as a mother (Arms 1996:2) .

It wasn't until her daughter turned one that she began to feel the "anger and sorrow" from the birth. These feelings produced a deep need to do something. Arms (1996:3) stated, "I had been deceived, and I was determined not to be deceived again. I set out to discover what had gone wrong, not just in my child's birth, but in the American way of birth, for I quickly discovered my experience was typical." She began to strongly apply her sociological imagination and through research developed an injustice frame leading her to become cognitively liberated through this framing process.

As a self-trained photo journalist, she slipped onto maternity wards and took some of the first ever publicly published photographs of hospital births in the 70s. Her photographs fueled the homebirth movement, providing clear images of the treatment in hospitals that homebirthers were seeking to avoid (See Figure 1: Hospital Birth Images from *Immaculate Deception* by Suzanne Arms page 103. The publication of *Immaculate Deception* (1975) provided clear diagnostic and prognostic collective action frames to the natural and homebirth movements, detailing the problems with modern obstetrics and why and how it should be changed. The book contains fictional accounts of what birth was like in ancient times and what the problems with modern childbirth are. She discusses women, childbirth, and the history of medicine. She provides a contrast with American birth by discussing midwifery practice in Denmark. She also covers the emerging lay midwives in Santa Cruz and elsewhere and describes their rationales and experiences. She also discusses the effects of fear and the fallacy of trusting modern obstetrics, based partially on America's poor record on infant mortality. In the 1996 edition, she added considerable material. She devotes a large portion of the 1996 book to birth and drugs, the cesarean epidemic, electronic fetal monitors, ultrasound, intensive care baby units, physician specialization, midwives and doulas. The book also includes a chapter on easing fear in childbirth and other socio-political issues relevant to moving maternity care more toward natural childbirth. She concludes with a section on issues related to the care of babies before, during, and after birth. One of my respondents, who worked for years as a homebirth midwife and then later as a labor and delivery nurse, commented on the narratives, statistics, and images provided in *Immaculate Deception*,

There is this one chapter in there where she paints such a great picture of like the snowball effect of intervention, and oh that is still so true. You

know I still feel like all this intervention really causes so many problems. And you know that's when I like get that little smile on my face. I'll look at the doctor, and I'll go, 'How come that's never happened at home?'

The information in *Immaculate Deception* was utilized by women all over the country. *Immaculate Deception* sold over 250,000 copies and in 1975 received the *New York Times* "Best Book of the Year" Award. Arms has since authored seven books on childbearing and rearing, produced three birth films, helped open the second out-of-hospital birth center, been a guest on all three national network talk shows, and a speaker at various conferences and events (www.birthingthefuture.com). She published revised editions of *Immaculate Deception* in 1994 and 1996 to help educate a new generation of childbearing women.

As Suzanne Arms' *Immaculate Deception* (1975) clearly detailed the effect of routine obstetrics in hospitals, Ina May Gaskin's book, *Spiritual Midwifery*, came forth the same year (1975) detailing the ecstatic, family-centered homebirths of approximately fifty-five babies.

Ina May Gaskin

Ina May Gaskin has been referred to as "the midwife of modern midwifery" (Granju 1999). Her book *Spiritual Midwifery* has sold over a half-million copies and continues to be a source of support for the ideas of homebirthing. The book's language is dated but still holds a critical place in the articulation of the movement's framings. Her impact on the homebirth movement from its inception to today is considerable. Ina May has published articles on the good outcomes of thousands of births that have occurred on

The Farm, her community in rural Tennessee. She has also published and lectured to doctors on “the Gaskin Maneuver,” a hands and knees approach for alleviating shoulder dystocia in delivery. It is the first obstetrical procedure known to be named after a midwife. She also published a new book in 2003, *Ina May's Guide to Childbirth* designed for a new generation of mothers. For twenty-two years she published *Birth Gazette*, a quarterly newsletter covering health care, childbirth, and midwifery issues. She served as the President of the Midwives Alliance of North America from 1996 to 2002. She has lectured all over the world at midwifery conferences and at medical schools, both to students and to faculty. She received the ASPO/Lamaze Irwin Chabon Award and the Tennessee Perinatal Association Recognition Award. In 2003 she was chosen as Visiting Fellow of Morse College, Yale University (www.inamay.com/biography.php 2004).

Like many of the midwives I interviewed, Ina May seemed to have an interest in birth from very early on, even if she never imagined herself being a midwife. In an article (Granju 1999), she stated that at sixteen she was reading *Childbirth Without Fear* by Grantly Dick-Read, which was a strange choice for a teenager. She also remembered every detail of birth stories in the historical romances she read. Ina May went on to marry, get a degree in English, work in Malaysia for the Peace Corps, and later return to the US to get her master's degree. While in graduate school she had her first child. Her faith in the natural process was strong and she believed she could have a natural birth in the hospital, but her experience didn't confirm this idea. She states, “During birth at the hospital, I was left alone and treated like I had done something nasty. Then, I was approached by a gang of masked attendants who came in the room and treated me like a ritual victim. They used forceps, and I wasn't allowed to see my baby for 18 hours”

(Granju 1999). After the birth of her daughter she and her husband moved to San Francisco to “become hippies.” Here she met Steven Gaskin who was lecturing to groups of thousands on everything from religion to sex. In this atmosphere she was exposed to women’s stories of out-of-hospital births and she was further radicalized, leading her to define birth practices as generally unjust to women and babies. In 1970, Gaskin and 250 followers set off in converted school buses on a five month long speaking tour around the United States referred to as “the Caravan.” After the caravan the group set off to Summertown, Tennessee, to establish “The Farm,” a communal living arrangement that has survived to the present day. A pregnant Ina May set off on “the Caravan” with her family. She states in the beginning of *Spiritual Midwifery*,

It was even before we settled in Tennessee that we knew we were going to have to learn how to attend our own births. The original three hundred settlers spent several months accompanying Stephen on a national lecture tour, traveling in a caravan of remodeled school buses and vans which were our homes and our transportation. Several of us were pregnant when we left San Francisco, including myself. No one on the caravan had ever attended a birth before. One woman had had her own baby at home, but her knowledge was limited. Our funds were primarily what savings we had among us and what we could earn on the way so it seemed beyond our reach financially for each woman to give birth in a hospital. We were a transient population with no desire to leave a trail of debts behind us....Besides this, several of us had given birth in hospitals previous to the Caravan and had been unsatisfied with the way we and our babies were treated. We wanted our men to be with us during the whole process of childbirth, an option that was not available in American hospitals at that time, we didn’t want to be anesthetized against our will, and we didn’t want to be separated from our babies after their births. We were looking for a better way (Gaskin 1977:17).

Ina May quickly became the midwife of the group, and she began teaching herself in earnest after the second birth she attended. Women stated she had a natural talent for midwifery (Gaskin 1977). The experiences of The Farm provided important models of

how women can birth in a supportive environment. The following passage is long but does an excellent job of describing what the environment was like that fostered the publication of “Spiritual Midwifery.” Pamela, one of the other midwives on the Farm wrote this account.

A few months after we settled in Tennessee, Ina May got pregnant again....Cara and Kathryn were helping with birthings, too, so I wasn't alone. Actually, all of us were pregnant, and all due between June and August. We had enough pregnant women that we were delivering between four and six babies a month. Starting families was one of our goals when we left San Francisco to find a place where we could live: we wanted to raise families in the healthy environment of the country. In early June, Cara went into labor. She lived in a small bus down a dirt path in the woods. Kay Marie, who was also helping with birthings now, and I had to walk the last 200 yards to her bus. Cara was beautiful in the lamplight and gave birth after an eight hour labor to a healthy full term, chubby girl. As soon as we had Cara cleaned up, the call came that Ina May was starting labor. Kay Marie was three months pregnant and feeling nauseous, so she went home and I went on to Ina May's. Ina May was on a bed in the corner of their big army tent with a lamp lit next to her when I arrived. She looked pink and golden as we exchanged smiles. This baby was full term and a good size. She was five centimeters dilated having good rushes when I got there. I lay down to sleep for a while and dreamt about her baby and Cara's new girl and my baby. My baby was very active that night and kept turning and kicking in my belly, which was very comforting. It felt like there were babies everywhere that night. I woke up two hours later hearing Ina May, and by the sounds I knew she would she would have the baby soon. I went to her and about half an hour later, she had a healthy pink, beautiful baby girl. After Eva was born, my baby settled down inside me and I went home to catch up on my sleep. A month later on a hot July night, Ina May delivered my baby, Stephanie, outside our bus on a large wooden platform that we had built under the trees for a cool place to rest in the summer. I remember feeling very well cared for pushing Stephanie out with Ina May, Cara, and Kay Marie all helping. As the sun came up, a dewdrop fell from a tree and hit Stephanie's forehead. I felt she had been baptized (Gaskin 1977:32-33)

This positive environment that honored the spiritual, healthful, natural aspects of maternity care helped develop a new vocabulary of birth. *Spiritual Midwifery* introduced new terminology, redefining contractions as “rushes” of energy. This switch in terms

emphasized the spiritual aspects of labor and not the “pain.” *Spiritual Midwifery* (1975) contained around fifty-five homebirthing stories, as well as approximately two hundred pages filled with advice to parents on birth, instructions for midwives for normal and “abnormal” births including twins and breeches, prenatal care and charting. Also statistics from 1,723 deliveries managed by Farm midwives were included in the revised edition of the book (1990). All this material would again provide the homebirth movement and individuals with motivational collective action frames for pursuing homebirth and/or advocating for homebirthing. *Spiritual Midwifery* (1975) provided inspiring accounts often mentioned by my respondents. One respondent commented, “*Spiritual Midwifery* really provided me with a sense of faith in the natural process.” *Spiritual Midwifery* was very important to the emerging homebirth movement, providing rationales, accounts, and practical advice to achieving homebirths

All the books and the lives of Arms, Gaskin, Lang and many others not detailed here were part of the process of developing the collective action frames that would come to encompass the homebirth movement. I have provided the stories of the authors’ lived experiences and the information presented in their books that influenced thousands of birthing women across the country. I’ll now turn attention toward delineating more clearly components of the collective action frames that were developed out of these books, communities, and other sources of shared knowledge.

Collective Action Frames

Homebirth literature has in part focused on linking women's birth experiences with larger social trends and issues. Much of the material in *Spiritual Midwifery*, *Immaculate Deception*, and *Birth Book* are about the problems with maternity care, and with American society. These books and others (such as Baldwin 1986; Davis 1983; Kitzinger 1979; Stewart and Stewart 1977a, c; Wertz and Wertz 1989), all provide an articulation of the diagnostic collective action frames developed by those in the homebirth movement.

The following passage from *Birth Book* (Lang 1972) does an excellent job illuminating the first framings of the homebirth movement. Note that much of her argument is based in women's experiences, clearly diagnosing aspects that are in need of change. Her prognosis is for homebirth. Her motivations are clearly mostly emotional. Only later as the movement matured were arguments able to be solidly based on research evidence. In this section she has just finished outlining the history of obstetrics.

But where has all this innovation of modern medicine brought us today? We, as women, are still forced to endure some of the most outrageous insults possible. We are still expected to labor and bear our children in hospitals, which are centers of disease and infection. Once we have entered them and entrusted our lives and the control we have over them to the authority of doctors, we are insulted with one indignity upon another. Thus a woman in the midst of labor is first required to juggle the bureaucratic red tape of the institution. Then we are given an enema, an experience that can be most painful when combined with a uterine contraction. We must then have all our beautiful pubic hair shaved off in the name of sanitation. At least one third of our body is considered 'sterile field' and beyond the boundary of our own touch.

We are handled by strangers and separated from our mate, barring us from one of the most intimate experiences we will ever share. Then we are administered all kinds of drugs, very often against our will, and must spend our energy on the delivery table turning away from persistent offerings of gas. Our movements and choice of position are restricted, and

we are most often forced to deliver strapped down to the modern cold, hard delivery table which instinctively feels too high from the floor. And then after a delivery including numerous potent drugs, perhaps the use of forceps and a compulsory episiotomy, our child is taken from us to be observed by strangers in a nursery full of screaming babies. At this point, if the mother is undrugged, she is overwhelmed by maternal feelings. She wants to examine, touch and hold this baby she has waited so long to see. Instead the baby is detached from the sounds, smells, tastes and closeness that are her/his birth-right. The father often gets his first look through a plane of glass. Where is there room for love? How can mother, father, and child share the true bond of these moments so vital to their mutual growth.

This is modern obstetrics, 1972. In light of this type of treatment, we women are now taking responsibility of childbirth out of the hospital, into our own hands. It is only with the changing consciousness of our times, that once again recognizes humankind as a being of the spirit who lives in a material world, that we are able to recover the joy and beauty of childbirth. Modern science has removed the medieval horrors of childbirth. The difficult labor no longer need end in tragedy. But in the technological advance, the uncomplicated labor has been neglected. Today, we are attempting to bring childbirth back to nature wherever possible. Women are learning how to listen once more to their long buried instinctive selves. Our children are once again being born at home in an atmosphere of love and beauty. We have taken the joyous task of bearing our young back into our own hands! And our mates are by our sides in fullfledged support. We have not neglected the advances of scientific knowledge, but we must now bring birth and motherhood back to its rightful place. Childbirth is a natural process, we need only relearn to work in harmony with nature. (Lang 1972:15-16)

Boundary Framing Through Images of Home and Hospital Birth

Boundary framing, a component of framing processes, involves a social movement's strategic efforts at delineating its ideological turf in opposition to opposing agents (Silver 1997:489). The photos included in all three seminal works discussed in this chapter effectively illustrated the differences between home and hospital birth. The homebirth pictures illustrate homebirth boundary framing as consisting of family-centered, women-centered, women-empowered life events. In contrast, the pictures used

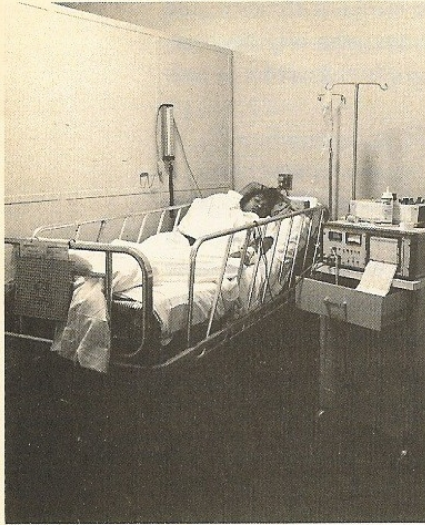
to frame hospital birth illustrate an institutional, mechanical, rough, lonely, doctor-centered birth.

Suzanne Arms' (1975) work was the first to expose the public to the images of hospital labors and births in the 1970s. Please see Figure 1 on page 103 and Figure 2: Hospital Birth Images from *Immaculate Deception* by Suzanne Arms on page 104, to see two of the pages of the hospital birth images included in *Immaculate Deception*¹⁰. These hospital images clearly speak to the separation of the family unit. Women are alone without partners or other support persons, and they are confined to bed attached to machines. During delivery their hands are literally handcuffed so they could not touch their babies or “contaminate” the sterile field during delivery. After birth the women are separated from their infants. The image of the parents looking through the nursery glass nicely illuminates this point. The images also expose the roughness with which babies were handled (e.g.. hanging upside down). The women are also clearly not in control. They are on their backs, being delivered.

¹⁰ These reproduced pages come from her 1996 edition where she consolidated many of the pictures from the 1975 edition into a single collection.

Hospital Birth in the 1970s

These pictures show some of the disturbing routine practices I observed in hospitals across the United States while I researched the original *Immaculate Deception* in the early 1970s. Most went unquestioned well into the 1980s; some continue today in many hospitals.



Above: This laboring woman is confined—the bed rails are up, the needle in her hand hooks her to an IV solution, and a belt wraps tightly around her abdomen.

Top right: Women who were awake presented a problem, as they might reach down and contaminate the doctor's "sterile field," so some women were handcuffed to the delivery table.



Middle right: The standard position for women who insisted on "natural childbirth" was supine, legs stretched wide apart in stirrups, allowing the physician easy approach for an episiotomy.

Below right: If a woman insisted on no episiotomy, the physician expected her to tear, a common result of this position.



Figure 1: Hospital Birth Images from *Immaculate Deception* by Suzanne Arms

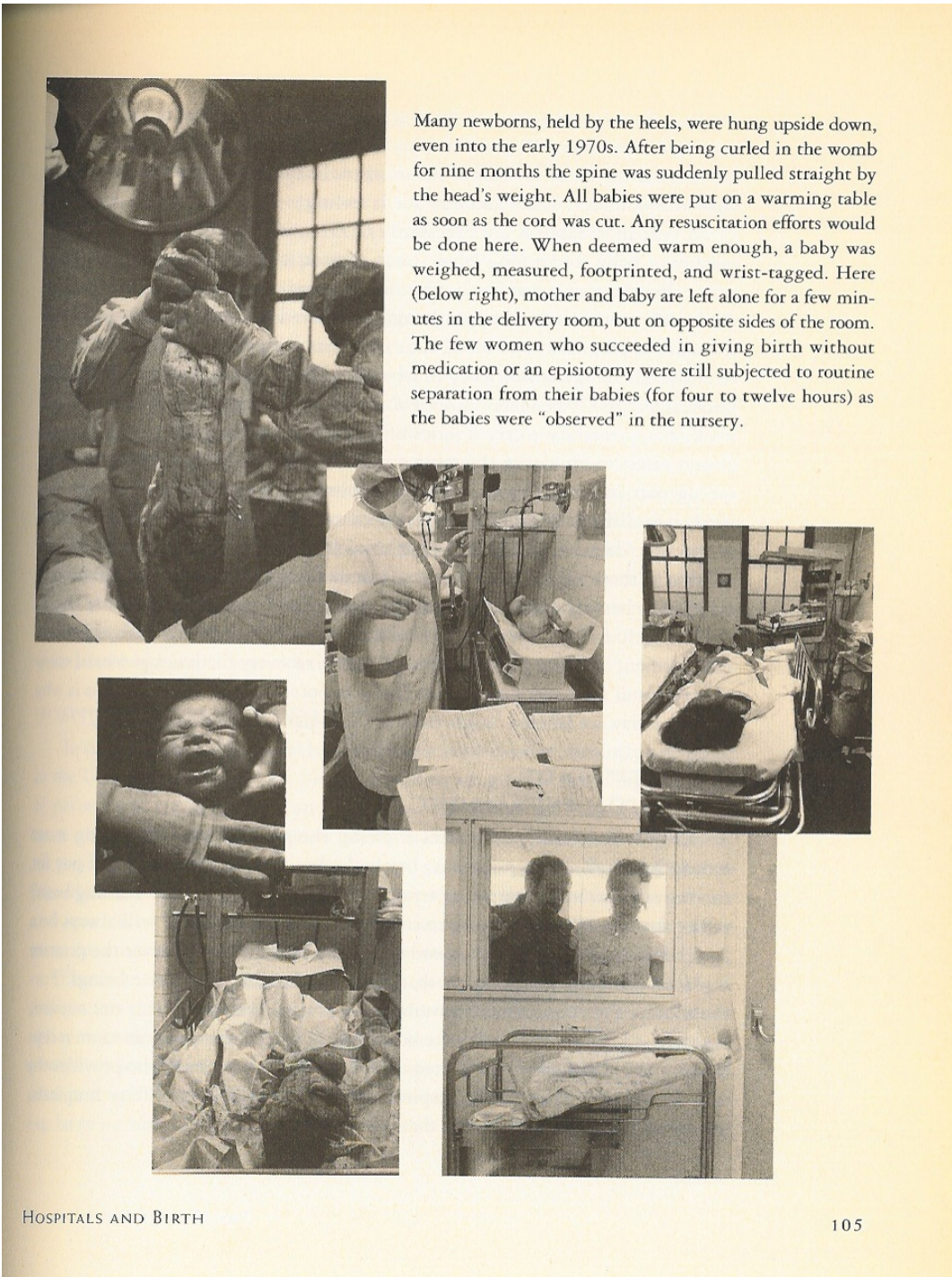


Figure 2: Hospital Birth Images from Immaculate Deception by Suzanne Arms

In comparison to these hospital images, pictures of homebirths included in the *Birth Book*, *Immaculate Deception*, and *Spiritual Midwifery* spoke to the power and beauty of homebirth (see Figure 1 on page 103, Figure 2 on page 104, Figure 3 on page 106, Figure 4 on page 107, Figure 5 and Figure 6 on page 108). These women are shown in control of themselves and their environments. They are surrounded by friends, partners, and loved ones. Image 3 in Figure 3: Images from Birth Book on page 106 illustrates the support many women had during their labors. As this image depicts, women are supported both physically and emotionally. These images also convey the care used in handling the babies at homebirths. The babies are immediately in the mothers' arms and are seldom separated (see Figure 4 images 1, 2, 4, and 5). Fathers or partners are clearly directly involved. As seen in Image 3 in Figure 3 on page 106, homebirths can be family events with friends, children, and loved ones present and involved. Overall, the women look tired but happy. The image of giving birth as a happy pleasurable experience is further highlighted in the images from *Spiritual Midwifery* in Figure 6 on page 108. There is a stark contrast to the pictures of isolation presented in Figure 1 on page 103. These images from these seminal works clearly visually present core differences in birthing, and in the framing of the event by those involved. The images in Figure 1 and Figure 2 from *Immaculate Deception* illustrate the use of technology, the isolation of women in the early 1970s, the medical inspection of the women's perineum, and the separation of women, babies, and partners. In the homebirth images birth is shown as a family-centered, women-controlled, bloody, messy, but happy and pleasurable event.



Image 1: Affection during labor



Image 2: Pushing on all-fours



Image 3: Women and children present at birth



Image 4: Delivering in an all-fours position



Image 5-7: Catching the baby as it is born

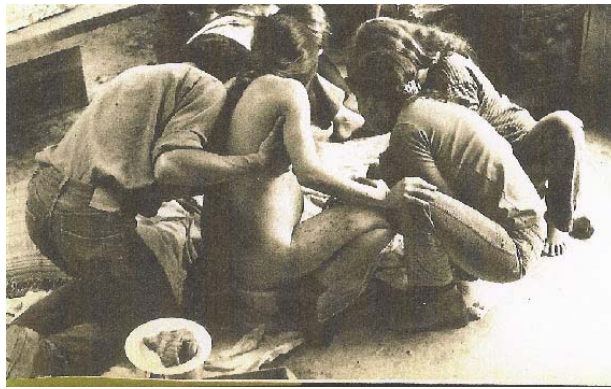
Figure 3: Images from Birth Book



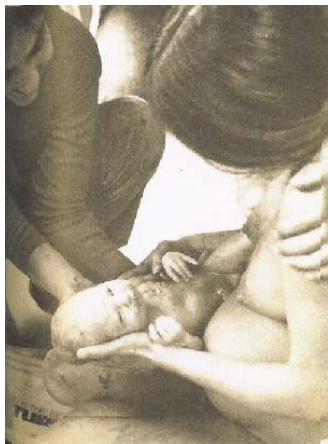
Image 1: Happy M...



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W...

Figure 4: Images from Birth Book



Figure 5: Homebirth Pictures from Spiritual Midwifery

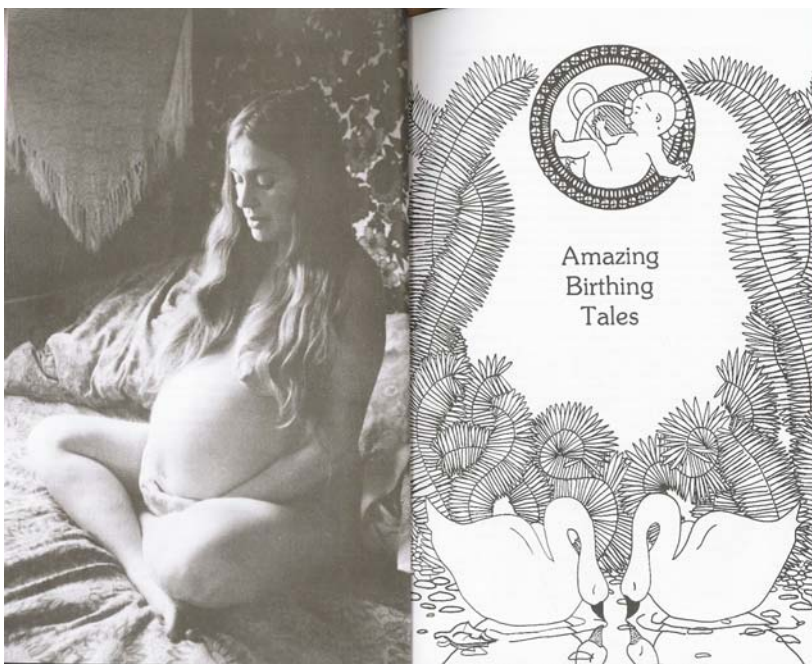


Figure 6: Homebirth Pictures from Spiritual Midwifery

Diagnostic, Prognostic, and Motivational Collective Action Frames

Immaculate Deception (1975), *Spiritual Midwifery* (1977), and *Birth Book* (1972) provided clear arguments in favor of homebirth. *Immaculate Deception* (1975) and *Birth Book* (1972) were especially clear in their authors' diagnosis of the ills of standardized hospital birth. They clearly articulated the following diagnoses of problems with maternity care in America in the 1970s:

1. Separation of mothers, husbands, and babies reduced bonding and sharing a peak life experience;
2. Increased use of technology such as electronic fetal monitors, forceps, pitocin, anesthesia, and cesarean sections, which have led to less satisfying births for mothers and families and have increased risks making normal births less safe;
3. The treatment of pregnancy and birth as a disease or pathology; which makes women fearful of birth and increases physicians' use of technology "in case something goes wrong;"
4. Physicians, who are surgeon specialists in pregnancy and birth complications, caring for all women, which leads to high-risk medicine applied to low-risk healthy women;
5. A lack of respect for women as consenting adults, who desire both a satisfying and a healthy, safe birth.

As a solution to these stated problems Arms (1975), Lang (1972), and Gaskin (1977) proposed the following solutions¹¹ or prognostic collective action frames:

1. The inclusion of husbands, family members, and other support people;
2. Decrease in the use of interventions, allowing birth to occur naturally. A low intervention birth is best achieved at home away from available technology;
3. The treatment of pregnancy and birth as a normal life event, not a disease. An emphasis on health and well-being, which reduces fears and increases confidence and enjoyment of pregnancy, labor, and birth;
4. Based on the Dutch model, midwives, who are the experts in low-risk healthy women, should care for the majority of women and physicians should care for the minority of women who are sick and have serious complications of pregnancy and birth;
5. Women should be respected and empowered in their choices and experiences.

These diagnostic and prognostic collective action frames were presented in the form of statistics, research on bonding, interventions, Dutch midwifery etc.; through the stories of birthing parents; and through the direct arguments of the authors. The authors also provided motivational collective action frames through statistics, persuasive arguments and birth accounts. These arguments were resonant with a segment of the population, as will be seen in the accounts of those early homebirthers in the chapters to follow. These important early books also helped lead the way to the formation of a movement

¹¹ I do not mean to imply that these authors were the first or only activists to propose these solutions. However, I am focusing on these authors presentation of these collective action frames.

coalescing around these core ideas. The central component was family centered homebirth with trained attendants that provided safe and satisfying homebirths. My discussion will now move beyond the contributions of Arms, Gaskin, and Lang, to explore the evidence against standard maternity in America.

As the years have passed, these arguments have been refined as trends and research in maternity care have changed and been affected by consumer pressures. Changes have come about partially due to the influence of the homebirth movement. For example, today most women are allowed partners or other support people to be with them through labor, pubic hair shaving has mostly ended, decorated labor/deliver rooms that look more home-like are more common, and forceps are used much more rarely now, although they've been replaced with an increased preference for cesarean section or vacuum extraction. Over the last thirty plus years the movement's arguments have been reinforced through much scholarship, research, and clinical practice. The core components of the modern movement's collective action frames are detailed in Table 8: Collective Action Frames in the Homebirth Movement on page 166. I will now cover specifics on arguments against interventions, and show how issues of safety have been framed and counter-framed. The homebirth movement has defined homebirth not only as socially better, but also safer, while the medical establishment sought to discredit homebirth by publishing negative outcomes¹² and declaring it unsafe and harmful.

¹² It is important to note that one of the difficulties for the medical establishment is most doctors only ever see homebirthers who need transport to hospitals, giving the impression

Medical Reaction

As this new construction of birth began to attract adherents, the medical community strongly objected. As in the case of the Birth Center in Santa Cruz, doctors began to “crack down” on lay midwives and sympathetic doctors who were helping them, leading some physicians to be ostracized and face the loss of hospital privileges and possible loss of their medical licenses. Midwives were arrested and prosecuted for practicing medicine without a license. The American College of Obstetricians and Gynecologists (ACOG) encouraged these activities. Freud and McGuire (1995:179) illustrate this point:

The policy move to community based health care has not usually reduced physician control and potential income, however. The home birth movement, for example, has been vigorously suppressed. In the United States, although some physicians have supported the practice of out-of-hospital births, professional organizations such as the American College of Obstetrics and Gynecologists have vigorously opposed it....Certification for trained midwives is available only to registered nurses who have taken extra training, but even those certified nurse-midwives have been severely restricted in their attempts to practice independent of physician control and have had great difficulty obtaining malpractice insurance. The virtual monopoly of obstetrics and hospitals has thus been preserved.

Doctors found homebirth a severe affront to the science of obstetrics, partially because middle-class white women were freely choosing it over OBs. When midwives (lay, granny, and nurse-midwives) had been attending low income or isolated populations they were mostly tolerated, but as lay midwives became political and a choice for middle-class

that they should have been there in the first place. They do not experience the advantages of successful homebirths.

women, doctors defended their territory. ACOG went on the offensive by issuing a press release that asked all physicians to report deaths associated with intentional home deliveries to ACOG. A statement by the executive director referred to homebirths as “child abuse” and “maternal trauma” (ACOG 1977). Doctors began counter framing the issue as a matter of safety, often arguing that birth was safer in the hospital “in case anything went wrong” even if it wasn’t as pleasant an experience as being at home. Some framed the question as “Do you want a pleasant birth at home or a safe birth in the hospital?” Later, the homebirth movement would counter that argument with well-designed studies that reflected both the safety and pleasantness of homebirth.

Framing and Counter Framing Safety

The issue of safety has been a contentious one in the framing efforts of the homebirth movement and the subsequent counter framing of the medical establishment. Both “camps” claim their approach to maternity care is “safer.” In many ways the issue of safety perception reveals the core model differences in the medical and holistic frames of birth. Arguments for or against particular obstetric practices reflect underlining leanings toward a perception of the proverbial glass half-full (midwifery) or half-empty (medical model). In the standard obstetric care camp, in an effort to “expose the dangers of homebirth,” several scientific studies were conducted. (Adamson and Gare 1980; Brown 1987; Phillip 1984), and recently Pang et al (2002) all concluded that out-of-hospital births had higher perinatal mortality rates. But a closer look at their data indicated that they had used raw aggregate data and that they had not, or not sufficiently,

separated out precipitous labors and other unplanned out-of-hospital deliveries that have at least a seven percent higher mortality rate than planned, non-precipitous, midwife attended births (Goer 1995; Vedam 2003). When studies of planned homebirths have been conducted with screened matched populations, the results contradicted these findings.

Mehl et al (1977; 1980) found that when midwife-attended homebirths were matched for maternal age, parity, socioeconomic status, and risk factors with a comparison sample of physician-attended hospital births, the results showed “no significant differences in birth weight, perinatal mortality, or other major complications. However, compared to the matched hospital cases, the homebirths are characterized by higher Apgar scores and significantly less fetal distress, meconium staining, postpartum hemorrhage, birth injuries, and need for infant resuscitation” (Mehl et al. (1980) cited in Sullivan and Weitz 1988:117). In the hospital group, women had a five times higher incidence of maternal high blood pressure, three times more cesarean sections, nine times more episiotomies, nine times as many third and fourth degree tears, three and a half times more meconium staining, eight times the shoulder dystocia, three times the rate of postpartum hemorrhage, and thirty times as many birth injuries (Rothman 1982). Mehl et al.’s (1977; 1980) study included in the homebirth category all mothers and babies who planned to deliver at home prior to the initiation of labor, rupture of membranes, or emergence of a complication necessitating immediate transfer and hospitalization. The inclusion of the transferred home-to-hospital outcomes in the homebirth group resolved some criticism other pro-homebirth studies had received in the past concerning the lack of inclusion of these transfers in their results. Rothman (1982:45) has pointed out that

within this study, “Although as many mothers and babies survived the hospital births as the home births, the home-birth group had appreciably better outcome.” Studies from the mid-70s through the 2000s (Anderson and Greener 1991; Anderson and Murphy 1995; Declercq et al. 1995; Durand 1992; Johnson and Daviss 2005; Koehler, Solomon, and Murphy 1984; Mehl et al. 1977; Sullivan and Beeman 1983) all concluded homebirths with low-risk healthy women have been shown to be as safe or safer than hospital births. This is particularly noteworthy given the changes in legality, education, and experience levels of homebirth midwifery over this time span. A recently published and very well-constructed study (Johnson and Daviss 2005) further reiterates the safety of homebirth with certified professional midwives. This study included 5000 births and had a national scope, and a comparative low-risk hospital group. These articles also illuminate the fact that positive homebirth outcome statistics are predominantly for white, educated, middle class women. However, Burnett (1980) also found that homebirths were as safe or safer for demographically higher risk populations in North Carolina (young, black, unmarried, less educated than state average). As Durand (1992:452) summarized it, “ The results of this study suggest that for relatively low-risk pregnancies, homebirth with attendance by lay midwives is not necessarily less safe than...hospital-physician delivery. Support by the medical and legal communities for those electing, and those attending, homebirths should not be withheld on the grounds that this option is inherently unsafe.” One of the main arguments inherent in the diagnostic collective action frames of the homebirth movement is that the over use of technology is at the heart of why homebirth is as safe or safer than hospital birth. Homebirth activists argue that many of the birth complications women and neonates experience are due to the risks of intervention and technology.

Framing Technology and Birth Interventions

The following six sections detail the arguments the homebirth movement, as well as natural birth advocates, have made against the over use of interventions and technologies in birth. I will discuss induction and augmentation of labor, painkillers, electronic fetal heart rate monitors (EFM), episiotomies, forceps/vacuum extractions, and cesarean sections. These arguments against birth interventions are at the core of the movement's collective action frames. The following sections provide part of the movement's diagnostic and prognostic collective action frames.

Inducing and Augmenting Labor

Inductions involve trying to start labor before it naturally has begun on its own. This often involves the "ripening" or thinning of the cervix with an application of either prostaglandin E2 (PGE2), in either a gel (Prepidil) or in an insert (Cervidil), or misoprostol (PGE1), trade name Cytotec. Sometimes prostaglandins can start labor on their own, but most commonly IV oxytocin (Pitocin or "Pit") is administered. Pitocin is the most common form of labor induction (Goer 1999).

There are several medical reasons for "jump-starting" labor such as severe hypertension, diabetes, kidney disease, or an intrauterine death followed by a long wait for labor to begin. More controversial reasons include diagnoses of a post-dates (overdue) baby, a large baby accompanied by a believed increased likelihood of cephalo-pelvic disproportion (fetal head too big to fit through a woman's pelvis), a small-for-dates baby, and a decreased amount of amniotic fluid. These are controversial because all are open to

interpretation and have a high variability of false positive test results resulting in inductions that were unnecessary (Gaskin 2003). Lastly, several nonmedical reasons also exist for inductions, such as timing of when a “favorite” doctor is on call or in town to deliver the baby; women’s frustration with waiting for labor to naturally begin; and lastly, timing the birth to occur during a set time frame (e. g. the beginning of her maternity leave, when family members are available to attend the birth, when it’s daylight and during the week, etc.). This combination of medical and nonmedical reasons has resulted in a marked increase in the number of inductions over the last two decades.

In 1989, the US induction rate was 9.2 percent. By 1994 it had risen to 14.7 percent, and by 1998 19.2 percent of births were induced (Gaskin 2003; Rooks 1997). Today, based on a national survey of birthing mothers (Declercq et al. 2002), almost half (44%) of all mothers and half (49%) of those giving birth vaginally reported that their caregivers tried to induce labor, most commonly through artificial oxytocin. Eighteen percent of mothers cited a nonmedical reason, with another 16% citing a nonmedical and a medical reason for attempting induction. Inductions were successful in beginning labor 80% of the time. Another study reported a labor induction rate of 21%, which represents only reported, successful inductions for low-risk women (Johnson and Daviss 2005). Figure 7 below illustrates how inductions are timed at the convenience of the physician, with a shift toward more births occurring during the midweek and during the day. It is also worth noting that the rates of serious health concerns indicating a need for inductions have not significantly increased during this period (Gaskin 2003). Table 3 presents a comparative table of inductions over the last two decades. Augmenting labors has also seen marked increases as well.

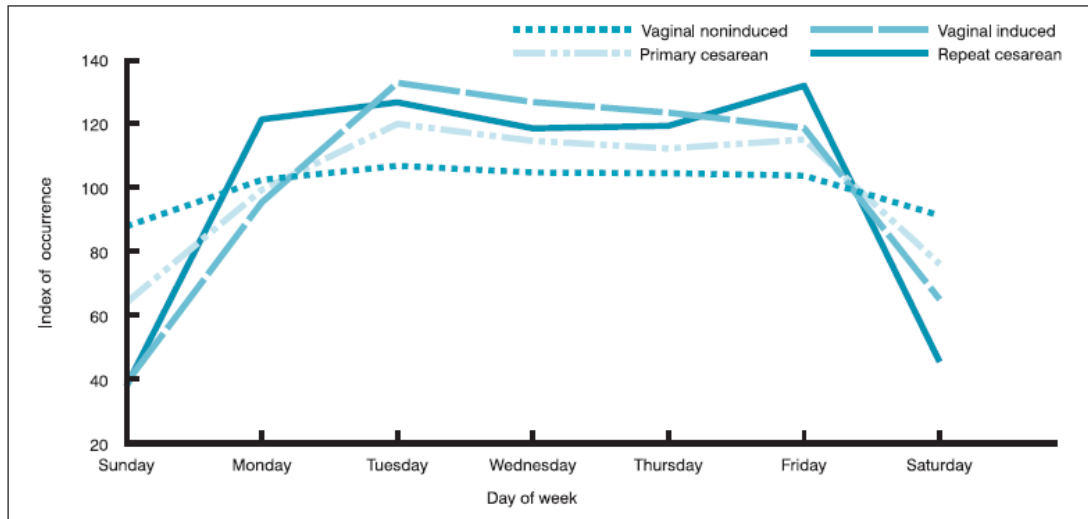


Figure 4 Births by day of week according to method of delivery: United States, 1997

Figure 7: Births by Day of Week and Method of Delivery: United States, 1997

* Figure from Curtin (1999).

Augmentation of labor involves the application of synthetic oxytocin (Pitocin) by IV to strengthen already occurring labor contractions. This is done to intensify and increase the rate of contractions--speeding up a “sluggish” labor. Augmentation can be done to counteract the depressive effects of painkillers on contractions; to simply speed up a labor that is progressing slowly¹³ for the perceived convenience of staff and women; or because a labor is “stalled” (experiencing a plateau of dilation progress.) Truly

¹³ Generally speaking “normal labor progress” is defined as labor progressing at a rate of one cm/hour in active labor (+4-5 cm dilation) until completely dilated in primiparas. For multiparas it is defined as progressing at a rate of at least 1.5 to 2 cm/hour in active labor until completely dilated. The length of “early labor” or latent phase is highly variable, and is often a point when augmentation is used to “get things going.”

prolonged labors do represent a greater risk to both mother and child, but the length and rate of dilation and delivery that represents “prolonged labor” and not simply the outer edges of the normal labor curve is of great dispute. It seems that OBs have an ever-decreasing limit to what is considered normal and hence quick enough progress. There is evidence that there is also an ever-increasing sense of carelessness with the application of Pitocin. As of 2000, women reported 53% of their labors were strengthened with Pitocin (Declercq et al. 2002). This represents a marked increase since 1989, when the nationally reported rate of augmentation was 11% (Rooks 1997). The following table provides comparisons for induced and augmented labors in the US.

Table 3: U.S. Rate of Inductions and Augmentations of Labor, 1989-2000

Year	Hospital Inductions	Hospital Augmentation	Planned Homebirths Induced	Planned Homebirths Augmented
1989	9.2%	11%		
1994	14.7%	15%		
1998	19.2%	NA		
2000	21% ¹ -44% ²	18.9% ¹ -53% ²	2.1% ³	2.7% ³

Compiled from (Declercq et al. 2002; Gaskin 2003; Johnson and Daviss 2005; Rooks 1997)

1. Johnson and Daviss (2005) represents singleton vertex births greater than 37 weeks gestation in US, 2000. Includes only successful inductions

2. Declercq et al. (2002) includes all attempted inductions.

3. Citizens for Midwifery Fact Sheet (2005b) provided clarification on homebirth inductions in Johnson and Daviss (2005); includes all forms of inductions, both natural means such as castor oil or sweeping of the membranes, and transfers of care for pitocin or similar pharmacologic induction agent.

Natural birth advocates, including members of the homebirth movement, have sought to discredit the arguments, attitudes, and practice styles that have lead to high

rates of inductions and augmented labors and illustrate the dangers of these interventions. Arguments against these interventions center around the following issues: first, the effect of the drugs used to induce and augment labors have considerable risks for both women and babies; second, induced and augmented labors are considerably more painful than naturally occurring labors, leading to an increased use of painkillers which have their own risks; and lastly, high rates of inductions and augmentations have led to a greater number of interventions including cesarean sections. These arguments by natural birth advocates coalesce around the framing of the over use of interventions as riskier to women and children compared to letting nature take its course. In contrast the medical model frames not actively managing labor as riskier than not acting.

The drugs used to induce or augment labor have real risks associated with their use. These dangers have been a main argument for limiting their use by natural birth advocates for the last forty years. Even as dosages and methods have varied over time, the central problem of induction agents remains. Prostaglandins and Pitocin all have the potential risk of creating contractions that are so strong that they either compromise the baby's blood and oxygen supply or cause uterine rupture, a rare catastrophic complication requiring immediate cesarean section and possibly hysterectomy. Uterine rupture has a high degree of maternal and infant mortality. In one study, between 1 and 3% of induced women had ruptured uteri (cited in Gaskin 2003). Having Pitocin in labor also doubles the odds of the baby being born in poor condition because of the restriction of oxygen-rich blood. Because of this risk, women who are induced or have their labors augmented are hooked up to a fetal heart rate monitor to assess the baby's tolerance of the contractions. As will be discussed in the section on fetal heart rate monitors, this

intervention has its own share of problems, mainly limiting mobility and an increase in false positive signs of distress. Administration of Pitocin also involves a woman being hooked up to an IV, further limiting her mobility. Homebirth advocates have argued against the use of prostaglandins and Pitocin, preferring more natural means of encouraging labor. Suzanne Arms, in *Immaculate Deception* (1975) details the dangers of oxytonics. She states, “Dr. Caldeyro-Barcia [an OB specialist] concluded that in oxytocic-induced labors, even with all proper precautions-such as the lowest effective dosage given and proper monitoring of mothers- almost 75 percent of the mother’s uterine contractions were shown through fetal heart rate tracings to result in a reduction of oxygen to the baby’s brain” (Arms 1975:58). In 2003, Ina May Gaskin was reiterating this same concern when she stated, “Oxytocin and prostaglandin inductions are well known to cause longer, more intense contractions of the uterus, thus interfering with the flow of oxygen-rich blood through the placenta to the fetus” (P.208). Henci Goer in her summary of available medical literature, clearly states, “Inductions work most often on those who need it the least, and are the most dangerous on those who may need it the most” (Goer 1999:49). Hence, babies who are showing in-utero signs of distress are the ones who can least withstand the extra stress of inductions. Inductions are commonly done because women are believed to be overdue. The limit to what constitutes overdue is again up to some interpretation. Most practitioners and midwives consider forty-two weeks “overdue;” however, more and more OBs are inducing women at just over forty weeks to “avoid” problems of postmaturity. Again Henci Goer in her medical literature summary found that this was a fallacy. She states, “Routine induction at any gestational age does not improve outcome” (Goer 1995:184). International research puts reasonable

medical inductions at no higher than 10% (Gaskin 2003). One induction agent, Cytotec, requires additional attention.

Cytotec, or misoprostol, is the newest induction agent. The use of this drug clearly illustrates a tendency in obstetrics to practice in a way that is not tied to evidence-based medicine. Cytotec, labeled by the FDA for treatment of ulcers, is used off-label by OBs to induce labor. At the inception of its widespread use, no research had been conducted to determine the right dose or method of administering the drug. By around 1997, Cytotec had been touted by many OBs as the most effective and timely way to induce labor—the problem is it's also the most dangerous (Gaskin 2001). Articles within the last few years have begun to surface, illustrating the catastrophic effects of the use of Cytotec. Ina May Gaskin (Gaskin 2001, 2003) and Marsden Wagner, MD (Wagner 1999a, 2000) began to alert the midwifery community about the dangers of Cytotec. According to Gaskin (2001:3), “Cytotec has been linked to an alarming rate of ruptured uteri, life-threatening hemorrhages, emergency hysterectomies, profoundly brain-damaged babies, stillbirths, newborn deaths and even some maternal deaths.” In her review of the available medical literature on Cytotec, Gaskin (2003) identified forty-nine studies on Cytotec, resulting in 5,439 inductions resulting in twenty-five women with ruptured uteri, sixteen babies who died, two women who had profuse bleeding leading to emergency hysterectomies, and two women who died. The risks were even greater for women who had a previous cesarean section. Cytotec is associated with a twenty-eight fold increase in uterine rupture. Part of the problem is that the literature on negative outcomes was widely scattered without a clear meta-analysis of risk. Searle, the manufacturer of Cytotec, has in fact warned OBs about the dangers of misoprostol induction both on their product label

and in a letter sent to OBs around the country. The label on Cytotec reads, “Cytotec may cause the uterus to rupture during pregnancy if it is used to bring on labor” (Wagner 1999d). Yet it is still used. In 1999, ACOG authored a statement stating that Cytotec should not be used to induce women who had had a previous cesarean section because research indicated a greater risk of uterine rupture. However, they left it open for use on all other women, despite evidence indicating there was a significant risk for all women of this life-threatening complication (Gaskin 2001). Midwives recommend sex, nipple stimulation, and castor oil as natural labor stimulants, with few risks and generally good results (Gaskin 2003; Goer 1999). Johnson’s (2005) study of certified professional midwives found an attempted induction rate of 9.6 %, which includes both natural induction techniques such as nipple stimulation, as well as transfers who had chemical inductions. These chemical inductions accounted for only 2.1% of planned homebirths (Citizens for Midwifery 2005b). Gaskin (2003) reported a 5.4% induction rate at The Farm midwifery center, all by castor oil or sweeping of the membranes. Natural birth advocates have protested the high rates of medical inductions, especially when linked to such high risks as are seen with Cytotec. Many natural birth advocates ask why risk a baby’s health simply for the convenience of “planning” when you deliver? Many natural birth advocates also ask why so many women use pain killers in labor when lifelong complications are a real risk factor?

Pain Killers in Labor

Pain killers (anesthesia and analgesia) are used in labor to reduce sensations of uterine contractions, dilation of the cervix, and the stretching of the perineum on delivery.

Two basic classes of pain killers have been used in labor and vaginal birth in the US in the last 35 years: broadly administered narcotics and nerve blocks. General anesthesia was also used for cesarean sections in the past, or for emergency cesarean sections today. Broadly administered narcotics are given by IM injection, pill, or IV and include such drugs as Demoral, Secanol, Stadol, and Nubane. These drugs tend to make women sleepy, and are said to “take the edge off,” but they do not completely block pain sensations. Nerve blocks are a mixture of drugs delivered by injection and/or catheter to a specific nerve area. These are based on the same principal as the administration of novacaine during dental work. These include pudendal block (injection in the vagina to deaden sensations in the birth canal), paracervical block (deadens the cervix and birth canal), spinal and epidural block (injections and/or catheterization of the dura space around the spinal cord causing a deadening of sensation and mobility from the waist down.)

Narcotics given during labor have one main disadvantage—they tend to sedate the baby as well as the mother, causing babies to be born who are lethargic and have more breathing difficulties. Because of this side effect, practitioners try to time the administration of narcotics just right, so they are given far enough from delivery to reduce the drugs’ depressive effects on neonatal respirations. Natural birth activists have vigorously fought for recognition of the respiratory depressive effects of narcotics on neonates since the widespread use of twilight sleep in the 1930s (Edwards and Waldorf 1984). Medical researchers in the 1970s (Brackbill et al. 1974:380), demonstrated not only the possible problems of respiratory distress, but also lasting neurological effects, stating, “[this study provides] clear-cut evidence that meperidine [Demoral] produces

outstanding neonatal differences in ability to process information.” Other researchers (Peterson, et al. 1977 as quoted in Mehl 1977) demonstrated that increasing amounts of anesthesia during labor and delivery were associated with decreasing levels of infant responsiveness to human contact and an increased responsiveness to sound for up to six months of age. Peterson et al. (1977 as quoted in Mehl 1977) also found a correlation between anesthesia and maternal-infant bonding. Their assertion was that a less responsive child who was more easily disturbed by noise was less responsive to the mother’s care and less able to engage in reciprocal interaction, creating a depressive effect on maternal-paternal-infant bonding. Arms (1975) contributed to a clear articulation of the research demonstrating dangers of anesthesia and the negative experiences of women with these drugs. She advocated homebirth to avoid such interventions.

Early research (Mehl 1977) that compared homebirth and hospital birth outcomes for a matched sample of mothers, found that 14/1046 (1.24%) homebirth neonates needed resuscitations, versus 52/1046 (4.97%) hospital birth neonates. This difference was statistically significant at the $p \leq 0.0001$ level. Mehl attributed much of this difference to the depressive effects of painkillers used in the hospital group. In Mehl’s (1977) sample, 53% of the mothers had analgesia, 5% paracervical block, 9.2% general anesthesia, 62.6% pudendal anesthesia. In comparison, only 0.05% of the homebirth group (including transports to the hospital) received any form of anesthetic or analgesia. Despite the ongoing efforts of the natural birth movement to educate parents and practitioners of the dangers of painkillers, they remain popular. Particularly, epidurals have become very popular in the last two decades.

In 2000, a national survey of birthing mothers found 63% reported using epidural analgesia for pain relief, including 58% of those having a vaginal birth and 76% of those with a cesarean section. Although 78% reported the epidural as very helpful in relieving pain, 26% to 41% of the women were unable to respond to several statements regarding risks or drawbacks of epidurals (Declercq et al. 2002). Some hospitals have epidural rates over 90% (Rooks 1997). In contrast, only 4.7% of women who attempted to give birth at home received epidurals when transferred to the hospital (Johnson and Daviss 2005).

Epidurals have several drawbacks that are often unknown to the general public and given little credence in the popular press (e.g. Iovine 1995) or downplayed by medical practitioners. Based on Goer's (1995) thorough review of the extensive medical literature, epidurals and other blocks have several serious side effects. First, epidurals can cause a dramatic drop in blood pressure, which ranges in incidence between 5%-16%. This reduces uteroplacental blood supply, which can cause fetal distress. For this reason, women who have epidurals are "buffed-up" with extra IV fluids to help counteract this complication (this fluid loading can have its own set of side effects). Women must also be attached to a fetal heart rate monitor to detect possible fetal distress from these interventions. Second, epidurals and spinals can cause a "spinal headache," a debilitating headache that can last for days. This complication occurs in around 0.1% of epidurals with up to 50 % of cases experiencing this complication if the dura mater around the spinal cord is accidentally punctured. Backaches (18.2% versus 10.2% non-epidural) and headaches (4.6 versus 2.9% non epidural) are also associated with epidurals. Third, epidurals have been shown to "get to" the baby, potentially causing abnormal fetal heart rate, neonatal jaundice, and adverse neonatal physical and behavioral

effects, such as a reduction in sucking reflex. This last effect often translates into mother-baby dyads that have a much more difficult time initiating breastfeeding, potentially resulting in breastfeeding discontinuance. Fourth, epidurals can increase maternal core temperature, leading to a septic workup of the infant to rule out infection. Fifth, epidurals are associated with substantial increases in oxytocin augmentation, instrument delivery, bladder catheterization, and cesarean section. Even with newer techniques such as lower dosages, continuous infusions, and adding a narcotic, there has been little decrease in epidural-related problems. Lastly, potentially life-threatening complications associated with epidurals occur at a rate of 1/3000- 1/14,000, including convulsions, respiratory paralysis, cardiac arrest, allergic shock, and maternal nerve injury. As one epidemiologist and natural birth advocate stated, “Women have died of epidural anesthesia but never of the pain of childbirth” (Goer 1995:253).

The discrepancy between the way natural birth advocates and medical model advocates frame pain is quite significant. Pam England, a childbirth educator and nurse-midwife, states the following in her book *Birthing from Within* (1998:240),

Nature’s blueprint for women giving birth includes pain, and this pain is purposeful. Pain is experienced when stretch receptors in the dilating cervix send signals to your brain, calling for more oxytocin to be released—which fuels labor and increases dilation.... With an epidural this feedback is wiped out....The pain and sensations of labor tell you what position is best for you and how to move in labor to get your baby out....Pain also raises endorphin levels in your body, while analgesic drugs and epidural anesthesia lowers them. This is significant because endorphin levels correlate with the release of oxytocin.

Numerous other authors in the natural birth camp, (such as Fuchs 2000; Gaskin 2003; Griffin 1997; McCutcheon 1996; Simkin 2000), all emphasize the physiological importance of pain and the risk factors involved with altering this

feedback mechanism with interventions. Natural birth advocates encourage the use of continuous labor support by partners, friends, or a doula to help cope with labor. They also use hydrotherapy (e.g. shower or tubs), massage, and relaxation techniques, including deep breathing and muscular relaxation. In comparison, the majority of the popular press underplays the risks involved with epidurals.

In the popular book, *The Girlfriends Guide to Pregnancy* by Vicki Iovine (1995:67) she states,

Here it is, Girlfriends; Epidurals are *great*. Cesareans can save lives and curtail unnecessary suffering. **THERE IS NO SUCH THING AS A SECOND CLASS BIRTH.** Willingness to suffer or put the baby or yourself in jeopardy, especially when you are frightened and tired, is a sign of questionable judgments, not heroism. You have a choice ; you can lay on a bed of nails to deliver your baby or you can lay on a bed of downy feathers. No matter what you choose, neither your doctor, your nurse nor your baby will think any better of you for suffering because of some possibly misunderstood notion of what is best for your child....Keep this in mind those of us who took a nip from the epidural tap are usually the life of the champagne celebration in our rooms after the baby is born, while our American Gothic counterparts are sound asleep with every capillary in their cheek's broken.

Iovine goes on to bash the “Nazi childbirth preparation teachers” and to express her love of doctors. She provides no research to backup what she is saying or to even touch on possible side effects. Other popular books such as *What to Expect When Your Expecting* (Eisenberg, Murkoff, and Hathaway 1996) and *Your Pregnancy Week by Week* (Curtis and Schuler 2000), although much less emphatic, also provide approval, if not subtle encouragement of epidurals. Phrases such as, “There is no need in this day and age to suffer through labor pain” are common in the popular press. This dichotomy of framing of labor pain is at the heart of the differences in the medical and holistic models. These arguments for and against drugs in labor will be clearly visible in the lived experiences of

the women under study. Their frame negotiations of pain and fear will be further discussed in Chapter Ten, as will their motives for birthing at home, and hence avoiding drugs. Now, after discussing epidurals and inductions/augmentations, which both require the use of an electronic fetal heart rate monitor, I'll now move onto discussing this intervention, and the arguments against its widespread use.

Electronic Fetal Heart Rate Monitors

Electronic fetal heart rate monitors (EFM) consist of a pressure gauge and a Doppler transducer, attached to the woman's abdomen with elastic and Velcro belts, and connected to a machine which interprets the data into fetal heart rate and contraction strength and length. Internal monitors can also be used in conjunction with the EFM. In this procedure the pressure gauge is inserted into the uterus through the cervix and an oxygen gauge is screwed into the top of the baby's head and attached to the EFM machine. The machine produces a tracing on special graph paper that is then interpreted by the OB and /or L&D nurse. EFM was originally introduced for use with high-risk patients to detect fetal heart rate (FHR) changes resulting from lack of oxygen. The baby could then be "rescued" with a cesarean section or instrument delivery. It was believed that cerebral palsy (CP) was directly related to lack of oxygen in labor, and detecting this drop in oxygen would decrease the cases of CP. This, however, has not turned out to be the case. In a large 1996 retrospective study, researchers analyzed and compared the EFM tracings of 155,636 babies to the EFM tracings of children who had developed CP. The researchers subsequently identified two ominous EFM patterns that were associated with CP; however, their predicative value was very weak. It was determined that of the

nearly 11,000 EFM tracings that showed one or both abnormal patterns associated with CP, only 0.2% of these children with these ominous EFM patterns actually developed CP. This means that 99.8% of the children with potentially CP associated ominous EFM tracings would be normal nonetheless (quoted in Rooks 1997:314). After two studies in the mid-1960s showed an improvement in infant mortality with high-risk patients using EFM (Arms 1975), this technology began to quickly spread to use on low-risk women, with very little research conducted to ascertain its actual effectiveness. The reported rate of EFM on birth certificates rose from 45% in 1980 to 84% in 2000 (see Table 4 below for incremental increases). A statistical sampling of mothers found a reported rate of EFM of 93% in 2000 (Declercq et al. 2002). It has been acknowledged that there is an underreporting of obstetric procedures on birth certificates (Martin et al. 2002), so it seems likely that the mother's self-reported incidence is closer to the accurate rate for 2000. Even with the publication of numerous studies¹⁴ indicating the weak predictive value of EFM, it continues to gain in use and popularity. It is in fact the most commonly reported obstetrics procedure on birth certificates. In 2003, EFM was used on around 85.4% (using the lower birth certificate reported rate) of live births equaling 3.2 million births in 2003 (Martin et al. 2005).

¹⁴ See Goer (1995) for review of over 15 clinical trials and meta-analyses indicating EFM's poor predictive value.

Table 4: Electronic Fetal Monitoring Rates, 1980-2000

1980	1988	1990	2000	2000
45% ¹	62% ¹	73% ¹	84% ¹	93% ²
1. 1980-1990 Birth Certificate Data- Goer (1995), 2000- 84% Birth Certificate Data (EFM found to be underreported on birth certificates)(Martin et al. 2002) 2. 2000- 93% “Listening to Mothers” Survey (Declercq et al. 2002)				

EFM provides practitioners and parents with several perceived advantages, which have led to its popularity. First, the monitor has made it possible for one nurse to monitor several patients at a time at a central nurses’ station, thus limiting the amount of patient interaction and reducing the number of nurses needed to staff a maternity department. Second, physicians feeling pressure from litigations for bad outcomes use EFM tracings as a shield to show they acted appropriately based on the EFM tracings (although some have found the tracings were used against them). Lastly, the monitor is alluring in concept. It seems reassuring to have a constant record of the baby’s heart rate and a continuous gauge on how the baby is doing, allowing an immediate alarm to sound if something goes wrong. The problem is, research has demonstrated repeatedly that EFM is a poor gauge for what it is supposed to detect--fetal heart rate patterns indicating serious distress leading to neurological deficits--but it does lead to numerous unnecessary cesarean sections and instrument deliveries¹⁵. It is a self-fulfilling prophecy--the EFM shows distress, an emergency cesarean section is performed, the baby is healthy, so the

¹⁵ See Goer (1995) for 14 studies that identified increased rates of cesarean section and instrument deliveries.

EFM and the OB appear to have done their jobs, but in reality the baby was fine all along. The number of unnecessary cesarean sections is not trivial in financial terms and in terms of maternal mortality and morbidity, and risks to the infant.

Many natural birth advocates have advocated for a very limited application of EFM. They encourage the use of intermittent auscultation. This involves listening to the baby's heart rate with a hand held Doppler device or with a fetoscope every fifteen minutes or so during labor and every contraction during pushing. This protocol is easily accomplished in out-of-hospital settings since it does not require complicated or bulky machinery. Over sixteen well-designed random controlled trials and retrospective studies have demonstrated the effectiveness and safety of intermittent auscultation over the use of continuous EFM (see Goer 1995). Several reasons are stated for intermittent auscultation's effectiveness.

First, a mother who is not attached to an EFM machine (or immobilized by an epidural) has the ability to be mobile. She can walk, sway, rock back and forth on hands and knees, be in a bath or shower, and use the bathroom without much assistance. This ability to easily change positions has many advantages for the baby and the mother. The mother can find positions that help her feel more comfortable and deal with contractions well; while frequent position changes, especially upright postures, usually increase blood flow to the baby. When a mother is lying down, her uterus compresses large arteries and veins and this reduces blood flow. Fetal blood flow is also affected by how the baby is lying in-utero and the compression experienced by the umbilical cord during contractions. The baby may also change position in response to the mother's position (e. g. a hands and knees posture can help facilitate rotating a posterior baby.) Also, by

changing positions frequently, the mother ensures that the baby isn't subjected to any one maternal position that may decrease its oxygen supply. In the hospital women are rolled from side to side to help counteract this effect, but this is not as effective as large full body position changes. Also, in upright postures gravity helps pull the baby's head against the cervix, facilitating dilation.

Higher levels of direct caregiver support and care are the second identified advantage to intermittent auscultation. With intermittent auscultation caregivers tend to focus more attention on the whole woman and her entire birth environment, versus the rather limited amount of data an EFM tracing provides either at her bedside or at a central nurses' station or lounge. Many birthing mothers believe labor and delivery nurses will provide continuous care, but in most hospitals this is not the case; they are responsible for multiple women and continuous care is not possible under current staffing arrangements. One of the "advantages" of EFM for hospital administrators is that it reduces staff-patient contact. This is in direct contrast to research evidence indicating the correlation between improved outcomes and strong labor support. High levels of continuous care and strong caregiver support have a strong correlation to a reduction in complications and pain experienced (Goer 1999; Issacson 2002). Issacson (2002) illustrated that for patients who received continuous support from a doula, compared to patients who did not, the following differences were found: duration of labor was 1.64 hours less, the need for any analgesia was 36% less, the need for oxytocin was 71% less, the need for forceps was 57% less and the need for cesarean section was 51% less (see also Scott, Berkowitz, and Klaus 1999). When caregivers and partners are distracted with a large machine that seems to dominate the birth environment, its beeping FHR and data output seem to take on more

importance than the woman, and this shift in attention results in poorer outcomes for babies and mothers.

A third advantage to intermittent auscultation is a marked decrease in the number of babies who are identified as exhibiting nonreassuring fetal heart tones. At first glance this looks like a problem, as one would think greater sensitivity would create better outcomes, but in this case it does not. Randomized controlled studies have illustrated that more babies are born stressed who have EFM than intermittent auscultation (Goer 1999). A couple of rationales for these findings have been proposed. First, immobility, due to the EFM, may cause reduced blood flow resulting in fetal stress. Second, the machine may pick up more normal variations than intermittent auscultation resulting in more babies perceived as stressed who were really fine. Lastly, immobility due to EFM increases discomfort (due to restriction of movement), and often leads to greater use of painkillers, which adds additional risk to the infant, possibly increasing the rate of stressed infants who experience EFM monitoring.

The arguments against EFM have been demonstrated again and again in the medical literature, yet its use continues today at an alarming rate. With 93% of births having electronic fetal monitoring in 2000, the warnings of the literature have clearly resonated with a limited number of practitioners and birthing women. Another technology that has been repeatedly shown to cause more harm than good but remains in widespread use is episiotomies.

Episiotomies

An episiotomy is performed during a vaginal delivery as the infant's head descends into the perineum and begins to "crown." Episiotomies involve cutting with surgical scissors through the perineum between the vaginal opening and the anal sphincter. This incision may be cut straight down toward the anus (mid-line), or at a 45-degree angle down from the vaginal opening (medio-lateral). During an episiotomy, an incision is cut down and back into the vagina through several inches of skin, muscle, connective and erectile/erogenous tissues. This is done to enlarge the birth canal opening. This may be done to allow for the application of forceps and/or vacuum extraction, to hurry delivery due to a concern over fetal distress, or for a number of other unsubstantiated rationales such as preventing "undue damage" to the perineum.

Joseph DeLee popularized episiotomies in the 1920s. In an influential AMA paper (DeLee 1920), he painted birth in harsh images. He equated crowning to having the infant's head squeezed in a slowly closing door and the damage to the mother as equivalent to her landing on a pitchfork. He believed the repeated thrusts down the birth canal, as the baby "pounded against the rigid perineum," were responsible for some cases of brain damage, epilepsy, and cerebral palsy. As discussed in detailed in CHAPTER FOUR: HISTORICAL ANTECEDENTS TO TODAY'S BIRTH CULTURE, DeLee proposed the following universal protocols to avert the dangers of birth: deep sedation during the first stage of labor, ether during delivery, large episiotomies, and pulling the baby out with low forceps. By the end of the 1930s this protocol became the norm in American hospitals and episiotomies became standard practice.

In the 1970s, episiotomy rates began to slowly decline, although these rates varied greatly depending on practitioner preference and hospital policy. The University of California had an episiotomy rate of 86.6% in 1976 which dropped to 10.4% in 1994, whereas Thomas Jefferson University Hospital in Philadelphia had rates of 69.6% in 1983 only down to 19.4% in 2000 (Weber and Meyn 2002). Overall, a decrease in episiotomies has been seen. In 1976, 65.3% of vaginal births involved episiotomies, in 2000 around 35% of all vaginal births involve episiotomies, but 70%-80% of first time mothers in 2000 had episiotomies. Research indicates a rate no higher than 10-20% is justified (Hartmann et al. 2005; Weber and Meyn 2002) In contrast to these numbers, in 2000, certified professional midwives (CPMs) primarily delivering babies at home, had an episiotomy rate of 2.1% (including hospital transfers). Some jurisdictions do not allow CPMs to cut episiotomies, but their low rate is more likely due to philosophical and practice style differences than legalities (Declercq et al. 2002). Two studies conducted in the 1980s that compared hospital-based CNM and physician rates of episiotomy in the same hospital, found statistically significant differences between the two groups: CNMs had a rate that ranged from 10.8-30.1% whereas the physicians ranged from 35.4-56.6%. The 1989 National Birth Center Study that was comprised of 80.6% of births attended by CNMs had an episiotomy rate of 17.6%, with over one third delivering over an intact perineum (no tears or episiotomy). For further time and birthplace trends see Table 5: US Episiotomy Rates for Vaginal Births by Birth Setting, 1970-2000.

Table 5: US Episiotomy Rates for Vaginal Births by Birth Setting, 1970-2000

	1970s	1980s	1990s	2000s
National Average ¹	65.3%	59%	52%	35%
In Hospital CNM	na	10.8-30.1% ²	na	na
Birth Centers (Mostly CNMs)	na	17.6% ⁴	na	na
Homebirths DEM, CPM, CNM	7.8% ³	na	na	2.1% ⁵
<p>1. National Averages-1976: (Weber and Meyn 2002); 1988-1992: Data from National Center for Health Statistics. Includes all US vaginal births in which an episiotomy was performed (Rooks 1997); 2002: survey of singleton births in all risk categories in US (Declercq et al. 2002).</p> <p>2. These rates differed from physicians in the same hospital at a statistically significant level. Studies conducted in Ann Arbor (1988-1993) and Los Angeles (Table 10 Rooks 1997 page 327).</p> <p>3. Five home delivery services in Northern California consisting of family physicians, nurses, and/or lay midwives (Mehl et al. 1977)</p> <p>4. 11, 814 Birth Center births 1985-1987 (Rooks et al. 1989)</p> <p>5. 5,418 Planned Homebirths attended by Certified Professional Midwives (CPMs) . (Declercq et al. 2002)</p>				

Doctors over the last thirty years have argued that episiotomies prevent fetal brain damage, “protect” the perineum from harm, heal better than tears, and prevent urinary and fecal incontinence, pelvic floor relaxation resulting in uterine or bladder prolapse, and sexual dysfunction. The legacy of these ideas can still be seen today. These arguments were made without any solid research demonstrating these benefits. Even into the early 1980s, almost no research had been conducted to demonstrate the benefits of this procedure (Edwards and Waldorf 1984). Natural birth advocates have argued against routine episiotomies ever since their use became widespread. Sheila Kitzinger, who published *Women’s Experience with Episiotomies* (1981), recorded that, “ Nearly all women complain bitterly about the pain of episiotomy and its association with difficult marital relations following birth” (quoted in Edwards and Waldorf 1984:142). In 1972, Doris Haire clearly stated that no research existed to support routine episiotomy. In

Suzanne Arms' (1975) *Immaculate Deception*, she illustrated one of the more insidious reasons stated for performing episiotomies: "They state that after birth husbands will be unable to enjoy intercourse with their wives if an episiotomy has not been performed, because the vagina will be permanently enlarged and misshapen" (Arms 1975:81). She also mentions that although the husband may have a wife who is "tight as a virgin" because of the doctor's approach to the episiotomy repair, the damage to her perineum hardly improves her sex life; she states, "Nerves and muscles are also severed in the process, and this can result in numbness to the area for months or years" (Arms 1975:80). In a recent *JAMA* systematic review of the research literature on episiotomy, Hartmann et al. (2005:2141) concluded,

Relevant studies are consistent in demonstrating no benefit from episiotomy for prevention of fecal and urinary incontinence or pelvic floor relaxation. Likewise, no evidence suggests that episiotomy reduces impaired sexual function—pain with intercourse was more common among women with episiotomy...Evidence does not support maternal benefits traditionally ascribed to episiotomy. In fact, outcomes with episiotomy can be considered worse since some proportion of women who would have had lesser injury instead had a surgical incision.

They also noted that women with episiotomies were slower to resume sexual activity. This research among others also demonstrates that there is no fetal advantage to episiotomy in the absence of clear fetal distress. Women who have episiotomies, when compared with women who do not, have more pain and slower healing. One argument in favor of episiotomy is that a straight incision is "easier" to repair than a jagged tear. This of course assumes a tear will automatically occur, which is not the case, especially with skilled non-episiotomy delivery techniques. Hartman et al.'s review (2005:2147) clearly states, "The literature we reviewed suggests that the outcomes with spontaneous tears, if they happen, are better than with episiotomy." Research such as Hartman et al. (2005)

has demonstrated what many homebirth advocates have been saying for years—“routine episiotomy causes more harm than good.” In summarizing these points, Gaskin (2003:254) listed the following disadvantages to episiotomies: pain that sometimes lasts for weeks or months; increased blood loss; more serious tears because a cut perineum is not as resistant to laceration as an intact one (leading to more third and fourth degree tears, or tears to the rectal sphincter); frequent infection; association with wound breakdown; abscesses; permanent damage to the pelvic floor muscles and other complications that cause incontinence (for example, rectovaginal fistulas—openings between the vagina and the rectum); these consequences potentially prevent many women from breastfeeding because of the pain they cause.

Assisted Deliveries: Forceps and Vacuum Extractions

Assisted deliveries occur during the pushing phase of birth and involve the use of forceps or vacuum extraction to rotate the fetal head in the birth canal to a more favorable position for delivery, and/or provide traction to pull the infant out of its mother. Forceps consist of two long blades or spoons that are inserted into the birth canal on each side of the fetal head. These are then locked together in some fashion and rotation or traction is applied to move the infant down the birth canal. Vacuum extraction involves the application of a “suction cup” to the fetal head. A handle or T-bar attached to the suction cup provides the traction. The suction needed to keep the cup applied to the fetal head during intense counter pulling is created through a variety of means, including being attached to a machine that creates a strong but adjustable level of suction.

Forceps have been in use since the 1700s. Dr. DeLee in his famous 1920 protocol for all births, recommended prophylactic use of low forceps. As his techniques became widespread so did the use of forceps. Between 1959-1965, 57% of white women's babies were delivered with forceps. In some hospitals the rate was as high as 90%. This was often "necessary" because 92% of white women were anesthetized (essentially asleep) during delivery and could not assist in voluntary pushing to aid in delivery of the baby (Rooks 1997:452). In 1994, forceps accounted for only 3.8% of all US births (Rooks 1997:322). Many believe early natural birth advocates and their campaigns against prophylactic forceps and DeLee's interventionist protocols were successful in reducing the use of forceps. Forcep use has also decreased due to safer cesarean section technique and the advent of vacuum extraction, which has fewer risk factors. In 1994, vacuum extraction accounted for 5.7% of all US births, up from 3.5% in 1989. These numbers have continued to rise in the late 1990s. Total assisted deliveries (both forceps and vacuum extraction) have risen from 9.0% in 1989 to 11% in 2000 (Declercq et al. 2002; Rooks 1997). Please see Table 6: Cesarean Section and Assisted Deliveries for further time trends.

Table 6: Cesarean Section and Assisted Deliveries

	Cesarean Section	Forceps	Vacuum Extraction	All Assisted Vaginal Births
1989 ¹	22.8%	5.5%	3.5%	9.0%
1994 ¹	21.2%	3.8%	5.7%	9.5%
2000 ²	24%			11%
2004 ³	29.1%			
1. Rooks (1997) 2. Declercq et al. (2002) 3. Martin et al. (2006)				

Several risk factors are associated with assisted deliveries. Forceps can cause lacerations on the baby's face and scalp and in extreme cases cause brain damage. They also pose risks for the mother by damaging vaginal tissues. Vacuum extractors cause a blood-engorged cone or bubble on top of the baby's head that leads to jaundice and can in rare cases cause skull fracture or brain damage. Assisted deliveries often occur because other interventions such as narcotics, epidural anesthesia, or the supine position slow down the birth process or cause fetal distress leading to a need for expedited delivery. In the case of epidurals, the anesthetic can cause the pelvic muscles to lose their tone, hence creating a situation where the baby's head does not rotate properly through the pelvic anatomy because the muscles lack the necessary tone to provide the resistance necessary for normal rotation. Epidurals are clearly associated with more instrument deliveries. Studd et al. (1980), in comparing women who had epidurals with those who did not, found epidurals reduced spontaneous (without assistance) delivery rates in both primiparas (34.0% versus 79.0%, $p < 0.001$) and multiparas (67.0% versus 94.0%, $p < 0.001$). Other researchers found women with epidurals had forceps 2.5 times more

often, and 27%, versus 8% of controls, had malpresentations (Kaminiski, Staf, and Aiman 1987). Statistics such as these have been used by natural birth advocates to illustrate the dangers of cascading interventions--one intervention leading to another, and another—each with additional risk to the mother. The procedure that represents the true culmination of the intervention cascade and which also presents considerable risk to the mother is cesarean section.

Cesarean Section

Cesarean sections (or c-sections) involve the removal of the infant and placenta through a surgical incision in the abdomen and uterus. Cesarean sections are predominantly done as a low transverse (along the bikini line of the pubic bone) incision. Vertical (also referred to as classical) incisions are occasionally done today but were the predominant incision for many years. Cesarean sections are performed for a number of reasons. Primarily, cesarean sections are an emergency procedure to save infants or women who are in serious risk of dying during birth. Placenta previa (placenta covering the cervix), abruptio placentae (placenta pulls away from the uterus prematurely causing hemorrhage and possible death for the child and/or mother), fetal demise prior to labor with an unfavorable lie for vaginal delivery, and persistent ominous fetal heart tones that do not resolve are examples of medical indications for cesarean sections. Other highly variable diagnoses such as cephalo-pelvic disproportion or failure to progress are also commonly stated as medical reasons for cesarean sections. Today's planned cesarean sections involve surgeries planned ahead of time for a number of reasons including a

previous cesarean section, breech presentation, multiple pregnancy (twins, triplets), and convenience of the mother or doctor.

Prior to the mid-part of this century, cesarean sections were reserved for last resort situations because risks from the surgery were quite high. Through advancements such as widespread availability of blood transfusions, antibiotics, and better anesthetic and surgical techniques, the procedure has become safer. Subsequently, the number of cesarean sections has dramatically increased over the last thirty-five years.

In 1970, only around 5.5% of all US births were by cesarean section. At that time some researchers (Mehl et al. 1977) believed this number was higher than necessary. By 1980, the cesarean section rate had jumped to 16.5% of births (CDC 1995). In 1985, The World Health Organization stated that a cesarean section rate between 10-15% is reasonable, without causing undue harm to mothers and babies (World Health Organization 1985).

Through the 1990s the national percentage of cesarean section rates hovered in the low 20s. During this time considerable activist effort was exerted toward limiting the number of repeat cesarean sections performed and encouraging vaginal birth after cesarean section (VBAC), which helped keep this number around this mark. In the mid 1990s, McMahon (1996) and Gregory (1999) identified increased risks associated with VBACs compared to elective repeat cesarean sections. Of special concern was the increased rate of uterine rupture during VBACs (McMahon et al. 1996). Since this time, the tide has dramatically turned on VBAC, leading to a new surge in the number of cesarean sections being performed. This increased rate has subsequently been partially linked to Cytotec and other induction agents; however the anti-VBAC climate persists.

Additionally, there is also a current active debate over the ethics of elective cesarean section by choice. This trend has been labeled “too posh to push” by cesarean section critics (ICAN 2005). In 2001, the national average of primary cesarean sections potentially by “choice” (no medical indication) was 1.87% of all deliveries with no cesarean history. In 2003, this number had risen 36% to 2.55% (Shapiro 2005). Declercq et al. (2005) found that primary “no indicated risk” cesareans had increased 67% between 1991 (3.3% of all births) to 2001 (5.5% of all births). In contrast to research that has derived “no indicated risk” (potentially by patient choice) primary cesarean rates from birth certificate (Declercq et al. 2005) and hospital discharge data (Shapiro 2005), research that actually surveyed a nationally representative sample of women conducted by Childbirth Connection (2006) found that of 1300 women who could have chosen a primary cesarean by “choice” only one respondent (0.08%) did so. This indicates that very few women are requesting cesareans for no medical reason, despite a growing interest in this “fictional phenomenon” in the medical discipline. ACOG has endorsed cesareans by patient choice, but the debate within the discipline continues regarding this practice (ACOG 2003; Harer 2000; National Institutes of Health 2006; NIH 1981).

This reduction in VBACs, along with increased rates of cesarean sections created by epidurals, EFM, and other interventions, and a general cultural acceptance of cesarean sections as acceptable, safe, and one more birthing option women can “choose” from, has resulted in a historic national high. As of 2003, the US national cesarean section rate was 27.6%. For low-risk¹⁶ women the rate was 23.6%. This included a rate of 19.1% for primary cesarean sections. These rates represented a 6% jump in both primary and

¹⁶ Low-risk defined as vertex (head down), singleton, term (37+ weeks) gestation.

subsequent cesarean sections from 2002. Please see Table 7: Cesarean and VBAC Rates by Year on page 146, Table 6: Cesarean Section and Assisted Deliveries on page 141, Figure 8: Total and Primary Cesarean Rate and Vaginal Birth After Previous Cesarean (VBAC) Rate: United States, 1989-2003 on page 156 and APPENDIX G: MAP OF CESAREAN SECTION RATES BY STATE, 2003 on page 464 for more information.

Table 7: Cesarean and VBAC Rates by Year

	<u>Cesarean Rate</u>		<u>VBAC Rate</u>
	<u>Primary</u>	<u>Overall</u>	
2003	19.1	27.6	10.6
2002	18.0	26.1	12.6
2001	16.8	24.4	16.4
2000	16.0	22.9	20.7
1995	14.7	20.8	27.5
1990	16.0	22.7	19.9
1985	16.3	22.7	6.6
1980	12.1	16.5	3.4
1975	7.8	10.4	2.0
1970	4.2	5.5	2.2

Sources: International Cesarean Awareness Network Table (2005) derived from:

2002-2003 data: National Vital Statistics Reports, Vol. 53, No. 9, November 23, 2004.

Births: Preliminary Data for 2003. http://www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09.pdf

2000-2001 data: National Vital Statistics Reports, Vol. 49, No. 5, July 24, 2001. Revised Birth and Fertility Rates for the United States, 2000 and 2001.

http://www.cdc.gov/nchs/data/nvsr/nvsr51/nvsr51_04.pdf

1999 data: Curtin S & Martin J. Births: Preliminary Data for 1999. National Vital Statistics Reports, Vol. 48, No. 14, August 8, 2000. Available online:

<http://www.cdc.gov/nchs/births.htm>

1989-1998 data: Ventura S, Martin J, Curtin S, Mathews T, Park M. Births: Final Data for 1998. National Vital Statistics Report, Vol. 48, No. 3, March 28, 2000. Available

online: <http://www.cdc.gov/nchs/births.htm>

1970-1988 data: Morbidity and Mortality Weekly Report. Vol. 44, No. 15, April 21, 1995.

Primary rate: Number of first cesareans per 100 deliveries to women who had no previous cesarean delivery

Overall rate: Number of cesarean deliveries per 100 deliveries

VBAC rate: Number of women who had a VBAC per 100 deliveries of women who had a previous cesarean

Arguments Against Cesareans

The framing and counter-framing of cesarean sections has been a particularly contentious one. The arguments reflect underlying beliefs in the technological or holistic models. Many physicians view cesarean section as safer than vaginal birth, while other doctors worry about the consequences of such high rates of surgical birth (Green 2001; Sachs et al. 1999). Levels of malpractice insurance and malpractice suits have also encouraged doctors to perform more cesarean sections, so they cannot be accused in court of not performing a timely cesarean section to save a baby. Natural birth advocates have sought to limit cesarean sections ever since the 1970s when the national rates were perceived to be increasing. Government agencies have also responded to the rise in cesarean sections with some alarm. The National Institutes of Health and the Healthy People 2000 and 2010 programs have all involved cesarean section reduction strategies and goal rates (NIH 1981; www.healthypeople.gov 2005). The public has also been active in cesarean reduction.

In 1982, Esther Booth Zorn started the Cesarean Prevention Movement (CPM). This organization was renamed in 1992 and is now known as International Cesarean Awareness Network, Inc. (ICAN). This organization is widely recognized as the country's leading voice in a growing chorus to reduce the nation's high cesarean rate. In the 1980s they successfully challenged the “once a cesarean, always a cesarean” dictum. Just two years after the founding of CPM, the American College of Obstetricians and Gynecologists (ACOG) issued guidelines promoting vaginal births after previous cesareans. Four years later, ACOG issued another set of guidelines aimed at dismantling

the old "once a cesarean, always a cesarean" rule. Unfortunately, today the pendulum has swung back toward "once a cesarean, always a cesarean" and the fight continues. As Suzanne Arms (1996:91) has stated, "The cesarean rate in the United States reached an all time high of 25 percent in 1990. We are usually alarmed when we hear of any disease or problem increasing by 40 or 60 percent. Yet the above statistics mean that in a twenty-year period, cesarean surgery increased in this country by 400 percent with only passing public and professional outcry."

The arguments against high rates of primary and secondary cesarean sections revolve around four main issues. First, cesarean sections lead to serious complications both during surgery and postpartum, as well as in subsequent pregnancies and births for both infants and mothers. Second, limiting VBACS increases surgery risks, and limits women's birth choices. Lastly, the midwifery model of care has been shown to decrease the use of interventions and cesarean sections, so advocacy for greater utilization of midwives will improve maternal and infant health. I discuss these concerns in the following two sections on infant and maternal morbidity and mortality.

Infant Morbidity and Mortality

Although cesarean sections are often performed to "save" infants in distress, there are several risk factors for infants associated with cesarean sections that are not commonly recognized. Burt (1988) found that infants born by cesarean section had a 1.29 relative risk of low Apgar scores at five minutes after birth compared to infants born vaginally. Burt (1988:1313) states,

We found infants of mothers undergoing repeat cesarean section were approximately 30 per cent more likely to have low Apgar score than those delivered vaginally. Our conclusions cannot be explained by differences in

birth weight, gestation age, race, maternal age, birth order, maternal income level, or the differential occurrence of complications of maternal health, pregnancy, or labor in the groups we studied.

This finding of low five-minute Apgar scores associated with cesarean sections is important because these are associated with increased infant mortality. Research has shown that infants with low five-minute Apgar scores have a 29.6% infant mortality rate compared to 1.06% among high Apgar infants (Miller, Levine, and Michel 1984). These risks seem to be compounded for subsequent births. Research done twenty years later and published in 2005 further elaborated on the increased risk to infants from elective cesarean sections versus trials of labor (TOL)¹⁷ with VBAC. Hook (2005) found that infants born by elective repeat cesarean section are at an increased risk for developing respiratory problems compared with babies born by trial of labor. Compared to infants born vaginally to mothers with no cesarean section history, babies born by elective repeat cesarean section had a 2.3 times greater chance of respiratory problems. These problems may be in part due to the lack of labor contractions and passage through the birth canal which squeezes out the liquid from infants' lungs. The neurological stimulation of labor and birth may also be important in early respirations of the infant at birth as well. Additional risk to infants are associated with injuries from the surgery such as nicks and cuts from the uterine incision and complications associated with iatrogenic prematurity

¹⁷ A "trial of labor" (TOL) is a phrase used to describe allowing a woman with a previous cesarean section to try to labor and perhaps deliver vaginally, versus planning an elective repeat cesarean section. If she has a successful trial of labor then she had a VBAC. Medical terminology has switched from "attempted VBAC" to "Trial of labor" indicating a perception that many "trials of labor" fail and end in emergency cesarean sections.

(being born prematurely due to an incorrectly timed elective cesarean section). As Goer (1995:23) explains in her summary of medical literature on cesarean sections, for babies born to women with a previous cesarean section, “Statistically the babies are born sooner, smaller, and sicker.” These findings are due in part to problems of placentation in future pregnancies after a cesarean.

Problems with placentation create additional risks to both mothers and infants. These risks included the risk of uterine rupture, placenta accreta (placenta grows into the muscles of uterus or out into abdominal cavity through scar), placenta previa (placenta lies on the cervix), placenta abrupta (placenta prematurely separates from the uterine wall). These risks are all dramatically increased due to scarring of the uterus and these risks increase substantially with each subsequent pregnancy and repeat cesarean delivery.

The incidence of stillbirth is also increased with a previous cesarean section. Smith (2003) found that infants carried by mothers with a previous cesarean section after week thirty-four of pregnancy had a prospective risk of 1.77 per 1000 to be stillborn compared to 0.89 for other women. In other words, 2.4 per 10,000 women with a previous cesarean section had a stillbirth compared to 1.4 per 10,000 women who only delivered vaginally. Perhaps of greatest importance to the argument for VBACs is Smith’s (2003) finding that compared to the perinatal death caused by intrapartum uterine rupture (estimated risk of this event 0.45 per 1000), after thirty-nine weeks gestation, the absolute risk of unexplained stillbirth in women with a previous cesarean section was greater than double this risk of uterine rupture. In other words, a baby in a subsequent pregnancy is more likely to be stillborn than die of a uterine rupture in a trial of labor. As far as perinatal mortality (for babies that die) in subsequent pregnancies and births the

rate is 3 per 1000 for planned VBAC and 4 per 1000 for elective cesarean (ICAN 2005). This small but perceivable increase in risk is also seen in maternal mortality.

Maternal Mortality and Morbidity

The foremost argument against cesarean sections revolves around issues of safety and complications. Almost no one disagrees that cesarean sections when used carefully and judiciously save lives and are worth the risk, but the number of unnecessary cesarean sections performed, and the complications that come from major surgery, cause undue harm to mothers and babies. Cesarean sections are associated with increasing rates of maternal mortality and morbidity associated with the surgery in the postpartum period, as well as in subsequent pregnancies and births. These increases in maternal morbidity and mortality are central arguments against high rates of cesarean sections articulated by natural birth and cesarean reduction activists.

In comparison to the general medical attitude that vaginal birth is riskier than a planned cesarean section, there is good evidence in both the US and the United Kingdom that cesarean sections are associated with higher rates of maternal mortality than vaginal birth. Increased risks range from 2 to 7 times greater risk of death from cesarean section. A recent US study found that four times as many women die who have cesarean sections as vaginal births (Harper et al. 2003) and (Hall and Bewley 1999). Petitti (1985; Petitti et al. 1982) also found a four times higher risk of death in cesarean sections than vaginal birth in the 1980s. When the births were planned elective repeat cesarean sections, which are associated with fewer risk factors, the chance of death was twice that of vaginal birth. Lilford (1990) found a 5.1 increased risk of maternal mortality associated with cesarean section compared to vaginal birth. When women with medical or life-threatening

antenatal complications, such as hemorrhage or hypertension, were included in the analysis, the risk was 7 times the risk of vaginal birth. This translates into a rate of 31/100,000 for cesarean sections versus 6/100,000 for vaginal birth. For perspective, the death rate in the mid-1980s for car accidents for women 15-34 was 20/100,000 (Petiti 1985). Hall and Bewley (1999:776) found that in the UK, “The case fatality rate for all caesarean sections is six times that for vaginal delivery, and even for elective caesarean section the rate is almost three times as great. These differences are highly significant.” Beyond the chance of death, morbidity is a much more common problem associated with cesarean birth.

Birth activists and researchers have pointed out that women who have cesarean sections have more complications and slower healing from cesarean sections than from vaginal birth. In fact, one in ten women report difficulties with normal activities – walking, lifting, and caring for their baby--eight weeks after the cesarean section (Goer 1999). Declercq (2002:5-6) found that one in four women reported pain at the incision site as a major problem. For about 7% of the mothers who had a cesarean section this problem persisted at least six months after birth. This study also found that women with a cesarean section were less likely to “room-in” with their babies and be breastfeeding at one week, and more likely to be experiencing more health concerns after the birth including abdominal pain, bladder and bowel difficulties, headaches and backaches (CIMS 2003). Twice as many women require rehospitalization (Lydon-Rochelle et al. 2000). Women who experience emergency cesarean sections also suffer emotional trauma associated with this form of birth. One study found 76% of women delivered by emergency cesarean section viewed their delivery as a traumatic event (Issacson 2002).

Women with unplanned cesarean sections are more likely to experience negative emotions including lower self-esteem, a sense of failure, loss of control, and disappointment. They may develop postpartum depression or posttraumatic stress syndrome. Some mothers express dominant feelings of fear and anxiety for as long as five years after the cesarean section (CIMS 2003). Women having a cesarean section are less likely to get pregnant again. They also may experience pelvic pain, pain during intercourse, and bowel problems common with all forms of abdominal surgery.

Other more serious complications are also associated with cesarean sections. Post-operative complications include: risk of injury to other organs (2 percent), hemorrhage (1 to 6 percent of women will need a transfusion), anesthesia accidents, blood clots in the legs (0.06 to 2 percent), pulmonary embolism (0.01 to 0.2 percent), paralyzed bowel (10-20 percent of mild cases, 1 percent severe cases), infection (up to 50 times higher than vaginal birth), and complications from anesthesia (CIMS 2003; Jukelevics 2004). A woman with a previous cesarean is four times more likely to have placenta previa (low-lying placenta) in her next pregnancy, putting her at risk for miscarriage, bleeding during pregnancy and labor, placental abruption, and premature delivery. Compared to women with no cesarean section history, one prior cesarean section increases a woman's odds of placenta abruption by three times the risk. Two or three cesarean sections increases the risk by a multiple of seven, and four or more cesarean sections raises the risk to forty-five times the risk of unscarred uteri. With placenta abruption 6 in 100 babies will die, and 3 in 10 will be premature (CIMS 2003; Lydon-Rochelle et al. 2001a). One birth by cesarean puts a mother at ten times the risk for placenta accreta (when the placenta grows into or through the uterus), for which women often require a hysterectomy to stop the

severe hemorrhaging. As many as 1 in 11 babies and 1 in 14 mothers will die from this complication. The incidence of placenta accreta has increased tenfold in the last 50 years and now occurs in 1 in 2,500 births (CIMS 2003; Jukelevics 2004).

Another rare complication that is rising at an alarming rate over the last decades is Amniotic Fluid Embolism (AFE). AFE is postulated to be related to induction agents and or cesarean section. AFE is a catastrophic cardio-pulmonary reaction when a considerable amount of amniotic fluid is forced into the maternal blood stream, resulting in death in more than 50% of the cases. AFE has jumped in incidence from an estimated 1 in 80,000 to 1 in 5000. The CDC now reports AFE as one of the most frequent killers of women in pregnancy and birth in the United States, with more than thirty women dying from this complication each year. Of cases of AFE reported to the Safe Motherhood Quilt Project, eight of eleven cases involved artificial induction or augmentation. In comparison, in the UK (1997-1999) there was only a total of two AFE deaths per year (Gaskin 2003).

Another catastrophic complication of the rising rates of cesarean sections is the increased incidence of uterine rupture in future pregnancies. Gregory (1999) identified a 19.5 times higher likelihood of uterine rupture in women with a history of cesarean section (includes both VBACs and elective cesarean sections) compared to women without a history of cesarean section. In comparison to this increased risk in scarred uteri, Miller et al. (1996) found that a normal uterus not scarred from a cesarean section has a chance of uterine rupture of approximately only 1 in 16,849 or 0.0593%. Their study spanned over eleven years and 188,819 deliveries at LAC and USC Women's and Children's Hospital, and found that of the few ruptures that did occur to women with no

uterine scars, 7 of 11 of these were associated with oxytocin or prostaglandin induction or augmentation.

Induction agents are linked to greater rates of rupture in scarred uteri as well (Lydon-Rochelle et al. 2001b; Rageth, Juzi, and Grossenbacher 1999). ACOG (1999) Practice Bulletin stated VBACs should not be induced with misoprostol (Cytotec) due to an increase in uterine ruptures (Plaut, Schwartz, and Lubarsky 1999). ACOG did leave open the use of other prostaglandins and Pitocin, for induction or augmentation but with “close monitoring.” Thus, a “trial of labor” can be attempted with induction and augmentation despite evidence to the contrary (Wagner 1999b). In 1993, Rageth et al. stated, “A history of cesarean delivery significantly elevates the risk for mother and child in future deliveries. Nonetheless, a trial of labor after previous cesarean is safe” (Rageth et al. 1999:332). They go on to state that induction, epidural anesthesia and failure to progress are all related to failed TOL and uterine rupture.

The risk of uterine rupture has received considerable attention in the last five years. This issue has brought the controversy of “once a cesarean, always a cesarean” versus allowing women to try a trial of labor for a vaginal birth after cesarean (VBAC) to the forefront of debate in both medical and natural birth circles. Part of this controversy centers around the shift in policy by ACOG in 1999 that has created an anti-VBAC medical culture. ACOG (1999) published new guidelines which made it virtually impossible for most hospitals or doctors to provide VBACs (Wagner 1999c). In the ACOG (1999) bulletin they stated, “Because uterine rupture may be catastrophic, VBAC [vaginal birth after cesarean] should be attempted in institutions equipped to respond to emergencies with physicians immediately available to provide emergency care.” The

previous recommendations had said “readily” versus “immediately.” This seemingly simple change of words has had far-reaching effects. Since most doctors are unwilling to “labor-sit” in the hospital through a VBAC labor, and/or because anesthesia is not available 24/7 in smaller community hospitals, many hospital administrators have banned VBACs in order to stay in compliance with “standard practice” as designated by ACOG. In 2005, over 300 hospitals have policies forbidding VBACs, resulting in a 63% drop in VBACs since 1996 (ICAN 2005). Wagner (2000) has pointed out that this simple change in one word has resulted in millions of unnecessary cesarean sections and severe limitations on women’s birthing options, and unfortunately these recommendations were made based on clinical experience not robust scientific evidence.

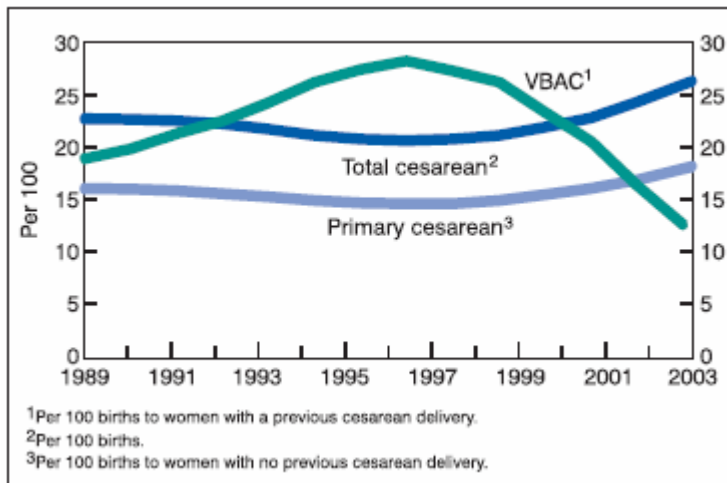


Figure 8: Total and Primary Cesarean Rate and Vaginal Birth After Previous Cesarean (VBAC) Rate: United States, 1989-2003

*Data from National Vital Statistics Reports (Hamilton, Martin, and Sutton 2004)

Cesarean Section Reduction

The national rate of 27.6% translates into 1.12 million cesarean births in 2003.

More than 680,000 were primary cesarean sections, and of these, 363,924 were to women

having their first birth. Of these first birth cesareans, 73% were to low-risk mothers (Menacker 2005). Nationally the rate of repeat cesarean section after a previous cesarean is at 89.4% for all mothers (Martin et al. 2005). Since repeat cesarean sections are extremely likely in subsequent births, the indications for primary cesarean sections are especially critical in reduction efforts. The Health and Human Services Department Program “Healthy People 2010” set a national cesarean section rate goal of 15% for low-risk mothers having a primary cesarean and a rate of 63% cesareans low-risk mothers for repeat cesarean deliveries. The 2003 rates demonstrate movement away from, instead of toward, this goal. A 36% decrease in low-risk women experiencing cesarean sections would have to occur to meet these established national goals, a reduction of 95,552 births. Given the 88.7% rate of repeat cesarean sections, this rate would have to fall by 29% to meet the Healthy People 2010 goal (Menacker 2005).

Cesarean section reduction has both financial and health benefits. As an example of the health benefits of cesarean section reduction, Goer (1995) utilized Lilford’s (1990) maternal mortality rate of 6/100,000 vaginal births versus a rate of 31/100,000 for cesarean sections; this analysis reveals that 125 women die needlessly every year. Given the number of unreported maternal deaths, this number may be closer to 250. Reducing the national cesarean section rate also reduces maternal morbidity. In addition to the possible reduction in preventable deaths, a reduction in cesarean sections would save health care dollars as well. Using the 1998 national cesarean section rates of 21.2% Issacson (2002) found a reduction to the WHO recommend cesarean section rate of 12% would reduce 362,622 cesarean sections per year, resulting in a cost savings of \$561 million dollars per year. In 1998 there were 835,609 total cesarean sections (Issacson

2002). In 2003, there were 1.12 million cesarean sections. Utilizing the same method of calculations as Issacson (2002) today, at the WHO cesarean section rate of 12%, the US could reduce 638,032 cesarean sections per year. The difference in cost between an average vaginal birth and a cesarean section was \$3,100 in 1993. Using the WHO recommended 12% cesarean section rate (halving the 1993 rate of 24%) translates into 1.5 billion dollars saved annually. Obviously the cost savings today would be considerably higher given rising health costs and number of cesarean sections in the last eight years.

The Intervention Cascade

The cumulative effect of the risks and complications of all the interventions covered in this section tends to lead to more and more interventions to ameliorate the complication from other interventions. The intervention cascade refers to the tendency for one intervention to lead to another and then another. Goer (1995:332) provides a description of the common cascade of birth interventions:

For example, [a doctor's anxiety] that any fetus may suddenly develop acute distress in labor leads to using electronic fetal monitoring (EFM) in normal, healthy women. EFM restricts women to bed, which may slow labor. Amniotomy or oxytocin may then be used to speed labor up. Increased pain results, which may lead to an epidural. The epidural may further retard progress, or perhaps the oxytocin or amniotomy causes abnormal fetal heart rate tracings. The labor then ends in a cesarean for failure to progress or fetal distress.

Goer's (1995) review of the available medical literature goes on to show how the majority of standard obstetrical practices such as episiotomy, adherence to the Friedman Normal Labor curve, amniotomy, lithotomy position, and withholding food and water do

not improve birth outcomes, and generally cause additional interventions and complications. The ultimate and tragic end to this possible litany of interventions may be death.

The rise in cesarean sections and other interventions, all of which bring additional risk of death, may be the cause for an alarming increase in the national maternal mortality rate. Berg et al. (1996) found that the number of pregnancy-related deaths per 100,000 live births, a rate that has been declining for the past fifty years, rose from 7.2 in 1987 to 10.0 in 1990. Hemorrhage, embolism, and pregnancy-induced hypertension were the leading causes of death. Pregnancy-related death rates for black women were 3.4 times higher than those of white women in 1987 and rose to 4.1 times higher by 1990. Some researchers indicated that this rise in rates may be due to better reporting, but others believe this is unlikely. Many studies indicate that as many as half of pregnancy-related deaths go unreported (Gaskin 2003; McCarthy 1996). The rate of pregnancy-related deaths could be twice as high as reported in 1990. Marsden Wagner (2003:49), a leading doctor and expert in maternal and infant health, commented, "If we look at the six leading causes of pregnancy-related deaths in the US, three--hemorrhage, anesthesia, infection--are often the result of invasive obstetric interventions." He goes on to state, "The scientific evidence strongly suggests that the increasing use of obstetric interventions and technologies--cesarean section, epidural block, and drugs to induce labor--is not saving more women's lives, but ending them"(Wagner 2003:50).

This leaves one asking, "Why do the majority of doctors practice the way that they do?" One answer has to do with the way many doctors have been taught to see the world (the medical model). Often research that points out the deficiencies in this model is

dismissed. The use of technology is part of this model. Another answer to the above question is that doctors are practicing medicine and are not generally researchers. They have to act as though they are right to make life or death decisions; however this reliance on being “right” can make it difficult to change behavior in the face of the evidence.

Marsden Wagner, who has a background as both a practicing MD and as a maternal/infant researcher, summed it up in this way:

Another reason for the overuse of technology is the mistaken belief by many doctors that technology is science and the use of technology is the practice of scientific medicine. They confuse technological advances with progress. Scientific medicine is practice based on the best scientific evidence, not practice that uses technology. Practicing doctors are not scientists. Scientists must believe they don't know, while practicing doctors must believe they do know (Wagner 2000:9).

Certainly some doctors try to provide the most current and research-based care possible, but currently the trend in obstetrics is toward more technology and interventions, which is not supported by the majority of the research literature available. The majority of research literature does, however, support alternative approaches.

Alternative Approaches

So if natural birth advocates don't support the liberal use of epidurals, fetal monitors, induction and augmentation agents, and cesarean sections, what do they support? The resounding answer is midwifery care. In the mid-1990s, The Midwifery Task Force penned the following Midwives Model of Care as an expression of the kind of care natural birth activists were seeking. The document states,

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

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

The application of this model has been proven to reduce the incidence of birth injury, trauma, and cesarean section (Midwifery Task Force 2005 quoted in Citizens for Midwifery 2006).

The Midwives Model of Care has been ratified or adopted by numerous organizations including the Coalition for Improving Maternity Services (CIMS) as the gold standard of maternity care.

The Dutch provide a prime example of well-integrated midwifery care and the advantages of this maternity system. In the Netherlands, one third of births occur at home and midwives care for the majority of women, with physician care reserved for women with additional health problems and high-risk births; and subsequently has the lowest rates of neonatal and maternal mortality in the world. Other Scandinavian and European countries with similar maternity systems to the Dutch, have similar low neonatal and maternal mortality rates. In the US, the rate of cesarean sections¹⁸ for direct-entry midwives (DEM) and certified nurse midwives (CNM) is well below the overall 2003 national average for low-risk women of 23.6%. Low-risk women are those with singleton

¹⁸ Rates for cesarean sections are tracked to the provider who was providing care at the beginning of labor, and the result is counted for that provider even if the patient was transferred to a physician's care for surgery.

pregnancies born after week thirty-seven in a head down (vertex) position. These are generally women whom midwives could attend at home under most state regulations. (Johnson and Daviss 2005) research on certified professional midwives (a kind of DEM) found that they had a cesarean section rate of only 3.7%. Ina May Gaskin's Farm Midwifery Center boasts a cesarean section rate of 1.4%, which is incredible considering they deliver breech and twins at their center, which is considered high-risk in most other out-of-hospital settings and not included in most estimates for low-risk populations (Gaskin 2003). In the 1989 Birth Center Study, which included some DEMs and mostly CNMs, reported a cesarean section rate of 4.4% (Rooks et al. 1989). CNMs in hospitals also demonstrate lower rates of cesarean sections as well. Research by Gabay and Wolfe published in 1994, which accounted for 50-60% of births by CNMs (predominantly in in-hospital settings), found an overall cesarean section rate of 11.6%. This was approximately half the national average at the time of the research. They also found a high proportion of successful VBACs that helped account for the lower cesarean section rate. They reported 88 % of CNM clients with a previous cesarean section attempted a VBAC, and 78% of these were successful vaginal deliveries. In comparison, only 21 percent of all women giving birth in 1991 with a previous cesarean section gave birth vaginally and avoided a repeat cesarean section (Rooks 1997). These CNM rates do vary by birth setting, and seem to be related to both philosophy and hospital policies and culture where the (CNM) midwives work. Lower cesarean section rates for CNMs seem at least partially due to a lower use of obstetrical interventions by midwives. A meta-analysis of six studies that compared doctors and CNMs found that in every study there was a statistically significant difference in use of internal fetal monitors, narcotic

analgesia, epidural anesthesia, and episiotomies between doctors and nurse midwives, and this difference was maintained even when the populations were closely matched (Rooks 1997). The positive outcomes of homebirth are often attributed to avoidance of the “intervention cascade” and prenatal screening. Ethnographic research has demonstrated that intense personal support, faith in birth, keeping women mobile, providing food and fluids in labor, and using a variety of birth positions are all linked to a reduction in cesarean section (Sakala 1993). The support and belief in the birth process demonstrated by CNMs is also linked to their lower use of interventions including cesarean sections.

Utilizing Goer’s (1995:301-302) review of the natural birth literature, the following conclusions about midwifery and the holistic approach to practice can be stated,

- In general, midwifery care differs from obstetric care in philosophy, style, and practices. It promotes the normal, speaks to the psychological state as well as physiological care, is women-centered, empowers women, and looks to simple, noninterventionist remedies before resorting to technology (14 articles).
- Midwifery care is safe (12 articles).
- Midwifery reduces intervention rates, but how much and which ones vary widely (16 articles).
- Midwifery clients have fewer epidurals, which results in lower intervention and cesarean section rates (2 articles).
- Midwifery care benefits medically and demographically high-risk women as well as low-risk women (8 articles).
- Midwifery care costs less; Issacson (2002) estimated midwifery levels as high as the Netherlands could save the US \$ 880 billion a year.
- In birth centers, good outcomes and lower interventions rates among birth center women are not due to intrinsic differences in the low-risk counterparts in the hospital.
- Women opting for hospital birth are more likely to have interventions than similar women opting for birth centers even when midwives care for both groups.
- The freestanding birth center is safe, providing women are prescreened for risk, care providers are trained professionals, physician backup is

available, rapid transport to the hospital is available, and emergency equipment is available on site.

- At home, no study of planned homebirths of a screened population of women with a trained attendant taking proper precautions has shown excess risk (5 articles). Johnson and Daviss (2005) has further confirmed this with national-level data.
- Because unexpected problems arise even within a screened population, those planning a homebirth should have appropriate backup arrangements with an obstetrician and a hospital. Home birth attendants should have the skills to monitor the labor and baby and the skills, equipment, and medication to manage or stabilize emergencies such as a baby who does not breathe spontaneously or a mother who hemorrhages after birth. (8 articles).
- Home birth becomes dangerous only when doctors and hospitals fail to provide backup services.
- Excellent outcomes with much lower intervention rates are achieved at homebirths. This may be because the overuse of interventions in hospital births introduces risks or the home environment promotes problem-free labors (15 articles).

In the newest research conducted by Johnson and Daviss (2005), these low rates of intervention and good rates of neonatal morbidity and mortality can be seen. They found that medical intervention rates included epidural (4.7%), episiotomy (2.1%), forceps (1.0%), vacuum extraction (0.6%), and cesarean section (3.7%). These rates were substantially lower than for low-risk women having hospital births. No mothers died. The intrapartum and neonatal mortality among women considered at low risk at start of labor, excluding deaths concerning life-threatening congenital anomalies, was 1.7 per 1000 planned homebirths. This rate is similar to risks in other studies of low-risk home and hospital births. For comparison, the neonatal mortality for homebirth midwives in Arizona from 1978-1981 was 1.4/1,000 (Sullivan and Beeman 1983). The Farm Midwifery Center, which does some higher risk births, has a rate of 3.9/1000 (Gaskin 2003). The Birth Center Study (Rooks et al. 1989) had a neonatal mortality rate of 0.7/1,000. Lastly, a study of CNMs doing homebirths between 1987-1991 had a neonatal

mortality rate of 1.0/1,000 (Anderson and Murphy 1995). All these rates are for neonatal mortality excluding deaths due to congenital anomalies not consistent with life.

Midwifery care and the Midwives Model of Care continue to be the main solution advocated by the homebirth movement to remedy the diagnosed ills of standard maternity care today. This diagnosis is built on the arguments against interventions and the standard approach of the medical model presented in the previous sections of this chapter.

Midwifery, as I've just finished discussing, is framed as providing safe, effective, family-centered care.

Summary of Collective Action Frames

The following chart provides a summary of the major collective action frames utilized within the homebirth movement. The diagnostic, prognostic, and motivational frames from (Lang 1972), Gaskin (1977), and Arms (1975; 1996) are included in this summary chart as well as points derived from multiple other sources, including some utilized in the discussion on specific interventions. Within the motivational frames column in Table 8: Collective Action Frames in the Homebirth Movement, I have also included quotes from my research participants who provided examples of these motivational rationales.

Table 8: Collective Action Frames in the Homebirth Movement

Diagnostic CAF (Problem identification)	Prognostic CAF (Solutions)	Motivational CAF (Vocabulary of motives)
Obstetrics treats birth as pathology . Birth is treated as “normal” after the fact. Medical textbooks state birth is a normal process then spend the next 800 pages describing every disease and intervention in pregnancy, labor and delivery	Have trained midwives attend births at home. They have the skills to be aware of the development of complications requiring additional care, but their overall emphasis is on physical, emotional, and familial health and fostering normal, natural childbirth .	“Birth is a normal, natural life event.” Midwives are skilled at facilitating normal birth
Technological intervention interferes with the natural processes of birth and contributes to complications in most normal births: This includes the use of narcotics, episiotomies, epidurals, liberal use of pitocin to speed up and induce labors, Electronic Fetal Monitoring, and cesarean sections. These interventions make birth less safe increasing neonatal and maternal mortality	Reduce the use of technology and interventions by having all low risk births attended by midwives who are trained in the normalcy of birth, and labor support techniques. Preferably these births should also occur at home away from the temptation to use interventions to alter a normal birth. This makes births safer.	An intervention free birth creates a sense of euphoria, empowerment, and aids bonding between mother and child. An intervention free birth is a safer birth. Epidural risks and complications EFM risks and complications Episiotomy risks and complications Induction and Augmentation risks and complications cesarean section risks and complications
Doctors are surgeons skilled at dealing with pathologies, not in dealing with the normal natural rhythms of labor and birth	Midwives should attend normal labors at home. They should be well trained and have good backup physicians to transfer care if a physician’s skills are required.	Hospitals and doctors are good back help
Doctors use technology because they are expected to “do something” and show skill, they also expect things to go wrong due to an emphasis on the pathology of birth inherent in the medical model	Exposure to normal natural childbirth outside the hospital to increase trust in the natural process	Doctors abuse technology and intervene too often.
Hospitals do not provide family centered maternity care. Women and babies suffer from lack of support and routine separation of families (This was an especially resonate frame before fathers were routinely “allowed” to be with their partners during labor and delivery in the 1970s)	Parents are empowered to make birth choices, have loved ones support the laboring woman, and have the birth occur in her home as a natural part of her life and never be separated from her child.	<ul style="list-style-type: none"> • Share the experience with loved ones • Feel supported • Never be separated from the baby
Women are disempowered and taught their bodies are defective (ie. Needing pit, not food or a different position)	Empower women to make choices in a supportive environment	“I felt strong and empowered. I knew I could make decisions and be strong after my homebirth”

Diagnostic CAF (Problem identification)	Prognostic CAF (Solutions)	Motivational CAF (Vocabulary of motives)
Standard medical care is hierarchical with the doctor in the position of power	Women should ideally have personal responsibility to make informed choices in a non hierarchical relationship with a caregiver	“I had personal responsibility”
With holding food and drink since a woman might need an operation at any minute in which case she might aspirate stomach acid into her lungs. Lack of food and water makes women become fatigued and more likely to have intervention	Laboring women should be encouraged to eat in early labor and drink during all of the labor to keep their energy up	“I ate and drank and I stayed strong”
Because of Standard Practice and the use of epidurals, which make most women immobile, most women in hospitals labor in a bed and give birth on their backs propped up. This slows labor and delivery and increases the use of pitocin, episiotomies, vacuum extraction and forceps.	Women should labor in whatever positions makes them most comfortable, ideally this should include positions that facilitate labor progression by utilizing gravity .This often includes walking, slow dancing, hanging support postures, kneeling, all fours, child’s pose, and squatting.	‘I was up and active and took whatever posture made me comfortable and facilitated labor and delivery’
Doctor’s adhere to timetables (Friedman Labor Curve) that limit the range of what’s considered “normal” before intervening. These timetables are to restrictive and increase the use of intervention	All women’s labors are individual, with individual variation. Watchful waiting is preferred over intervention	“I was so glad no one rushed me, my labor happened at its own pace.”
In the hospital naturally occurring labor pain is problematic and unacceptable, but iatrogenic pain (caused by practitioner) is acceptable. This attitude is problematic	Pain is part of an essential and healthy feedback mechanism in labor. Women can learn to cope with it, especially with the proper encouragement and support. Including her own safe environment at home	The pain was part of the process
Stress of someone else’s turf	Her turf	Comfort and security

(American College of Nurse-Midwives Clinical Bulletin 2003; Anderson and Anderson 1999; Anderson and Murphy 1995; Arms 1975, 1996; Armstrong and Feldman 1990; Bailes and Jackson 2000; Baldwin 1986; Beech 2000; Berg 2005; Bewley and Cockburn 2002; Brackbill et al. 1974; Brown 1987; Bruner et al. 1998; Burt et al. 1988; CIMS 2003; Citizens for Midwifery 2005b; Cohen and Estner 1983; Davis-Floyd 1998; Davis-Floyd and Davis 1996; Davis 1983, 1987; Davis 1979; Declercq 1994b; Declercq et al. 1995; Declercq 1992; Durand 1992; Edwards and Waldorf 1984; England 2000; England and Horowitz 1998; Enkin et al. 1995; Flamm et al. 1994; Fuchs 2000; Gabay 1997; Gaskin 1977, 1990, 2001, 2003; Goer 1999; Goetzl et al. 2001; Granju 1999; Griffin 1997; Hall and Bewley 1999; Hartmann et al. 2005; Hodges and Goer 2004; Hook et al. 2005; ICAN 2005; Issacson 2002; Johnson and Daviss 2005; Jolly, Walker, and Bhabra 1999; Jukelevics 2004; Kaminiski et al. 1987; Kaufman, Bailit, and Grobman 2002; Kitzinger 1972; Klassen 2001; Kozlowski 2003; Lang 1972; Lay, Wahlstrom, and Brown 1996; Leung, Leung, and Paul 1993; Marsden Wagner 2000; Mathews and Zadak 1991;

Menacker 2005; Midwifery Task Force 2005; Mitford 1992; Murphy and Fullerton 1998; Myers-Ciecko 1999; O'Connor 1993; O'Mara 2003a, c; Oakley 1979, 1980; Pearse 1987; Petitti et al. 1982; Rageth et al. 1999; Reed and Roberts 2000; Reents; Rooks et al. 1989; Rooks 1997; Sakala 1993; Sandall 1995; Scott et al. 1999; Simkin 2000; Simonds 2002; Smith et al. 2003; Stewart and Stewart 1977a, c; Studd et al. 1980; Sullivan and Beeman 1983; Susie 1988; Tjaden 1983; Tritten 1998; Valdez 1999; Wagner 2003; Walker 2000; Walsh and Downe 2004; World Health Organization 1985; www.inamay.com/biography.php 2004; www.meacschools.org/ 2005)

This chart represent one way in which birth can be framed, as a safe, woman-centered empowering experience, or as a medical experience that emphasizes risks and fear, and emphasizes the use of technology and technological fixes to physical pain and birth. Throughout this chapter I have detailed how the framings of the movement, and central women as makers of the movement, constructed the main arguments and rationales for the homebirth movement's goals. I have also detailed the research and arguments against standard hospital technologies and interventions. I now finish this chapter by discussing why these arguments are not resonant with more women today.

Empirical Credibility and Experiential Commensurability

These research framings of the homebirth movement now take us to the interrelated framing issues of empirical and experiential credibility. These two framing tasks can be either complementary or contradictory. Empirical credibility refers to the apparent fit between the framings and events in the world. Often this fit is related to "evidence" claimed by the movement. Benford and Snow (2000:620) explain, "Hypothetically the more culturally believable the claimed evidence, the greater the

number of slices of such evidence the more credible the framing and the broader its appeal.” The irony is, for a country which generally speaking gives high cultural value and empirical credibility to evidence-based research, obstetrics continues to use practices and procedures that have been shown repeatedly to be of questionable use if not downright harmful in the research literature. Episiotomies are an excellent example of this¹⁹. This is of course of great frustration to the homebirth movement, which has demonstrated repeatedly the safety of homebirth and the value in reducing technological interventions. However, birthing and direct-entry midwifery at home remain stigmatized if not illegal. Ina May Gaskin in *Ina May's Guide to Childbirth* (2003) commented on her and other homebirth practices in other countries that had very low rates of neonatal and maternal mortality and interventions²⁰. In response to discussing these findings with medical persons, Gaskin (2003:270). stated, “Drs. Stevenson, Rockenschaub, and I have all been told at one time or another, by doctors who could not imagine that low mortality and morbidity rates are possible with such low cesarean and instrumental delivery rates, that our outcomes were ‘unbelievable’.” This incomprehension illuminates deeper issues. Social scientists (Davis-Floyd 1987, 1992; Martin 1987; Rothman 1989) have attributed this disjunction to the deeper cultural value given to technology and patriarchy (fostering

¹⁹ For a review of the medical literature, generally discussing the gap between evidence and practice, and for episiotomies specifically see Goer, Henci. 1995. *Obstetric Myths Versus Research Realities*. Westport: Bergin & Garvey..

²⁰ This included hospital transfer rates of 4.9%, and cesarean section rates between 1.6% and 1.4%. This is in comparison to the National 2003 cesarean section rate of 27.6% Gaskin, Ina May. 2003. *Ina May's Guide to Childbirth*. New York, NY: Bantam Books..

the idea that women's bodies differ from men's and are hence deficient and defective), making research-based evidence less salient and effective than one would predict. It is difficult in American society not to assume that technology would make birth "better and safer," even if it is generally shown not to. Underlying medical birth models have great sway in the choices, interpretations, and actions of most American women and their practitioners.

Despite the general lack of over-all cultural resonance with the empirically credible evidence produced by the homebirth movement, these articles and books have been of importance to the movement as motivational frames for the women who choose to birth at home, their midwives and advocates. For the homebirth movement, public health literature (e. g. Mehl 1977) as well as published personal accounts (e. g. Davis 1983; Gaskin 1990; Zimmer 1997), comprise evidence of the movement's claims-makings. Today, (Johnson and Daviss 2005), the good results of this national study of Certified Professional Midwives in homebirths can provide solid evidence of the movement's collective action frames. Building on my previous research (Pfaffl 1999), these claims-making efforts are integrated into the accounts and rationale espoused by homebirthers. Accounts and statistics from books are commonly quoted for explaining individual's choices to birth at home. These espoused claims are representative of the resonance these claims had with adherents in that they were incorporated into their personal vocabularies of motive for their actions. This brings us to the second issue of experiential commensurability.

Experiential commensurability refers to how congruent or resonant a collective action frame is with a person's everyday life. Benford and Snow (2000:621) state,

“Hypothetically, the more experientially commensurate the framings, the greater their salience, and the greater the probability of mobilization.” For homebirthers, the homebirth movement’s claims-making may not have been resonant until they were pregnant, but once they entered into this “liminal” phase (Pfaffl 1999) this claims-making became much more experientially commensurate with their everyday lives. Personal experience and personal accounts are given high value within the movement itself and its framing efforts. Ideas inherent in the homebirth movement’s CAFs such as inherency of the natural process, valuing inner body knowledge, a family-centered approach, and avoiding procedures and the medical model found experiential commensurability in these women’s lives. They had personal experiences that told them that these ideas were of value to them. This level of personal experience was also a large part of the early homebirth books that were published in the 1970s (e.g. Gaskin 1977; Lang 1972). It is important to note that these books and the homebirth movement attempted to blend both empirical credibility and experiential commensurability framing strategies into their prognostic, diagnostic, and motivational frames by providing personal stories that were meant to “resonate” with birthing women as well as statistics, history, and procedures to “back up” these personal experiences of homebirth stories.

I have detailed these framing strategies throughout this chapter and provided a context with which to understand the individual women’s stories and frame alignment processes that I will present in upcoming chapters. Moving from the framing strategies and the produced collective action frames of the homebirth movement, I move my discussion to the development of homebirth midwifery in Tucson, as a backdrop to the stories and evolution I will further discuss throughout the remainder of this work.

CHAPTER SIX: THE HISTORY OF THE HOMEBIRTH MOVEMENT IN TUCSON, ARIZONA

This chapter provides an overview and recounting of the changing midwifery landscape that existed over the last thirty years in Arizona. This information is presented so the birth frame construction, alignment, and adoption model I will present in the following chapters will have context. The women's birth stories which populate my description of this birth framing process are colored and flavored by the background information presented in this chapter. First, I present information on the early days of lay midwifery in Tucson, including the development of the Arizona School of Midwifery. I also cover the early development of the rules and regulations of state licensing, as well as the implications of state licensing for practicing lay midwives. Second, I present the contemporary changes that have occurred in the state regulations for licensed midwives and the implications of these changes. I also discuss information regarding the practices of licensed midwives, certified nurse midwives, and the Tucson Birth Center.

The Early Days of Lay Midwifery in Arizona

The legal status of lay midwifery was undergoing flux in the 1970s as officials became aware that nationally out-of-hospital planned homebirths had more than doubled from 0.6% in 1970 to 1.5% 1977 (Rooks 1997). During the 1970s many states repealed permissive midwifery laws, which mostly dated from the late 1900s. Due to this restricted legal environment, midwives in California were arrested and jailed for

practicing medicine without a license and for neonatal or maternal deaths. At the end of the decade, only eleven states had statutes or regulations explicitly sanctioning the practice of midwives other than CNMs. A few states reactivated old laws to facilitate lay midwifery, or legal decisions occurred which provided permission to practice. Arizona, New Mexico, and Rhode Island enacted new laws or strengthened old ones to involve the state health department in licensing and oversight of lay midwives and to require training, an exam, case reports, and oversight (Rooks 1997). This makes Arizona of particular importance since it was one of only eleven states to legally regulate and license lay midwives. The women who were part of the Pioneering group who I interviewed were part of the homebirth movement that helped enact these regulations which have made Arizona a more “homebirth friendly” state. I will now present details of Arizona’s homebirth movement.

As Chapter Five discussed, the homebirth movement emerged from the lived experiences of birthing mothers. Their personal processes of birth frame construction were part and parcel to the movement. The same is true in Tucson, Arizona, where the majority of my respondents gave birth, and where our historical review will now turn. In my discussion of the history of homebirth midwifery in Arizona, and specifically Tucson I cover Nasima Lomax’s part in the evolution of lay midwifery in Tucson, the legal changes to midwifery in Arizona, the origins and activities of Committee for Arizona midwifery (COFAM), The Arizona School of Midwifery and its evolution, and current trends and issues for midwifery in Arizona. Although I focus on the developments that occurred in Tucson, Arizona, many other localities and people played a part in the evolution of Arizona’s homebirth midwifery history and evolution. There is certainly a

larger story to be told, but for the time being I have restricted myself primarily to the background and events that directly relate to the people included in my study population.

1957 Licensing of Arizona's Midwives

In 1957, Arizona passed a midwife licensing law to regulate “granny²¹” midwives. Many states in the early part of the 20th century had such laws, which were designed to track and regulate traditional granny midwives, and protect women and children. Arizona is a mostly rural state with large populations of Native Americans, Mexican nationals, and religious groups (such as Mormons), whom lay “granny” midwifery still served in the mid-part of this century. In 1957, twenty-five midwives were put on the health and human services records as obtaining provisional or renewed licenses. To obtain this license, a midwife needed only register with the department, know the fundamentals of hygiene (i.e. wash hands), have basic although not clearly defined knowledge of the mechanics of labor and delivery and complications, and be able to read and write English (Sullivan and Weitz 1988)(2001 study interviews). This law fell into disuse over the next twenty years and the number of women licensed under this provision began to drop; how many women exactly remained in practice is unclear. The state’s Health and Human Services records indicate that in 1966, eleven midwives were

²¹ “Granny’ or “grand” midwives learned from other experienced midwives or learned as they went. These midwives often emerged due to a talent or propensity for the work as midwives have for eons. They served women in rural, isolated, ethnic, and underserved areas. Their level of “formal” obstetric knowledge may have been limited, although their experience was often considerable. Public health departments made efforts to regulate granny midwives in order to protect the safety of women and children Susie, Debra Ann. 1988. *In The Way of Our Grandmothers*. Athens: The University of Georgia Press.

licensed; by 1975 four women, Clair Bell²², Gilata Lopez, Lita Jessep, and Martha Barlow were licensed under this 1957 law (Glass July 2003). A local newspaper reported that in 1971 the last “granny” midwife was 71 years old and gave up practicing (Davis 1978). According to Sullivan and Weitz (1988:92), “By the early 1970s, in Arizona, only three women, who practiced together in an isolated, polygamous Mormon town with no nearby physicians, still held active licenses.” These discrepancies in numbers may be due to the difference in being listed on the records versus actually practicing. In the 1970s, as new “lay” midwives emerged and political homebirthing gained momentum in Arizona, women who became midwives essentially practiced illegally, until this 1957 law was discovered and revised. These developments are tied at least in part to the contributions of Nasima Lomax.

Nasima Lomax’s Contribution to Lay Midwifery in Arizona

In Tucson, just as was seen in other areas of the county, small enclaves of women began in the 1970s to birth at home together. Communities of friends and acquaintances passed information about homebirthing and midwifery contacts. They knew of each other through various circles. Social movement researchers have clearly demonstrated the importance of networks in the sharing of information, support, and movement goals (Friedman and McAdam 1992; Klandermans and Oegema 1987; Snow, Zurcher, and Ekland-Olson 1980; Wiltfang and McAdam 1991). Although other networking communities surely existed, a Sufi community in Tucson was of particular importance to

²² The spelling of some of these names may not be correct

the “pioneer” respondents in this study. Sufism is a mystic form of Islam. One branch in America was led by an American, Murshid Samuel Lewis. Murshid sent Nasima and Daniel Lomax to Tucson to start a Sufi community there, and it is with Daniel and Nasima’s first birth, and eventual move to Tucson, that begins our discussion of Tucson’s midwifery history.

The renaissance of homebirth in Tucson begins in part with Nasima Lomax. Her evolution into a homebirth midwife helped set the stage for many others who came after her. Her and others’ activism in support of midwifery led to the changing of state regulations, the development of a political action group to support lay midwifery, and a school to train midwives. Many respondents commented on Nasima’s charisma and leadership. Her passion for lay midwifery was derived in large measure from her personal experiences. The timeline presented in Figure 9: Sequence of Events Related to Nasima Lomax, 1969 -1981 on page 178 provides a sketch of the events and changes related to her.

Figure 9 begins with Nasima and her husband, Daniel Lomax’s, first childbirth in San Francisco. In 1969, Nasima and her husband Daniel were expecting their first child. Nasima wanted to give birth at home, but her mother convinced her it would be wiser to have her first birth in a hospital. During the birth, her wishes were ignored, she had to fight with her birth attendants, her husband was kept from her, and her child had a physician-created injury, which kept her separated from her child. This experience was so traumatic Nasima swore to the doctor she would never have a birth like that again and would help other women have better birth experiences as well²³.

²³ Her birth experience will be presented in more detail in the chapters to follow

Nasima and Daniel Lomax later moved to Tucson, Arizona to start a Sufi community. Many of the women whom Nasima and Daniel helped have homebirths came to them through networks of people associated with their Sufi community. Their home also became their “church” or community meeting area.

In October 1970, Nasima gave birth to her second child, Miriam. She had contacted an obstetrician in the hopes that he would be willing to help her deliver at home, but he refused. He lent them a *Grays Anatomy* textbook, and they decided to birth on their own. Nasima and Daniel delivered their daughter Miriam at home without any assistance. Nasima recalls that this birth was a wonderful experience for them all. After Nasima had her second child at home, other families began to hear about what they had done, and they began requesting Nasima and Daniel’s help with homebirths. Nasima and Daniel initially went to homebirths just as parents who had had a homebirth and who knew more than most. Nasima essentially filled a support role; Daniel had done most of the studying. Nasima was not yet an active practitioner, she did not do internal exams, prenatal care, etc. Rachel and Sharon recalled that Nasima attended their first births in this capacity. Each homebirth built on another, and their reputation grew. Nasima shared that between 1970 and 1971, “I was starting to get somewhat of a reputation as an underground illegal lay midwife here in the Tucson area. I would go out to Teepees, or to the desert wherever they were, I would go to them, Daniel and I, actually both of us.” Nasima was a warm, caring, charismatic personality and people enjoyed her. According to several respondents, Daniel pretty quickly stopped attending births since he was a “funny” or odd personality, better suited to the political and intellectual work. Nasima’s support role eventually developed into practicing midwifery.

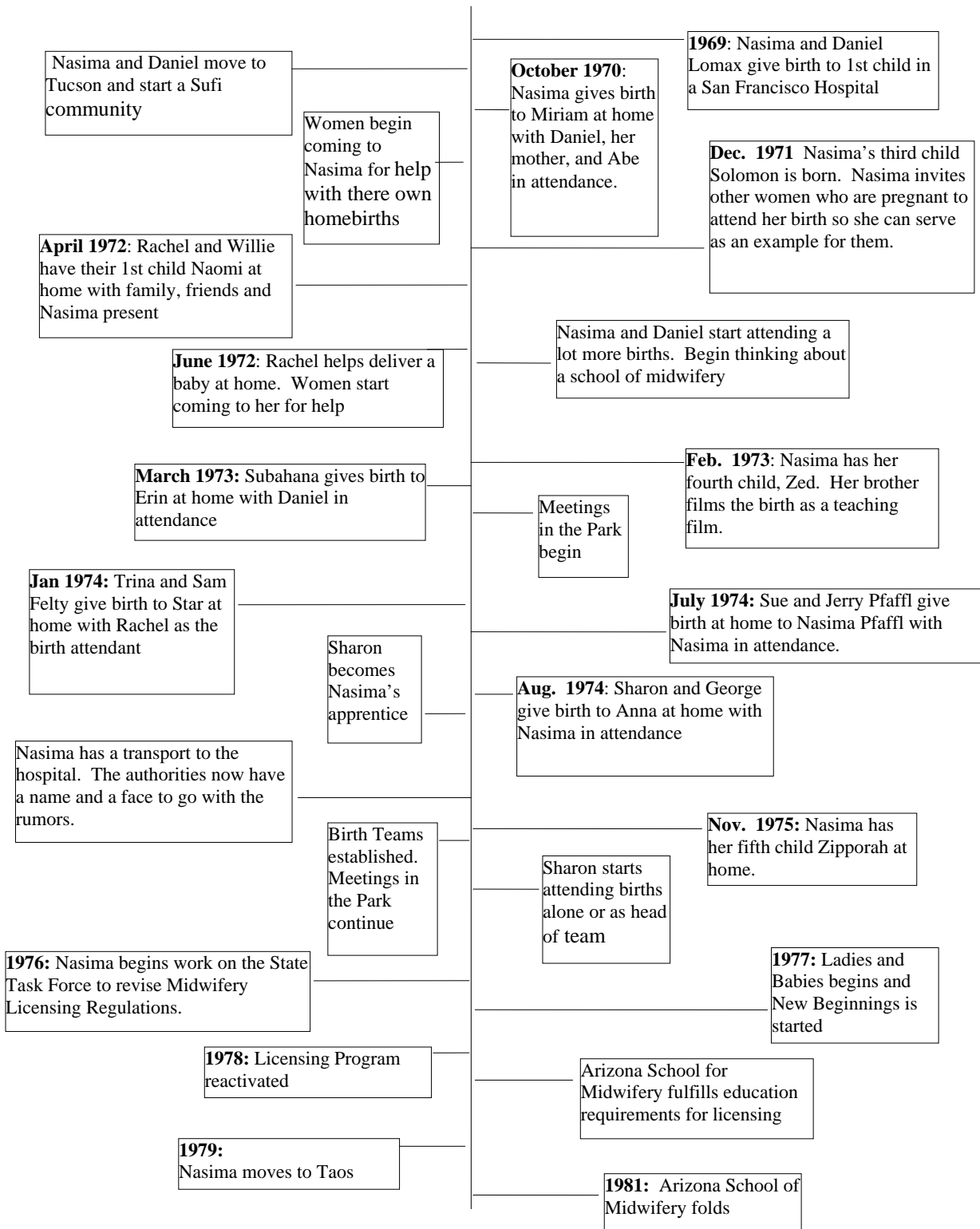


Figure 9: Sequence of Events Related to Nasima Lomax, 1969 -1981

In December 1971, Nasima's third child Solomon was born at home. By this time, Nasima had quite a few²⁴ women coming to her for help with their births and she decided to invite them to her birth to act as an example for them. This proved to be a poor idea. She had a harder time with an audience present. Six days after Solomon was born she recalls, "Carol Marie needed me to come and help her have her eldest child. So that was six days apart from me giving birth to being back on duty, helping somebody else." She started to acknowledge that too many people were coming to her.

I couldn't be in two places at once. Enough people were starting to come to me, and as nature would have it two or three would be due around the same week, or when the moon was full, or when the moon was new. So all of that started in my mind that at some point we were going to have a school, to teach people to become midwives.

So between 1971 and 1972 she started thinking about teaching midwifery, although this would not come to pass for several more years.

When Nasima's fourth child, Zed, was born in February of 1973, she had her brother film the birth to use as a teaching film. At this point more and more people were coming to Nasima for help with their births,

After I gave birth to Zed someone called and said they were going into labor, and I said well the only way I can help you is if you come here and they came to our house and in another room eight hours after Zed was born I was helping someone else have a baby in my home. And that's when it really hit me that I was only one human being, and I really needed some help with this.

²⁴ Nasima in her interview with me was unspecific about the exact numbers of women who were seeking her assistance. In this section I focus on her feeling that the number of women was more than she could handle, and her desire to train more midwives.

In 1975, Nasima continued to do lay midwifery while pregnant with her fifth child, Zipporah, but the need for student midwives was increasing. Nasima, Daniel, and others started putting meetings together of homebirthing parents.

Meetings in the Park

During most of the 1970s, “meetings in the park” were organized so midwifery activists, midwives, and homebirth parents could socialize with each other, share birth stories, and provide support for homebirthing and lay midwifery. Some of these meetings occurred at a park at Plaza Antigua. These meetings were considered to be invaluable by my respondents. The support and gratification of telling their stories to those who had similar experiences and sentiments was important to maintaining confidence in the homebirth philosophy.

Around 1975, those women who voiced an interest in practicing midwifery “organically” turned into a class lead by Nasima and Daniel. They contacted people who had voiced an interest in midwifery and a meeting was held. One who attended was Sharon Milan, who had been with Nasima since a year or so after her daughter, Anna, was born with Nasima in attendance. Another of these was Emily, who brought her friend Susan Merski. Susan, unlike most of the women who were interested in apprenticing with Nasima, had not had a baby, but she had been looking for a life direction, and midwifery quickly took root. She decided she could help out with her good clerical and organizational skills. She recalls that the original “core” group of students consisted of herself, Sharon Milan, Leda Davis, Lisa Hulette, Cherie Bilsmuth, Angela Lucas, Emily

Camp, and Susan (Babs) Greenstein²⁵. Classes were held twice a week and selected students would go to births with Nasima.

Interaction with State Authorities

In 1971, the state authorities had recorded one in two hundred births were occurring at home in Pima County where Tucson is located (Davis 1978). These statistics worried some physicians. The authorities in Tucson became aware that there was someone out there doing a lot of homebirths, but they didn't know who that was. At one point after 1974, Nasima had a transport to the hospital. This is represented on the timeline in Figure 9 as the mid-point in the sequence of events. Nasima recounts the events of a failure-to-progress transport to the hospital,

I finally took someone to the hospital, who was far enough along in the labor that was obvious nothing was going to resolve itself, whether it was changing positions or having them walk, or any of the things I had learned or intuitively known to do in the past. She really wanted me to stay with her the whole time. So I walked in and told them who I was and what was happening.

The hospital sent in a CNM named Doreen Lang, to confront Nasima about her homebirths. Nasima stood up to Doreen and in the end she became Nasima's ally, but the authorities now had a name and face to go with the rumors. They threatened to prosecute Nasima for her homebirths, but instead with the help of Doreen Lang, Nasima was invited to sit on a task force to revise the state laws on midwifery.

²⁵ The spelling of these names may not be exact. I spelled them phonetically in the transcripts when a secondary source was unavailable to double check the spelling.

1976 Midwifery Licensing Revisions

Nasima then spent from 1975 to 1978 working on the state midwifery revisions.

Nasima recalls,

[Those] were the three really intense years of me going back and forth to Phoenix on this task force, being a lay midwife, standing up and arguing with doctors and obstetricians and pediatricians and standing my ground. It was a very interesting time politically. God knows why, but I had the strength and the will to do it.

Sullivan and Weitz (1988) in their sociohistorical analysis of Arizona's midwives have pointed out that the legislature in Arizona had a history of opposing regulation and supporting free trade. This antiregulation sentiment in the capitol helped to stem the demands of the medical community to outlaw midwifery in Arizona. According to Sullivan and Weitz (1988) doctors pressed for a prosecution of a lay midwife by the attorney general. Her defense lawyer found the 1957 licensure law allowing granny midwives to practice (Sullivan and Weitz 1988:92). After this licensure law was discovered, the Department of Health Services began considering requests for the "granny" license. They were receiving a lot of requests from all over the state, and it was a problem to have a law on the books, but no licenses being issued (Sullivan and Weitz 1988). According to Sullivan and Weitz (1988:92), nine practicing lay midwives became licensed after "passing a written, oral, and clinical qualifying examination and without any formal course work." Of the core group associated with Nasima, Lita Davis was licensed in Nov of 1977, Lisa Hulette in March 1978 and Sharon Milan and Nasima in March 1978 (Glass July 2003). The 1976 state revisions of the midwifery regulations included a qualifying exam, and Nasima sat on the committee that helped write the test. The law stated,

The applicant shall furnish evidence satisfactory to the Director [of] completion of a course of instruction in midwifery or successful completion of a qualifying examination. A provisional license may be granted for a period of not more than six months at the discretion of the Director, pending completion of a course of midwifery (Added Reg. 7-57)

This “or” statement made it possible for women such as Nasima who had experience and informal training but no avenue to “formal” instruction to get licensed and start The Arizona School of Midwifery to provide the needed instruction to future midwifery candidates.

These ("Licensing of Midwifery" 1976) (R-16-202) regulations also required a physical exam and lab tests to demonstrate the physical health of the midwife (that she was free of syphilis, etc.). The new regulations stated the responsibilities of the midwife, including requiring a blood test for syphilis of clients, application of silver nitrate in the newborn's eyes, keeping of records, filing birth certificates, and calling a physician or transporting the mother and/or child to a hospital if abnormal conditions arose during labor or delivery. The regulations prohibited the midwife from knowingly attending abnormal births, administering any drugs or herbs, or using any instruments except scissors to sever the umbilical cord. This last provision became quite problematic because midwives could not suture tears, hence requiring transport or a qualified person willing to come to a woman's house to do the sutures.

Section R9-216-205 ("Licensing of Midwifery" 1976) required that equipment be taken to each birth for the hygiene, cleanliness and safety of the mother and child, and for weighing the baby, and keeping records.

Section R9-16-206 (1976) detailed the Course of Instruction needed for midwives. This instruction was required to include: information regarding laws and

regulations of midwifery; the reasons for hygiene, sanitation, and prenatal care; information on the proper conduct of a normal delivery; signs and symptoms indicating complications of delivery; instruction in the immediate after-care of mother and child; and special care of the premature.

Section R9-16-207 (1976) stated that denial, suspension or revocation of a midwifery license may occur if a midwife violates the articles and regulations, permits, aids, or abets the commission of an unlawful act, or indulges in conduct or practice detrimental to the health and safety of the mother and child. Included in this same provision was the requirement of consultation with a physician when the following occurred: bleeding from the uterus, swelling of the face and hands, excessive vomiting, contracted pelvis, persistent headaches, dimness of vision, convulsions, complicated presentation of vertex presentation, prolapse of cord, swelling or tumor obstructing delivery, signs of exhaustion or collapse, unduly prolonged labor or deformities or malformations of the child, as well as bleeding from the mouth, navel, or bowels and other signs and symptoms of abnormalities of the newborn. It is interesting to note that the 1976 rules and regulations did not clearly define twins and breech deliveries as out of the scope of practice of midwives, although I suspect it was intended to in the term “abnormal conditions.”

1978 Licensing Revisions

In January 1978, these rules and regulation for midwifery licensing were again revised. The new rules and regulations R9-16-201("Article 2 Licensing of Midwifery" 1978) of the Health Services Chapter 16 occupational licensing, now stated that a course

of instruction, not just an exam, was required for licensing meeting the requirements of section R9-16-203, as well as an application form, licensing fee, and a request to undertake the next available qualifying exam. This change in rules from either an exam or a course of instruction, to needing both instruction and an exam, created two problems. First, the only school in the state that I am aware of was the Arizona School of Midwifery in Tucson; this created problems for lay midwives in other areas of the state. Second, once the school closed in 1981, there existed no route to instruction within the state. Women interested in lay midwifery were required to go to an out of state school recognized by Arizona to obtain the necessary course of midwifery training to be eligible for licensing in Arizona. Exceptions to this catch-22 occurred during a 1982-83 window when temporary state regulations lessened educational requirements, and a 1981-83 community college certificate program that provided an educational route to licensure. Not until 1994, when preceptor and out of state licenses were accepted as educational means to licensure, did this educational requirement become less of a burden for aspiring Arizona midwives. This lack of educational routes severely limited the number of new midwives in the state after the school closed. The following rules established the elements of instruction necessary for licensing.

Section R9-16-203 (1978) stated the acceptable course of instruction for midwives must include: laws and regulations of Arizona midwifery; basic course in aseptic techniques; basic observational skills; recognition and management of emergency situations; special requirements of home delivery; clinical courses covering the knowledge and skills necessary for providing care during the antepartum, intrapartum, postpartum and newborn periods; management of birth and the immediate care of the

mother and newborn infant; observation of a minimum of ten births; delivery of a minimum of fifteen women, under direct supervision by a licensed physician, licensed midwife, or certified nurse-midwife, and verified by a written statement from the supervisor that competence had been demonstrated; last, the course of instruction needed to meet the requirements of knowledge and skills to recognize the conditions listed in R9-16-205 (1978) (Responsibilities of a midwife) listed the a following section. These new rules clearly established the number of births needed for licensing; obtaining this number of births was at times challenging for aspiring midwives, especially after the collapse of the Arizona School of Midwifery. You may note in upcoming chapters that new midwives seem to take a number of years to get licensed in the 1980s; this is largely due to these factors. In fact, most of the students from the Arizona School of Midwifery did not receive their full licenses until the early 1980s.

Section R9-16-204 (1978) detailed the need to pass an exam given by the health services department consisting of written, oral, and practical components. This test was first administered in 1978 and 10 of the 17 women who took the test passed, including three women from the Tucson group. Nasima recounted in her interview that several nurses and other medical people sat for the test, some of whom did not pass. The fact that they did not pass indicated to Nasima that the test had been well designed for “homebirth” practice and home-based practitioners.

In Section R9-16-205 (1978) presented the responsibilities of the midwife. Several additions, clarifications, and revisions were made in this section from the 1976 version. Some of these additions include the laboratory tests required, a visit to the prospective birth place at least once before expected delivery to make sure conditions are

adequate for delivery and prepare the family, and a formal arrangement prior to delivery for backup medical care for the mother and infant and necessary transport based on section 205. The wording of the 1978 statutes does not clearly define midwives' roles in prenatal care beyond "a midwife shall encourage all clients requesting her services to seek regular prenatal care, and shall require that they show evidence that they have been examined at least once in the last trimester by a physician or a practitioner working under the supervision of a physician" ("Article 2 Licensing of Midwifery" 1978). This created a problematic situation for women receiving prenatal care. Often they would go to a free clinic, or to private doctors for prenatal care while covertly planning a homebirth delivery. If doctors found out that they were planning a homebirth, they often spent considerable effort dissuading them from this choice.

The (1978) revisions (section 205) added a number of conditions that required transport or consultation with a physician. Some of these additions included the midwife to call a physician and/or transfer the mother and/or infant to a hospital when a: specified increase or decrease in blood pressure and pulse; specification for fetal heart rate; meconium-stained amniotic fluid; specified elevation in temperature, unengaged head in primigravida or during labor for multipara; presenting part other than vertex; ruptured membranes longer than twenty-four hours; prolonged labor with established criteria; multiple gestation, retained placenta over one hour; retained placental fragments or membranes; persistent uterine atony; vaginal or perineal lacerations, excessive pain during or after birth; shortness of breath, seizures; wishes of the client. Conditions of the infant now requiring consultation or transport included: weight less than 5 ½ pounds (2,500 grams); congenital anomalies; low Apgar score at 5 minutes; respiratory distress

or irregular heartbeat; signs of prematurity, immaturity, or postmaturity on assessment of infant; jaundice; abnormal cry; pale, cyanotic, or gray color; excessive edema. These regulations also required a midwife to place silver nitrate or other solution in the newborn's eyes; inspect the umbilical cord for number of vessels; inspect the placenta for completeness; file a birth certificate within ten days; reevaluate mother and child between thirty-six and seventy-two hours of delivery for any need for consultation; keep all midwifery equipment in aseptically clean and in working manner; maintain records and provide them for audit by request of the director. Section R9-16-206 (1978) required midwives to provide the Department with quarterly reports, and failure to do so could be grounds to deny renewals of license.

Last, section R9-16-207 listed the prohibitions or limitations to the practice of midwifery. Midwives were prohibited from accepting responsibility for births in which there was a history of third trimester bleeding; preeclampsia or eclampsia; persistent low hemocrit; multiple gestation, abnormal presentation or lie; client under fifteen; previous cesarean section or uterine surgery; syphilis or gonorrhea; active infectious disease (e.g., hepatitis, genital herpes); severe psychiatric disorders; any systemic condition recognized to cause problems in delivery; suspected or diagnosed congenital anomaly that may require immediate medical interventions; contracted pelvis; current narcotic addiction; suspected prematurity, immaturity, or postmaturity. Midwives were limited to managing women under the supervision of a physician when a client was under fifteen or over thirty-five, parity greater than four; history of specified complications. Again the midwife was prohibited from any operative procedures except cutting the umbilical cord. She was prohibited from performing external or internal versions (turning

a child in utero). She was also prohibited from administering any drugs, medications, or herbs. This last point has been a problematic part of the regulations because it meant that midwives could not give women an emergency shot of antihemorrhagic drugs in the case of a severe postpartum hemorrhage. Midwives complained over many years about this restriction (Sullivan and Weitz 1988)(personal interviews).

In an attempt to improve communication between Licensed Midwives (LMs) and health care providers an Advisory Committee to the Midwife Licensing Program was developed in 1979. The committee was composed of an obstetrician, a family practice physician, a certified nurse midwife, a neonatal nurse-practitioner, a consumer, and three midwives. This committee worked to develop guidelines for clinical practice and educational programs (Sullivan and Beeman 1983).

1982-1983 Licensing Revisions

The 1978 rules and regulations stayed in place until an emergency directive effective April 1982 (permanent January 1983), when some procedural changes were integrated, including: application for provisional license, examination of provisional license, and requirements for provisional license, and eligibility for licensure after license revocation. This change was initiated at the request of women attempting to obtain licensure when no educational routes existed for them. This period represented a temporary lessening of the regulation allowing for provisional licenses to be granted for taking the required exam, demonstrating compliance with the rules and regulations of the midwifery-licensing act, but without the need for formal instruction. Sullivan and Beeman (1983) reported that only four of the twenty-two applicants who took the first

exam under the lessened regulations passed. All four had been attending or had attended one of the educational programs in the state, but had not finished due to family responsibilities or geographic distance. At the time these procedures passed, legislative members tried to eliminate the midwifery licensing, but were unsuccessful (Sullivan and Weitz 1988). Further changes that occurred to these rules and regulation will be further discussed in the upcoming section: “Additional Changes to Arizona’s Midwifery Licensing.”

Committee for Arizona Midwifery and The Arizona School of Midwifery

In 1975, Committee for Arizona Midwifery (COFAM) was developed by Nasima, Daniel, and others in response to a need for an organized course of instruction in midwifery to prepare students for eventual licensing, at the same time as licensing rules and regulations were being developed on the state level. According to a pamphlet distributed by COFAM in April 1977, “Committee for Arizona Midwifery (COFAM) began as an organization of parents and others concerned about the lack of professional support for homebirth and determined to remedy the situation” (p. 1). COFAM was formed out of the “organic class” that had been set up, and consisted of the “core group” and other interested people. COFAM was the nucleus of what would become the Arizona School for Midwifery in 1975. Lisa Hulette expressed in a newspaper article that in 1975, when she started studying, that thirty to forty people were interested, but when the realities of midwifery hit, such as being called to births in the middle of the night, the number of interested women dropped considerably (Stengel 1978b). During the mid-seventies, the school was the only kind in the country that provided training with the

purpose of providing training for licensing of lay midwives. The school started taking applications from students around the country in 1978. In an interview with the Arizona Daily Star, the main Tucson newspaper, in April 1978, Daniel Lomax was quoted as saying, “The school is gaining national recognition, with inquiries received regularly from around the county. The school has 15 students”(Stengel 1978b:D1). The Arizona School of Midwifery had a homebirth service named Arizona Homebirth Service affiliated with the school. Daniel Lomax stated that this service had participated in 250 births since 1970 and averaged 10 births a month in 1978 (Stengel 1978b). In 1977 the service began charging \$200 for their services not including midwifery care since it was not yet licensed (Committee For Arizona Midwifery August 6, 1977). At the time of the Stengel (1978b) article they charged \$450 for everything including prenatal care, delivery, and follow-up.

COFAM and The Arizona School for Midwifery had to carefully walk a legal tightrope. Before Nasima and the state task force revised and reactivated the licensure program, someone practicing “midwifery” without a license could be charged with a misdemeanor offense, most likely practicing medicine without a license. The law at the time, according to the 1977 COFAM pamphlet, defined a midwife “as a person who, ‘habitually or for hire’ attends women in childbirth...”(pg.3). Due to this law, birth attendants could not call themselves “midwives” without risking legal action. COFAM students had to have parents sign a statement agreeing to take personal responsibility for the birth. Parents were informed that COFAM students were not qualified as “licensed midwives” and they would be present at the birth as observers and helpers under the direction of the parents. Students also could not accept money in the form of donations

or fee for services. Donations made to COFAM were used for education and equipment. Despite the restrictions mentioned above, the students were required to satisfy all public health regulations regarding prenatal care and physician referrals in the event of complications. Once the legal status changed, and the school was accepted as fulfilling the requirements for education for licensing, the legal restrictions were lessened.

After the regulations and an examination test were established, the school's unaccredited program was recognized as fulfilling the requirement for formal instruction now required in the new 1978 licensing regulations ("Article 2 Licensing of Midwifery" 1978). The Health and Human Services records for 1977 list the faculty of the Arizona School of Midwifery as composed of Nasima Lomax, Lita Davis, Lisa Hulette, Maureen Wolfe, and Sharon Milan (as director) (Glass July 2003). British-trained midwives, Certified Nurse Midwives and sympathetic physicians also provided occasional seminars. These same records from 1977, list twelve students at the Arizona School of Midwifery, including Kathleen Winningham, Ivy Stearman, Gretchen Kraus, Linda Goodwillie, Alice Toordseen, Mary Henderson, Stephanie Penick, Pamela Mayers, Paula Mathews, Rachel Hackyl, Ingrid Gold, and Janice Connall. COFAM notes (Committee For Arizona Midwifery April 1977, May 7, 1977) indicate that Dr. Pollack agreed to provide the school midwives with backup and to do the required third trimester physician prenatal exam. Dr. McEvers, who used to deliver babies at home, also occasionally provided backup services (see interviews).

Once licensed, midwives could now advertise and legally practice "midwifery," but the regulations still limited their practice. Midwives now had strict rules about who they could accept as clients and what constituted an emergency necessitating a hospital

transfer. The rules also restricted lay midwives from administering pitocin in the case of maternal hemorrhage or suturing minor perineal tears ("Article 2 Licensing of Midwifery" 1978). These regulations were a nuisance to some who were accustomed to practicing without restrictions. The process of establishing these rules also diminished Nasima's desire to continue midwifery in Tucson.

Between 1978 and 1979, Nasima began exiting the Tucson homebirth scene. Her marriage to Daniel was falling apart and she was constantly at a pre-birth meeting, a birth, a post-birth meeting, or teaching students. As Nasima stated, "My heart started to go out of it [midwifery]." She felt very badly that her children barely knew her. Daniel had indicated that he would be interested in continuing the school. Nasima stated that three of her students, Sharon, Angela, and Susan, who had been with her since the beginning, had passed the state exam and were licensed. There were others who could now take over for her, so she felt she could leave the responsibilities to someone else. All in all, during Nasima's career as a midwife, she helped to bring between 600 and 650 babies into the world and for most of that time she was what she calls an "illegal underground hippie midwife." So in 1979, she decided to move to Lama, a Sufi community in Taos, New Mexico. Once in Taos, she essentially stopped attending women in birth. She did however end up feeling guilty that the school broke up after she left. Nasima said, "I've lived with a certain guilt about that, but at the time I had to weigh that my children were only going to be children one time in their lives, and they needed me. They needed their mom. At this point I could give over the midwifery work to someone else." She was in many ways the charismatic leader of the Tucson movement and without her it began to change.

Midwifery Practice in Arizona After the Demise of the Arizona School of Midwifery

In 1981, The Arizona School for Midwifery folded due to “internal dissension and financial difficulties” (Sullivan and Weitz 1988:65). This point is the last event presented on the diagram in Figure 9. According to Sullivan and Weitz (1988) this created a catch-22 in the licensing process. Without access to an education program there was no route to licensure. In response to complaints, the State Bureau of Maternal and Child Health initiated in 1981 a midwifery demonstration program at a rural community college, resulting in a two-year certificate. In 1983 the program had twenty-three students (Sullivan and Beeman 1983). The program lasted three years (Sullivan and Weitz 1988). Holly Rainier, after being a midwife in North Carolina, got into this program and was able to get her license to practice in Arizona. In 1988, during Sullivan and Weitz’s study there was no active training program. The lack of training opportunities during the 80s and early 90s was the main difficulty with the licensure regulations that were developed. However, many of the students that came out of the Arizona School of Midwifery have continued to practice for many years in the state.

New Beginnings Birth Cooperative was an offshoot of the Arizona School of Midwifery that began around 1979 or 1980. Lisa Huette led this group of midwives since she held a midwifery license, and all the other midwives were in the process of obtaining the necessary number of births for licensure. This midwifery cooperative developed after the licensing came through and they were “nice and legal.” New Beginnings represented a split from the Arizona School of Midwifery due to overly heavy demands on the faculty; however, the cooperative did provide Arizona School of Midwifery students with opportunities to get the required number of deliveries. Rachel Hackyl, Susan Merski,

Angela Lucas, Maureen Wolfe and Bette Kibble were part of New Beginnings and worked out of the Archer Center on “A” Mountain. Four of the students of the Arizona School of Midwifery, Bette Kibble, Paula Mathews, Stephanie Penick, and Mary Henderson, have maintained their licenses and are still in homebirth practice in 2005 (Arizona Association of Midwives 2005; Arizona Department of Health Services 2005). Sharon and Rachel continued to attend homebirths as licensed lay midwives for several years after the break up of the school, and have gone on to receive their certifications in nurse-midwifery.

Statistics on Midwifery Practice, 1978-1981

Sullivan and Beeman (1983), in a report that summarized the outcomes of 1,449 homebirths in Arizona between 1978-1981, found that midwives transferred 15% of homebirth clients for postnatal outpatient care, mostly for repair of perineal tears; only 3% of their clients were hospitalized when transported; 5% of the newborns were transferred after delivery, half of which were hospitalized. They found that the 1,243 midwife-assisted homebirths between 1978-1981 represented less than 1 % of the state’s births; however, they found that estimated blood loss and length of labor decreased in the homebirths. Only 3% of newborns had an Apgar score under 7 at 5 minutes, mostly associated with respiratory distress due to shoulder dystocia and tight nuchal cords. Five percent of the low Apgar babies were transferred and 2% were hospitalized. In total, five fetal and neonatal deaths occurred: two died due to congenital anomalies inconsistent with life; one was a breech that was delivered at home; one died prior to delivery but was delivered at home; one had fetal heart tones during delivery but was unable to be

resuscitated by the midwife or paramedics at birth. This equals an overall neonatal and fetal mortality rate including congenital anomalies of 4.02/1,000. Excluding congenital anomalies the neonatal/fetal mortality rate was 2.4/1,000. Overall, it was the researchers' conclusion that maternal and fetal outcomes continued to improve for the midwives as their educational and experience levels grew.

Sullivan and Beeman (1983), found that between 1978-1981, LMs ranged in deliveries from one midwife who did 10 births per month, to two who delivered 3-4 birth per month, and eight who delivered 2-3 birth per month. They stated, "Many of the midwives, including almost all those in charge of less than two deliveries per month, work as part of a labor and delivery team of two or three licensed midwives, or licensed midwives and students midwives. The team approach provides more experience than is indicated by the number of cases for which they have primary responsibility"(Sullivan and Beeman 1983:642).

Additional Changes to Arizona's Midwifery Licensing

1994 Licensing Revisions

In March of 1994, additional changes were made to the state's rules and regulations for the licensing of midwives. These changes included R9-16-101("Article 1 Licensing of Midwifery" 1994)} a section for definitions of terms. The qualifications for licensure were also changed. Under new rules midwives must be at least 18 years old, be high school or equivalent graduates, be certified in adult and infant CPR, file appropriate forms and complete a midwifery apprenticeship within five years prior to application of

license; or they may be licensed in another state, comply with specific sections of the rules and regulations of licensed midwifery, and provide evidence of midwifery apprenticeship or state-licensed and professionally approved school equivalent to listed subsections; if requirements were not completed within five years prior to licensure application, then evidence of at least fifty births per year with specific requirements had to be documented. Additionally midwives now required letters of recommendation and a background check. Section R9-16-103 ("Article 1 Licensing of Midwifery" 1994) also introduced a number of new procedural requirements. The most significant change was the acceptance of preceptor grading for instruction. This represents a very important shift in the rules and regulation, allowing midwives to be educated in a traditional manner and removing the catch-22 of Arizona's licensing rules limiting routes of entry into licensed midwifery. These procedural rules also changed the number of births a student midwife needed to be part of. Specifically the new rules required: sixty prenatal visits for fifteen women; attendance at the labor and delivery of at least twenty- five live births for the purpose of observation and assistance to the preceptor; supervised management of labor and delivery of the newborn and placenta in twenty-five births; twenty- five newborn exams; twenty- five postpartum evaluations of mother and newborn within seventy-two hours and again at six weeks; and observation of one complete set of at least six childbirth classes. Specifications for grading, competency, and needed forms were also added.

Section R9-16-106 (1994) added and revised the responsibility of a midwife. Some specific changes that were significant included: informed consent signed by the client upon acceptance to midwifery care; oral and written notification to clients of the

midwife's scope of practice; risks and benefits of homebirth; required tests, the tests risks and benefits, and the need for written refusal if applicable; use of physician or medical services for consultation; transfer of care; and specifics of termination care. This subsection also delineated the schedule for prenatal care and what should be included in this care. It dropped the need for a third trimester consult with a physician. It also delineates and specifies the responsibilities of the midwife to evaluate and determine if the woman is in labor and the appropriate course of action. During labor the subsection also specified the rules for assessment of the labor including maternal vital signs, fetal heart tones, and periodic assessment of contractions, fetal presentation, dilation, effacement, and position by vaginal exam; fluid balance; support and comfort measures; and the acceptable duration and progress of labor. Normal labor is defined in R9-16-106 (1994) as labor progressing at a rate of one cm/hour in active labor until completely dilated. The second stage of labor should not last longer than two hours for primiparas. For multiparas normal labor is defined as progressing at a rate of at least 1.5 to 2 cm/hour in active labor until completely dilated and a second stage not longer than one hour²⁶. These rules regarding duration of labor are stricter than many midwives like. They note that labors are very individual, and hard and fast rules such as these are inappropriate. Even if a mother plateaus during active labor and does not progress as quickly, as long as the baby and mother have no other signs of distress, time alone is

²⁶ Active labor is generally defined as starting between four and five centimeters with contractions lasting a minute and coming every five minutes Davis, Elizabeth. 1987. *Heart and Hands : A Midwife's Guide to Pregnancy and Birth*. Berkley: Celestial Arts.

insufficient determinant of abnormality of labor (Davis 1987). The 1994 rules also specify that the placenta must be delivered within forty minutes.

The 1994 changes also delineate a number of additional requirements for midwives during the immediate postpartum period. These include things such as helping with breastfeeding, vital signs, and assisting bonding. Also they added that the midwife shall now administer erythromycin to the newborn's eyes and recommend or administer Vitamin K. Additional assessments and requirements were also specified. Record keeping and report requirements were also changed.

The most significant change in the 1994 rules concerned emergency procedures (R9-16-110). The rules now state that in an emergency, before the arrival of emergency medical personnel, midwives may perform emergency procedures for the health and safety of the mother and newborn determined to be of sufficient risk, including: performing CPR on the mother or newborn with bag and mask; administration of oxygen; performing a midline episiotomy to expedite delivery during fetal distress; suturing a tear or episiotomy to stop active bleeding, following the administration of local anesthetic (contingent on consultation and/or standing orders of physician); release of shoulder dystocia by rotating the shoulders; manual exploration of the uterus for control of severe bleeding; last, a midwife may administer the specified doses and duration of pitocin for the control of postpartum hemorrhage (including consultation, orders and transport).

2002 Licensing Revisions

The rules were again updated in Article 1: Licensing of midwifery R9-16-101 ("Article 1 Licensing of Midwifery" 2002). Briefly, the changes included more

procedural changes; practice of universal precautions; techniques for drawing blood; the prohibition from accepting as clients women with diabetes, hypertension, heart disease, kidney disease, and blood disease, and those who would birth in an unsafe delivery location; prematurity or labor before 36 weeks; gestation greater than 34 weeks with no prenatal care. Midwives should not deliver at home when there is the presence of thick meconium, blood-stained amniotic fluid, or abnormal fetal heart tones. This new regulation revision provided clarification on what constituted meconium stained amniotic fluid requiring transport. Previous rules had been vague regarding this issue. The regulations (R9-16-101) also state that midwives must have a consultation with a physician if a woman tests positive for HIV, has a second degree or greater laceration of the birth canal, or an abnormal presentation after 36 weeks; addition criteria for newborn transport or consultation are also delineated; last, acceptance of college-level courses, or through self-study and demonstration of competencies and knowledge to a preceptor at a level at or above average or excellent in each of the core subjects. This last change reflects a further strengthening of preceptor-based education in the midwifery community nationally as well as available college-level midwifery programs. These college-level educational routes are now accredited through the Midwifery Education Accreditation Council (MEAC) and the American College of Nurse Midwives Department of Accreditation (both accepted as Department of Education Accrediting bodies).

These changing legal statutes create the institutional backdrop to which all the women who birthed in Arizona and all the licensed midwives who attended them must act. Some of these rules and regulations have clearly improved the health of women and children, such as the rule changes adopted in 1994 that allowed emergency administration

of pitocin for postpartum hemorrhages, emergency episiotomies, and emergency suturing to prevent blood loss. Midwives had complained for years that these rules prior to 1994 “bound their hands” and endangered women (Sullivan and Weitz 1988). I know of several midwives who carried antihemorrhagic medications and administered them in emergencies for the safety of their clients in spite of the rules. Other rules such as labor limits and some of the exclusion criteria limit midwives more than they themselves believe they should be limited. Formal arrangements for consultations with physicians and medical services remain a good idea, but are difficult to arrange in reality. Doctors are few and far between who are willing to work with a lay or direct-entry midwife. These regulations, however, have provided critical legal standing for midwifery in Arizona that has allowed midwifery to legally exist and be a viable option for birthing parents.

Alternative Options in Maternity Care: Arizona’s Licensed Midwives, Certified Nurse Midwives, and the Tucson Birth Center

Over the last thirty years the maternity care options available to women in Arizona have been dynamic. Licensed midwives (LMs), certified nurse midwives (CNMs) and the Tucson Birth Center have all existed as alternatives to hospital birth with doctors; however, their numbers and ability to practice have fluctuated. The following sections highlight the dynamic changes of these options and their evolutionary paths in Tucson.

Licensed Midwives

The number of licensed midwives (LM) practicing in Arizona has fluctuated over the last thirty years. The Department of Health Services in Arizona listed fifteen LMs in 1978, twenty-one in 1979, twenty-six in 1980, and twenty-four in 1981 (Glass July 2003). In 1984, forty-two LMs were licensed and in 1986 they delivered 2,000 babies in Arizona (Valdez 1999). In a 1987 newspaper interview with Lisa Hulette²⁷, acting manager of the state's maternal Health Services Department and manager of the state's midwifery licensing program, she stated that fifty-two midwives were currently licensed, with approximately thirty-five in active practice (unknown 1987). In 1988, another newspaper article stated that forty-five midwives were licensed in the state, accounting for 2.5% of the births in the state (unknown 1988). In 1999, Linda Valdez reported that only forty-five licensed midwives existed in the state and only twelve of them were making a living at it: "In 1996 they delivered only 500 of 75,146 babies born that year" (Valdez 1999:B7). This amounts to 0.66% of the state's births. Currently, in 2005, fifty-three licensed midwives hold licenses in Arizona (Arizona Department of Health Services 2005). These LM licenses are held by women ranging in credentials from registered nurses (RN), to Certified Nurse Midwives (CNM), to Certified Professional Midwives (CPM), to direct-entry midwives (DEM) . It is unclear how many of these are actively practicing, but I am personally aware of at least four in the Tucson area. As the number of LMs has fluctuated the number of CNMs in Arizona has steadily risen.

²⁷ Lisa Hulette was also a practicing midwife associated with the Arizona School of Midwifery and New Beginnings Birth Co-op before moving on to the position in the State Health Services Department.

Nationally, in the US it is estimated that between 1300-2300 Direct Entry Midwives (DEM) practice in the US, compared to 5700 Certified Nurse Midwives (MANA 2003), and over 45,000 OBGYNs (ACOG 2004). In 2006, 1112 CPMs were certified nationally in the US (Pulley 2006) (see APPENDIX E: CERTIFIED PROFESSIONAL MIDWIVES GEOGRAPHIC DISTRIBUTION MAP). In Arizona there are approximately 158 CNMs currently residing in the state, and there are seventy-three nurse-midwifery practices. This is up from ninety-one CNMs in practice in Arizona in 1987 (unknown 1987). In 1997, Arizona nurse-midwives attended 9.14% of the state's deliveries. CNMs have had prescription writing privileges for over ten years, and third party reimbursement for CNMs is mandated in Arizona (American College of Nurse-Midwives 2005). The number of delivers by CNMs jumped from 2,200 in 1986 to more than 6,000 in 1996; with 150 CNMs in Arizona (Valdez 1999:B7). Despite their increase in numbers, CNMs have had a hard time maintaining malpractice insurance, hospital privileges, and affiliated physicians (see interviews). Dorthy Hanson, the manager of the state midwifery-licensing program in 2000, provided me with graphs demonstrating the peak and decline in homebirths in Arizona, and the counter trend of increased overall midwifery births in the state, mostly accounted for by in-hospital CNMs. See Figure 10: Number of Non-Hospital Births in Arizona, 1986-1996 and Figure 11: Number of Arizona Births Attended by All Midwives, 1986-1996 for graphical representations of these trends.

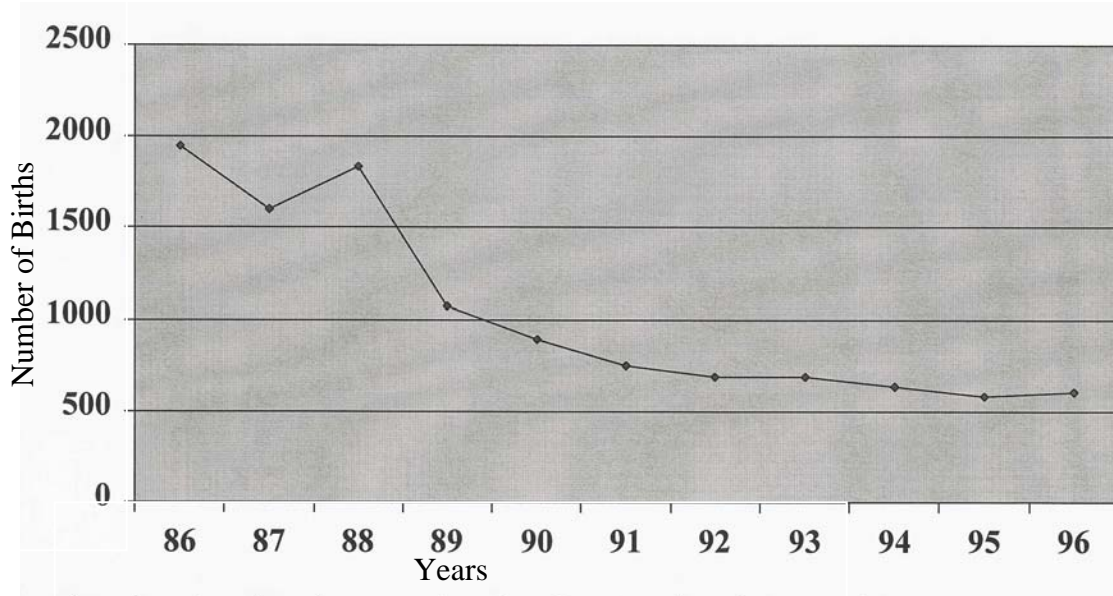


Figure 10: Number of Non-Hospital Births in Arizona, 1986-1996

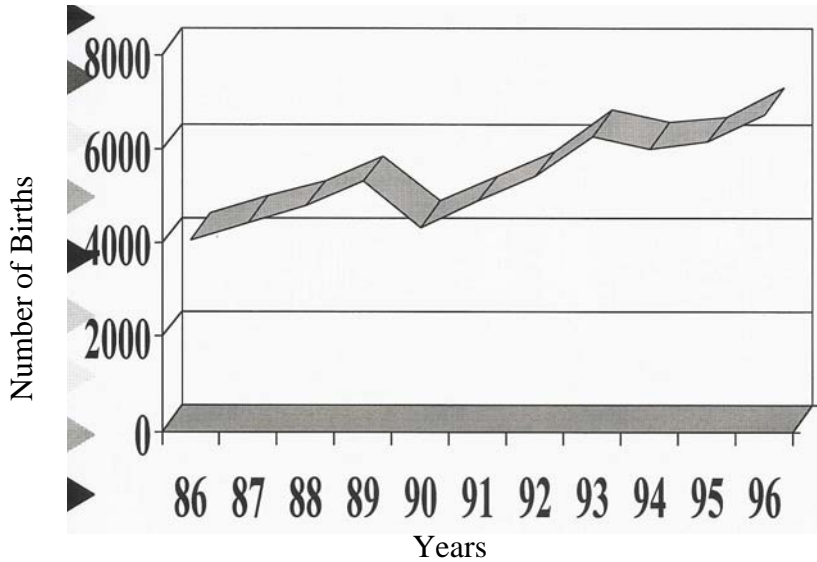


Figure 11: Number of Arizona Births Attended by All Midwives, 1986-1996

Valdez (1999) attributes the loss of LM births and a huge jump in CNM births to HMOs and insurance companies who reimburse for CNMs and birth center births but not licensed midwives and homebirths. In 2004, when my sister gave birth in Tucson, she

was able to get her insurance company to cover the birth, so I am aware of at least one large insurer in Tucson who will reimburse “out of network” for LM services, so perhaps some progress is being seen in this regard. The loss of LM births may also be attributed to more alternative birth options. Today, women can have a CNM, in a birthing room, with the perceived “safety” of a hospital. The Birth Center has also attracted women who may have chosen a homebirth as well. Prior to the early 1980s, CNMs in hospitals were unavailable to women in Tucson, making a homebirth a more likely choice for women interested in having a midwife attend their birth.

Certified Nurse Midwives in Tucson

Certified Nurse-Midwives began to provide services in Tucson in the early 1980s. Barb Novak, a CNM who had previously worked for a local OB, provided services at TMC and begun The Tucson Women’s Health Center (Cunningham 1982a). She was the first CNM to obtain hospital privileges in Tucson, but was required by Tucson Medical Center (TMC) to have her backup physician in the hospital when she was catching a baby (Kathryn Shrag interview, 2000). This was clearly not an ideal situation for her backup physician. Kathryn Shrag, who was one of the first CNMs in Tucson and would go on to help found the Tucson Birth Center, was brought into the El Rio Neighborhood Health Clinic to do births at Keno, the county hospital, by another CNM. That CNM, Marianne Shinoskie, got four CNM positions funded allowing Shrag and others to join the practice. Shrag worked in that position for 2 ½ years until the circumstances of inexperienced second year residents, strong medical orientations, and funding uncertainties motivated her to move to a faculty position at the University of Arizona, which she shared with

Marianne, and then work to organize a birth center (interview with Shrag, 2000). After much planning and organizational work, Marianne Shinoskie and Kathryn Shrag opened The Tucson Birth Center.

The Birth and Women's Health Center

The Tucson Birth Center opened its doors in 1982, the first freestanding Birth Center in Arizona. Marianne Shinoskie stated, "We're fulfilling a need in Tucson. Women haven't had much of a choice so far...Although many hospitals now offer 'birthing rooms,' where childbirth becomes a more natural experience, the addition of carpeting, plants, and frilly curtains does not change the traditional methods" (Cunningham 1982b:2C). Kathryn Shrag recalls the challenges of starting the birth center:

The business part was the scary part, because we were sort of hippies more than business people, and so we bought pumps and pearls. You know, we got our go-to-the-bank outfits. We bought clothes. And we, we were in our early 30's, passionate, both pretty articulate, Marianne's *really* funny....She's an attorney now, so we were a good, charming kind of team. I mean, I really think this was a piece of what made this all work. And we just started talking to everybody we knew, and we got an attorney that did pro bono work for us who really believed in what we were doing, and we got an accountant, and we got a business manager, and got them excited about the project. And borrowed money from friends and family. It was a classic small business venture. There was no licensing at that point. There was no national accreditation. I would say we were within the first 50 birth centers that opened up in the whole country. We were the first one in Arizona...and then we had to go through zoning issues...we went to this mayor and the council, and being the first, you just have to do all, all these sorts of things

They arranged for a group of local obstetricians to handle complicated cases and provide backup to the CNMs. Kathryn recalled, "We found John Vrtiska, who's the OB who we

still work with now. Who is a wonderful man, who just said, ‘I’ve never worked with midwives, I know nothing about out-of-hospital birth, and this makes a lot of sense to me. Yes, I’ll be your backup.’ He’s a treasure. He’s really a treasure of a person.” The Birth Center provided services at a reduced cost of \$1,200, about half what most hospitals were charging at that time (Cunningham 1982b).

For the next four years the Tucson Birth Center did well and had good maternal and infant outcomes. However, in 1986, the American College of Nurse-Midwives lost their malpractice carrier, including the Tucson CNMs, creating an insurance crisis with the potential to close the birth center. In addition, Tucson was starting to be a “managed care town” which the birth center financially needed to be part of. Because of these factors the CNMs decided to sell the birth center to Thomas Davis, which was one of the biggest HMOs in Tucson, and the group their backup doctor, Dr. Vrtiska, now worked for. Thus in 1986, the Tucson Birth Center became the Thomas Davis Birth Center. This allowed them to get malpractice insurance under the physician policies in the group and be part of the “legitimate and mainstream” health care system. For a time this helped the birth center thrive, but this growth came at a price. The group continued to grow and hire additional doctors, one of whom tried vigilantly to close down the midwives. He was hired knowing he would be working with midwives, but he worked every year to get rid of the midwives and the birth center in the practice.

During this same time, the Birth Center Study was published (Rooks et al. 1989) and Kathryn did a presentation on the findings, showing the good outcomes for birth centers nationally, and the Tucson center’s good numbers as well. This presentation had no effect on the physician who was trying to close them. Kathryn recalls, “After the

meeting, he came to me and said, ‘Kathryn, nothing you ever do or say will make me change my mind about this.’ And that’s when I finally got that he meant it. That this was like religion. We don’t talk facts, we talk about ‘I believe that what you’re doing is wrong’.” Kathryn realized that this could become a serious problem for the survival of the birth center.

Around the same time in 1988-89 the birth center became a pawn in an HMO “turf war.” The new CEO of University Medical Center (UMC), in an effort to elevate and expand the university’s medical services, seriously underbid Tucson Medical Center (TMC) to be Intergroup/Thomas Davis’ admitting hospital. Intergroup/Thomas Davis could not refuse the cost savings, so on October 1, 1988, TMC lost one third of its patients to UMC. Kathryn states that a rift still exists today because of that deal. As part the deal with Thomas Davis, UMC had promised to build a new birth center for the practice close to its hospital. However during the interim, TMC approached Kathryn and said they had done market research and women “really wanted” midwifery services, so they began to have conversations. TMC needed business and they wanted to take Dr. Vriskta, who was now the vice president of Thomas Davis, away from UMC. In the end Kathryn, the other midwives, and her physician partners resigned from Thomas Davis and built a new birth center right next door to the TMC hospital on the land of a perinatologist. Kathryn recalls how it all came together, “Then the people who were going to lend the money to do the building said, well we’re not willing to lend half a million dollars to a brand new practice, because it might fail. So TMC said, ‘We’ll guarantee the loan.’ So, this building is owned by the perinatologist, the hospital came in and signed a 15-year lease, and we sublet it from the hospital because everybody wanted

it to work.” Under this deal Kathryn, the midwives and her physician partners owned the practice.

Thus in 1990, the Certified Nurse-Midwives who began the center joined with their obstetrician, Dr. John Vrtiska, to form Birth and Women’s Health Center. In the spring of 1991, they moved into their beautiful new facility (BirthCenter.org 2005). The center thrived until financial difficulties and receding reimbursements from managed care began to take a toll, and they cut costs, cut back staff, and reduced salaries. Thomas Davis and GHMA also were feeling the strain and eventually collapsed. Because of this a group of physicians came to them and they formed a larger organization named Associates in Women’s Health Care (www.charityfinders.com), which was financially good for the birth center.

This was a private practice that received 100% of its revenue from insurance and self-payments of patients which resulted in continued financial pressure from rising costs, and decreasing reimbursements. In 1996, The Foundation for Women’s Health and Wellness was created by staff at the Birth Center and other concerned community members to provide options, quality, and sensitivity in the promotion of women’s health and wellness. In 2001, The Foundation began exploring ways to sustain the midwifery services at the birth center (www.charityfinders.com).

In May of 2002, the Associates in Women’s Health care (AWHC), the parent organization of the Birth Center, announced their decision to abruptly discontinue midwifery services and close the Birth Center due to financial concerns (www.charityfinders.com 2005a). The community responded quickly; they wanted their birth center. Several midwives incorporated together and were given three months of free

rent out of the old Birth center and they delivered women in the hospital at TMC. The Foundation for Women's Health and Wellness worked to reopen the birth center as a nonprofit entity.

On Labor Day, 2002 the Birth Center reopened. The midwives chose to continue operating the Birth Center independently, without physician partners. However, Dr. Vrtiska continued to consult weekly on high-risk cases and is available for medically necessary interventions (BirthCenter.org 2005). A Board of Directors now guides the Center, led by President Kathryn Shrag, who brings wisdom, institutional memory and personal dedication to the volunteer board. Janice Rodenberg, once a CNM in the practice, now serves as Director of Midwifery, and an executive director has been hired to provide leadership, fiscal management, and critical fundraising for the foundation. The Foundation has worked to secure funding and maintain staff and continued care for the families in Tucson who need and want the birth center to survive (www.charityfinders.com 2005b).

The advent of Tucson's Birth Center was just one of the developments that occurred as maternity care was being changed by consumer pressures in the late 70s and early 80s. The birth center, hospital CNMs, and homebirth midwives have sought to provide alternatives to standard medical obstetrics and by providing these alternatives alter the medical system as well.

Changes in Standard Maternity Care

The homebirth movement served as a “radical flank,” pushing mainstream care toward more changes. This “radical flank” effect has been seen by researchers (Declercq 1994a; Henry 1995a; Lay et al. 1996) (Davis-Floyd 1998) and reporters. The homebirth movement also provided nurse-midwives with a group to contrast themselves with. By marginalizing homebirth midwifery, CNMs in the 1970s and 80s were able to describe themselves as clearly part of “medicine” and within the system, making themselves appear more mainstream and acceptable. Headlines such as “Doctor OKs Midwives Opposes Homebirth” highlight this effect (Henry 1995a). This “radical flank” effect also affected hospitals. Under pressures from increased homebirths and general consumer dissatisfaction, hospitals began to change some maternity policies. In an article for the Arizona Daily Star discussing homebirth, Dr. Palmer Evans, the secretary of the Tucson chapter of the American Society of Obstetricians and Gynecologists, was quoted as saying, “We’ve accomplished a lot in terms of technology, better babies and safer births....Now what we’re trying to do is make birth more humanized” (Davis 1978:12). By more humanized he was referring to changes in policies not mandating that mothers be strapped down and that “twilight sleep” is rarely used any longer. Policy changes also involved “allowing” women to have an hour or so with their baby to “bond” before it was taken to the central nursery for a six hour observation period (this was a drop from a 12 hour period previously mandated), fathers and family members were “allowed” to be present at the birth, and mothers could go home sooner than they used to. In Davis (1978), Dr. Palmer also mentioned that advent of birthing rooms with color coordinating wallpaper, floors, and linens, and kitchens and private bathrooms (versus a shared labor

room and a surgical delivery room). Nationally, this trend toward birth rooms began in 1969 in Manchester Memorial Hospital, which mostly amounted to curtains on a standard hospital room. By 1979, 158 hospital-based alternative birthing centers were identifiable. By 1987, 80% of the nation's 3700 hospital maternity care units had some form of single room maternity care (Mathews and Zadak 1991). In Tucson, three hospitals opened birth rooms in 1978 (Davis 1978). In Davis (1978) a LM responded by saying a hospital is still a hospital no matter how much wallpaper is put up. Natural birth advocates continue to comment that few deep changes have really occurred even if these rooms now feel "nicer"(Arms 1996).

Licensed Midwifery in the Arizona Press

An analysis of Arizona's press provided another window into the way homebirth was presented to the public and how these changes in maternity care were covered. I requested all news articles published between 1970 and 2002 that were associated with homebirth, licensed midwifery, and midwives in the main newspapers in Tucson and Phoenix. From this request I received twenty-nine articles ranging from opinion pieces to news stories. I would say the media rarely covers this subject since several of the twenty-nine occurred together. This means that something even just barely mentioning homebirth isn't seen in the paper for years at a time. Of the 29, six focused on homebirth in Tucson (Davis 1978; Henry 1995a, b, c; Stengel 1978a, b). Common themes included state events such as changing regulations, midwives' training and background, number of deliveries, why parents choose homebirth, their experiences, the difference in cost of

home and hospital deliveries, and physician comments about the risks of homebirth. The media seems curious about homebirth, but their coverage tends to emphasize the risks.

Of the in-depth articles, two mentioned negative outcomes. Stengel (1978b) reported that of the 250 births delivered through the Arizona Homebirth Service affiliated with the Arizona School of Midwifery one baby death had occurred, and this was a baby born with multiple birth defects who was transported to the hospital and died. Daniel Lomax countered by saying even that horrible birth had the advantage of giving the mother a chance to hold her infant and bond before it died, allowing better acceptance of the events. In another article written about Nancy Aton (Henry 1995c), it was reported that she also had had a fetal death involving a couple living in Safford, which is about three hours from Tucson. She recounted that a lay midwife was supposed to be with the woman but wasn't, and that the mother delivered without assistance before Nancy got there, and the baby died. She stated that she rarely has problems and hardly ever has to transport moms or babies. The rest of article focused on why parents choose homebirth, and the disparity of insurers not covering homebirths. A companion article followed one of Nancy's clients through labor and delivery at home (Henry 1995b).

Almost all of the articles provided either doctors or public health opinions of birth as well. Ruth Beeman, who was hired as a nursing consultant to the Department of Health Services in 1977, helped revise the exam and rules and regulations (Stengel 1978b). She later published results of a review of the records of 1449 homebirth clients between 1978-1981. She stated in an article that the Health Department isn't "pushing midwifery" but that they are trying to work with midwives who are working within the law even though physicians aren't happy about it (Stengel 1978b). She added that, "The Lomaxes'

operation is a very dedicated group working to make homebirths an acceptable alternative””(Stengel 1978b:D1). Doctors in repeated interviews stated that they didn’t understand why women wanted to go back to a dangerous and outdated form of midwifery care (Davis 1978; Henry 1995a; Stengel 1978b). Daniel responded by saying, ““We’re not trying to go back to the 19th century. We’re trying to bring 20th century obstetrics into the home’ ... Sharon Milan added, ‘It doesn’t mean we are anti-hospital. We’re not at all. This is a place for people who want to try that at home. People should have that option.’”(Stengel 1978b:D1). .

Concluding Thoughts

The development of homebirth midwifery in Tucson evolved in much the same way it did across the county. Small enclaves of women helped each other birth at home and gained experience and commitment through this process. In Tucson, Nasima and Daniel Lomax emerged as leaders in the effort to legalize and educate lay midwives. Through Nasima and others’ interactions with state authorities, the rules and regulations of licensed midwifery in Arizona were passed. Rules and regulations were put in place and have evolved over the last three decades. State statistics are now collected and homebirth maternity care has continued to improve with the licensing of direct-entry midwives. The work of COFAM, The Arizona School of Midwifery, its homebirth service, New Beginnings, and many other committed midwives contributed to Arizona’s midwifery community. Homebirth has also served as a radical flank pushing mainstream care toward greater humanism. Although licensed midwifery has been in decline in

Arizona, midwives still practice who began at the Arizona School of Midwifery and other new midwives continue to emerge in the state. Homebirth with LMs, hospital births with CNMs and birthing at the Tucson Birth Center have all become part of the options available to women seeking alternatives to standard maternity care. Today homebirth midwifery has a solid base in Arizona; it has its difficulties, but midwives have survived. They continue to evolve within the state and across the country. But midwifery would not be what it is today if it were not for all the women who have chosen to birth at home with midwives. Taking Tucson's history in this chapter, and the national history provided in the preceding chapter as our back-drop, we now move onto the individual level analysis of women's birth frame construction, alignment, and adoption process expressed by my respondents

CHAPTER SEVEN: BIRTH FRAME CONSTRUCTION PROCESS

In Chapter Five I presented how women writers such as Suzanne Arms, Raven Lang, and Ina May Gaskin had personal birth experiences that left them feeling that there must be a “better way to birth.” Each individually, within her submerged network, acted within her cultural laboratories to develop new collective identities (Mueller 1994). Part of this identity formation was a process of “cognitive liberation” (Nepstad 1997) that created recognition of the injustices of women’s birth experiences. Hence, they created an “injustice frame” as a component of their developing diagnostic collective action frames. These injustice frames were an important motivator for adoption of the movement’s collective action frames (Gamson 1992). By studying earlier natural birth advocates and by doing research on the history of birth and the psychological needs of bonding, they articulated the dangers of drugs, the problem with routine separation of mother and child, and the need for low-intervention family-centered maternity care that treated women with respect and caring. They diagnosed the problems with the current birth trends, and proposed homebirth as the main solution to these diagnosed problems. On a personal level, Ina May Gaskin in particular presented the process her group of alternative minded families took to altering current birth models in the early 1970s. By sharing the experiences of The Farm’s successful homebirths, she provided concrete examples of the motivational rationales for having a homebirth. All these women writers and many more not detailed here shared their personal processes of cognitive liberation. They used their subsequent research and personal birth experiences as a means of altering the social

landscape of birth. Hence, from their personal experiences they were motivated to research and articulate the movement's diagnostic, prognostic, and motivational collective action frames. These provided personal and social rationales for what was, and is, wrong with current maternity care and why homebirth offers a better way to birth. The previous chapter outlined the first rotation of the individual to the public, from the micro-to macro-model I am presenting. These homebirth pioneers who became public figures through their writings took micro-level experience and articulated them into macro-level arguments for change, advocating both governmental and institutional level changes, and also changes in "life politics" in the birthing choices of individual women.

This chapter now focuses attention on the model I will present in the remainder of this work, derived from the micro-level study of the birth frame construction and adoption processes of the homebirthing women I studied in Tucson, Arizona. This represents the second and subsequent rotations of the micro-macro wheel presented in Figure 13: Wheel of Macro-Micro Flow of Events from 1940-2000 on page 225 which further elaborates on the links between personal action and political effect. As stated earlier, my "Birth Frame Construction and Alignment" model builds on Taylor's (1996; Taylor and Van Willigen 1996) work on the postpartum depression movement and the link between "life politics" and social change. This micro-model is also informed by the theoretical grounding of collective identity. Collective identity, according to Taylor and Whittier (1992:105) involves a "shared definition of a group that derives from members' common interests, experiences, and solidarity." Collective identities also involve boundary framing, a creation of a sense of "us" and "them," often demarcated with labels such as "homebirther" or "breast cancer survivor" (Taylor and Van Willigen; Taylor and

Whittier 1992). Lastly, framing at the individual level is also explicated in my birth frame construction, alignment, and adoption model, as a way to understand how individuals adopt frames and utilize them to make choices and interpretations of experiences. Kebede (2000) and Nepstad (1997) have illustrated how framing can be a means with which collective identity and cognitive liberation occur. Framing is the interactive continual processes of meaning construction with which collective identity and cognitive liberation have context and process. It is to this process I now turn.

In the chapters that follow I delineate a five-stage process of birth frame construction, alignment, and adoption. In order, these stages include: Frame Foundations, Frame Bridging, Frame Negotiations, Testing the Frame, and Frame Transformations. In Chapter Eight: Frame Foundations, I delineate the effects of women's childhood experiences, their mother's birth accounts, social milieu and lifestyles, as well as prior experiences with doctors and hospitals, as part of their stated accounts of what factors affected their adoption and receptivity to the collective action frames of the homebirth movement and their subsequent choices of pursuing birthing at home. These foundations change some as we move forward in time from the 1970s to the present, and these variations will be discussed.

Chapter Nine: Frame Bridging delineates the effect of books and other media on women's exposure to and subsequent accounting for their rationales for homebirthing. Frame bridging also occurs through interpersonal networks and educational routes such as childbirth education classes, which have been identified by other scholars as important factors in micro-mobilization (McAdam 1989; Mueller 1992). These outlets of information provide a bridge of the framing of the homebirth movement and individual

women's search for information to deal with birth. Often referred to as a receptive constituency (Snow et al. 1986), women utilize the information they receive during frame bridging to provide them with the collective action frames (CAF), which provide individual level motivations for pursuing birthing at home. These CAF articulations are then utilized as rationales for behavior and choices. Additionally, the bridged CAF articulations of diagnoses of the problems and injustices in current maternity care are utilized by women as they act as further articulators of the movement's CAFs in their attempts to share and encourage others to birth at home. Frame bridging essentially affects all other stages in the model through the sharing and evolution of CAFs through media and personal interactions. I do not imply that this is a one-way street of absorption and regurgitation. Women modify, consider, and process the movement's CAFs through their interactions with others. They also test these CAFs through their idiosyncratic lived birth experiences. Over time the movement's CAFs evolve through women's interactions with these framings.

Chapter Ten: Frame Negotiations presents the main processes through which women negotiate their birth frames and try to apply them within a social field. This stage involves five aspects. First, women are confronted with the need to develop a birth frame when they find themselves pregnant. I refer to this as a liminal stage- a time of transition. Second, women seek out a birth practitioner, as is the norm in American society. During this process of seeking out a provider, some women have interactions with doctors or midwives that motivate them to seek out different or alternative providers. This process may also illustrate the challenges of finding a practitioner who fits with their developing birth model. Third, women negotiate financial concerns and their developing birth frame

and subsequent birth choices. Fourth, women's frame negotiations involve the motives and rationales that were motivational and explanatory, for those women who sought to birth at home. I provide considerable detail to the motives expressed by my respondents. I do this for two reasons. First, these motives are directly related to, and part of, the CAFs of the homebirth movement and as such illustrate the movement itself. Second, they have value as accounts of women's lived experiences. I discuss six motivational categories: the supremacy of nature/God; the desire of control, authority and personal responsibility; the value of personal growth through birth pain; the desire for better treatment of infants; creation of a family-centered and sacred birth; and lastly the avoidance of interventions, drugs, doctors, and hospitals. These categories are quite similar to the chart on CAFs presented in Table 8: Collective Action Frames in the Homebirth Movement on page 166. The fifth, and last, component of frame negotiation involves the negotiating of risk perception on the part of the birthing woman and her family. I discuss how education, faith, and a deep felt sense of trust in one's caregivers are mediating factors in overcoming birth fears. This is an important section because it illustrates how homebirthers deal with the stigma of their birthing choices, and deeply utilize parts of the CAFs to provide psychological comfort in the face of fear, both internal and social. These frame negotiation components most actively occur in preparation for giving birth.

Chapter Eleven: Testing the Frame discusses four women's birth stories. These represent a sampling of the seventy birth stories in my sample. These four women's birthing accounts equal fourteen birth stories, including two of the eight transports to hospital from home or birth center in my sample, two of the fourteen planned hospital births, and nine of the forty-eight homebirth accounts. I provide these birthing stories as

reflections of women's experiences, and as illustrations of the effect of CAFs on women's expectations and interpretations of their lived experiences. These lived birth experiences either serve to confirm or challenge a woman's adopted birth frame and the CAFs she espoused. Subsequent births continue to "test the frame" in the face of experience, either confirming or challenging these CAF frame interpretations.

The last chapter of the birth frame construction and adoption model is Chapter Twelve: Frame Transformations. This chapter discusses how women's birth experiences (some of which were discussed in the "testing the frame" chapter), have come to transform the women under study. I discuss how women express "life politics" through their birth choices and how this is reflective of adopted collective identities. I discuss how these frame transformations create movement support. I present six levels of movement support from the most personal to the most public. These levels are intra-personal, inter-personal, public support, birth practitioner, activist, and movement leaders. I argue that all levels of movement participation are important and have a place in the movement. Additionally, in this chapter I discuss transformations that bring women into, and factors that lead them away from, supporting the movement and homebirthing.

This birth frame construction and adoption model emerged from the accounts of the thirty-five women in my study. I have also looked at 109 published birth accounts in Lang (1972), Zimmer (1997), Gaskin (1977) , and Wellish and Root (1987) as a comparison to the seventy birth accounts I collected. The specific examples I will use to illustrate the personal birth frame construction process will come primarily from the interviews I conducted, but they are similar to the events and experiences depicted in the additional birth accounts. These depictions of birth accounts are also important for their

articulation of the homebirth movement's diagnostic, prognostic, and motivational collective action frames. For a visual interpretation of the birth frame construction process please refer to Figure 12: Micro-Level Birth Frame Alignment Process on page 224 at the end of this chapter.

I want to note that I am delineating the process of frame construction into distinct stages for analytical purposes; however, I believe the women experienced frame construction and adoption generally as a nonlinear process. As Rachel put it,

I kind of came to homebirth as a very, um...I would have to say gradual thing...I was just one of those people who in a lot of ways was kind of always preparing for this stuff, even thou I didn't really think about it, think that I was you know? I think it was just a real instinctual kind of thing...just forming my point of view.

As Rachel comments, preparing and formulating her point of view on birth was a gradual process that occurred over a period of time without her even paying much attention to it. Frame bridging, in particular, occurs throughout the women's lives. Exposure to birth literature and interpersonal contacts that fostered a positive view of homebirth was an ongoing process. Also birth frame interpretations were an ongoing process that continued to evolve for each woman as her experiences and interpretations changed. Different stages were also of greater or lesser saliency to different women. Some women spent considerable time dealing with frame negotiations-- particularly concerns of risk and fear—while others seemed to barely consider this. Different motives in the frame negotiation chapter also were of varying importance to different women. For example, some homebirthed primarily because they wanted a family-centered “nicer” birth, others actively sought to avoid interventions, and still others saw it as expression of their beliefs in God. These variations in saliency are reflective of personal variations and social trends

over the thirty years under study. Figure 13: Wheel of Macro-Micro Flow of Events from 1940-2000 on page 225 details my respondents' timeline location in reference to larger social forces at play at the same time they were adopting their personal birth frames. These personal birth frames are also presented in Figure 12: Micro-Level Birth Frame Alignment Process and linked with some of the larger social changes occurring in the homebirth movement and social maternity trends.

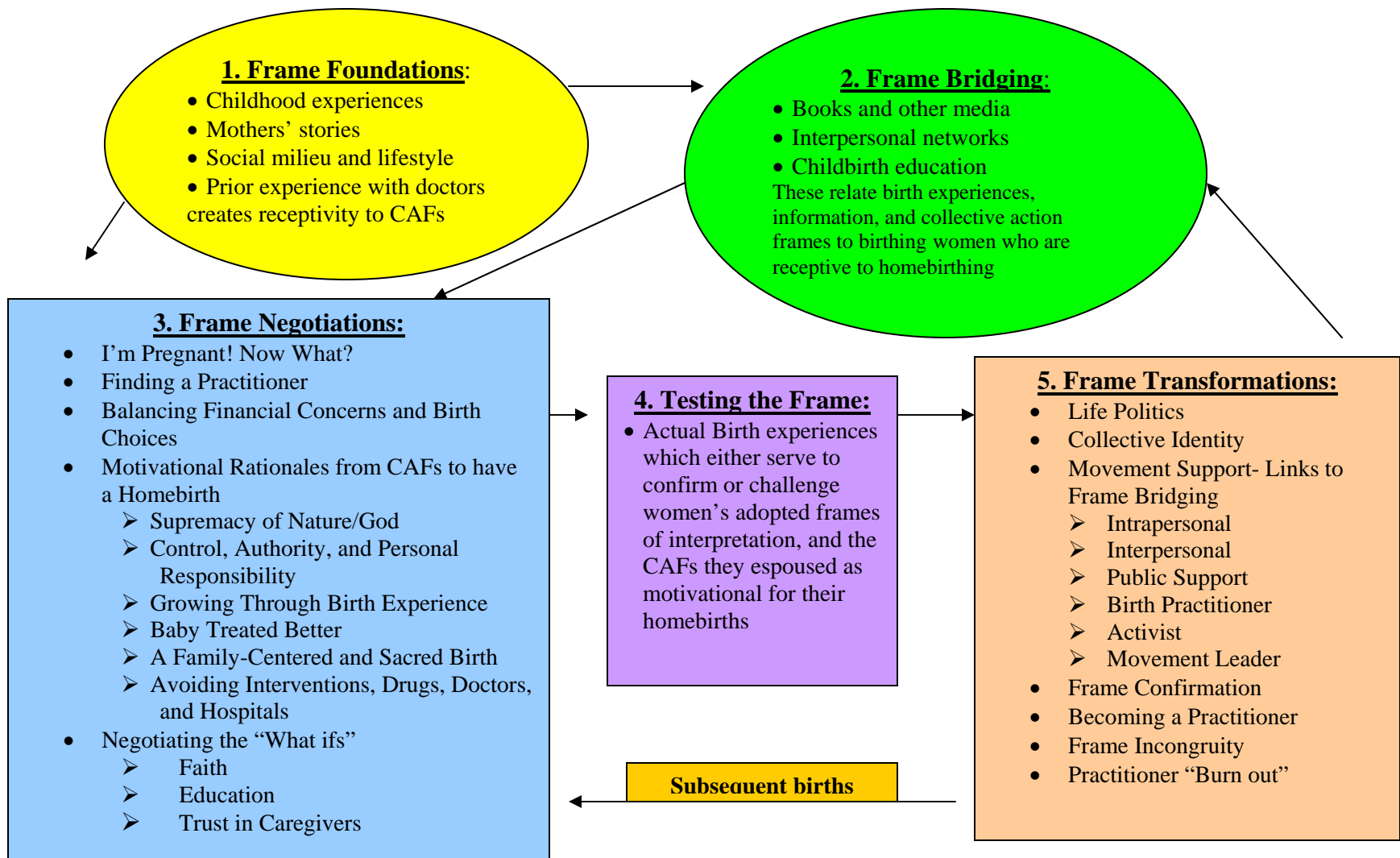


Figure 12: Micro-Level Birth Frame Alignment Process

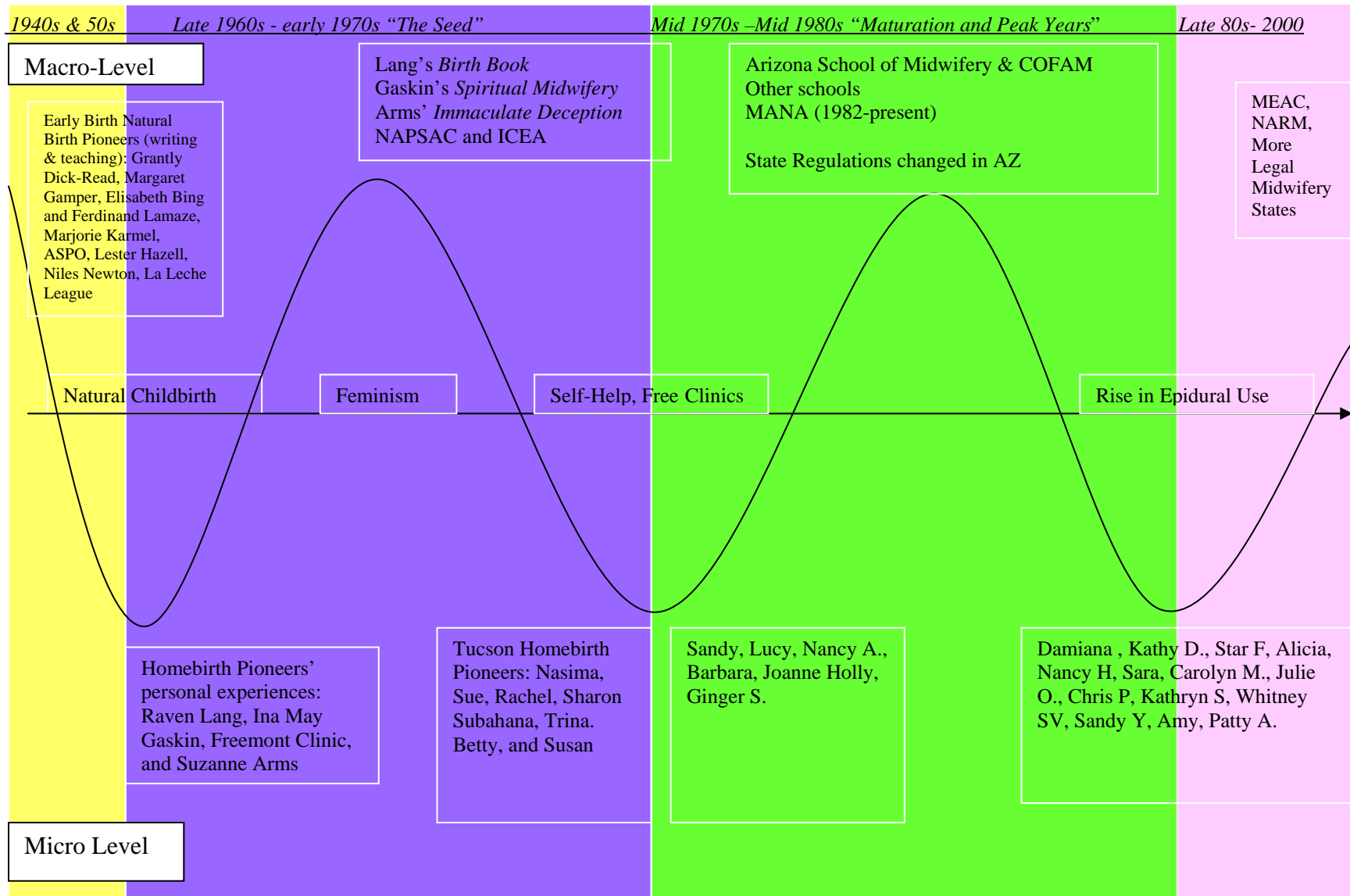


Figure 13: Wheel of Macro-Micro Flow of Events from 1940-2000

CHAPTER EIGHT: FRAME FOUNDATIONS

The frame construction, alignment, and adoption model begins with the first stage, Frame Foundations. This stage includes the dominant social themes of the 1960s and 1970s that were important to the homebirth pioneers under study; effects of the women's mothers' stories of birth; and women's prior experiences with doctors and the medical establishment. These factors are important to understanding the foundation on which the pioneering women constructed their birth models, as well as how later women became aligned with the homebirth collective action frames.

Socio-Historical Foundations for Homebirthers

The homebirth movement emerged out of the late 1960s and early 1970s. This emergence was fueled by the sociopolitical culture of the era and the resulting social movements. The self-help, populist, environmental, feminist, and civil rights movements assisted the growth of the homebirth movement (O'Connor 1993). By "spilling over" people, ideational components, activist experiences, and organizational knowledge, these movements fostered each other (Meyer and Whittier 1994:277). By spilling over into each other they acted to flavor the era itself. Staggenborg has noted the importance of the emerging counterculture for fostering feminism. According to Staggenborg (1998:43),

a 'counter culture' was blossoming across the country, particularly on college campuses. Students and other young people were examining their own lives and changing their lifestyles, wearing the long hair, beards, jeans, and beads that came to be associated with 'hippies'...The

counterculture provided one of the bases for women's liberation through its rejection of middle class standards and lifestyles and its focus on personal issues. It called into question basic defining institutions...

The early individuals in my study point out the importance of this era. They were affected by the belief that they were capable of making decisions and challenging the male-dominated medical establishment. Rachel illustrates the importance of the social movements of the 1960s and 70s in affecting her worldview.

I was young, I was really into my own thing and I wasn't really part of that [the women's movement] and I had been raised very traditionally, so I can't say that I was much of an activist, but still it had an affect on everything that was going on. I began to realize, that was really a real political time too, right, Vietnam and rejecting the system and rejecting the government and, rejecting the diet, so I just pretty much decided that they didn't know what the heck they were talking about, rejecting western medicine completely.

The ideas that were fostered through the sixties helped to provide fertile ground for individuals who became involved with the homebirth movement's emergence. An era characterized by questioning authority, seeking out new levels of consciousness and personal responsibility, and experimentations in thinking, relationships, and goals were important to providing a gestalt to the early individuals in my study. Subhana stated,

There was dissatisfaction in general with being a hippie person, not wanting to be doing things the way they were usually done, you know, the establishment vs. us free thinkers...[it] became a movement and almost a political statement and a whole subcultural youth statement to have a homebirth and to be in a relationship, to not be married, and to be pregnant ...

One aspect of being a "free thinker" was openness to alternative spiritual paths. These alternative spiritual communities provided an organizational starting place for several homebirth groups. The ground laying book *Spiritual Midwifery* by Ina May

Gaskin (1977) was based on the homebirth experiences of The Farm commune in Summertown, Tennessee. The Farm was a utopian community based on the ideas of communal property and Eastern spirituality. In Tucson, the Sufi community lead by Nasima and Daniel Lomax is another example of the outgrowth of homebirth midwifery from alternative spiritual communities.

Sufism is a mystic form of Islam that came to the U.S. in the 1900's. Haeri (1990:92) has pointed out that, "Western interest in Sufism shows the growing thirst and interest in spiritual knowledge in the west, where the various versions of Christianity which were mind- or emotion-based, rather than 'heart' based, had failed to provide any real spiritual nourishment for several centuries." As a mystical religion, Sufism seeks an ecstatic communing with a transcendental God, who is the ultimate beloved. Sufism emphasizes unity and balance in people and the world. It is very much in line with the holistic approach to birth that sees the mind, body, and spirit as one. Sufis teach an all-encompassing worldview that combines mysticism, metaphysics, music, poetry, education, ethical behavior, spiritual training, and practice (Shah 1964:1). Sufism's emphasis on the divine spirit penetrating all creation is compatible with the holistic approach of the homebirth movement. As Subhana stated, "It was just like the Sufis to have lots of babies at home."

Nasima and Daniel's community regularly held Sufi dancing. The women who participated in these dances became an important networking resource for the homebirth pioneers in Tucson. All the women in my first sampling had some connection to a friend who was part of the Sufi community or to Nasima herself. However, it is important to note, most of the women were not "declared" Sufis themselves, they simply had

connections to the Sufi community. The importance of exploring different spiritual paths and developing different ways to live played an important part in the early development of the Tucson cell and the homebirth movement in general. The emphasis on the spiritual aspects of life and birth invigorated the ideas of the sanctity of birth and contributed to the emerging vocabulary of the homebirth movement. Feminism also had an important role in the development and resonance of homebirth.

Feminism contributed to collective and personal birth frame developments via the issue of wanting more control over childbearing experiences. As Kathy stated,

The ability to be in your own home, to have who you want there. To make and be empowered in your choices. I mean, women, a lot of women are all about being empowered in our culture right now and, hey, you want to be empowered, you have a homebirth, you know what I mean. You get to choose what you're doing, how its going to be, what its going to look like.

Feminism's emphasis on seeking greater control of one's body and life has produced a birthing backlash in the last ten years or so. Today for many professional women control means choosing another professional to "manage the birth." It means technology, interventions, and mind/body separation (Rothman 1991). Davis-Floyd (1992) found professional women primarily satisfied with this type of control. A homebirth midwife commented on the effect of feminism on birthing options today,

I feel like initially... the feminist movement helped move women to be in control of their bodies, and their selves, and their decisions...and then maybe in the evolution of it all with like women being equals, which we are, and having the same jobs as men have, um... perhaps that's really moved women into that whole space of ...it's real hard to find time now to have a baby, because you have a great job that you've worked really hard to get to,.. I mean we are women trying to fit into a man's world? ...maybe it's created its own demise in a way,

Ramification of the Movement's Origins

Although all the women in the early group in my study in my interpretation fall under the rubric of the label “hippie” as Subhana mentions, and although the early books of the movement emerged from alternative communities, homebirth has been embraced by a much wider group of people. As the movement has evolved and dispersed from its origins, the label “hippie homebirther” is no longer an accurate description. This label can in fact be a hindrance to the movement’s frame resonance. Today homebirths are sought out by a spectrum of parents from religious conservatives to mainstream families to neo-hippies. This collective identity boundary marker has had to be widened to be more inclusive of a greater number of people and ideologies (Taylor 1996; Taylor and Whittier 1992). In an effort to support this widening base, newer books such as *Gentle Birth Choices* (Harper 1994), *Birthing From Within* (England and Horowitz 1998), and *Ina May’s Guide to Childbirth* (Gaskin 2003) have been written to resonate with a larger audience beyond the original “hippie” enclaves where political homebirthing and lay midwifery were reestablished. As the homebirth movement evolved, it has softened some of its rhetoric to be more inclusive, with a greater emphasis on “choice” and “control.” As one middle-class Republican mom told me, “Its about control and healthiness. Its not just for hippies- a lot of people have that stereotype and its wrong” Today’s homebirth books (such as Gaskin 2003) make a great effort at not alienating today’s childbearing women with a lot of “hippieness” but an articulation of collective action frames on safety, health, and the dangers of intervention, but the underlying collective action frames have remained in place. The homebirth movement’s origins in a “nutty fad from a noisy group of lentil-eating earth goddesses” (Mitford 1992:168), as one homebirth critic put it, was

critical to opening up the options of childbearing in America to all women. One of the other frame foundations that was important to the personal development of birth frames were the women's childhood experiences and their mother's birthing stories.

Mothers' Stories:

"When I was growing up my mom had the good sense not to tell bad birth stories"

Also important to the women's birth frame foundations are the attitudes about birth that the women received from their mothers. The women in my sample had mothers who ranged in birth experiences from twilight sleep with no memories of their births to homebirth pioneers. These maternal experiences either provided examples of birthing that my respondents wished to emulate, or accounts that they hoped to avoid.

For some of my sample, their mother's births were a nonissue. Their mothers simply did not talk about it. For many early homebirthers this was due to their mothers giving birth during the years when twilight sleep was common. They truly had no memory of the birth since they were anesthetized. Kathy, a contemporary homebirther, describes her mother's experience as follows:

They went in and put her under and woke up and there it was. My dad wasn't involved and I don't know what was involved in terms of...I can't imagine how it must be to get a child, ya like forceps and just yank. I mean I'm sure I was drugged.... And just her experience with not having any recollection of any of that. You go in, IV, you're out, you wake up, hey baby. ... and mean I guess I, being a very visual person had a scenario in my mind of what I thought that would be. And she had a little book with a photograph booklet when she had when she was with me that I remember I was fascinated by as a child and I would just read through it... those little black and white photo and they're all in their sixties do, kind of thing and she's going to the dentist and getting teeth cleaned and she's eating her little salad and then she goes to the hospital. Her feet are

in the stirrups. Its all black and white and the hospital is all very sterile and there's tile everywhere and she goes into the hospital and her feet are in the stirrups and the next thing you know, baby. I mean it's all very neat. There's no like messiness involved and so I mean I guess that that did probably influence how I saw hospital birth. I had that visual image right there.

Lucy's mother's births had been "in a hospital knocked out, she didn't breast feed." Lucy commented, "All things I wanted to change." Trina felt the same, "My experience had been stories of my mom's births. She had very difficult times. Having my brother die in a hospital before I was born, when he was a week or so old. So you know, birth stories really had been traumatic as far as my understanding. I wanted something to be more positive so I came out here [to Tucson]."

Nancy commented on her mother's births:

She didn't see me born. She never saw them till hours later. She didn't see me till the day after I was born for the first time, because back then, they drugged the mothers and put them to sleep. . . ., and in fact after her first one was born, my dad, when she woke up, told her that they had a son and she didn't even know she had delivered yet. She's like, oh no, he hasn't been born yet. That's how drugged they were. She didn't even know she had delivered a baby yet, so...: No, and I'm thinking, you just, you miss out on, you miss so much by not having ever experienced...and the excitement of, of that moment is so special.

All of these experiences helped the women frame birth in a new way. They drew upon these experiences and identified the things they wanted to change. Rachel commented that American society "didn't know what the heck they were doing," and these women sought out a birth experience that differed from the experiences of their mothers.

In contrast, some of the daughters in my sample wanted to emulate their mother's birth choices. For the recent homebirthers, some had parents who were birthing

at home in the 1970s, or who were generally more alternatively minded. This provided many with an established holistic birth frame. It should be noted that out of the second generation of homebirthing parents in my sample, three daughters had homebirths. These were myself, my sister, and Sharon's daughter, who gave birth at home where her mother acted as her midwife. This birth was originally planned to occur at the birth center where Sharon worked. Mary Jane's daughter Sara had homebirths and acted as a midwife's assistant for a while. Subhana's daughter gave birth at the birth center. Trina and Rachel's daughters both planned homebirths but ended up in the hospital (one with a breech cesarean section and the other early at thirty-six weeks). So even daughters who had strong backgrounds in homebirthing had to negotiate their own birth constructions as well. But the support of a pro-homebirth family was certainly helpful. Those who had families who questioned their choices to birth at home had additional frame negotiation issues, which I will discuss further in that section. One respondent, when asked if her family supported her choice, replied,

My family absolutely. The woman I babysat for was one of my mom's close friends [who had a homebirth], and so, in my mother's eyes, she would have been very disappointed if I chose a hospital birth. And my father, too, said, 'You're in charge. You don't need these people telling you how to run your body,' and so, oh yeah.

Mary Jane, Sara's mother, was a natural birther in the 1950s when it was uncommon to be awake and aware. Her first two births had been in a maternity hospital in Africa where she and her husband were doing missionary work. When they returned to the United States, birth was characterized by being "put under," episiotomies, forceps, and separation of family members. As Sara states her mother's experience,

When she came back to the United States, birth was very different. They were knocking them out, they shaved them, the episiotomies, there were so many things that were just standard, and my mom. . . so she had my

brother, and just begged the doctor not to have any of that, and when she was in labor, he turned to her and said, 'see, don't you wish you were knocked out?' Furious, but he let her have them natural,... Then my mom connected with this group of midwives in the early '70's in Tucson, and she was real close to Tucson Medical Center; her house, so they had births at her house.

Her mother, Mary Jane, commented that she had hoped she had had a positive natural birthing influence on her children. She said, "Of course, my children for their whole life, you know, heard me talk." Whitney's mother had had five hospital births, which were fairly positive experiences, but as an economic choice they had their last child at home. The homebirth ended up having more beneficial effects than just economics. This experience left Whitney with a positive feeling about homebirth. "It turned out really nice, because it was, like I said, for once, my dad got to be there, and that was the only one that he got to cut the cord, and he, you know, he had a special bond with that baby because of that.." Amy, a homebirth midwife, remembers her first homebirth--the birth of her brother,

When I was little, my parents wanted to have the child at home so that we could be at the birth, and so... I think I was in... must have been in fifth grade, and I remember going to school and telling that my little brother was born at home, and he came out feet first.... So that was the first time I was exposed to homebirth. I was nine.

All these experiences helped reinforce the benefits of homebirth for these women.

For others, rural grandparents or parents who were born or gave birth at home provided a basis for thinking birth at home was something that people at least used to accomplish. Sandy commented,

I was born in Indiana. My mom is one of twelve and so all of them were born at home simply because they were from Arkansas and that was just how you did it, ...[she] only had two children [in the hospital] and I had never heard of homebirth quite truthfully and it had never even hit me that all my aunts, my mom had been born at home. It just wasn't talked

about... N: Did [your mom] talk about those at all? S: Ah, not a whole lot. That was when they did the hunky dory drug you out and you have no idea what's going on

Rachel explained, "It was in rural Kentucky or Tennessee. The first two of her kids.. But...um... so I think that you know in an odd sort of way from very early on that was planted in my mind that birth can happen at home."

All these familial influences were part of the women's personal birth frame construction process. For some their mother's twilight sleep births were motivation to "find another way." Others who had natural or homebirthing parents who exposed them to positive birth images from early on commented on the importance this contribution made to their birth frames. Some of whom then went on to birth at home. Another experiential foundation for birth frame foundations revolves around the women's experiences with doctors, hospitals and the medical establishment.

Experiences with Doctors and Hospitals: "I didn't want him to touch me"

Women's experiences with the medical establishment were also critical to helping them construct their birth frames. For some they had positive associations with medicine, but felt homebirth was still a better choice. For others, their experiences with medicine were traumatic and in many ways turned them toward an alternative to doctors and hospitals. Rachel shared the importance of her mother's death when she was fifteen years old. "I got at that point a huge mistrust and rightly so. A realization of who doctors really are and a really bad taste for hospitals...and this fit right into my earliest

impressions that this was a bad place to be...not a place to have a baby.” One of the women had a childhood experience that made a similar association,

When I was in Junior High, one of my friend’s nephews went in to get his tonsils out and he died, because he was give too much anesthesia and it really has affected most of my life about hospitals. And they make mistakes like everybody else, but it’s amazing how clearly I remember the day she told me that, and I remember her, because her sadness around it and my surprise. I couldn't believe that that could happen, in a hospital. So that was a key piece...

Both Patty and Alicia had childhood procedures that were traumatic. Patty recalled having an accident as a young child that fostered a negative feeling about hospitals and doctors,

When I was about ten years old, I was, doing cartwheels out beside a pool, into the pool, and I landed right on my vagina...I went to the hospital for that. And just really majorly traumatic, just the whole thing was traumatic for me. Before that, I had had my tonsils out, and that really wasn't that traumatic. I mean, for one thing, at ten years old to have a doctor just working on your genitals. And that was exactly what they were doing, working on my genitals. They had to drain the blood, because it had kind of, it had swollen up, and they had to make cuts on the sides of my labia so it would drain. Incredibly painful. And the people who worked with me were not very, they just, they were very kind of professional and not really like, kid oriented... So I just, that was my experience with kind of doctors and nurses and a trauma situation. ...Ya, they weren't very sensitive. And for me, I really didn't want, I didn't want that to come up for me in giving birth to my son. I really felt like I wanted...I really wanted to be supported in every aspect that I knew how, and I knew that that was a piece for me, that I don't, even if people would have been supportive in a hospital, it would have been hard for me to go there,

Alicia had a similar experience. As a six-and-a-half-year-old she moved to the US from Romania, and needed a catheterization procedure for a heart defect.

The whole procedure and the way that it was done in the hospital was, I mean, I felt, I literally felt like a wild animal...I wasn't, I don't remember once being told, plus I didn't speak English, so there was that language barrier but I don't even remember my mom telling me this is what's going to happen and the doctors certainly weren't into that at the time. I mean,

this was in the 70s. I just remember them coming in and have their needles, their syringes and they were trying to get a hold of me and I was just flailing, I was just all over the place, I was just so scared and they turned me over and they gave me shots in my butt so it was again it was like this thing coming from behind that I had no idea, literally, that I had no clue what was going on and then I was just scared and then I was put on this table with no clothes on, just under a sheet and everything and I just remember just feeling so cold and so scared and being wheeled into this and my parents weren't around at all complete strangers around me, and completely different country. No one spoke my language. It was frightening. Frightening experience.

I don't contend that all women who have traumatic childhood medical experiences will go on to choose homebirth, but for those who do, it is an important part of their personal frame construction process and how they account for their choices. It's a piece of experience that brings them closer to adoption of the midwifery model and more aligned with holistic/homebirth collective action frames. For them, removing the hospital from their birthing experience is resonant.

The same held for experiences with the medical community that could best be categorized as condescending. One woman commented, "Well I was called a whore by a doctor once because I didn't have any bathing suit marks and I was going to get oral contraceptives and I was nineteen." This really angered her. It made her feel betrayed. She felt she was going in to get contraceptives to be responsible and she was treated very judgmentally. This, in fact, was a turning point for her. It sent her into medicine so she could provide women with better care. Holly reported a similar experience when she tried to get off the pill for safer barrier methods. And Sue felt exploited by a doctor who was open to homebirth but wanted to do tests and charge an exorbitant amount of money. She felt this exploitation was similar to the treatment experienced by women who wanted to get illegal abortions.

Even as maternity care began to improve by “allowing” more natural births with less intervention and the presence of loved ones, doctor’s practice styles remained problematic for many of the women in my study. As an example of this treatment in 1976-77, Jane explained one of her experiences with a particularly insensitive doctor, when she was a labor and delivery nurse.

So the classic thing that he did was unbelievable. He use to dress meticulously in these little outfits with matching vests, and a meticulously clipped beard. So one day this lady was in the labor room and she was going to deliver. She was going through transition and typically in the hospital the nurses are right there and then at the very last minute, you know when, I mean, they wait until the baby’s head is crowning and the woman is giving her last push before they even go in there and glove up. It's like “Wait, wait. I don't have my gloves on yet.” Well, so, we were still in the labor suite and you know the guy's in there with his little outfit on, and he's not gloved, and this lady is going to push, and there is just no way, and we're all watching and assisting and the baby is coming out and he doesn't have his gloves on and doesn't have his gown on, he let the baby hit the table. Rather than get his suit dirty. I will never forget that. This guy is like nothing to me, I swear. Anyway, I saw the same doctor do dreadful things afterwards, real disrespectful.

Nancy also recounted her natural hospital birth, “I had my brother and sister-in-law and my husband all with me and the nurses were great, but the doctors were cold. And I felt like I was not treated like a human being and he just talked really, I thought really rudely to me and it was, the doctor had the intern doing everything.” At a subsequent birth, the doctor wanted to do an episiotomy for a preemie baby, which Nancy didn’t want done. She retold her experience,

[The doctor] was going to insist...Larry and I both firmly told her no, she was not to do an episiotomy, and she turned around to get the instrument to do it anyway and so that got me, so when the contractions came while she was turning around, I pushed him out and so then she was really mad at me and bawled me out.. Right after he came out, he had a bruised eye. She blamed that on me, and they often can have bruised eyes, that’s just part of the labor process. It can happen, but she blamed me for the bruised eye

because I pushed him out before she could do what she wanted to do and it was a very negative experience. Very negative.

It has been noted by sociologists that birth is one of the only times in medicine when a consenting adult's rights to make decisions are often ignored or overruled (Rothman 1991). In fact, many consent forms that women are asked to sign when they check in to a hospital have a blank spot for type of procedure and risks. They are asked to give Carte Blanche permission for procedures. Many respondent told stories of their wishes being ignored.

Many of the women recounted negative experiences with the medical establishment before, during, or after their homebirths. Others, however, had positive experiences with doctors. Some had had accidents and felt they had been well taken care of. Others had been at births with "nice" doctors. Primarily for these women, although their experience had been positive thus far with doctors, when they were introduced to midwifery they found it a more appealing practice style. As Kathy explained about her care with her midwife Nancy,

[I] never realized how sterile the medical community was until I realized what medical care really could be. So up to that point it wasn't like I had thoughts about that. And especially I come from a medical family, my aunts were all nurses, my grandmother was an OB nurse. My mother was a dental assistant. I've been involved in mainstream medicine, so I never really had that much negative experience with it. What happened was that when I met Nancy, I am thinking its like oh wow, it really can be so great, I mean she would ask me like beyond just baby stuff. She'd ask me like how are you eating and how are you feeling. How are you and Bert getting along? How's the business going? Are you sleeping well? Did you see movies lately? Beyond just small talk but really the whole person care kind of thing. It made me realize that the community outside of that was more sterile.

These initial experiences with the medical community were important aspects of women's construction of their personal birth frames, and aligning with the homebirth

movement's collective action frames. Most women found the movement's diagnostic frames of medicine's inappropriate treatment of women as resonant with their lived experiences.

In conclusion, all these foundational experiences helped women construct birth frames aligned with the homebirth movement's collective action frames. Socio-historical factors and movement "spill over" and frame extensions from feminism, self-help, spiritual communities, populist movements, and the social unrest of the late 60s and 70s were critical to developing the initial collective action frames of the homebirth movement. These times were also critical to the early women in my sample in their frame construction process. As times have changed so has the movement. It has attempted to stay true to its historical roots while providing arguments that resonate with a new generation of homebirthing women. Personal-level foundations have remained important, such as the accounts of the respondents' mothers. These provided examples of birth experiences to either emulate or reject. In constructing their personal birth frames, women also drew from experiences with medical care which often helped turn them from standard obstetric care in search of a "different way" of receiving and giving care. The homebirth movement's diagnostic collective action frames also provided a framework with which to interpret these experiences and judge them as inappropriate. Their frame foundations were built in the times they lived and the lived experiences that shaped their lives. Part of coming into alignment with the movement's collective action frames required a bridging of ideas. The next chapter discusses what processes were involved in women seeking out information with which to develop their personal birth frames, which led them into alignment with the homebirth movement's collective action frames.

CHAPTER NINE: FRAME BRIDGING

“But doctor, I heard you don’t need an episiotomy”

Either while pregnant or in anticipation of getting pregnant, women seek out information about pregnancy and birth. In this search for information, they are at the receiving end of the social movement alignment process of frame bridging. They are also an instrument of information bridging by their participation in groups and networks that facilitate sharing of their birth stories and motives for having a homebirth. What Snow et al. (1986) have termed “Frame Bridging” occurs most acutely during pregnancy, but also occurs throughout their lives. Frame bridging is defined by Snow et al. (1986:467), as “the ideologically congruent but structurally unconnected frames regarding a particular issue or problem.” At the individual level this frame bridging occurs as linkages between a social movement organization (SMO) and unmobilized sentiment pools or public opinion preference clusters (Snow et al. 1986). These sentiment pools share common grievances and orientations. The general “counter culture” orientations of the pioneer women in my study represent one such sentiment pool, as do the Christian communities and the more mainstream women who came to homebirth through their interests in self-care. As stated by Snow et al. (1986:467), frame bridging “occurs primarily through outreach, information diffusion through interpersonal and intergroup networks, the mass media, telephone, and direct mail.” One powerful frame bridging mechanism is the information and collective action frame diffusion and articulation present in books.

Books: “I read everything I could get my hands on!”

For the homebirth movement, frame bridging occurred through interpersonal relationships, group exchanges, and mass communication, especially books. Information about the collective action frames (CAFs) of the homebirth movement that were disseminated through interpersonal exchanges were essentially diffuse, unorganized, and partial, as would be expected from natural conversations. Shared birth narratives and the behavior of the midwives and other homebirthers also disseminated important information. Books, however, provided the clearest arguments for homebirth (prognostic CAF) and against hospital interventions (diagnostic CAF).

Most of the books produced for the homebirth movement have been a combination of assaults on standard medical practices, homebirth narratives, and practical advice for having a homebirth. A common theme especially among the pioneering women was a need to read as much as they could find to cement their knowledge and choices around homebirthing. A common term used was “cramming” or “reading everything they could get their hands on.” As Sue, an early homebirther comments,

I just started cramming. I mean I checked out Obstetrics texts. I read everything that Nasima and Daniel were willing to give to me. Anything I could get my hands on including I think...Spiritual Midwifery. And so I read a lot of accounts of homebirthing, and I became more and more confident that in fact statistically the risk was very slight, and that I didn't have any reason to believe that I couldn't birth safely on my own.

As detailed more completely in Chapter Six: Collective Action Frame Emergence and Diffusion, homebirth books advocated a prognostic collective action frame of homebirth. This prognostic CAF included a holistic framework of the birth process that emphasizes a holistic approach to the maternal body that recognizes the link between

mind, body, and soul; a belief in the inherent health of women and pregnancy; an emphasis on personal responsibility and women's empowered decision-making; and treatment of the family as the essential social unit. These prognostic CAFs call for maternity care to be woman-centered, with care based on body knowledge and intuition, where the mother is seen as actively birthing her baby. Lastly, inherent trust in the natural process is the core basis of this holistic model. This "holistic" model was presented in more detail in Table 1: Comparative Table of the Technocratic and Holistic Birth Models.

Effective diagnostic framing often includes an "injustice frame." Snow et al. (1986:466) explain, "The emergence of a significant social movement requires a revision in the manner in which people look at some problematic condition or feature of their life, seeing it no longer as misfortune, but as an injustice." The early alternative birth literature did exactly this. It brought to light the standard obstetric practices, the problems they caused, and the dissatisfied experiences of birthing women

As I detailed in Chapter Six, books such as Suzanne Arms (1975), *Immaculate Deception* helped establish this injustice framework. After the birth of her daughter Suzanne Arms (1975:5) felt,

The overall effect was shattering. Molly's birth did not show me my strength, it made me question my abilities as a woman and a mother...I began to feel the sorrow and anger from the birth, and with that came a driving need to do something about it. I had been deceived, and I was determined not to be deceived again. I set out to discover what had gone wrong, not just in my child's birth, but with the American way of birth.

Her book discussed the historical changes in maternity care and illuminated the harmful nature of many standard procedures. In a response to her book she received letters that proclaimed the deep chord she had reached in many women. These responses are reflective of successful attempts at helping others become cognitively liberated regarding

homebirthing. In her 1996 re-release of *Immaculate Deception II*, Arms (1996:4) commented, “ I received hundreds of letters and phone calls thanking me for ‘waking them up’ and for ‘telling the truth’ .”

Books such as *Immaculate Deception* (1975) provided a framework for women to exercise C.Wright Mills’ idea of the “sociological imagination.” They were able to see that their own birth experiences and their sense of dissatisfaction were not personal troubles but were part of the social issues of the medical structure. The injustice framework conceptualized by Snow et al. (1986:474) also incorporates the importance of this shift from personal to public blame, a shift from, “fatalism or self blaming to structural blaming, from victim blaming to system blaming.” The frame bridging work of Kitzinger (1972; 1979), Dick-Read (1972), Lamaze (1956), Stewart and Stewart (1977; 1976; 1977a; 1977b; 1977c; 1979a; 1979b; 1979c), Gaskin (1977), Arms (1975), and Mehl (1977; 1980), to name just a few, have added fuel to the injustice frame of the homebirth movement. These books and others provided research, statistics, narratives, and histories detailing the dangers in standard maternity care. They strongly indicted the social system that perpetuated these norms. Works such as these created a “mode of interpretation that defines the actions of an authority system as unjust and simultaneously legitimates non-compliance” (Snow et al. 1986:466). As mentioned in Chapter Eight, the social foundation of the 1960s and 1970s political and social upheavals assisted the creation of this injustice framework. Social injustice was at the forefront of thinking, and early homebirthers extended this gestalt of social injustice to include standard obstetrical care. This injustice frame was necessary for the homebirth movement’s arguments to create the stirrings of social protest and a shift in individual-level behavior. This shift was

indicative of a successful process of becoming cognitively liberated in regards to homebirthing. Some of the literature that created a bridge to the homebirth movement wasn't written with that intent but had that effect for the early homebirth respondents. Rachel, who gave birth to her daughter before any of the early homebirth books were published, recounts the effect of three books she encountered.

...When I was a young girl of about... twelve, thirteen, fourteen, and I think the first one was *Gone with the Wind*. I read and where the woman, Scarlet, had her whole little birthing episode and had her baby in the home and all the babies were born in the home and I was just kind of like hmmm. Ok, and then the next book I read was a *The Good Earth* which was wonderful, classic book and of course in this book the female heroine actually works in the field until the baby is just about out...She had them all by herself in the room and took care of everything...and at that moment I remember thinking right then and there somebody has been lying to me.

Rachel also mentioned the importance of Lamaze books and other natural childbirth literature in developing her personal belief in birthing at home. Once homebirth books such as *Spiritual Midwifery* (Gaskin 1975) and *Birth Book* (Lang 1972) were published they offered more narratives, accounts, and clear prognostic and diagnostic arguments for potential homebirthers.

The book, *Spiritual Midwifery*, by Ina May Gaskin (first published 1975), is mentioned repeatedly in the interviews. The importance of this early book at providing prognostic and motivational collective action frames is clear both from the number of copies it has sold (half a million), to the number of comments made about the book from my respondents. *Spiritual Midwifery* (1975) was of particular importance to the early “political” or “hippie” homebirthers. As Susan mentions,

A lot of them read *Spiritual Midwifery*. I used to lend out my copy to them. Because... especially in the early years, people who were having their babies at home... were really pioneers. By the '80's it had changed a

little bit, and there... was this history, and we had been midwives now for years. But these first...these first clients, they were very brave. And they really needed some reinforcement that women did this and midwives did this, and... *Spiritual Midwifery* when it first came out was a great book for them to read.

Sandy commented that,

One of the things I read during that time was the book *Spiritual Midwifery* from The Farm. That was so affirmative of the natural process and it was so much emphasizing the importance of confidence and belief in what was going on naturally with the birthing process, and the emotional level of things and where people got blocked in delivery with their own emotional issues. That was real helpful.

This book also changed the vocabulary of birth. Gaskin began calling contractions “energy” and “rushes.” This shift in vocabulary deemphasized pain and the singularity of the biological process, and emphasized the spirituality and wider degree of sensations experienced during birth. Sue also mentions the importance of *Spiritual Midwifery* as well as *Birth Book* by Raven Lang. For Betty, who would become a student at the Arizona School of Midwifery in the late 1970s, discovering the book in a bookstore helped set her life on a path toward midwifery.

I found Ina May Gaskin's *Spiritual Midwifery* book. I was just in a bookstore. Not looking. Saw it, and I was like... I had never even heard of midwives. I don't know why. And I saw the book, looked through it, and bought it. I felt instantly at that moment... I mean... I had always had this feeling that I had a vocation that God was wanting me to do something... I always felt like I was searching and hadn't found it. “Please, when is it going to appear?” That kind of feeling... I saw the book, and right in the bookstore I felt, “Oh my God, this is what I want to do! This is wonderful! This is great!” I read some of those birth stories right while I was standing there... “This is it!” And I felt chills up my spine.

For many as the times changed and midwives became relatively more established, the early “radical” works did not resonate as well with a new generation. As Nicolle, who had her children in the late 80s and 90s, commented,

[I] recommend *Spiritual Midwifery*... I liked ... how very clear and concise she was in the terminology she used. ‘This is what's going on.’ It was way too hippie for where I was at. The rushes, and this and that, and feeling this whole energy. I'm not there. I'm from a totally different generation. But nonetheless, I liked how the birth stories... There were so many birth stories, and so many very different birth stories... but it wasn't a book you could recommend to just anybody. Most people were very put off by the book... you'd have to be careful who you gave that book to. [I]t was a little overwhelming, and it would make homebirthing look too radical to most people.

As the injustice frames matured, these CAFs were translated into a rhetoric that captured a new generation. This new articulation shifted the argument somewhat away from a “caustic assault” on the standard medical system, to a more compromising position, discussing the pros and cons of different choices.

These rearticulated CAFs emphasized choice, self-care, a belief in the inherent healthiness of the female body, and a belief in the family-centered and sacred aspects of birth. *Ina May's Guide to Childbirth* (Gaskin 2003) provided current information and three generations worth of homebirth stories. Barbara Harper's *Gentle Birth Choices: A Guide to Making Informed Decisions About Birthing Centers, Birth Attendants, Water Birth, Homebirth, Hospital Birth* (Harper 1994) continued to present the case against high tech hospital birth with statistics and other “empirical” evidence but presented it as a “choice,” as is clear from just the title. For many of the later homebirthers the rhetoric of safety and family-centered birth was more resonant, while the cultural milieu of the early 70s which fostered the beginning of “political” homebirthing was now viewed as a “stereotype” that hindered the growth of the movement. The softer rhetoric and

acceptance of multiple avenues to birth was reflective of this shift. Today there is a wide field of books covering homebirth from mainstream to radical, and these books often find their way into the hands of potential homebirthers through recommendations of friends.

Interpersonal relationships and idea exchange also played a strong role in frame bridging. In some cases this mixed with the bridging of books. Women would not only tell each other about their own birthing experiences but also lend or recommend books that supported homebirth. As Trina stated,

I enjoyed reading the *Spiritual Midwifery* birth experiences. I mean that was interesting to read other people's experiences. It is very supportive. This is what I think is why the New Beginnings monthly meetings were so important, you know, for women who were pregnant to hear other women who had been there. It was an affirmation. They knew each one of their birthing stories were an affirmation. So, I think that was very important

Networks provided support for women's frame construction processes toward having a homebirth. The following section explores this issue in greater detail.

Networks: "A friend introduced me to my midwife"

Social movement theorists have emphasized the importance of social networks for social movement recruitment (Friedman and McAdam 1992; Marx and McAdam 1994; Robnett 1998; Snow et al. 1986), and collective identity (Melucci 1989; Mueller 1994; Taylor 1996, 1999). Participation in a variety of groups and activities provides opportunities for learning about a movement's collective action frames, joining activities, and making additional personal contacts. (Marx and McAdam 1994), using a social-structural approach to activism recruitment, present three preconditions for participation:

prior contact with another activist, membership in organizations, and the absence of “biographical constraints.” I argue that within self-help and more internally focused movements, such as homebirth, the presence of organizations is not necessary; however the importance of interpersonal contact networks and “biographical constraints” remain important factors.

Networks also aid in the development of a collective identity. As Taylor (1996:127) defines the term, “Collective identity is the shared definition of a group that derives from members’ common interests, experiences, and solidarity.” Melucci (1989) calls these groups where collective identities are forged “submerged networks.”

The submerged network is a system of small, separate groups engaging in cultural experimentation, and it is also a system of exchange in which persons and information circulate freely within the network. These networks act as ‘cultural laboratories’ submerged within civil society (Melucci 1989:60).

These submerged networks are fragmented in terms of their relationship to each other. They are invisible to the “outside world” because they are immersed in “everyday life.” They only become visible when they come into contact or conflict with public policy or the state. These collective identities also stem from face to face interaction. As Mueller (1994:237) states,

In these cultural laboratories, new collective identities are constructed from the expressive interactions of individuals experimenting with new cultural codes, forms of relationships, and alternate perceptions of the world. The creation of the collective identity occurs in the midst of tensions, as well as, the close face-to-face interaction, develops a heavy emotional investment that encourages the individual to share in the collective identity.

This develops a sense of boundary framing a “we” and “them” understanding (Silver 1997). Groups within my sample that were important to both the development of the

“homebirther” collective identity and collective action frames were friendship networks, playgroups, homeschooling networks, religious communities, holistic health providers, and gatherings of homebirthing families, midwives, and supporters, such as the potlucks put together by the Arizona School of Midwifery. The importance of first-hand accounts within the movement ideology makes this sharing of birth accounts and personal experience even more important. Interpersonal ties facilitate finding a provider and a more complete alignment of a woman’s birth frame with the homebirth movement’s CAFs. Marx and McAdam (1994) note the importance of prior contact with another activist, membership in organizations, and the absence of biographical constraints. Many homebirthers in my sample had prior contact with a midwife or another woman who had had a homebirth, and this helped provide support and encouragement for undertaking a homebirth. Membership in, or association with, the Sufi community was also important to networking and providing support for the early homebirthers in Tucson.

It seems this network effect has remained salient during the entire thirty-year spectrum under study. The networks present in my study do differ some by time period. These range from the 1970s Sufi community, New Beginnings, COFAM and Arizona School of Midwifery meetings in the park to the 1990s missionary community in Catalina, Arizona. Friendship networks have always been critical. In the early years the women’s connections had a particularly “political” feel. This support was especially important in the early days when it was very unusual to have a homebirth. Today, although statistically homebirth is still rare, it’s more “out there” as one of the possible choices available to childbearing women. Discussions of homebirth can be found in mainstream magazines, books, and on on-line discussion boards. The more recent groups

are more focused on mutual support than political change. This shift in support may be partially due in Arizona, to a history of midwives and positive legal status, but it still shouldn't be forgotten that, in the 1970s political activism through networks of homebirths helped make these accomplishments possible.

The meetings in the park, which were started by what would be the Arizona School of Midwifery in the mid 1970s, were central to sharing common support for homebirth and the ideologies behind it. For the homebirth pioneers, this social support was very important. Sue recalls, "We had these little gatherings, these were not very many people, maybe fourteen as far as men and women and the midwives and so forth and people who were involved with the homebirthing movement in 1974. There wasn't a lot of us." As the midwives became better known, and especially after licensing, these meetings grew to include more people. Many commented how supportive this environment was. Lucy commented, "It was such a supportive environment and I don't know if that could be recreated." The families and midwives would share birth stories and a potluck dinner. This helped keep a sense of community and maintain the homebirth ideology in the face of medical opposition. These meetings were also continued by the school's off-shoot New Beginnings. Beyond the importance of networks for facilitating support in, and undertaking a homebirth, the importance of the interpretive work done within these groups cannot be strongly enough emphasized.

Snow et al. (1986: 466), emphasized the importance of interpretive work and social movement organizations (SMOs): "SMOs and their activists not only act upon the world, or segments of it, by attempting to exact concessions from target groups or by obstructing daily routines, but they also frame the world in which they are acting.

Moreover, the strategic action pursued by SMOs, their resource acquisition efforts, and their temporal viability are all strongly influenced by their interpretive work.” In Stengel’s (1978a) *Arizona Daily Star* newspaper article, this interpretive work is visible in an account of the meetings in the park where the women shared their homebirth experiences.

One woman is quoted as saying, “I couldn’t feel any pain and shall never forget the sight of the head, an incredible joy....It was a beautiful morning. Jack delivered the baby wonderfully....” A midwife is quoted as saying, “It’s important to, ‘ stay on top of what is happening with your body during the birth process...and familiarize yourself with the taste of Gatorade before that time during labor when it must be drunk’” A woman named Karen explained why she had a homebirth, “A hospital is a place for sick people and I’m not sick. I’m just having a baby” (Stengel 1978a:D1). Inherent in all these statements is the interpretive work of the homebirth movement and the adoption of a homebirthing “collective identity,” drawing on shared understandings and experiences. Each individual draws on aspects of the movement ideology and collective action frames that are most salient to them. During opportunities such as newspaper interviews, homebirthers share their experiences and core motivational CAFs with a wider audience. In their comments are reflected the ideologies of the naturally healthiness of pregnancy, the importance of being in touch with one’s body, and hence the validation of embodied knowledge, and the importance of being an active birther that emphasizes joy over pain. During the personal birth frame construction process, individual and group interpretive work was conducted using the information, attitudes, and behaviors espoused by the national homebirth movement through the movement’s literature. Throughout Frame

Bridging, these ideas and attitudes were disseminated through intergroup and interpersonal exchanges, and through mass communications such as books.

For the women in my study, the injustice frame and the more general frame bridging of the homebirth movement occurred through books and through interpersonal support. For the early homebirthers, ideas were also exchanged via the interpersonal connections of the meetings in the park, Sufi dancing, and personal networks built on these connections. The interpretive work of frame bridging helped foster a holistic framework of the birth process with no separation of mind, body, and spirit. Interpretive work supported beliefs in the inherent health of women and pregnancy, the sanctity and spiritual aspects of birth, the importance of the family unit in birth, with actions based on body knowledge and intuition, with care that is woman-centered, and the mother being seen as an active birther of her baby. This is all combined with an inherent trust in the natural process. The next stage explores how these ideological points emphasize the individual personal motives for choosing homebirth. The next chapter discusses the heart of making birth choices. A process of negotiating options, structural barriers, and fears operates to constrain a woman's birthing choices.

CHAPTER TEN: FRAME NEGOTIATIONS

Frame negotiations represent the third conceptualized stage in the personal birth frame construction, alignment, and adoption process I am delineating within this thesis. This stage involves the negotiation of choices and the making of decisions. These decisions are influenced by ideas and experiences already present in women's repertoires as part of their frame foundations. These decisions are also based on her particular health history, which may act to constrain her choices. These constraints come both in personal assessments of available options as well as options health providers are "allowed" to provide by state authorities. Frame negotiation decisions are also influenced by information and interactions, which provide frame bridging of motivational frames and create support for a course of action. This frame bridging is an ongoing process and as such occurs both before and after a woman is pregnant. The information gained through frame bridging serves to provide motivational frames. It is my intention here to provide a descriptive model of the factors that women expressed as salient to their decision-making in regards to homebirthing. Other researchers (see Garro 1985; Janis and Mann 1977) have provided complex explanatory models on health-related decision-making, which is outside the scope of my research. My data speaks specifically to the experience of those who positively negotiated obstacles toward having a homebirth. I discuss the obstacles that these women encountered in their pursuit of a homebirth, but I cannot provide detailed information on the framing processes of those who were deterred from having a homebirth during their negotiation process. This is an avenue for further research.

In the following three chapters, I illustrate a descriptive model of “Frame Negotiation,” which includes processes that expectant mothers deal with or negotiate in order to have a homebirth. First in Chapter Ten, I discuss immediacy of decision-making, finding a practitioner, and balancing financial concerns. Second, in Chapter Eleven, I discuss the motives or rationales that women express as “the reasons” they homebirthed. Additionally these rationales will be linked with the movement’s motivational collective action frames and how some of these motivational frames were important to navigating fears for themselves and others. Third, in Chapter Twelve, I discuss the “What ifs” and how renegotiating fear and risk is important in the frame negotiation process. I discuss how women deal with questions of birth fears both for themselves and in their interactions with the concerns of partners, friends, and family. I will discuss the processes through which these fears and concerns are mitigated. To begin, I will present how immediacy of decision-making is the starting place for describing the frame negotiation process.

“I’m pregnant! Now what?”
Frame Negotiations: Immediacy of Decision-making

Once the women found themselves either trying to get pregnant or accidentally pregnant, they were faced with needing to develop a frame to deal with the pregnancy and eventual birth. Choices regarding the pregnancy and birth become immediately salient and relevant. Some women take a path of embracing alternatives, while others gravitate toward the status quo; either way, their framing decisions become immediately

important. I label this immediacy of decision-making a liminal phase. Birth is considered by anthropologists van Gennep (1960) and Turner (1977) to be a liminal phase. This liminal phase is characterized by a sense of being in a transitional state. Birth brings into question a woman's sense of self and her changing role in the world. This is especially true for the birth of her first child. Liminal phases also commonly involve a practitioner who helps usher the initiate through the liminal phase. Doctors and midwives serve that purpose in American society. "Liminality is regarded as a time and place of withdrawal from normal modes of social action, it can be seen as potentially a period of scrutinization of the central values and axioms of the culture in which it occurs" (Turner 1977:167). To a degree, women today have choices about what axioms of culture they would like to emphasize through their birthing rite of passage. To this point, a modern collection of "positive" birth narratives collected by Judith Zimmer (1997:4), illustrates this importance,

The choices we make about where we deliver and with whom reflect our feelings about ourselves and our bodies...The way we handle ourselves during childbirth is symbolic of the way we live in the world. To change the experience of childbirth means to change women's relationship to fear and powerlessness, to our bodies, to our children; it has far reaching psychic and political implications."

Davis-Floyd's (1992) work on *Birth as an American Rite of Passage* illustrated the importance for developing a cognitive matrix to interpret the pregnancy and birth experience. Women who did not develop a cognitive matrix for dealing with the transitions of birth fared poorly in their birth experiences (Davis-Floyd 1992). This cognitive matrix may develop under a degree of time pressure, given that approximately

half all U.S. pregnancies are unintended (Division of Reproductive Health Division of Reproductive Health 1999).

For the women in my sample, the liminal phase was marked by two divergent groupings. The first group knew they wanted homebirths from the beginning, often having familial, book or professional knowledge prior to becoming pregnant. The second group came to homebirth gradually. Rachel commented,

I kind of came to homebirth as a very um...gradual thing. I was just one of these people who in a lot of ways was kind of always preparing for this stuff, even though I didn't really think about it. I think it was just a real instinctual kind of thing. Just forming my... point of view.

Sue commented that it wasn't until later in her pregnancy that she started to reconsider doing something alternative for her birth. "I was careful about announcing to people about being pregnant, because I knew that I had miscarried before, and so there's all these steps inside of pregnancy of what you're concerned with, and it wasn't until the last trimester that I really focused on the issues of birthing."

The first step in a liminal phase such as pregnancy is finding a practitioner to usher the initiate through the social and physical transition to her new role. All the women sought out practitioners, as is the norm in American society. This process of finding and interacting with birth practitioners has a strong effect on women's birth models and is the next step in the frame negotiation process I will discuss.

“I’m pregnant and I need to find a Doctor”
Frame Negotiations: Seeking out a Birth Practitioner

The experience of finding a practitioner varies greatly by time frame and state legal status. This stage is also critical to the woman’s frame construction and is the critical turning point for many of the women. Research by Howell-White (1997) documented the strong influence a birth attendant’s definition or framing of birth has on a woman’s birth; it is in fact the strongest determinant of how a birth is conducted. Through this interaction with a provider, the woman’s expectations and frame are either reinforced or called into question. If the woman holds a high level of self-efficacy and confidence in her frame, she is likely to seek out an alternative provider who demonstrates a better fit with her worldview. Sometimes the search for a “like-minded” practitioner occurs over the course of several births. Attempting to find a practitioner who fits with the woman’s developing frame is often a radicalizing experience. When a medical practitioner cannot be located, or the experience with a medical practitioner is interpreted as horribly unacceptable, she turns to a more radical option. This is a very critical stage; the woman moves from ideas to action.

Early homebirth pioneers in Tucson had very different experiences in locating providers compared to their contemporary sisters. Today’s choices are in large part a product of the early pioneers’ radical activism that created legal licensed practice for midwives in Arizona. In the earlier 70s, direct-entry midwifery had been almost completely extinguished by the medical establishment’s efforts to eradicate midwives (Sullivan and Weitz 1988; Wertz and Wertz 1989). In Arizona in 1970 only seven midwives were registered with the Health and Human Services Department, and several

of these were Native American women serving only women on their reservations. In comparison, as of 2003 there were 134 licensed midwives in Arizona (personal communication Glass July 2003). Today a woman can simply look in the phone book or look on the HHS state website if she is looking for a licensed midwife. Thirty years ago, it was quite different as the first section, *Birth Among Friends*, will illustrate. However, even contemporary homebirthers who now have considerable choices and legal options, navigate difficult financial and personal obstacles in seeking a homebirth practitioner. Let's now turn our attention to finding a practitioner and the obstacles associated with that process. I break up these accounts of finding a practitioner into the following categories; First, *Birth Among Friends* discusses the early years of homebirth. Second, *Licensed and Legal*, discusses the years after licensing occurred up to the present day. Lastly, *Balancing Financial Concerns* will discuss the effect of reimbursement on women's search for practitioners.

Birth Among Friends

The early years of the homebirth movement, both in Tucson, Arizona and around the country, are characterized by a development of midwifery skills within a selective community of like-minded individuals (see Gaskin 2003). The beginning stages of the development of these seminal midwives' skills occurred as women with a talent for midwifery emerged and took on helping others with their births at home. Often these women knew relatively little in the beginning but quickly increased their skills with experience, reading, and interaction with sympathetic doctors. This process is evident in the experiences depicted in important early books such as *Birth Book* (Lang 1972) and

Spiritual Midwifery (Gaskin 1977). Interestingly, this process has also been illustrated as the main way midwives in colonial America emerged and practiced (Wertz and Wertz 1989). The tradition of midwives entering the field through direct experience and apprenticeship is still valued in the midwifery community (Gaskin 2003). Although direct-entry learning is given value, heightened practice requirements, the development of schools and curricula, and state licensing requirements have all changed the nature of these learning environments and pathways to practice for midwives (see Davis-Floyd 1998). The seminal days of modern homebirth midwifery were particularly characterized by friends helping friends. Early midwives often did not call themselves midwives; they only presented themselves as friends who had had a homebirth and who knew more than most. For pregnant women, deciding to have a homebirth with a friend's help was often a radical decision. It was deciding to dramatically alter the way women were having babies and with whom. The early homebirth pioneers' frame alignment processes are reflective of social activism and the time in which they lived. The effects of frame bridging of information and interaction were all critical to the frame negotiation process, as were their frame foundations, which led them to seeking out homebirth and someone to help them. Most of the early homebirthing women first encountered doctors, as is the norm in our society. This was especially true in 1970 when direct-entry midwives²⁸ were

²⁸ In the late 1980s, midwives began working toward greater standards for practice and education. One way they began to redefine themselves was by slowly replacing the term "lay midwife" with the term Direct-Entry midwife (DEM), as a reflection of their ever increasing levels of knowledge, experience, professionalization, and more in-line with European non-nurse paths into midwifery. The term lay midwife is historically appropriate to the early days of homebirth midwifery.

basically nonexistent and certified nurse midwives were very rare. For many in the pioneer group, seeking out a provider of maternity services was a radicalizing experience. Step by step all these women came to desire a homebirth, and began to search for someone to help them have the kind of birth they desired. The best place to begin discussing the search for providers is to discuss the emergence of the midwives that would eventually serve the women in Tucson. To that end we will begin with Nasima's transformation into a midwife.

The Seed

Nasima is the starting place; within this group she is the original pioneer. Her transformation process became a foundation for subsequent women who had homebirths in Tucson. Nasima's first birth occurred in a hospital in San Francisco in 1969. Nasima explains,

My mother encouraged me that in England the way it was done is your first one is born in a hospital then you know everything works right. Then you can go on and have others, whatever way you want. So I got talked into doing it in a hospital and I was assured everything would be the way I wanted it. I could do it naturally; lots of people do natural birth. Daniel would be there and I'd have no problem.

Her birth was the opposite of what she had expected. All the promises of "natural childbirth" that her doctors assured her she could have, were ignored during the birth. A doctor she had never seen during prenatal care delivered her, her husband was kept out of the room, and her child was kept away from her. As Nasima recalls with great frustration,

I wanted to get up and walk around, they didn't want me to get up off the bed. They wanted to shave me and do all the prepping, and just stay on the bed. Oh, it was just so frustrating. Very frustrating. Then finally I said I really feel like I have to push, they said, "oh no you

couldn't be you're hours away yet." I said, "couldn't someone please check?" They said, " Oh you know, you've not been in here long enough to be that far, you don't even know, you've ever had a baby before how would you know how far along you are?"...They made Daniel stay out in the hallway. Which was number one violation that they had promised that he could stay with me. Then they go to take a sample of fetal scalp blood. And there's the baby's head. "I told you I have to have this baby soon." Then they're scrambling. "Get her in to the delivery room, blah, blah, get her prepped." I'm screaming at them, "Get my husband in here; I want my husband in here!" Well he walks in as Abe is being born.

She then felt that the hospital staff was angry at her for doing the birth without drugs or any other assistance. Her son was taken to the nursery to be "observed" for 6-12 hours.

Her experience became more disturbing to her after Abe was in the nursery for six hours.

Six hours later I kept hearing him crying down the hall. Six hours later they come in and say "He spit up blood. We're putting him in an incubator and he's going into ICU he won't be rooming in with you." I was beside myself. I could only touch him with rubber gloves on, through these holes in an incubator. The worst of that was that they finally had to admit to me that it was old blood. They had nicked his throat with the aspirator, doing it so hard and at such a panicked level. That they had caused that to happen and it wasn't that there was something wrong with him. They'd had him in this incubator with tubes going into his navel and all kinds of stuff. It was more than I could handle, I was so so furious. To make everything worse I heard him screaming and screaming and I knew it was Abe. And then they walked in with him five minutes later, when he was three or four days old, they had just circumcised him without me there. I was so livid, I screamed and I yelled, and I looked at the doctor and I said "I will never have a baby like this again, and further more I will help as many women in my life do this in a more sacred and respectful way!" So that was the seed.

This experience was a radicalizing event; the "seed" as she puts it. The lack of respect for her and her wishes, her lack of control, the way the hospital staff devalued her inner knowledge of the birth process, and the separation from her baby due to the errors of the hospital staff all acted to radically transform her future. Similar experiences by other

early women helped to develop many of the central motivational frames in the homebirth movement and are evident in much of the literature on homebirthing (see Arms 1996; Gaskin 1977, 2003). After this experience, Nasima and her husband moved to Tucson where she delivered her second child, Miriam.

She was very clear about not wanting a hospital birth again. She searched for a practitioner who would help her at home. She contacted an OB who was unwilling to attend the birth, although he seemed to understand where they were coming from. She pointed out, “He was too scared and couldn’t agree to do that. It was rather unheard of at that time.” He did provide them with a *Gray’s Anatomy* textbook. They decide to have an unattended homebirth. Nasima recalls,

Miriam was born here and it was sooo different. I fixed the evening meal, I went in and scrubbed the bathroom so I could take a bath. My mom was there, my husband was there, and Abe was there, and that was it...[The doctor] lent us this text book, and of course the way Daniel was- we can handle this! And we did, and she was born so much easier, in the bed, and then we laid there with her, it was completely different.

Nasima’s hospital experience and subsequent husband-attended homebirth were the beginnings of Nasima’s entrance into midwifery.

After Miriam’s birth in October of 1970, other women began to hear of Nasima’s homebirth. She remembers, “Slowly after that people started hearing that I’d had my baby at home. And would I help them? I don’t even remember who the first one was.” By the time her third child was born in December 1971, “I was starting to get somewhat of a reputation as an underground illegal lay midwife here in the Tucson area.” At the end of her career in Tucson she had helped between 600 and 650 women give birth at home. Her experience of her hospital birth and then her subsequent homebirth became the

foundation for her midwifery practice. She began attending births as just someone who knew more than most and who had done it herself. In the end she became responsible for training women to become lay midwives. Nasima became one of the practitioners the other women would seek out.

Helping Friends

Rachel delivered her daughter, Naomi, in April 1972. When she first became pregnant she was living near Washington D.C. with her husband Willie. She went to see an obstetrician at the urging of her mother-in-law.

When I got pregnant the first time, I didn't like this old little OB that I went to see in Maryland. I thought he was very condescending...I think anybody would have offended me. Any male, father figure, OB figure would have offended me and I was, I was just well fortified that I didn't want to do this....I never went back. I did not feel that he had the proper respect for my body. I thought that it was a pretty marvelous thing and it was a miracle, you know, that I was pregnant and my body was just a miracle in general, anyway, and I thought that when he touched me and stuff that he did not display a sense of wonder and awe and I thought that he was really privileged to have anything to do with me at all and I did not get any indication from him at all that he felt that way. So I wasn't going back to him.

The obstetrician did not fit with her birth frame. She had decided that homebirth was the way she wanted to go and her experience with this doctor furthered this conviction.

Rachel and Willie then moved back to Arizona to be close to Rachel's family. After she told a few friends about her intentions to have a homebirth, a friend told her about Nasima.

This girl who was living with an old friend of ours from college told me that she knew a woman, she was a Sufi, my friend, they went to the Sufi church and she said that there was this woman who had had her baby at home and that they did go to homebirths. And, that it was her husband

that had done all this studying up until then, had actually delivered the babies and she had gone as a support person. She had like four babies at home or something... But he was the one who had done all the studying. So I hooked up with them, and I asked would she come and she said sure.

Rachel then learned Lamaze breathing techniques from a nurse. She went on to have a successful birth with friends and family present. Nasima did attend her birth but took a very passive role. After the birth of her first child, women started to come to Rachel for help with their births as well. A few months after her first homebirth, she started attending other homebirths in much the same manner as Nasima was at that time. Rachel then became another maternity care provider option for other women. Rachel and Nasima were both important to the process of Sharon seeking out a provider.

In 1974, Sharon first went to see doctors at a clinic at an old county hospital on South 6th Ave in Tucson. She went to them for a while but was dissatisfied with her experience. She didn't like that she saw a different resident every time. She generally didn't like the doctors. She recalled, "I remember not wanting them to touch me." After her experience with these doctors she heard about Nasima from Rachel. Nasima directed her to a doctor of osteopathy (DO) who might help her. When she went to see him, he created a lot of fear in her about her pelvic dimensions.

It was enough that he really worried me, he also told me, he was looking through his book and there was a picture of this woman with these really large breasts and he told me that was going to happen to me cuz I wasn't wearing a bra, he was really bad. He really laid a lot of fear in to me about whether I could have a natural delivery, but at the other extreme I knew I didn't want to see those doctors at the hospital. I was really torn. I did continue my prenatal care there (at the hospital) though, and I set up with Nasima. She didn't even call herself a midwife at that point. She and her husband would just come help since they had their babies at home.

Her dislike of the doctors at the clinic helped draw her frame away from the medical purview and into a holistic framework, although Sharon had to deal with the fear the doctor created in her throughout her pregnancy and birth. Nasima became the helper/practitioner for Sharon's reframing of birth. Other women also helped assist her in overcoming these fears. Rachel was helpful in giving Sharon a sense of confidence to combat the warnings of the doctor. Sharon met Rachel at a friend's house and shared her concerns with Rachel. As Sharon recalled,

Rachel kinda put her hand between my sit bones [ischial tuberosities] and said your pelvis is plenty big. Oh I held that in my head. I was really grateful. She was this voice of- It was such a lesson of how these things stay with women. I think that's one thing doctors don't get. The power of what they say to women and how that influences what they think, and feel and their fear.

At her birth Nasima also helped Sharon overcome the sense of fear the DO had instilled in her. After her successful homebirth, Sharon decided to pursue midwifery herself. She began apprenticing with Nasima and became another helper/provider option for other women. So far I have illustrated seeking out a provider through the accounts of women who ended up becoming practitioners themselves; I'll now shift to Sue's account. She became very involved with the homebirth movement but did not become a provider herself.

In her seventh month, Sue and her husband Jerry attended classes at Tucson Medical Center where her obstetricians, Gillette and Oates, practiced; but was she was so "turned off" by the hospital that she turned to homebirth. She remembers, "I didn't want our child born that way." Sue then connected with Nasima through Subhana. Subhana had had a homebirth and was in Sue's dance classes at the University of Arizona. Nasima connected Sue with the same DO who saw Sharon. He was willing to help with

homebirths and she went to see him. The doctor wanted a lot of money and made her feel awful. She felt the doctor was exploiting her in the same manner illegal abortion doctors had exploited women in the past. She left the office crying, where she coincidentally met Nasima on the sidewalk. As Sue puts it that brought her, “one step closer to Nasima.” She tried one more doctor, a Peace Corps pediatrician who did agree to come to the birth. He was a compromise between doing a homebirth by herself and a medical birth. She felt relieved, but a week later he called to say he couldn’t come for insurance reasons. This just strengthened Sue’s determination to do homebirth. Sue turned to Nasima, who attended her birth. Sue sought out several medical providers and only after continual disappointment did she fully convert her frame to a midwife-assisted birth with Nasima. Janis and Mann (1977) refer to this process as “vigilant information processing” and consider it an effective strategy when dealing with health decisions. Her account represents a gradual strengthening of her homebirth frame through adversity and challenge.

The shift of birth frame was not easy for any of the women involved in the earlier years of the movement. There were very few examples of other women doing homebirths to draw strength from. There were no “legitimate” providers to assist them. Homebirth was also semi-illegal and assistants had to walk a careful legal line. Couples were just beginning to question medical authority. Many of the women in my study also had minimal to moderate support for their birth choices. Their partners were generally supportive but less confident in the decision to have homebirths. Their partners or husbands went along with their judgments but when the “chips were down” they often suggested going to the hospital. The women’s families were also generally not

supportive of the women's birth decisions. They were truly pioneers. These early births with fairly inexperienced and poorly equipped birth attendants could be considered dangerous, but this legacy proves two points. First, birth left to its own devices is mostly successful and, second, the beginning of change is often risky but the foundation is needed for the change to occur. Their early efforts paved the way for others.

All four women initially sought out a doctor, as is the norm in American culture. They all came into the medical arena with a predisposition to a holistic approach through the effects of frame bridging, through the internalized ideas developed in the social foundations of their lives and frames, and through sharing and experiencing the medical system themselves while undergoing frame negotiation. For Nasima, the birth of Abe in the hospital was a radicalizing event, which sent her into midwifery. Sharon and Rachel so disliked their doctors that they turned to alternatives as well. Sue "didn't want her child born that way" at the hospital so she also sought out an alternative. All the women underwent a shift in their frame to a holistic model and located a provider who most appropriately fit with their revised birth frame.

The following accounts of other early homebirthers represent a less radicalizing switch of frame. They all had personal challenges to overcome, but many of the organizational obstacles had been removed. As the rules and regulations got established, seeing an obstetrician at least once during pregnancy became part of the requirements for a homebirth. The midwives tried to find physicians who would not belittle patients for their choices. Lucy's experiences with the backup doctors in 1978 and 1981 were both positive. The doctors she saw had ties with the lay midwives and the School for Midwifery. They treated Lucy with more respect and consideration than the other

women had experienced with other nonaffiliated doctors. Due to the greater degree of legitimization and organization of the midwives, her frame transformation was less radical.

Trina had been present at Rachel's first birth. This very positive introduction to homebirth provided a solid grounding for doing her own homebirths. She recalls, "I was really glad that I was not having the baby in the hospital. That never really seemed like an option unless there would of been some kind of a problem, then I certainly would of gone. It didn't seem like the route that I wanted to go at that time." Trina had her first daughter with Rachel's assistance, her second daughter with Sharon's assistance, and her son with Rachel and Sharon's help. She did see doctors for her prenatal care.

The doctors she saw tried to convince her to have the baby in the hospital and she had to hold her ground. She recalls, "They kept trying to talk me into coming in and having the baby there. I was really not very comfortable with the whole situation. They really did not exhibit the kind of treatment I would want to have." Trina's most difficult time with the medical establishment was after the birth of her first child. She had to go in due to hemorrhaging from a small piece of retained placenta and the doctors were very rough with her and critical of her decision. When Trina delivered her second daughter in 1977 and her son in 1983, midwifery had undergone legalization due to the revision of the licensing rules and her midwives were now "nice and legal," which made the choices for subsequent homebirths even easier.

In 1977, Sandy utilized the lay midwives, a nurse practitioner, and a backup doctor associated with the midwives for her maternity care. She had seen a flyer for the New Beginnings group of midwives and had contacted them, but she continued to see a

nurse practitioner at a free clinic. Her experience with the backup doctor was a “neutral to not great experience.” Her search for a maternity care provider was less radical due to the development of the birth teams through the Arizona School for Midwifery. She and her partner also had a very clear idea that, “the hospital was the worst possible place to have a child.” She was able to locate the midwives who acted as providers that fit with her established birth frame.

Many of the women underwent an alignment or a shift in birth frame while seeking out a maternity care provider that coincided with this developing holistic frame. This is a process. The early pioneers had a more radical shift than did the later women. They all ended up having to accept giving birth in a stigmatized setting with varying degrees of support. Many of the issues illustrated by these accounts are still relevant today in states where direct-entry midwifery (DEM) is still illegal or alegal (see APPENDIX C: DIRECT-ENTRY MIDWIFERY STATE-BY-STATE on page 456.) In these states, direct-entry midwifery is conducted by word of mouth, parents have to sign birth certificates, midwives cannot go with clients if transported to the hospital, and midwives practice with fear of prosecution (Tjaden 1983). In Arizona, women were fortunate to be birthing in a state that was homebirth tolerant. For an expanded discussion of the politics of the time, see Sullivan and Wertz (1988). As licensing and legal homebirth midwifery became more established in Arizona, the issues women experienced when seeking out a provider began to change. Over the span of research from 1970 to 2001 the number of midwives practicing, who was practicing, the midwives’ backgrounds and the medico-political environment for midwives underwent ups and

downs. These factors are reflected in the accounts of women seeking homebirth practitioners in the 80s, 90s and 2000s.

Licensed and Legal

Women who gave birth in Arizona after the implementation of (lay) direct-entry midwifery (DEM) licensing had a very different experience of seeking out a provider. These were eras marked by amazing choices compared to the pioneer group. In the early 80s the birth center opened; as of 2003 there are now 134 licensed midwives in Arizona (personal communication Pat Glass 2003), midwives can be located in the phone book or looked up on the HHS state website. These improvements do represent progress in choices, but overall DEMs are still relatively rare. It's estimated that between 1300-2300 DEMs currently practice in the US, compared to 5700 Certified Nurse Midwives (MANA 2003), and over 45,000 OBGYNs (ACOG 2004). Other challenges also remain. Issues of limited insurance coverage (both malpractice and medical), some improvements in hospital maternity care, homebirth's stigmatized social status, and fear all still constrain women from choosing homebirth. Licensing provided homebirth midwifery with more legitimacy, but it has remained a stigmatized choice. This stigma means it's still a difficult choice for many women to make. Birth at home is still today considered a radical option, although not quite as radical as it was for the early pioneers, who had no social structure such as licensing to create legitimacy. Some women come to homebirth during their first pregnancies; others come to it after several other experiences with hospitals and birth centers. The processes of frame bridging and frame foundations are just as critical to

these contemporary women as they were for the pioneering group. Motivational frames still play an important role in providing rationales for homebirth.

All my respondents experienced variable degrees of seeking out a provider as part of their frame negotiation process. Some quickly found a provider they liked; others had to negotiate and search to find their provider. This process is also reflective of the rhetoric on “choice” found in the movement’s recent CAFs. The process of locating a provider is now facilitated by legal status and advertising; but new issues have arisen, most notably interviewing midwives and dealing with financial concerns. Interviewing midwives involves looking for someone a woman “clicks with” and sorting out different midwives’ practice styles. This has become even more central as the “type” of people attracted to homebirth has widened from its “hippie” origins. Some people are looking for DEMs who are very “straight” while others are looking for more grandmotherly or hippie style midwives. The midwives all commented about this process.

Interviewing midwives is the common approach to locating a provider today in legal licensed states. This is in contrast to the early days, or in states where there are no legal, licensed midwives, where women have to be connected to an “underground” network of friends to find a midwife. In these “underground” networks little choice exists due to a very low number of midwives. Sometimes this precludes women from having homebirths if they are unable to find someone to help them at home, or are unable to find someone they feel comfortable with. Today, in licensed states word of mouth references are also still very important, but there is not the same need to be “connected” with a homebirthing network of people to “get connected” with a homebirth midwife (e.g. The

HHS website). This level of choice facilitates women making homebirth a viable option for birthing. As Nicolle recalls in the early 1990s,

We interviewed several...There was at least 10. And we basically found about five in our area... They were very different kinds of midwives. ...The first one, we walk in her house and you walk through a room, and here's a doorway with beads hanging down. You walk through the beads, and there are tie dye material hanging all over the walls...like a hippie haven.. a bed on the ground, and I just knew my husband wasn't gonna go for that one... and she just didn't seem very competent. And then the other one was very abrupt , and very just matter of fact, and no connection there. Just no sincerity in what she said, so I didn't like her. And then the third one...she seemed very nice, very competent, and all right, and she was very hands off...[I said to myself] "all right this is good. We'll just go with her."

For midwives this shift from community barter-style midwifery to for-profit practice had its advantages and its pitfalls (Gaskin 2003). The process of midwifery's professionalization was challenging. A balance between clinical skills and mothering skills characterizes midwifery; and midwives express these traits in different ways. Midwifery as a "vocation" has a different character and different issues than midwifery as "friends helping friends." As a vocation, midwives have to balance their financial need for clients with the understanding that clients and midwives have to feel comfortable with each other and have a good relationship. This in some ways makes the "interviewing processes" challenging for midwives since they have to "sell" themselves but not too much. Ego, professional "camps," and financial need all complicate this process. One midwife characterized it in the following way,

I finally got to the point where I realized whoever becomes my client is the right person for me to work with, and I could finally get to a point where people would interview me and I would know, they were making the circuit, and they were going to interview everybody else, and I could finally get to a point where I could honestly say with my heart that we're

all good, and you need to just find somebody that you feel like you have a connection to.

This desire for connection seems to be a strong screening factor in the interviewing process. Over and over in the interviews you hear the words “clicking” and “connection” mentioned. In geographic areas where there are enough DEMs to choose from, like Tucson, women interview midwives both to find someone they feel is competent and with whom they feel a connection or affinity. Patty commented about her midwife Damiana Cohen,

When I meet her I knew right away that she was going to be my midwife...I had a sense with her, that she was going to make this a really safe situation for me and also that she was going to support me in whatever choices I wanted to make about it. [When my husband and I left the interview] we said ‘she’s it’ That was it. This is the woman...We clicked.

This level of closeness that develops between midwives and clients is one of the attractions of homebirth for many clients who have received much less personal care in the past.

Unlike many physicians or nurse-midwives who work in group practices, many DEMs work solo. This means that the client is actually screening the person who is planning on attending her birth, not just the person who ends up being on-call. This creates an opportunity to develop rapport and trust between client and midwife. One midwife, who was a DEM but became a CNM, commented that in comparison to the hospital, at home “I always knew where my client’s pots and pans were and what was in their refrigerators.” She meant this both literally and figuratively. Homebirth midwifery allows for a level of connection and knowledge that provides very personal care. Several

midwives and clients stated that having a solo provider was a motivating reason for having a homebirth. As Amy, a practicing DEM, stated,

A lot of clients come to me because they go somewhere else and they realize they may never actually see the person [during prenatal visits] that delivers their baby...Like [at] the birth center or to a OB office or whatever their insurance covers, and they realize they're gonna see a lot of people, but they really don't know who's gonna be at the birth, and they don't like that, so they want consistency.

This consistency often results in remarkable loyalty between clients and midwives. Networks of clients stay very loyal to their midwives. Women also report great grief when the midwife they had birthed with was unavailable for subsequent births. One woman commented when Holly stopped practicing, "I thought I'd die." Women find other midwives but often hold a sense of loss about not having the original midwife they "loved" or who was "the best fit." Midwives also see this sense of "a good fit" as important to their practices.

The emphasis on connection present in the midwifery model and the CAFs of the homebirth movement do have the potential to create stress and eventual burnout for midwives due to an unending level of care taking and responsibility. Benford found similar burnout in peace activists (1993). Today, a balance of friendship and professionalism between birthing women and midwives characterizes midwifery. Part of this balance is negotiating financial concerns.

Balancing Financial Concerns

Economics is a strong mitigating factor in the politics and choices surrounding homebirth. Financial payment for birth services is a difficult issue for both midwives and

clients. For some clients it can be the determining factor in their process of frame negotiation that may lead them toward or away from birthing at home. Table 9 provides a comparison of birth fees in different birth settings. The following birth fees averaged using 1999 numbers illustrate the dramatic differences in fees charged for maternity care.

Table 9 : Comparison of Birth Fees for Home, Birth Center and Hospital

<u>Homebirth</u>	<u>Birth Center</u>	<u>Hospital</u>	<u>Cesarean Section *</u>
\$2,300 - \$5,000	\$3,500 - \$8,300	\$4,300 - \$16,000	\$9,300 - \$26,000

*Includes a four-day hospital stay.”

Source: (O'Mara 2003b:322)

In 2006, 10 states (AK, AZ, CA, FL, NH, NM, RI, SC, VT, WA) provide some level of Medicaid reimbursement for direct-entry midwifery homebirth services (Midwives Alliance of North America 2006a). However, for most of the women in my study in Arizona, this was not the case at the time of their births. Medicaid involves a good deal of politics and a lot of paperwork, so even if DEMs can get reimbursement it may be logistically prohibitive. This limits the choices available to families who choose to birth at home. Some private insurance companies provide reimbursement for DEM services, but these are the exception not the rule.

Overall, the client pays for most homebirth services. This creates several issues: First clients who would like to birth at home and do not have insurance, or their insurance will not cover homebirth with a DEM, must pay for services out of pocket. This is often a considerable expense for most families. Second, women who would like to birth at home but do not feel they have the financial resources are forced to birth in a setting not in line

with their birthing philosophy, namely in hospitals. Third, some people who would like a hospital birth but do not feel they can afford it end up choosing homebirth since it can be a cheaper option (i.e. \$5,000 versus \$16,000). This last rationale has recently diminished due to Arizona's adoption of liberal new maternity guidelines for acceptance into the state Medicaid program, called AHCCCS; but was a strong factor in the 70s and 80s. Lastly, birth centers that receive more insurance and Medicaid reimbursement have gotten more clients who want a "home like" birth but with more financial coverage.

The respondents in my study who paid for homebirth out of pocket came to homebirth mostly from a strong ideological standpoint. For many, they had access to either state assistance (AHCCCS) or had private insurance that would have covered a hospital birth but not DEM homebirth services; but they chose to pay out of pocket for homebirth despite the financial burden. As Patty, who had her son in 1992, put it,

Well the thing is we could have, I mean with AHCCCS I could have been at the hospital for free. I mean that really was a reality. I could have, even though we didn't have health insurance. The state would have covered me and the baby for the birth, and so we basically had to borrow money....I mean, well, we really didn't want to be in the hospital.

Nicolle, who had her son at home in 1989, stated, "I had health insurance when I first got pregnant, and still that wasn't a factor (to not do a homebirth)." Her insurance would have provided coverage for a hospital birth, but not a homebirth, but this financial situation did not deter her from choosing her preferred homebirth choice. For some the choice is less clear-cut.

As Nancy Aton, a naturopath and homebirth midwife, stated,

I do think economics is a big factor. I think that it's a driving factor....I have the whole spectrum. I have delivered babies in little trailers to huge huge houses...and a lot of people have insurance, and they're still willing to pay for a homebirth...They step outside of their insurance.

One of Nancy's clients, who wanted a homebirth but had insurance, stated,

At that time I had another healthcare (plan), and I was like no, I can't ... they won't cover a naturopathic doctor and midwife, so I said, I'm going to go the other way, because that's the way my coverage is, and then it ended up where I got out of that coverage anyway. Great you lost your job, now we don't have insurance (laughing) Good! Now we can do what we wanted.

Midwives express great frustration about the inequality of reimbursement. Some respondents commented that because of the reimbursement structure today homebirth is primarily for the wealthy. Clients who do not have ample financial resources, but who are ideologically committed, work to find ways to pay for homebirth out of pocket, and for some this can be a very difficult financial choice, one which illustrates their true convictions.

For others their interest in homebirth is outweighed by their desire or need for financial coverage, and so they birth in hospitals or birth centers. Some of these individuals manage to have successful natural births in these settings, but others are often dissatisfied with their experiences. Amy, who later became a DEM, commented,

I knew I wanted it natural, and I knew I wanted to breastfeed. But I was afraid of doing it at home because it was my first time. Plus there was insurance coverage if I didn't do it at home, so that played into my decision...I'd thought about doing it at home up until the very last minute. But,, and there was no reason why I couldn't, but still I opted for the hospital cuz it was paid for. And being young and not knowing a lot about homebirth."

Amy is typical of the group for which midwives constantly grieve the disparity in coverage options for women--Those who want natural births at home but can't overcome the structural barriers such as insurance coverage. Several midwives commented that they thought their practices would grow if there were more equality in coverage. The Tucson

Birth Center in many ways benefited from this situation, despite the director's ideological support for homebirth as a viable option for birthing women. Several DEMs commented that they felt their practices took a dive when AHCCCS started covering hospital and birth center births, but not homebirth. Holly, a DEM commented, "I ended up charging \$950. And for some that was a lot of money.. when they could easily get AHCCCS or they already had insurance that would pay...so the Birth Center got a lot of clients." The Director of the Birth Center, Kathryn Shrag, reiterated this point,

I believe that birth happens best when a woman is in an environment that she feels comfortable in. And for some that's a tertiary care hospital. You know, and for some women it's her bedroom and her living room. And for those people who feel most safe and at ease in their home to leave it is not as good. So I think that's the compromise for some women. [The birth center] is an economic compromise...I think the birth center has hurt the homebirth practice in Tucson."

Kathryn's comment that "birth happens best when a woman is in an environment she feels comfortable in" applies in both directions. Economic compromises also apply to some couple's that choose homebirth.

Some expecting parents come to homebirth with no convictions other than the knowledge that homebirth is a cheaper option. After Arizona implemented liberal guidelines for maternity coverage for the state's Medicaid program, this "economic compromise" was lessened. However, previous to this occurrence, especially in the 80s midwives commented how difficult this economically motivated group was to work with. Many clients felt they were not getting the "highest" level of care, and had "a chip on their shoulder" about not being able to afford the "best obstetric care." Others were introduced to homebirth for economic reasons but quickly found the care preferable to standard obstetrical care.

For some clients their economic “compromise” works out well, and leads to ideological commitment to homebirth. Kathy, who had her children in 1993 and 1995, explained,

When I got pregnant, the first way we started looking at it [homebirth] was we had a pretty limited insurance and I know that having a birth in a hospital is very expensive, and so, that was one of the first things that you know was helpful for us was to know that it was an affordable option and a woman that I was working with at the time was also pregnant and had been seeing Nancy and she said, “why don’t you just go and meet with her and see what you think.” Nancy and I had a very good connection and I felt very confident in her abilities...And she won me over.

Kathy is a good example of economic motivations leading to ideological commitment; however, she is an exception according to many of the midwives. Unfortunately more often than not, according to homebirth midwives, those who come to homebirth as a “purely” economic choice often don’t “work out.”

A midwife commented,

The only people who were difficult were the people that only wanted to do homebirth because it was the cheapest option. And I did not have that same working relationship with them. Um, just ideologically we didn’t mesh...They want to be “delivered.” They want you to be in control, and they want you to make their decisions.. They’re not really in charge of their bodies in the same way....a lot of times I think that people would weed themselves out because they weren’t really committed.”

As Amy Zenzio, a currently practicing midwife, stated,

They don’t have insurance. It’s cheaper to have a homebirth and they don’t realize what they’re getting into, those people. And then, either they make it or break it,...they don’t realize that they have to do it without drugs or what doing it without drugs is like, and so if they’re willing to prepare and learn about it they usually are pretty successful, but if they really have it in the back of their mind that they’re forcing themselves to do this, but they really want drugs, that comes out at some point..

For homebirth midwives these clients are difficult since they are not always “ideologically congruent” with the midwifery model of care. These

“economic” clients are somewhat demoralizing to some midwives. Homebirth midwifery is a difficult occupation, and working with people who feel they aren’t getting the “best” can be disheartening. Midwives commented that sometimes that was worth it when they saw a woman empowered and educated through the homebirth process. For some women, like Kathy, coming to homebirth for financial reasons leads them to become ideologically committed once they are exposed to this option, while others are ideologically incongruent and often end up as transports or more challenging clients for midwives. These women are in sharp contrast to the women who initially participated in the emergence of the homebirth movement.

In the early days of midwifery, many of the groups who started doing homebirths were based in ideas of equal exchange bartering and communal living. For example at The Farm in Tennessee for the first twelve years of its existence the thousands of births that occurred there were as part of the communal living arrangement. This was also true for the Sufi community that Nasima Lomax led. In the early days the homebirths that Nasima and her early COFAM midwives attended were done in large part for barter or very little money. Lucy commented about her late 70’s births, “(for Leiba’s birth) Doug made a set of pottery for Sharon and George. (For Pel’s birth) I think we paid \$300.” This ethic of bartering was an important part of the social activism at the time, and for many midwives it was a difficult transition to start earning a living doing something that had relatively little value outside the networks that supported homebirth early on.

Many of the midwives in my study ended up leaving direct-entry midwifery because they couldn’t make enough money to support their families. As one busy full

time midwife put it, “I think the most I ever made was maybe take home 9 or 10 thousand dollars a year...its pitiful. You don’t put kids through college doing that...but I mean I just realized that economically this is insane. I cannot keep doing this.” Direct-entry midwifery fees vary greatly from state to state. Over thirty years my respondent’s fees varied from \$350 to \$3,000. This variability is explained by the evolution of midwifery, inflation, and changes in insurance coverage, as well as differences in state legal climates, and existing “bartering” communities. The consistent theme is that midwives are providing huge amounts of time and energy to patients with very little financial reimbursement. They provide approximately ten months of prenatal, labor, delivery, and postpartum care within these fees. This lack of financial reimbursement contributes to the low number of practicing DEMs. Despite the difficulties of practicing midwifery, DEMs and CNMs who practice at home provide care that is both safe and very satisfying to the mothers they serve (Johnson and Daviss 2005; Murphy and Fullerton 1998; Rooks 1997). Unfortunately, midwives are often treated as substandard caregivers who are endangering the lives of women and babies. This misunderstanding is a major hurdle for women to overcome in their frame negotiation process. Part of overcoming these hurdles is the core collective action frames of the movement that provide rationales and arguments for having a homebirth. These collective action frames are seen in the expressed motives of homebirthing families.

Chapter Ten has covered three aspects of frame negotiation: immediacy of decision-making, finding a practitioner, and financial concerns. These aspects all are part of women’s decision-making considerations regarding homebirth. I now turn to the next

major aspect of frame negotiations: vocabulary of motives. I will discuss women's espoused motives, rationales, and reasons for homebirthing.

CHAPTER ELEVEN: FRAME NEGOTIATIONS: VOCABULARY OF MOTIVES

Central to the decision-making processes inherent in frame negotiations are the women's motives or rationales for choosing a birth frame. Mills and Gerth (1953:129) present motives as, "social justifications for one's own conduct, and as a means of persuading others to accept and further one's conduct." These motives are often referred to as a "vocabulary of motives." The motives presented by homebirth advocates provide justifications for action, as well as, motivational collective action frames which are reflective of the women's interpretive schema. The women's espoused motives reference their personal experiences and their interpretations drawn from the holistic frame of birth presented in Figure #1. They include the "reasons" and "rationales" espoused by homebirth advocates, and the homebirth literature that was important during frame bridging. It also includes a balancing or negotiation process between the holistic and technocratic frames. The area where this is most evident is in negotiating the concept of "risk." In order to give birth outside the hospital, an individual must deemphasize the risks medicine and the majority of American society claims necessitate a hospitalized birth. The motives my respondents claim correspond with the information, statistics, rationales, narratives, and arguments provided in the majority of homebirth literature. See Table 8: Collective Action Frames in the Homebirth Movement on page 166 for details on these CAFs. Essentially these motives are the expression of these CAFs on the micro-level. The scope of the study sample also provides an understanding of the consistency and shifts in motives over thirty years. The central motives of homebirth have remained

remarkably consistent during this time. The central motives provided by my respondents center around five main ideas: 1) the sufficiency of the natural process, 2) the reciprocal and interrelated concepts of control, authority, and personal responsibility, 3) inclusion of a holistic family-centered approach to birth that included a sacred aspect of birth, 4) treatment of the infant in a gentle, peaceful respectful manner, 5) avoiding interventions, drugs, hospitals routines, and doctors.

Sufficiency of the Natural Process of Birth

The primary frame of homebirth is the belief in the sufficiency of the natural process. It is the underlying difference between the holistic model and the medical model. Midwifery education emphasizes the normal process of pregnancy and birth with an emphasis on knowing when to transfer care if complications arise. In comparison, obstetricians are specialists in the pathology of pregnancy and birth. Many argue (e.g. Goer 1999) that it doesn't make sense to have a surgeon managing women through normal healthy labors. This leads more and more to high-risk approaches being used on normal labors. The increased use of electric fetal monitors is a case in point. These began as useful tools in high-risk labors, but have come to be used in almost all hospital births with no proven demonstration of improved outcomes (Goer 1999). In countries such as Holland where midwives care for low-risk women at home and doctors care for women with serious complications or diseases in hospitals, great success has been achieved in infant and maternal mortality as well as low rates of interventions and cascading complications (Goer 1999). Homebirth literature heavily emphasizes the importance of

interfering as little as possible with the natural progression of labor and birth and seeing pregnancy and birth as states of healthiness not illness (e.g. Gaskin 2003). These motivation framings are a central call to arms to move normal birth from high-intervention hospitals to low-intervention homebirth. These collective action frames were developed over time both in the homebirth literature and in the lives of women themselves. For example in early works (Lang 1972) lived experience illustrated that birth without interventions was more pleasant and better. Later as the movement matured, “good” statistics (e.g. Goer 1995; Johnson and Daviss 2005; Mehl et al. 1977) were published to “back up” these embodied understandings.

For the women in my study, arguments in favor of allowing nature to take its course come from several knowledge sources: from published statistics that demonstrate better outcomes with fewer interventions (e.g. Goer 1995); from personal narratives; from the lifelong personal experiences of women that taught them to trust in their bodies; and lastly a generalized belief in nature and/or God.

Nature and God

The beliefs in nature and or God were foundational to the women’s world-views and lifestyle choices. For many, homebirth was a “natural” extension of beliefs in God, or of a commitment to living a healthier lifestyle such as vegetarianism. Nancy stated,

God made our bodies. There’s natural ways and there’s a reason for everything...a reason for the way our body responds and does things for us and to try to change it doesn’t seem wise to me...lets trust what God created before we trust what man created. God did things perfect. Man has flaws.

Chris also commented, “God made us to give birth just beautifully and wonderfully, and I really believe in that process very strongly. I was also a really healthy woman...I knew my body could do it well.” Many used “God” and “nature” interchangeably. I should note that the sample population ran the gamut of religious beliefs from atheists, to new age spiritualists, to fundamental Christians. Those who didn’t feel particularly “religious” primarily talked about the capacity of “nature,” but the underlying frame seemed the same: nature or God’s creation of nature is perfect and tinkering with the natural process causes problems, especially in normal birth.

A faith in the female body and the natural process underlies many of the statements made by my respondents. Sandy commented that, “The midwives wanted to be there to help in the way we wanted. They might of had a little doubt about us self-delivering [catching the baby ourselves], but they had a lot of faith in the ‘natural process’.” This belief in the natural process is seen in contrast to the attitude of hospital personnel. The women in my study were motivated to keep a sense of health and the capacity of nature at the forefront. Repeatedly I came across the phrase, “I’m not sick, I’m pregnant.” The women saw home as a place to keep birth healthy and as a part of their everyday lives. As Sandy explained,

I felt like it was much more safe to have a child at home than it was to have a child in the hospital...in all the studies that I read, the incidences of infection, the possible cesarean sections and everything, it goes up because of all the interventions. And my baby has my antibodies and my house is what I get them from, but to take them into a hospital situation, I don’t trust that to be clean...I mean I treasured those times of being in labor and of being at home and hearing my kids downstairs and knowing that my neighbors are outside and this is the process of life. I am not sick to give birth, it’s just a process of life.

Nicolle further makes this point,

It just felt like if I went in the hospital little things could become complications, and I just needed to be where, as long as everything was fine, then there was no reason. I wasn't sick. I'm pregnant! And I'm having a baby, and this is a normal everyday thing and there's no reason why I should be in a hospital when I'm fine.

This sense of healthiness of pregnancy and birth and its place in the "everyday lives" of women was reinforced by a second "common sense" argument that was repeated in the interviews.

Women commented repeatedly that millions of women have had babies for thousands of years and most of it without modern obstetrics so why couldn't they do it too? As Nancy stated, "I just felt intuitively that thousands, millions of women have done this before, I can do it. I felt if I needed to go to the hospital, I would. I just wanted a healthy baby. I trusted my body." And Trina stated, "The numbers were on my side" meaning millions of women had birthed at home and she thought she could also.

At the same time that my respondents clearly thought homebirth was the best choice, they also demonstrated a balanced attitude. Most held a deep appreciation of hospitals if they were needed, as shown in the above quotes with phrases such as, "as long as everything was fine" or "if I needed to go to the hospital, I would. I just wanted a healthy baby." Another woman who had had very traumatic experiences with hospitals in the past commented, "I told myself that if there's a dangerous situation and my son needs to go to the hospital, I need to go to the hospital, I'm going to do this, cause this is what this is good for. But I don't want a natural birth this way." Overall, they were happy that doctors and hospitals were there as backup, but felt that if all went well, birth was best accomplished in their own homes with knowledgeable attendants. They believed in the capacity of their bodies, and that nature and birth are better left to their own course. For

many of the respondents this was a strong motivational frame that had been confirmed through their frame foundations of personal experience and through learning and interacting through frame bridging.

Control, Authority, and Personal Responsibility

Control, authority, and personal responsibility are important interrelated motives for undertaking a homebirth. A desire for more control of the birthing experience was and is one of the most “resonant” motivational frames within the natural birth movements. This motivational frame is derived from both feminist and populist movements. This motivational frame has also encouraged women birthing in hospitals to take more control of their birth choices. Part of the motivational frame of control is a feeling of personal empowerment. This is the creation of an atmosphere where one feels capable of making decisions and is made to feel powerful and good about herself and her choices. Empowerment also entails that the woman’s decisions are authoritative. Her authority must count and be given legitimacy, and hence power, by those present at her birth. In the hospital technological and expert advice are generally valued more than the woman’s own inner knowledge. This takes away a degree of her authority, because it’s not valued. Freud and McGuire (1995:7) define control as, “the exercise of power in a particular situation. Like a sense of empowerment, control is related to one’s ability to manage one’s environment and feel safe and secure in it.” In the homebirth rhetoric, women seek out control so they are empowered to make decisions, be comfortable in their birth environments, and not be subject to institutional routines.

Authoritative knowledge is transferred to the woman in homebirth. Bridgette Jordon (1997:58) has defined authoritative knowledge as,

The knowledge that participants agree counts in a particular situation, that they see as consequential, on the basis of which they make decisions and provide justifications for courses of action. It is the knowledge that within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand .

The women in my study were able to create birth environments that legitimated embodied knowledge, respected a woman's intuitive knowledge of herself and the birth process, and considered this knowledge as authoritative. This is in contrast to the hospital where embodied knowledge was and is generally devalued and objective knowledge provided by technologies such as fetal heart monitors is given authority.

Nasima's experience in the hospital with her first child Abe is a perfect example of devaluing embodied knowledge as authoritative. Nasima tells the staff, "I really feel like I have to push.' They say 'oh no you couldn't be you're hours away yet.' She says, 'couldn't someone please check.' They say, 'Oh you know, you've not been in here long enough to be that far, you don't even know, you've never had a baby before how would you know how far along you are?'" When they finally check to take a fetal scalp sample, the baby was crowning. They refused to listen to Nasima's own embodied knowledge since her information didn't conform to the standard timetable for normal first labors. Chris, who had her three children at home in the 1980s, reiterated how her knowledge of her body was given legitimacy in her homebirths, versus a machine in a hospital birth.

I mean I felt like in control. I can't imagine. You must feel like you are out of control, cuz somebody's sitting there saying "OK, here it comes. Push! Telling you when to push cuz you can't tell [when you have an epidural]. I was telling people, 'here it comes!' and they were watching my belly it see it come. So the woman is much more in control. And I

think you feel so effective, I mean I knew I was pushing. I mean I was having my babies myself.

Moving birth to home, Nasima, Chris and the other women in my study ensured they would be listened to, their knowledge would be authoritative and given legitimacy.

The issue of control is complex and should be explained in greater detail. All women want control of their births and lives, but the kind and recipient of this control varies greatly. The majority of hospital birthers use technology, doctors, and interventions as a means of controlling a frightening biological process. Homebirthers, however, do not seek control over the physical process, which at home is allowed to proceed without technological interference, but control of the birth environment. The birthing woman has authority over who comes in and out of her home. They are her guests, not the other way around. She is able to choose to eat, drink, walk around, be intimately close with her partner, or do most anything else that makes her comfortable without breaking any institutional policies. As illustrated in Nasima's birth to Abe in the hospital, the breaking of policies tends to bring a sense of condemnation and anger from the hospital staff.

It should be noted here that non-homebirths might also seek out control of the birth environment as well. They may carefully choose their physician or the hospital where they give birth, and feel they are active in decisions and their births. But, in the homebirth literature and rhetoric, this is not seen as the norm. Within the diagnostic collective action frames, hospitals are seen as reducing personal decision-making, devaluing embodied knowledge, and imposing detrimental institutional constraints on the birthing woman. Homebirth literature strongly emphasizes the lack of control possible in the hospital. Some women may achieve a sense of control of their surroundings in the

hospital, but homebirthers don't see this control as sufficient. And the national statistics support this assertion. As of 2002, 93% of women had electronic fetal monitoring, 86% had IVS, 55% had their water broken artificially, 53% had oxytocin to strengthen contractions, 63% had epidurals for pain relief, and more than one-third of the labors were induced. All of this means that 75% of the women were restricted to bed and three out of four delivered their babies lying down on their backs (Declercq et al. 2002). There is also little evidence that most women have much control of whom on the staff, such as which nurses or other support staff, are present during their births.

In contrast to these statistics, women at home enjoy a freedom to do what makes them comfortable, which almost always also encourages dilation and pushing (Goer 1995). This involves walking, showering, eating and drinking in labor, using different upright positions, and various pushing positions. This also involves control of who is present and what their role is. These women also have greater control of how their baby is treated. For Kathy, having control of her environment was very important to her,

Nancy and I had many conversations about how I wanted it to be. We talked about who would be there, what their role would be. Um, and that if I had to go to the hospital, what her role as an advocate would be, so it was very well thought out in terms of how I envisioned my own experience and I think that if I had been in a hospital circumstance that that option would have been greatly reduced for me. My choices in terms of how I wanted my environment to be, the people around me, how I wanted my experience to be. That choice is removed. And that there's procedures for their own liability and their time concerns and their profitability that takes away from that.

Nicolle, who had her children in the 1990s, commented how important control and freedom were to her,

I wouldn't go in the hospital because it...that was one of my main reasons was I needed to be able to be in charge of this, and I needed to be able to say when I moved and how I moved and so that was what I really

liked...and it just felt like if I went to the hospital little things could become complications, and I just really needed to be where, as long as everything was fine then there was no reason. I wasn't sick. I'm pregnant!

Chris emphasized similar feelings,

I wanted to labor where I could move my body around and have my body work with nature to deliver and not have to be strapped down. I definitely didn't want a Doppler on all the time and to be monitored like that...I didn't want to put my self in that kind of situation.

Nasima was frustrated during her hospital birth when the hospital staff restricted her movements, "I wanted to get up and walk around, they didn't want me to get up off the bed. They wanted to shave me and do all the prepping, and just stay on the bed. Oh, it was just so frustrating. Very frustrating." During her subsequent births she was able to eat, drink, take a bath and do whatever made her feel at ease and comfortable.

Trina realized she would have little say in who was present at her birth and she experienced this as a feeling of disrespect, "I remember being examined at one point in time, and without asking me- you know I really wouldn't of cared if they had asked me- but without asking me they brought in a group of residents to observe...I thought it was unacceptable for them to bring in people without me giving permission." This treatment in the hospital during a prenatal visit added to her conviction that the hospital was a poor place to have a baby. Holly, who has worked with women both as a homebirth midwife and as an labor and delivery nurse, illustrated this point by explaining the difference in women's expressions of power in these different birth settings. She explained,

If you are at home, women want everybody to be quiet during their contractions. They don't realize for some reason here [the hospital] they don't realize that it's a distraction, and they don't ask them to be quiet...But typically at home if you talk during a contraction, 'shhh. Shut Up,' is what the woman will do.

From her experiences women at home clearly express their desires and feel a sense of control and authority in their birth environments. Homebirthers often recognize they want control of the situation, but that birth is unpredictable and can't be controlled. Lucy commented, "I liked being in control, out of control but as much in control as possible and being in tune with it (labor) and going with it. It was fun." Patty commented letting go and letting birth happen as an important part of learning from birth, "It was a turning point for me...it wasn't just my physical body, because my physical body was going to do it one way or the other, and that I just needed to be mentally prepared to let it all go, and to not get in the way." Kathy stated,

The ability to be in your own home, to have who want there. To make and be empowered in your choices. I mean women, a lot of women are all about being empowered in our culture right now and, hey, you want to be empowered, you have a homebirth. You get to choose what you are doing, how its going to be, what its going to look like.

Sue commented, "It was the woman's decision, I think that the biggest thing about doing a homebirth is realizing that you are empowering yourself to make decisions."

This motivational desire for control of the birth environment and avoidance of various interventions spans over thirty years. The women's quotes just used to illustrate these motives ranged from 1969 to the 1990s, but the rationale has stayed remarkably consistent over that time frame for homebirthers. Part of control is responsibility.

The emphasis on taking on personal responsibility is part of what makes homebirth a socially stigmatized choice. Rothman illustrated how women who follow a doctor's orders, even in the event of tragedy due to these orders (such as the problems caused by DES) are not held responsible. "None of these women are responsible, because they followed the doctors' orders. The moral was that the more control I gave

up, the more responsibility I gave up for the consequences, and the more socially acceptable my behavior would be” (Rothman 1982: 18). This is part of why defensive medicine is practiced. When responsibility is not held at the personal level, it is easier to expect perfection out of a profession that claims to hold all authoritative knowledge. If this authoritative knowledge fails, then the individual is more apt to blame the doctor. This is a repeating cycle that has exacerbated the use of technology in normal birth in an effort to prove that the doctor is “doing something.” The use of technology is also a means by which doctors protect themselves from lawsuits and demonstrate authoritative knowledge. In many ways these factors are taken as the norm in our society. For many women this loss of control is exactly what they are looking for.

As one midwife explained to me, many women seem to want birth to be “taken care of” for them. She stated,

You can control what your birth experience is like and let your body do its own thing...[versus] the epidural is not so much, your not in control, you're an absolutely numb body. Can't control your urinating, your defecating, your birthing, your body temperature, you can't control anything and people know that and say fine, just give me the baby at the end and make it so I don't have to hurt. Clean it up, package it. Make it look pretty...It's a loss of control for the women and a lot of people easily or really freely give that control up, you know, “do it for me so I don't have to work so hard or feel it so painfully.”

Many women, as Declercq et al (2002) research has demonstrated, have greater frame resonance with medically controlled birthing and demonstrate a better narrative fidelity with this model. This contrasting desire of many women to have birth “packaged” takes us to the next motive for birthing at home: valuing the process and the benefits of hard work.

“To Hike or Drive”

Another motivational frame is the importance of “going through the process of natural birth.” Natural birth is seen as less interfered with and easier to achieve in one’s own home. There is high value in the homebirth CAF rhetoric on the personal growth gained from this experience. This rhetoric has varying levels of resonance with women. Some expressed fear of the process and/or pain but still felt that natural birth was safer. Others highly valued both the pain and natural process as an important part of their personal development and growth as a woman and a parent. Most of the midwives noted that “birth is birth”, meaning that birth is a transformative moment in a woman’s life no matter how the birth happens. Beyond these caveats, however, most midwives and homebirthing women bemoan the lack of respect and desire expressed by most women and the medical establishment to going through the process of birthing naturally and the disregard for the benefits reaped by doing so. Many of my respondents commented on the importance of going through the experience of natural childbirth. They commented on how it was “empowering,” “strengthening,” and “important.” They were motivated to choose homebirth because it would facilitate a natural birth in a supportive environment. Books such as *Labor of Love* (Zimmer 1997) portray labor as running a marathon, hard to do but very rewarding in the end. Because epidurals and other pain medications are so ubiquitous and culturally acceptable, most women had to negotiate this motive for birthing at home and choosing to not have pain medication as a choice in birth. Some women planning homebirths were afraid of going through the experience of childbirth pain, but were motivated by other motivational frames to overcome this fear (such as avoiding drug effects on babies). Many of these women were rewarded with a sense of

accomplishment and empowerment by finding inner resources to deal with their labors.

As Betty, a homebirth midwife, explained,

If you can get through that without drugs, they feel like, "I did it! I did it!"
The ones that think that they can't do it, and then do it. Gives them that confidence. Cuz if you can do that, I think you can do anything!
Truly...Because.. that's you! And if you can go through that, come through that... and do it the way you wanted to do it, it's very empowering. I did it. I can do it.

Kathy stated,

It does take a certain mental attitude to overcome the physical pain of childbirth. And we live in a pretty spoiled world that, hey instant gratification...instant gratification, instant pain relief. Give me a pill, make my depression, make my pain, make my weight gain, make my water bloat, whatever, go away, as opposed to like really having to move through it. And so um that I think is something that needs to be overcome individually, maybe culturally, where homebirth is concerned, because it is definitely not a quick fix, I mean moving through the pain of childbirth is...is painful. And it's, I'll tell you, its very empowering.

Sue, who had her first homebirth in 1974, also felt homebirth was very empowering and strengthening.

Oh! It was such an act of will. Such an act of will.... even now I mean just fills me with emotion. I can't tell you how strengthening it is. The whole process of carrying a child, of birthing a child, and carrying them thru infancy is one that just builds so much strength on all levels: spiritual, mental, and physical....I mean I was so centered on the birth, and it was truly a beautiful experience. And I loved the little bit of footage I saw of the ecstasy on my face. There's nothing like it. You just... there is no other experience in a woman's life like birth.

Kathryn Shrag, director of the Birth Center, who does childbirth education talks about

this issue in her childbirth education classes, explains:

Educating them about the medical consequences (of epidurals and other interventions) isn't too difficult. It's harder to talk about the "what it does to your soul," ...what you're missing by not engaging in this life experience. What are really the long-term implications for someone who, who misses that opportunity to suffer a little bit, to endure, to learn what deep inside, what skills, what coping skills you have. To escape that, to be

so fearful not to even go there. You know, I wonder what happens next time it gets hard in life, because it does get hard. And if it doesn't get hard for you, your kids will make it hard for you..... You know, one of the analogies that is sometimes used at class is backpacking, and if you backpack to the top of the mountain, it also has another road to it, to the top. You get to the same place, and it is just as beautiful and just as inspiring and awesome and all that stuff. But it's a very different experience, you know. And there are times when I backpack that I wonder, why the hell am I doing this? This is my vacation! You know, I could be on the beach having a margarita, but there's something about being out there, experiencing it, pushing yourself, you know, and that makes it feel different when you get to the top than if you had got in the car and drove to the same place...Part of it is that it robs the woman of an opportunity to experience one of the most profound experiences of her life, or a pathway to one of the most profound experiences....And it gives the women the message that they can't trust themselves and they can't do it. That is terrible...and you've got to keep that baby in there 48 hours because something terrible might happen. And then they're supposed to go home confident.

Those who birth at home know they are choosing to go through the process of birth without anesthesia. They know it will be painful, but believe there are physiological, spiritual, and emotional benefits to experiencing birth pain. This is a subject that many respondents talked about but which many felt was one of the hardest motives to explain to others. This was also part of a general criticism of society.

They were critical of the mainstream society's preference for drugs, technology, and the deceptively "easier" way out of major life events. Damiana, a homebirth midwife turned labor and delivery nurse, commented,

I think people are really afraid of pain. I don't feel like society realizes the value of pain. Pain and hard work...my thing was always comparing it to... having hiked really high mountains and gone through days of carrying sixty pounds on my back, and getting to the top, and just seeing a view that I would never have been able to see, and having all that adrenaline, and working to get somewhere I wanted to be.

Another midwife also commented about epidurals.

Oh, it's fashionable and it's the easy way out, which is what the American culture is all about, and it's the "do it for me. Let me just kind of be back there while something is done to me and hand me the baby." I've been kind of cynical about that. I think our culture's pretty messed up and you know why? Cuz its there, cuz its new fangled, its technological, its, my insurance will pay for it, so give me one and I'm entitled to one. So its, ya, it's a lot of people don't want to experience a lot of things about life, including their births. Birth is messy and, you know, its smelly and loud, and just clean it up for me...you know, do it for me so I don't have to work so hard or feel it so painfully.

Many natural birth advocates feel high-tech birth does not send the same messages as un-medicated, undisturbed birth. In line with the medical model, as discussed in Chapter Four, women internalize messages that tell them that their bodies are defective and need help, that they and/ or their babies may die without medical intervention, and that the pain of labor should be avoided.

This issue of not truncating the birth experience with anesthesia is a divisive issue. "Birth is Birth" as one midwife, reminded me; it's a transformative experience no matter how the birth occurs, a baby is miraculous no matter how it enters the world. However, the feelings women internalize about their bodies and their capabilities tend to differ based on their birthing experiences. Their choices regarding birth practitioners, birth setting, and interventions also vary greatly based on the birth model they espouse. For many mainstream women the idea of not having a hospital and pain relief seems ludicrous. As one woman stated in Armstrong and Feldman (1990:225),

When friends assured me that I could take it [drugless birth]. I countered by asking Why should I? After all, Americans on the whole embrace the notion of pain relief- our burgeoning over-the-counter and prescription drug market attests to that... Childbirth, I pointed out, involved severe, prolonged pain.

This question of why should women “endure” the natural pain of labor is a hot topic that is often divisive. What’s interesting about this debate is that considerable evidence exists showing that all interventions add to the risks to mother and baby, and common interventions such as painkillers have neurological suppressing effects adding to behavioral and breathing abnormalities in newborns (Buckley 2002a)(see also Chapter for more citations on intervention risks). In the research conducted by Armstrong and Feldman (1990), they found women understood this but remained so fearful of going through labor pain that these risk concerns were offset. This appears to be the norm for women today. In ground breaking research conducted by MaternityWise, the first national survey of women’s birth experiences found that epidurals are very popular, but many women are unclear of the potential dangers.

Almost two-thirds of the mothers used epidural analgesia, including 59% who had a vaginal birth. Mothers gave high ratings to the ability of epidurals to relieve labor pain, but between 26% and 41% of mothers were unable to respond to questions about side effects associated with epidurals (Declercq et al. 2002).

Evidence has existed for some time (e.g. Kitzinger 1972; Odent 1984; Stewart and Stewart 1977a), on the dangers of interventions and the advantages of natural undisturbed, unmedicated birth. Several of my respondents felt better education would help more women to choose to go drug free, particularly that childbirth pain is different than other kinds of pain; it has hormonal rewards (endorphin release), it helps to facilitate labor, it stops after birth, it has breaks between contractions, and it has a purpose. Kathy commented,

I think a lot of women are afraid of the pain and there needs to be some education about that. The thing about pain of childbirth that so impressed me was, ya, it hurts, but there are a lot of good things that come from that and it stops as soon as the baby is born. It’s not like when you break your

leg and the pain is just indefinite. You know that that baby comes out and its like yahoe I'm fine now

Barbara, a CNM, stated,

If you don't think in terms of always of anesthesia as a way out, you think you can take the pain because that's what you were built and made to do and this is how we have babies and, you tell them the same thing. I believe that you can to anything in a short period of time if you know there's an end to it. While your in it, you can't believe that it will ever end. You just feel like you are trapped, but you know that if you keep reassuring people in labor, "it's just a little bit longer, this is where you are in labor, soon you'll be pushing, soon it will be over. Soon it will end." You can get people through it step by step

Understanding the value of birth pain and the hormonal blueprint that helps to birth a baby naturally is also an important part of this education. Buckley (2002b) has demonstrated how the hormonal coordination in a natural labor produces high levels of endorphins and produces a birth high. She also demonstrated how hormones that are released in an unmedicated labor function to keep labor progressing and reduce the chances of hemorrhage. This is a clearly understood complication of epidurals that often leads to the use of pitocin, fetal heart monitors and instrument delivery. Several women commented on how much energy they had after their homebirths. In contrast, women who receive anesthesia often fall asleep after birth. Several of the homebirth midwives turned L&D nurses commented on how women are robbed of this natural high when they use epidurals to deal with birth pain. Another advantage to not using medication is the possible effects on the babies. A natural birth has lower risks for the child. Many of my respondents found keeping interventions away from their babies a motivating reason to have a homebirth.

“I Want My Baby Treated Better”

The women in my study clearly define the ability to make decisions as central to their decision to have a homebirth. This included the ability to control who was present, what they ate or drank, what position they labored and delivered in, and what happened to their child once they were born. For many, the ability to have their child come into the world in a peaceful, quiet way, without the standard hospital routines was central to their decision to birth at home. This motive was as strong for the early 1970s homebirthers as it was for the women in 2001. Lucy recalled, “It fit totally into my life...Doug was so happy not to have anybody interfering with that very special event. Nobody was coming and taking the baby away and doing things. She’s all ours.” Sue emphasized protecting their child as even more important than the experience as a couple, which had started to improve in 1974,

[in the early 1970s] the husband could even go into the delivery room, you might even find an occasional doctor that would let them dress up and cut the umbilical cord. But it was all focused on liberalizing the experience as a couple at birth. And there’s still this cliff. The minute the baby is born it was the hospital’s...without getting really aggressive....you didn’t really have any control. I mean they could flat out just take the infant away from you, put drops in their eyes, which again from studying texts I knew was a reaction to disease conditions that flat out didn’t exist in my life and I didn’t want my infant in a situation where that even had to be called into question...I didn’t want you to have any injections right after you were born. I didn’t want people probing you... [we] didn’t want our child born that way.

She wanted to avoid the standard treatment of infants in the hospital, which she saw as inappropriate. Subahana also saw the hospital as not only restricting her choices, but hard on her baby. She described what she thought the hospital would have been like.

It would of been under bright lights. I wouldn’t of had personal freedom. People would of been doing things to me that I wouldn’t want them to do

that were invasive. Which wasn't as bad as the thought of the things happening to the baby like drawing blood and you know putting them in incubators and doing all the things they do...so hospital birthing seemed just so dreadful to me. You know, it was violent and not respectful.

Just as the homebirth mothers had birthed at home to avoid excessive medical interventions for themselves, they hoped birthing at home would also limit the procedures they felt were inappropriate for their babies as well.

Specifically the way babies were handled and the environment they first entered into at birth was also important to most of the homebirth moms. Chris stated, "we wanted to bring our baby into the world in a peaceful, personal, quiet situation." Alicia stated, "The most important reason for me to have had a homebirth is that I wanted my baby to come into the world in as peaceful and loving way as possible...I believe in soft lighting and soft voices and everything should be hushed around the baby." Sara emphasized the way her children were handled at home,

You saw [on the video] how tenderly he was cleaned up and how gently my kids were handled and by people who loved them. There's a big difference in the conscientiousness. There's a big difference in the way people are when they love you versus they're just doing their job. My children were loved when they came out. They were handled well. That's important to me.

One last motivation linked to how babies were treated at home was the desire to optimize bonding and the lifelong benefit to this early time together. Almost all the mothers talked about wanting the baby put right on their chests, nursing immediately, having the newborn exam done in their arms or close by, and they also emphasized having the baby with them at all times. They felt all these points were important to bonding with their children in the best way possible. Several midwives also talked about encouraging women to reach down and pull their baby out and onto themselves, and

encouraging parents to discover the sex of the baby on their own time. This was done as a way of encouraging parental empowerment, confidence, and attachment to the child. Susan, a homebirth midwife and L&D nurse, stated, “The first hands on a baby should be the mother’s. I always encouraged them to pull them out and onto their chests. It was really empowering for most of them.” Many parents and midwives expressed opinions that related problems in society (ie. child abuse, violence, drugs) to the lack of deep bonding experienced by most Americans at the time of birth. Nicolle explained it in this way,

I think that [homebirth] base really helps make being a parent much easier. You've bonded with your child. You have a very intimate relationship with them, and I think sometimes more intimate than someone who's not as attached to their child, having a hospital birth and having the baby taken away for 4 or 5 hours, those are your prime bonding time.. I think you lose a little, lose a little bit of the relationship. [Its an] analogy into the way society's going today? How many kids are miserable, and committing crimes, and all of this. I think homebirthing really, if you can do it, if it's medically OK (laughs), if it's a normal birth and a normal pregnancy, I think it's much more of a benefit to you, your family, and your child in the long run.

This attitude has been reflected in the writing of several authors who have presented studies on the link between bonding and social consequences (e.g. Arms 1975; 1996; Lang 1972; Stewart and Stewart 1977a).

The motivational frame of having a homebirth in order to insure the treatment of their infant in a loving, low interventionist, peaceful way was an important motivation to many respondents. Part of creating a loving environment for a baby to be born into is creating a birth that is family-focused.

Family-Centered and Sacred Birth

The ability to have loved ones present is another motive for having a homebirth stated by my respondents. Even though today, the presence of fathers and a few other loved ones is common compared to thirty years ago, a homebirth still allows a birth to occur in a family setting, not a medical setting. It also more readily allows children to be part of the birth experience. This family setting, which is full of welcoming love for this new child, also encourages feelings of a sacred component of birth. Many midwives and mothers commented on the feeling of spirit present in the room during homebirths.

For the early homebirthers in the 1970s, the presence of fathers in the delivery room was still fairly new. This desire to be together without restriction was a motivating rationale for some of the early couples in my sample. For example, Daniel was separated from Nasima in her hospital birth in 1969. In comparison, when she had her second child at home she had her husband, her mother, and her son present. After Trina's birth to her second daughter, her husband, her daughter and she all climbed into bed together and slept. Sue allowed her older daughter to do what suited her; to come and go and be present at the birth. Her husband and her daughter brought mint water to her while she was in labor, giving her daughter a way to assist her mom. Susan stated that she was always very focused on the family aspect of homebirths,

The most important thing for me was that the family share this experience, not that I did. And I always... I used to say that they're the stars. This birth is starring this woman, this man, this baby. It's co-starring her sister that was there or her mom that was there. And then my role was midwife #1, midwife #2. I wasn't a star. I wasn't a co-star. The most important thing was that the family came together and was stronger because of this birth. And that's how I operated. And my favorite births were the ones where I left, and the whole family was in bed together, and they were all tucked in. If there were other kids, and they were sleeping, and I would let myself

out the door... For me the most important thing was that the woman came through thinking that she'd done a really good job, that the husband felt like he had really helped her, and that he was really impressed with what a good job she'd done, and that the baby was treated really gently.

A common stated advantage to this “family- oriented” birth is a perceived reduction in family conflict over the new child. In an Arizona Daily Star article published in April 1978 (Stengel D-1), a homebirth mother was quoted as saying,

The other children have a very good feeling toward the baby. They really like the new addition to their family. There are no negative feelings about the baby, like I left them and came back with this new person. Elijah was really good to me. He didn't climb on me and was always gentle with me because he'd seen what I did to have a baby.

Both Sandy and Nancy emphasized the way the baby was welcomed into the family by all the older children and family members, who would help dress and bathe the baby the first time and gently greet their new family member. Sandy recalled, “a wonderful experience... my daughter who at the time was close to three came in right afterwards and she helped dress [the baby] and she was with Kathy in the bed...[and] my mother coming in and my mom always dressed my babies first and helped the other kids do that.” Sandy, as well as several other mothers, mentioned how much they felt sibling involvement helped alleviate sibling rivalry after the homebirth.

I do much better if I'm in my own atmosphere and I think that my kids accepting my other children, yes my three girls cried and they really didn't want a boy, but he was theirs and they were very proud of him and they dressed him and they washed his feet and it was the same thing as with all the other ones. I think its because its a celebration and they are not taken out of someplace where they could feel comfortable to participate in that

Midwives also mentioned how much they often enjoyed the presence of children, especially preteen girls at homebirths. They felt this was very important, but a rare opportunity for young women to see a woman's body work well. Amy shared the

following, “I love it when children are there, especially girl children to watch. And I think that sometimes I find the look on their face when they see their sibling come into the world is just one of the most delightful things I've ever seen in my life.”

Sharon emphasized the importance of family to the birthing process. When her daughter, Anna, had her homebirth in 1998, their family created a protective circle around Anna. Her son was born into a world of love. Sharon, who works as a CNM, emphasized to me that whether a woman births at home or in the hospital that it is so important that practitioners appreciate what a life-altering experience birth is for couples, children, and whole families. That maternity care must shift toward even greater levels of being “family-friendly.” And overall, hospitals have made some improvements such as sometimes allowing siblings to be present, allowing more family members to be involved, and more rooming-in with infants; but not to the extent desired by the homebirth movement. Since at home, birth is more readily seen as a family-oriented event, versus a medical event, many felt birth at home allowed for a greater amount of spirituality to enter into the moments around delivery.

Almost all the women and midwives mentioned how sacred the moment of birth is. Most felt an overwhelming sense of joy and spiritual light at most homebirths. Amy, a homebirth midwife, commented,

[Birth is] absolutely life-changing. I mean it is. It changes everybody's life involved, including the doctor or the midwife, and so it's just the most powerful wonderful thing I've ever been involved with. I see a lot of light in it. A lot of spirit that is just... it's still unknown, how big it is. We can't describe it. We can't imagine it. We cannot put it into words. It's so big, and so powerful. I'm just honored to be a part of it.

Chris also emphasized this point,

There was a whole picture there to know that there was a gift, and it was a very special thing, and you weren't doing it by yourself, but with higher powers, too, so...that was there for both of us.... Everybody, yeah. My mom, too, the woman who babysat for me, she was a real Christian...Tell ya, there's just a sense of God being there with us to do that too. To know that we were safe, and if something went askew, we were still in that, within that spiritual energy and space...you had to trust in that....

Most of the women and midwives acknowledged that birth is a moment of crossing from the spirit plane to the earthly plane of existence for souls. That awareness is more present at home and much more attended to. Several of the women mentioned that birth and death are very similar and as such are filled with a spiritual component. One midwife confided that she saw angels or spirit guides at births. She stated,

there's a lot more going on than this plane...it's like the door opens to the other side, and a spirit comes in, a soul comes in. It's very similar to death when the door opens to the other side and a soul leaves. And there's very definitely angels and beings that go to births. There were definitely helpers that came. And I was forever grateful for that.

I inquired whether she also saw guides when she worked at the hospital and she responded that it was very rare. Another midwife, Damiana, also contrasted her experience at home and hospital in regards to this sacred aspect of birth. She stated,

It was always just such an amazing thing to be with somebody doing [a homebirth]. It was just so incredibly special. I don't feel that at all in the hospital. At all. Because there they don't feel like that...it's just totally different. Never do they see it that way. I mean it's... (sighs) ... You know what was really strange? When I first started working, I was the only one in the room that was crying when the baby was born... I mean that was always what would happen at home. It was just like such a release, it was just so much joy. Now, I was the one that was crying. And then, it got to the point where I started feeling a little strange. It was like Holly and I both, we would feel like, "Where is the joy?" Not there. It's just not there. You know why? Because it's the same thing as having to have, having to work, and sweat, and feel pain, and all that, and it's just like... it's so primal.

Klassen (2001) has provided a detailed thesis on the spiritual aspects of homebirth and has emphasized spirituality as an important component of homebirthing. Some homebirthers choose to further this spiritual component of birth with rituals, special prayers, or religious practitioners. Devout Christians may have a small prayer group present or special passages they want read. Others created their own rituals. Alicia described one such experience at a friend's homebirth in the late 1990s.

It was incredible, incredible experience and I had learned from friends who had another friend who had had a homebirth and she had... eleven of her women friends there and they had planned like rituals and stuff. They were singing, they were going to sing this song when the baby was born, and its just this incredibly beautiful, beautiful song, I learned it at my friends birth when Emma was born. [At the birth] they asked me to hold the baby. And I just held the baby and rocked her and sang her the song, and I just felt like one of those fairy godmothers...It was just an incredibly spiritual experience, to be a part of it.

Homebirth advocates acknowledge that in the hospital people still pray, and thank God, and feel a sense of spirit, and some childbirth advocates such as Pam England (1998) encourage families to emphasize faith in the hospital. However, homebirth practitioners often explain that these spiritual sentiments are more rare in the hospital and are often easier to feel at home. Women and families are on their own "turf" and they feel free to express themselves. Midwives at home are often sensitive to the sacred aspects of a soul entering the human plane, which is often not attended to in a medical setting. The early homebirth literature such as *Spiritual Midwifery* (1977) gave more emphasis to this sacred aspect of birth than do most of the more recent publication which tend to focus more on safety, and statistics for avoiding common interventions. There's good reason for this shift in framing given that many dismiss the "niceties" of homebirth. Critics have counter-framed the issue of homebirth as a dichotomy between "niceness" and "safety."

To counter these framings it's been critical for the movement to demonstrate safety and produce statistics to support noninterventionist homebirth maternity care. These rationales provide the strongest support, and were focused on to a large degree by my respondents.

Avoiding Interventions, Drugs, Hospitals and Doctors

A strong motive espoused by homebirthers is the desire to avoid interventions, drugs, hospitals, and doctors for normal birth. These motives are part of the larger collective action frame of the homebirth movement that sees normal birth as safer when it is not interfered with and allowed to occur naturally. For many women there is also a feeling of distrust and fear of hospitals and doctors. Personal interaction, frame bridging of information, and personal experience reinforced the desire to remove hospitals and doctors from the birth experience. Much of this experience was discussed in the Frame Foundations chapter.

For many, staying home was and is a means to accomplishing a drug-free natural birth or a birth without interventions such as pitocin, epidurals, EFM, or cesarean section. At home women work with a “different tool kit,” such as position changes, hydrotherapy, or vocalizing. In the hospital it is often “easier” or “faster” to reach for a drug than it is to try different non-drug alternatives. This is due to medical culture, stretched nursing resources, and patient expectations. Midwives explained that this “restriction” of tools available at home makes homebirth safer. Sharon stated, “It's just appropriate use, I think one of the blessings of homebirths is that you can't... you don't have things to use to

misuse at home...I mean you're depending on it being natural.” Another homebirth mom stated, “I didn’t want it [drugs] to be down the hall. I knew I could do it without drugs, but I didn’t want it around so if in the thick of it I felt weak...it wouldn’t be an option.”

The first national study on women’s birth experiences conducted by The Maternity Center (Declercq et al. 2002), found that virtually all women giving birth in a hospital setting will experience at least one intervention ranging from IVs to c-sections. This current research illustrates the pervasiveness of interventions in American birthing. The Maternity Center Study found that technology-intensive labor was the norm, “A majority of women reported having each of the following interventions while giving birth: electronic fetal monitoring (93%), intravenous drip (86%), epidural analgesia (63%), artificially ruptured membranes (55%), artificial oxytocin to strengthen contractions (53%), bladder catheter (52%), and stitching to repair an episiotomy or a tear (52%)”(Declercq et al. 2002:1). As Declercq (2002) has demonstrated, it is very difficult to have a birth without interventions in a hospital setting, which helps explain why homebirthers choose to go “all the way” to having a homebirth to avoid the medical model of interventions and the dangers of these interventions that have been well documented in the literature.

Homebirth literature details the dangers of drugs and intervention from the early publications (e.g. Cohen and Estner 1983; Karmel 1965; Kitzinger 1972; Lang 1972; NAPSAC 1979a, b, c; Rothman 1983a; Stewart and Stewart 1977a; Wertz and Wertz 1989) to the most recent (e.g. Arms 1996; Gaskin 2003; Goer 1999; O'Mara 2003b[Johnson, 2005 #292]). Many of the early homebirth pioneers came of age at the height of “drugged” birth and the counter framing efforts of the emerging natural birth

movement. Their radical choices to birth at home were built to a large degree on the framings of the natural birth movement. Both in the 1970s and in the 2000s birth at home is an effective way to avoid standard hospital routines and common interventions. This was repeated clearly in the motivational rationales expressed by my respondents. One hot button issue was the liberal use of painkillers, sedatives, and epidurals in birth.

Patty had to work through her fears of labor pain and whether she could “do” it; but her desire to birth in a “better way” over came that fear. When she went on the hospital tour, this was her impression,

Lots of machines, lots of people, lots of, kind of, I felt that there was a detachment between the people who were working with the women who were pregnant and the pregnant women. Felt like there was kind of this, this separation, and...um, I just kind of got the sense that I was going to be monitored more by machines than by people. That was my sense, and when I went there, that’s pretty much what I saw and what I told myself was that if there’s a dangerous situation and my son needs to go to the hospital, I need to go to the hospital, I’m going to do this, cause this is what this is good for. But I don’t want a natural birth this way.

This experience was important to her frame negotiation process. It further cemented her resolve to have a homebirth despite her fears. A desire to avoid hospital routines was also part of Chris’s negotiation process. Chris didn’t want to be restricted by hospital policies,

I wanted to labor where I could move my body around and have my body work with nature to deliver and not have to be strapped down. I definitely didn’t want a Doppler on all the time and to be monitored like that. I definitely didn’t want any um forceps or any suction... so I didn’t want to put myself in that kind of a situation. I think we felt like the labor would go so much better if we were just in our own surroundings...

Many of the practitioners who had worked both at home and in the hospital were the most vocal about the effects of interventions. Their experiences provided them with insight into both birth environments and the kinds of things that occurred in both environments.

Susan especially disliked epidurals and all the interventions they bring. She made the following comment about epidurals,

I mean epidurals are a wonderful tool, but for a normal woman having a normal delivery, it's wrong. I saw women come up to the hospital these perfect homebirth candidates. I mean I could just see these women having their babies at home. They were young. They were healthy. They had a great body for having babies. Their pregnancy had gone great. They had a baby already, just popped out. And there they are. And they want an epidural. And this one woman I think of... you know he gave her an epidural. The level went too high. She went into respiratory arrest. The baby went into severe distress. It became a crisis. It became an absolute crisis. Why? For a little pain?

Holly also disliked a lot of the effects of interventions she saw in the hospital. She stated,

because I came from homebirth to the hospital, and I see that a lot of those problems were created because of the hospital, that the babies dropping their heart rates, that the blood pressure going down, that the fundus not being able to contract, those are all hospital things usually. And that the baby came in great, and as we progress in this labor doing more and more and more, it didn't look so great by the end. If you saw that at home you'd be really worried...

Damiana has a similar feeling about standard hospital culture and finds the opportunity to express this to the doctors she works with as an L&D nurse. She stated, "You know I still feel like all this intervention really causes so many problems. And that's when I like get that little smile on my face. I'll look at the doctor, and I'll go, 'How come that's never happened at home?' She related that they respond 'because they're not being natural,'" she thinks doctors do not feel ethically challenged by what they see, but she is. Patty, who had a homebirth and works as a doula, also shared her frustrations,

I think the C-section rate is just outrageous. I'm amazed at how many C-sections happen for failure to progress...because a woman's on her back for hours and hours and isn't able to move because she's hooked to a monitor and blah blah blah . Or her uterus is tired because she's gotten too much Pitocin blah blah blah . It just ... oh boy..

Another homebirth midwife detailed the problems with medical culture and why epidurals are such a problem. She is discussing when she worked in the hospital in the early 1990s.

They still are operating on it's a medical emergency. Anything can go wrong to anyone at any time. And ... the pain is unbearable. It cannot be borne, and it shouldn't be borne. And now... at that time, epidurals were the thing. And... I mean 99% of the women got an epidural. And I hated that. I hated that. I hated it. I hated it. The moment the anesthesiologist came in to do that epidural, to me it wasn't childbirth any more. It was... a medical procedure. Because then it's like all of these problems can happen then. All these... they can't pee anymore. You gotta cath 'em...They can't push. Gotta use vacuum and forceps. Their blood pressure bottoms out. You gotta like pour in fluids and drugs and... ach! You know, the babies go flat from it. It just... oh man I hated epidurals. I hated those. And I don't believe that they do not damage the babies. I don't believe it. I think we're gonna see the damage, if we're not seeing it already.

Betty, a currently practicing homebirth midwife, has been confronted by hospital people who react as though she has been torturing women at home without pain medication.

Betty recalled this interaction:

They are like 'why are you torturing this woman.' I have very few women that at home that ever even ask me for pain medication.' And I tell them that, and that's true. They said, 'Oh, they don't feel it?' I said, 'Yeah, they do, but,' I said, 'there's other things to do for pain than drugs.' We are a drug society.

The assertion that interventions cause problems has been well documented in the homebirth literature, and personal experiences of practitioners and women have reinforced this perspective; however, this belief is held by a minority of the American population. Most Americans live with technology, trust it, and love it, as one respondent stated we are "daughters of cell phones and microwaves." The problem is that technology causes more problems in birth than we often realize (Gaskin 2003). As the research by Declercq (2002) has demonstrated, almost no one in the hospital avoids interventions

completely. The majority of the population sees interventions such as IVs, electronic monitoring, and pain medication as helpful and/or necessary to make birth safe despite ample research to the contrary. This widely held belief makes people question the safety of homebirth. Homebirthers almost universally have to deal with concerns of others regarding their birth choices. This takes us to the next major section in the frame negotiation process that of negotiating risk.

CHAPTER TWELVE: FRAME NEGOTIATIONS-WHAT IF?: RENEGOTIATING FEAR AND RISK

The most common question of anyone who is naïve or critical of homebirth is “what if something goes terribly wrong?” This question typifies the way the medical model dominates our cultural thinking about birth and how successfully the issue has been counter framed by ACOG and the medical community, thus imbuing our thinking with fear and doubt in the natural process and women’s bodies. Socially, we seldom hear someone saying, well “what if the epidural paralyzes you for the rest of your life?” (which is a rare complication of the procedure) or, “what if it gives you a splitting ‘epidural headache’ for days?” (a more common side effect). Additionally most complications that arise during homebirths are either known about ahead of time (e.g. breech births), develop with time to transport (e.g. prolonged labor), or can be handled by a competent midwife (e.g. shoulder dystocia). The media-induced idea of a baby’s heart rate plummeting out of nowhere and rushing the mom into the OR for an emergency cesarean section to save the baby is mostly a myth, as this is really quite rare. Most complications develop slowly, and are predominantly associated with cascading interventions. But this myth is still commonly believed and deeply affects women’s birth choices. A lot of the bad birth stories you hear passed around illustrate our social fears, but when examined deeper illustrate the dangers of interventions. Rothman (1983a:14-15) discussing this issue of “what if” illustrates this point with the following story,

Some women told me how they, or mother or aunt or friend, would have died if she hadn’t been in a hospital. When asked why, it always turns out not to be so simple...[a friend] told me that her mother would have died

without emergency care. Why? The hospital had given her the wrong drug and if she hadn't been in a hospital they couldn't have corrected the error!

Many women choose to remove the hospital from their births with the very intention of trying to avoid such mistakes, but for the general population hospitals are seen as the "safest places" to give birth "in case anything goes wrong."

Fear and risk of childbirth are not completely unwarranted. Mothers and babies do die. If a problem develops, the advances of Western medicine are a god-send, but from the point of view of the holistic model, the constant state of fear produces problems. As presented in Table 1, the holistic model sees the majority of pregnancies as healthy and normal and not in need of medical assistance. From this perspective, a normal birth needs constant emotional support and an assistant with the knowledge to know when more help might be needed but who spends most of her time "sitting on her hands." A "good" midwife often does very little to interfere in the natural process of birth. In the hospital risk is emphasized, in the home it is de-emphasized. The belief in the natural process is given greater importance than is the sense of something might go wrong at any time. Arms (1996) has pointed out that today's approach to childbirth is an extension of 19th century city culture. This culture saw women as too fragile, and birth too risky and painful to be allowed to proceed on its own. Underlying this idea is the belief in the inadequacy of women. She comments,

Fear is an intrinsic part of humans' existence and is vital to our survival, catalyzing us into action in our own defense. But the fear that is unhelpful and that inhibits the birth process is the kind that so many childbearing women and health workers today possess: the ever present expectation of something going wrong. There must be a dynamic balance between trust and fear if we are to live with an appropriate sense of awe and reverence for those forces beyond our control (Arms 1996:117).

This sense of impending doom that is inherent in the medical system is largely responsible for why 99% of births go to the hospital “just in case something should go wrong” (Davis-Floyd 1992:177). With this ever-present sense of fear I wondered how the women who chose homebirth were able to overcome this cultural emphasis on risk. They described a process of frame alignment that brought them to a place of confidence regarding their choices. Through their frame foundations, their experience and interpretive work of frame bridging, and the solidification of their motives in frame negotiation, they came to a place of belief in homebirth. This belief offset the social fears that say homebirth isn’t safe. It often got to the point where they were considerably more afraid of the hospital than they were of homebirthing. I will further describe how they dealt with their own fear in the up-coming section, but first I’ll discuss how women dealt with the fears of others. I asked them if they felt supported in their choices to birth at home and how others around them felt about their birthing choices. Most shared that they had parents or friends who were actively worried about their choices to birth at home.

Negotiating the Fears of Family and Friends

“What if something goes wrong?” This is the question that most women who choose to birth at home are often asked. Family and friends are often particularly worried. No one can ever know exactly how birth will occur in any setting, but for all the reasons listed in the motives section of this chapter, the women in my sample found their way to deciding that birthing at home was safer and better for themselves, their babies,

and their families. Part of that process of frame negotiation was dealing with the fears of family and friends.

Families and friends expressed concerns about the birth setting (being away from emergency facilities), the birth attendant, and the role of interventions. For most Americans the hospital seems like the safest place to have a baby. Most loved ones felt deeply worried at the woman's choice to be away from medical facilities. The media induced idea of a baby's heart rate plummeting out of nowhere and rushing the mom into the OR for an emergency cesarean section to save the baby, is mostly a myth, this is really quite rare. Most complications develop slowly. But this myth is still commonly believed. Additionally, the medical community has given midwives a bad reputation. Physicians in the early part of the 1900s were almost able to eradicate traditional midwifery by claiming they were dirty, unknowledgeable, and unsafe. Most midwives at that time were immigrant women with little social standing, which made these claims even easier to make (Wertz and Wertz 1989). This smear campaign was quite successful and these labels have maintained to today. Many families and friends expressed concerns regarding the capabilities and experience of women's midwives. The concern was probably more warranted in the early years of modern midwifery when many of the midwives had very little formal training or experience. However, today with training and licensing, the concern over skills and capabilities is much less valid. Women often recounted that families expressed concerns regarding the skills of the midwives, but once a concerned family member (such as the woman's mother) met the midwife, they were "won over" by their knowledge and capabilities. Lastly, a concern over the need for interventions is another issue where homebirthers encountered fears from others. Many

women recounted in their interviews other women telling them they were “brave” to do it without drugs. The general acceptance that birth is better with drugs and technology is almost ubiquitous. This is often to the frustration of natural birthers who counter that most people are unaware of the dangers of epidurals and other interventions. These three areas of concern meant that many homebirthers, even those encapsulated in like-minded communities, often had to deal with the real fears of others. Several women recounted stories of mothers-in-laws who spent considerable energy trying to dissuade them from their choice to birth at home. This often meant there was a serious difference of birth frames or ideologies that were often unresolvable.

In dealing with partners, family and friends, women have utilized several tactics to dissuade people of their fears. First they encouraged others to become educated about homebirth. This involved reading books and research articles. For partners, it sometimes also involved childbirth preparation classes geared toward natural birth such as Bradley childbirth classes. The women seeking homebirth often utilized evidence-based medicine much more readily than do women who birth in a more mainstream way. This is ironic considering most would think that modern hospital obstetrics would be based on evidenced-based care, which it is primarily not (Goer 1995). Homebirthers use literature to show the safety of homebirth and the dangers of interventions. They try to illuminate the rationales which were motivational for them for choosing homebirthing. By doing this they also act as agents of the movement, providing movement rationales (CAFs) and persuasion to others while articulating their own salient motives. A second approach to dealing with the fears of family members is a request to not discuss the issue. Some homebirthers found that family or friends were not the least bit persuaded by the evidence

of homebirth's safety and continually tried to dissuade them from birthing at home. In this case, several women found avoidance the best approach to dealing with others' concerns. Along the same vein, some found compassionate acceptance of others' points of view to be the most effective approach. They asked that family and friends respect their choices as they would respect theirs. Nicole recounted her birth experience and the fear her husband's family had,

My husband's family. Two of his sisters. One was just about to finish nursing school, and the other is in nursing school. They refused to witness the birth. They walked out when it came time. As I hit transition they went outside and sat outside the rest of the birth. They were very offended that I would do this. His mother threatened to call 911 several times. This is what my husband's internalizing all this, "Oh my mom is losing it," and Damiana came in and talked to him a little bit about what we needed to do to handle this, because she was out in the living room pacing and threatening, and, and so he went and talked to her quickly, and that was that. And she backed off, and I don't think she saw the birth. I think she left right as he was being born. And so it was a little overwhelming for them.

Kathy also had to deal with a very concerned mother-in-law,

My mother-in-law was very uncomfortable with the idea of homebirth and made that clear from the very beginning. So, for me I knew that my body was strong. I knew I was in excellent health, my pregnancy progressed very normally everything was textbook, so as my pregnancy progressed, my fear of having the homebirth declined, declined, declined. I think in terms of the risk factors, it was more of a social kind of thing that we had to work through to explain to people. I cannot tell you how many times we had the conversation like, these are the reasons why this is safe, and these are the reasons why we think this is ok. I mean it was very difficult for my mother-in-law to work through. I mean she didn't really have much of a choice but she was, boy I can just remember the day we sat at her kitchen table and we told her that we were going to have a homebirth and she was very much opposed to it. And she spent considerable energy, I would say from time to time, in various kinds of ways, trying to talk us out of it, trying to convince us out of it. I think that she was mostly, she wanted a hospital birth, because I think she was afraid that something might happen to the baby. I don't think she was all that worried about me. But I think she was worried about something might happen to the baby. Because there are a lot of unknowns during the birthing process. You

know, “what if the cord gets wrapped around the neck, what if the heart beat, what if the this, what if the that, kind of thing,” so she wanted that medical care right, right there. So I think that we just continued to reassure her, especially since we were so close to the hospital we would have taken us a matter of less than five minutes to get to the hospital and I think that that went a long way for her sake.

Patty utilized the avoidance approach to her husband’s family’s concerns:

But we didn't really have people around us that were kind of resistant about it. Mostly my husband’s family. I didn't talk with them. I just, I told them that I have a lifetime ahead of me where I can discuss the reasons that I am doing this, but for right now, I am the one that is pregnant. I don't want to deal with the conflict. I don't want my baby to have to deal with this ongoing, trying to decide. I don't want to have to convince someone of the choices that I have already made. So I just really kind of said I am not going to communicate right now.

Other parents were more involved but continued to have fears. Sandy had a more accepting view of her father’s concerns. She described her father’s reactions to her births in the 1990s in the following account,

He had too many people saying, “oh she’s going to hemorrhage and die.” And when I looked at where they came from, Arkansas and it was during depression era and there was a lot of poverty, they knew people that that happened to. And I just think my mom could get over that but my dad ...I don’t know if he’d seen it or if it was the fear of something happening to his child that it was always very hard. He always was there and even for our fourth out here, my mom and dad came about three weeks ahead of time and they were there for the birth and they stayed for three weeks afterwards. I mean its important family time for them, but for him to walk into the room, I mean he would stay in the hall and even Alise would say, “come up, Grandpa, come up” and I could hear him at the bottom of the stairs, “I’ll just right stay here. Is everything ok?” He just could never get himself to come up the stairs... he said he had finally got to where he told me, “well I just told people that Sandy, she’s going to do what she’s going to do.” And he has utter trust in Mike I mean he can say, they will take care of it, and they know what they are doing. So I never felt like they felt like we were stupid. And with Mike’s family, I have in-laws that don’t judge. They were probably a little scared and probably felt we were a little weird, but they never told us that and they’re ok with that.

Julie’s family also questioned her and her husband’s choice of homebirthing after a

complicated hospital birth with their first child.

They said to me, "After all your problems with the first one, why would you do a homebirth?" And my husband said, "With all the problems with the first one, why would we ever NOT want to do a homebirth? Why would we want to repeat THAT?!"..And he's from a dentist family. And so they think we're nuts... "You're going backwards in technology. What's the problem?" They did a lot of that type of thinking.

Whitney, who labored at home in 2001 but was then transferred to the hospital for failure to progress, remarked the following about other people's responses to her desire to homebirth.

I have one girlfriend who was just like, "oh, Whitney, that's crazy," and she's just a scaredy cat anyway, she's like, "I wouldn't, I wouldn't do it, if I were you." And she was almost mad at me, because I decided, and I was like, I don't want to tell her because I'm going to do it anyway, but you know, and she was like, "ok, well, if that's what you're going to do, you know." And we're still friends and nothing happened from it. And my mom [who had a homebirth], of course, is very, very supportive of it, and you know, like the neighbor across the street, "oh, you must be really brave," you know, that's what most people said, and I said, "yeah, either brave or stupid, I don't know what to expect yet."

Chris also commented on people's concerns in the 1980s when she had her three boys

Question: Did you have to counter any flack, or questions of what if?

Answer: You know, probably a little bit of that, but I really think my family for the most part was pretty supportive, or, if they had some reservations, they didn't really vocalize them too much. They tried to support us or were quieter about it. And I know that I had people say, "Oh, doesn't that make you nervous?" and I remember my canned response was, "It makes me nervous to think about going to the hospital." (laughs) It doesn't make me nervous about staying home.

Midwives were also involved in calming family concerns. Betty explained how she helped clients deal with familial concerns.

When they first tell their family, that's the big thing. There's the big pressure. They first tell their family they're gonna have a homebirth. "Oh my God! What if something happens?" "What if something horrible happens and you can't get to the hospital in time?" And I try to explain to them ... I do pass out a handout that talks about Amish births, having the

faith in the natural process and not having intervention. And then I talk about how that's what prenatal care is for. To weed out anything that might possibly show a complication coming up. And if everything's normal at the end of your prenatal care, the baby's in a good position, and everything's normal with you, the baby, prenatal care, then you've got about a 98 to 99% chance that it's gonna continue on normal. And there's always early signs that things are not going normal. And sometimes you can correct that. And sometimes you can't. If it doesn't start correcting itself, then you can go to the hospital before it becomes this emergency that people visualize. All of a sudden something just appears! It's like this dragon or something! This horrible thing's going to appear suddenly, out of the clear blue. Good grief. I've never seen things just suddenly. There's always little signs. You know there's some real clear signs. And just act on it.

Alicia's family was extremely concerned about her lifestyle, alternative ideas, and her choice of homebirth. She came from a family of conservative medical practitioners, and they believed she might be involved in something dangerous "out in Arizona." Alicia had to deal with not only their concerns over her homebirth, but that she wasn't in a cult.

When her mother met her midwives it helped to calm her mother's concern to a degree.

My mom felt better about it when she came out. She came out when I was on bed rest, to help me out and she met Paula and Melanie when they did a home visit. And she felt a lot more confident after that, just seeing how confident they appeared, the way they spoke about things and, she asked them a few questions and stuff. But...Ya...but even then she wasn't saying anything 'til after the birth but she was kind of holding in and saying she's still not comfortable with it.

As women who have chosen to homebirth deal with the concerns of others, they also have to deal with their own internal fears. Just as reading and being educated about birth issues as well as and the capabilities of midwives helped to calm familial concerns, these same factors helped women deal with their own concerns.

Negotiating One's Fears

In addition to dealing with the fears of partners, family, and friends, women also had to work through their own concerns. These concerns tended to center around complications (things happening to the baby or themselves), perceived safety, and a woman's fear of not being able to do "it" (birth). Fear of hospitals if transported due to complications also created anxiety. I see this anxiety as normative. It is my assertion that frame negotiation of "what ifs," or the management of one's sense of fear, risk, and concern for one's self and child, is a universal component of birth preparation. Birth is transformative and at times unpredictable, when coupled with the socialization of culturally derived birth fears; fear of birth seems highly likely. However, how much at risk or how fearful a woman feels, is a reflection of her culture and her adopted model of interpretation (Davis-Floyd 1992). It represents an interrelationship of framing and emotion. I contend that in preparation for birth women develop and become aligned with a birth frame, which in this context is primarily associated with the holistic model of birth consistent with homebirthing and midwifery. This frame alignment process provides a schema for interpreting her emotions of fear and anxiety. This discussion of negotiating fears and concerns highlights the interaction of emotions or "hot cognitions" in the framing process (Hercus 1999). These emotions motivate actors to negotiate their feelings about birth, and their fears in particular. This negotiation provides both "devitalizing" emotions such as fear and anger and "vitalizing" emotions such as comfort, care, and confidence (Taylor 2000). In focus on the interactive effects of frame negotiation I do not mean to discount the importance of emotion work in framing processes.

I will demonstrate how my respondents utilized three main factors in developing and maintaining their frame alignment while dealing with their concerns and fears about birth in general and homebirth in particular. First, they utilized a sense of faith in the body, the natural process, and their own embodied knowledge and intuition to mitigate their concerns. Second, education regarding natural/homebirth occurred through the reading of books and research articles, childbirth education classes, and dialoguing with their midwives and other homebirthers which helped develop their confidence and faith in the holistic model of birth. This education helped them be prepared and knowledgeable which provided a sense of control and reduced anxiety. Support provided by midwives and other homebirthers also acted to reduce fear and anxiety as well. Third, women placed considerable trust and faith in their midwives to make homebirth a safe experience for them and their baby. This faith helped them feel reassured about their fears. Part of this frame alignment and negotiation process was developing a birth frame to deal with concerns. This birth frame was developed through frame bridging, frame foundations, and the frame negotiation processes already discussed in previous sections. Practicing midwives and second generational homebirth daughters came to homebirth with greater levels of frame foundations and frame bridging of homebirth experience, rhetoric, and greater reliance on the holistic frame, which provided them with greater levels of confidence and commitment to homebirthing. For other's it was more of a process of frame alignment with the holistic model of birth and birthing at home; leading them to greater confidence and commitment. These feelings of confidence and commitment acted to reduce fears and anxiety and provide a positive birth frame and schemata for interpreting homebirthing fears.

Belief in the Natural Process

The first factor in developing and maintaining a birth frame alignment, which is utilized in overcoming fear, is a deeply held belief in the body, the natural process, and one's own embodied knowledge and intuition. This birth framing represents accessing a motivational frame, which provides an interpretive schema. The respondents expressed great faith in their belief in the inherent ability and safety of the natural process and their bodies. This attitude was especially strong in the accounts of the early women. This faith in themselves and the natural birthing process offset the lack of structural supports that existed for homebirth at that time. Sandy D. put it this way: "I had solid (smacked knuckles into palm) faith in the process of the body with this. I had very little doubt throughout this time." Rachel said, "I had this incredible sense of well-being. I knew it was perfect. Nature would take over and do this thing for me. The baby was fine ... she radiated health and well-being." For Sue, her own inner knowledge (intuition), embodied experience, and knowledge combined to support her faith in the natural process. During her birth in 1974, her water broke on a Tuesday but she didn't deliver until Friday. She kept track of her temperature, used a fetoscope to monitor fetal heart tones, and tried to really "listen to her body." Today she would have been outside the allowed scope of practice guidelines for homebirth midwives. Under today's regulations she would be transferred and induced because she would be considered at too high of risk of infection due to concerns over labor time limits. She was aware of the concerns regarding infection, but she was clear that all was well, and in the end she had a safe, uncomplicated birth. Sue commented about her intuition and faith in the process, "I didn't have any inner feeling [that anything was wrong]...I felt very tuned in to how I was and

how you²⁹ were. I just felt like everything was fine and that it was going to be OK. So I didn't really ever have a temptation to go to the hospital.” This faith and belief in their bodies and the natural process helped dispel the sense of fear often present in hospital births.

More contemporary homebirthers also expressed great faith in the natural process and themselves. Sara stated, “Birth to me doesn't feel like high risk. Birth to me feels like more of a natural process. And that's what we did at home.” Barbara, a CNM, commented about her pregnancy, “I had a total faith that I would be OK.” Kathy commented on her view of the natural process,

My body knew what to do to get that baby out. My baby knew the perfect time to get that baby out. The chemical reactions, the hormone changes that say it's time, it's time for this baby to come out now, not yesterday, not tomorrow, today is the perfect time. Just the whole process of the changing, the colostrum, the milk, the the interaction of those enzymes with their brain that causes brain development. It's a beautiful, incredible process that it's intelligent beyond what we understand. And in that sense, it was transforming.... I knew she was participating with me. I mean she was doing her part and she knew what to do. I mean she'd never been in the world, no one coached her, but her body knew what to do to get her out of there. You know, just the whole working together of all that is a beautiful process.

Nancy H. commented,

God made our bodies. There's natural ways and there's a reason for everything and so there's a reason for the way our body responds and does things so for us to come and do something that's actually a natural thing and try to change it is, doesn't seem wise to me and especially the pitocin. I think that has done more harm to babies. I think using pitocin is much more harmful to the baby and the mother than is really worth the risk, and if they would just be more willing to use natural means and let the natural timing of things work its way, there'd be less need for c-sections. There'd be less need for other emergency things that can come up, and that's how I feel about it

²⁹ The speaker is referring to her daughter who is conducting the interview.

Many women commented that this faith developed over time and experience. This experience represents part of their frame foundations and was further elaborated in CHAPTER EIGHT: FRAME FOUNDATIONS. Their lives had taught them to trust their bodies and themselves. Their understanding of research literature and the dangers of interventions reinforced the importance and capacity of the natural process and heightened their faith in the natural process. These understandings occurred through the stage of frame bridging of motivational frames.

Education

The second factor involved in developing and utilizing a birth frame to deal with birth fears and concerns was education. Almost all the women emphasized the importance education played in giving them confidence in their choice to have a homebirth. This education included the reading of books and research literature, childbirth classes, and dialogues with their midwives and other homebirthers. Part of this education was developing a sense of preparedness and understanding of how labor happens, as well as an understanding of possible complications and how they would be handled.

When respondents were asked about their process of birth education, almost every woman mentioned the important role books played in this process. Comments ranged from “I felt like I was studying for a final” to “I looked at a couple books.” “Cramming” was a commonly used term in the interviews, to indicate the level of reading and research most homebirthers did in order to develop a sense of confidence and understanding. This reading acted to provide strong frame bridging of natural/homebirth motivational,

prognostic, and diagnostic frames. Lucy recalls, “I read tons of books. I read a lot, I wasn’t worried.” Rachel also felt confident about the knowledge she had gained,

I had studied the stages of labor. The birth process. I knew exactly what I was going to do, how it was going to happen. And I think that’s always a big key and still is a big key for anything that goes on with your body. If you understand what’s happening, it’s immediately defused.

Rothman (1982:13) also demonstrates the importance of reading in her decision-making process,

I decided I needed to know more about birth...I went on to some obstetrical texts. I thought I’d read all the things that can go wrong and scare myself out of the whole idea. But the more I read, the less I wanted to go to the hospital. There had to be a way of having a baby with dignity and joy.

Sue also stated that after all the doctors she had asked to attend her birth had refused, she started “cramming like crazy.” She studied obstetrical texts and she felt, “the risk was very slight.” Patty also felt reading was really important when she had her son in 1992,

I felt like I just needed all the information I could possibly have and when the birth came, I just totally forgot it all... none of it really mattered. But I felt like it allowed me to be confident enough to go through it. Give me more information. Give me more. Give me more.

Sandy Y. commented on the effect of her reading and becoming educated about birth issues,

My husband and I often said that through this, if we would have just stayed dumb, this would have been... easier. [I]t would have been so much easier because now everything that we do, we feel like we need to make an educated decision. That’s why when people say, “Oh you homebirth,” I always feel like saying, “Well you idiot, you know if you ever studied anything you would realize that that going to the hospital isn’t the end all to all things.” So there’s a place for that and I don’t have a problem with that but I mean the more studies you read, the more you realize... we read a lot of professional studies and Beth [her Bradley teacher] would bring in her journals and we were welcomed to check those out. I did a lot of reading.

The literature available over the thirty-year span included in this research has also dramatically changed. Early birthers were more likely to have read obstetric textbooks, older natural birth material (such as Dick-Read's (1972) and Lamaze books (Karmel 1965)), and the first homebirth books such as *Spiritual Midwifery* (Gaskin 1977), *Birth Book* (Lang 1972) and *Special Delivery* (Baldwin 1986). As time passed, the volume of pro-homebirth books (or chapters on homebirth in general books) and research articles increased, as did the research literature supportive of low-intervention births (see Goer 1995 and 1999 for a review of this research literature). The women stated that knowledge gained through "cramming like crazy" created an understanding about the birth process, its risks, and its capabilities, as well as the dangers of interventions and standard hospital procedures and policies. This information generally solidified their choices to homebirth and eased internal fears.

Childbirth education classes were also part of women's education process that helped ease fears. These classes included both formal Bradley Childbirth education and International Childbirth Education Association (ICEA) classes. These ICEA classes are generally the childbirth preparation classes that are offered at hospitals and use to be referred to as Lamaze classes. More informal childbirth classes were also taught by some of the homebirth midwives. These classes often included many of the components of other childbirth prep classes (e.g. stages of labor) but information and issues specific to homebirthing were emphasized. Patty recounted the role childbirth education had for both her and her husband,

Well, we both had a lot of fears and questions about were we doing the right thing. This is riskier, quote, unquote than going to a hospital, that kind of thing. Societal thing. But, we took, birthing classes together at TMC. And those were helpful. Our teacher, herself was kind of odd. We

didn't click with her, but the information she gave us, we really got a lot from. For me it was just getting to know the whole process better, and knowing that it was all the natural process of what birth is about. What the beginning is, what the middle is, what the end is, and then it all, it [can] look very different for all different women but there are certain stages and ultimately you have a baby. That, there are lots of stages that are predictable, and that was really helpful for me to see. And for me to be there. Also it allowed my husband and I to set aside one time a week, that that's specifically what we did was just think about the baby together.

Sandy Y. expressed how important her experience with her Bradley teacher was to her childbirth education.

I mean my Bradley instructor that we had, Beth Elmore, I just think that she taught so many women to listen to their heart instead of listening to what other people say. And she helped us feel strong enough as women and as husbands and fathers and mothers to do that...I look back and I think she empowered us to think about not just doing status quo. And that is what I think that Bradley was about and that's what I think homebirthing is, that that changed us...to know that we could do this and that we could make the best decisions for our kids.

Nicolle stated, "The Bradley method enlightened us on... I think it was more for my husband than for me. For him to see what was going to happen. For him to see a timetable of what we were looking at the relaxation and all the breathing stuff." Both Nasima and Rachel, in the early group of homebirthers, also mentioned doing Lamaze classes or learning Lamaze breathing techniques and finding them helpful. Betty, as a practicing homebirth midwife, recommends her first time clients do Bradley classes-

I always tell my clients, my first time mothers, do Bradley. Cuz that'll give them a sense of some tools and some relaxation things. It also just to give them an idea of the stages of labor, and what to expect... And I tell 'em, the more you educate yourself, the more when something happens that's normal you won't think it's abnormal. Little bit of blood, "(Gasp) What's this?" Well, it's bloody show. You know, what is bloody show? Why is it? So I think the more they know, I think education is the tool, where the more they know about it, the less scary it is. And so, definitely do Bradley. Definitely read. Um... and just talking. I think that's the ...

the reason I do at least an hour visit, so that you can talk, because sometimes things come up, and...visualize. Visualize how your birth is gonna be. How do you want it? That's a big one. And I have some clients that are really good at that.

These childbirth classes helped women develop an understanding of the anatomy and physiology of birth, its stages, and how relaxation could be used to ease labor pain. They recounted how this education eased their fears of the process and created a greater sense of faith in birth.

Midwives are also an important part of this education and support process. Most homebirth midwives take around an hour during prenatal appointments with clients to provide education, support, and clinical care. This is in comparison to most physician settings where a ten-minute visit is commonplace. The additional time shared between clients and midwives helps develop a deep sense of connection and trust. The education and support provided by midwives and other homebirthers is also important to dealing with the “what ifs” and other fears. Interacting and dialoguing with their midwife and other homebirthers provided both support and education to my respondents. For the early homebirthers in Tucson the midwives created a very supportive environment both through their interactions with their “ladies” but also through the meetings in the park, which were held through the Arizona School of Midwifery and its offshoot New Beginnings Birth Cooperative. At these meetings women would tell their homebirth stories and share information, experience, and support with other pregnant women and new parents. Sandy emphasized the importance of the meetings in the park, “The meetings with the midwives were really great...To have those contacts with people who were good for me and the baby. It was great to hear about other peoples’ lives and their birth stories. Very loving people, encouraging, and supportive.” Trina recalled,

With the midwives the women got together. I felt that was very supportive. All the pregnant ladies would meet once a month for this picnic. And all the women who were pregnant would come to the picnic, from people early on to people who had recently had their babies. Even to people who had had their babies over a year ago. Sometimes people would be recycling coming through the midwives again. Having a child that might be two or two-and-a-half. So there was really a great deal of support with the whole entire group.

Lucy also attended the monthly meetings held by the midwives. She, “loved hearing the birthing stories, the meetings were fabulous.” The midwives facilitated women supporting each other through these meetings in the park. The sharing of personal accounts helped maintain a faith in the belief system and created a supportive environment for homebirth in the early years.

These meetings lasted from approximately 1973 to 1981, providing a strong support network of people of like minds and proving especially helpful in the years of working hard to license midwifery in Arizona. The late 70s through the early 80s are often referred to as the heyday of homebirths. For a chart of the ups and downs in homebirths occurring in Arizona see Figure 10: Number of Non-Hospital Births in Arizona, 1986-1996. Events such as the “Meetings in the Park” would also be helpful today. Although homebirth has a degree more legitimacy, it continues to be a radical choice. Women often feel outside pressures regarding their birth choices, as was evident in the previous section on family concerns. Meetings in the park presented a way for people’s choices to be affirmed by others who had gone through the process. Individual midwives have had similar meetings or reunions of clients over the years, but never with the consistency of the original meetings in the park held by the Arizona School of Midwifery and The New Beginnings Birth Cooperative. Today most support for homebirth occurs between clients and midwives without the additional support of a

homebirthing community. Some are fortunate to have other friends that have also homebirthed or to be part of on-line support/discussion groups, or local advocacy or education organizations, however, the level of community experienced by the early homebirthers during the time of the Arizona School of Midwifery was special in a lot of ways.

Interacting with a midwife provides a woman with both the second and third components to reducing fears within the frame negotiation process I am describing. These include providing an educational route to the frame bridging of motivational frames, and a sense of confidence in her skills. Which both act to build confidence and reduce fears and anxiety. The midwives describe providing clinical care, emotional support, and education to their birthing mothers. The women clearly stated that their interactions, dialogues, and care provided by the midwives gave them faith and confidence in the birth process and in the midwives themselves. Women found a faith in their midwives to be a highly important factor in mitigating fears. Faith in the midwives' capabilities has only gotten stronger as midwives have gotten licensed and more experienced. Nancy Aton, a currently practicing naturopathic physician and homebirth midwife, described her interaction with clients about "what ifs" and fears,

I try to talk to them about it a lot. I like to have them read as much as they can. I do tell people there is a 'what if.' Obstetrics is unpredictably unpredictable. And my job is to be a keen observer of your health and the baby's health, and the only things that you can really control are your attitude, your eating, and your exercise level. And I try to work on the attitude, and I try to find out well, "Why do you want to have a homebirth? Is it just economics? Do you have a fear of giving birth? Do you hate hospitals? Do you hate medical doctors?" I try to work on those issues, so that if there are places where people are stuck or have some issues that they are unwilling to budge on, that we try to budge those issues.

One of Nancy Aton's clients, Carolyn, described her dialogues with Nancy around her birth in 1990, "You know, Nancy was the person that really was the one that explained to me the "what if's," I went through you know, the prolapsed cord, da da da da, you know, and knowing that she had done like hundreds of births." They discussed how some things could be handled at home, and what things required transport. Whitney, another of Nancy Aton's clients in 2001 also recounted these interactions. Her account is particularly interesting because Whitney ended up being transported to the hospital.

I trusted Nancy enough to know, just like what happened, if it looked dangerous, she warned us about that, she's like "If it looks like the baby is in danger at all, we're going to the hospital. And I'll be able to tell that with this and that. With the, you know, the heart rate or whatever, and then you know, it will be in plenty of time for us to be able to get there." It took us 25 minutes to drive there from here. Being new parents, we didn't know really what to even ask, you know. So a lot of it was just, you know, as we go along we'd hear somebody else's story, or see something else on TV, or something would come up and we'd be like 'what about that?' And then you know the next time we'd go ask and Nancy was great about answering all of our questions, and it was nice because, like I said, my husband could come and he could ask all the different questions he had too.

Patty recalled her dialogues with her midwife, "Damiana was really good about having us aware of the things that could happen--the risks, the risks just of birth, in general. She was very clear about things that, I think it was just out of her realm in terms of her legality." Damiana discussed her relationship with her backup physician and what her role in the hospital as advocate would be if that was necessary with her clients. Susan Merski, another midwife during the 1980s, described her education and interaction with clients as a means to reduce fears,

I'm a very wordy person...I always believed that the more a person knew, the less fear they had. So I did a lot of educating. I was always always educating them. I was always telling them what was going on, what to expect, what was probably gonna happen next. And that really displaced

fear. I mean if I could say to a woman, “you're gonna start to feel a lot more pressure building with your contractions now, and your contractions are gonna get a lot stronger, and you're gonna feel them here and here, and...” and then that would happen, and they'd think, “Oh, OK.”

Education and support provided by midwives was greatly appreciated by most clients I interviewed and was often seen in contrast to medical doctors.

The support, experience, and knowledge shared by both midwives and other homebirthers were important to the women’s frame negotiation process of dealing with concerns, fears, and “what ifs.” The information and confidence they gained through reading books and articles and attending childbirth education classes were also instrumental in their frame negotiating process. The process of education provides confidence, understanding, and faith. Sue commented, “I was prepared and that dealt with the fear.”

Faith in One’s Midwife

The last component to dealing with one’s internal fears was a deep sense of faith in the midwives. I have observed that faith in one’s practitioner is a common feeling in pregnant women, but the interviews showed a remarkable sense of faith and attachment between midwives and their clients. Many women recounted that their faith in their midwives’ skills was the strongest mitigating factor in easing their fears and concerns of the “what ifs.” Patty expressed her faith in her midwife, Damiana,

But when I did meet her, I knew right away that she was going to be my midwife. I really felt, I felt what I wanted to feel with someone who’s going to help me with my baby that just, I felt like I had a sense with her, that she was going to make this a really safe situation for me and also that she was going to support me in whatever choices I wanted to make about it. And those were really, both of those were really important to me

Sara, who became Holly Rainier's birth assistant, recounted her faith in Holly for her births. I asked her about her process of dealing with "what ifs," and she responded,

Well, there wasn't a huge process in one because I really trusted myself and the other person I really trust with my life is Holly. I saw all those births with Holly, I saw what she did, I saw what she did for every sort of situation, and she always told people if there was any minute that she said it's time to go to the hospital, it's time to go. That never seemed like a risk, and she came all prepared and Holly's good. There wasn't a risk. I knew that it would be safe and well, and we had a backup doctor in case. I did all the backup I feel like was possible, but I've never seen even an emergency birth that couldn't have been remedied because our ambulance driver was five minutes from the hospital so it didn't seem like a big risk. It wasn't a factor for me. I never really even considered that part so much. **Question:** Did your partner have to work through it a little bit? **Answer:** No, he really, he knew how much I trusted Holly and he also felt very comfortable. For us, it was more of an issue going to the hospital.

Sandy recalled,

I just, in all the studies that I read, and in the research that we did and in the United States death rate with children and everything, I just feel like we [socially] are very ignorant, that I came to overcome those fears with realizing that my midwife was capable. We had backup support at the hospital and I was registered at the hospitals in case we needed to get there quick. We knew how long the ambulance would take. It wasn't ignorance. It wasn't just thinking everything will be OK. It was planning ahead and finding a midwife that I felt was prepared to handle those situations. I mean when we interviewed her, I said, "what if this happens or what if this happens then what would you do with this," and I had read up enough that I felt comfortable with the answers that she gave me and that took care of my fear.

Damiana stated her role as a midwife,

I can sit there and just be who I am and help them be who they are which is really what you do as a midwife, and...help them get what they need. If they don't have baby clothes... I feel like I can just like... help people be honest about and not ashamed of who they are and what they're going through and um...so I kind of feel like, 'Oh, I've found a way to be a midwife, and a midwife is not about catching a baby.' I've never felt that way. A midwife is just being with that person, and helping them go through that space.

Those few women who were transported or had complications during their homebirth especially expressed appreciation of their midwives' skills. Whitney, who Nancy Aton transported due to an overly long pushing phase, stated,

It's really nice like I said it's just so...I get such personal care and my husband too...I trust her judgment. I feel that she is very qualified. You know, even though she told me that it seems like 'this is my year for ending up having to go to the hospital' because she said she's had quite a few percentage ending up going to the hospital, but to me that doesn't really look like a negative thing on a midwife. To me it looks like it could be a good thing because like, just like with me, I feel like it was just the right time for her when she said, 'I think we might need to go to the hospital.' You know, and I was glad that she said it, because I was like, 'oh, do you think we should, I think we should too,' you know, because it looks like nothing's happening here

This faith and appreciation of their midwife's skills was most prominent in the contemporary women. The pioneering women recounted liking Nasima, and other early midwives but they laid their faith mostly in themselves. As midwifery has become more legitimate and regulated, women seem to put more faith in their midwives and their skills.

In conclusion, I have demonstrated how my respondents utilized three main factors in developing and maintaining their frame alignment while dealing with their concerns and fears about birth in general and homebirth in particular. First, they drew upon their deeply felt faith in the natural process and their bodies to soothe fears of the birth process and having a homebirth. This accessed their frame alignment motivational frames, which provided rationales for choices, actions, and interpretations of experiences. Within the exemplar of "negotiating one's fears," the frame bridging of information through educational routes served as a second component to calming a woman's internal fears regarding birth. Childbirth education, dialoguing with midwives and other homebirthers, as well as, reading about birth provided avenues to reduce anxiety by

increasing knowledge. These educational routes also provided support and motivational rationales, which also calmed fears. Lastly, I observed women's faith in their midwives' skills was generally a strong component in calming fears and dealing with concerns. Generally, through interactions with their midwife women grew confident in their choices to homebirth, in their midwife's capability to make homebirth a safe experience for them and their baby, and they became increasingly committed to the motivational rationales, such as fewer interventions are preferable, through dialoging with their midwives. Respondents commented on how these interactions made them feel more confident of their choices and generally less fearful of possible birth complications. I demonstrated through the section on "negotiating the fears of family and friends" how education through books and articles, partner participation in childbirth education, and interactions with midwives were used to calm fears of families and friends. I also demonstrated how women utilized avoidance or acceptance of other people's viewpoints as ways of dealing with conflict over their birth choices. I would like to note that the data doesn't specifically speak to the process of negotiating fears of partners beyond their role in childbirth education classes. Generally the women commented that their partners had seen their evolution in birth choices, and had trusted them to make good choices, or the women simply asserted their choices on their partners. Beyond these comments, I can only assume that partners who found homebirth motivational rationales unconvincing, who felt birth should occur in hospitals, or who felt birth was too "risky" to do at home, had sufficient sway to convince their partners to birth in settings other than at home. As such, they would not have been included in my data, and I am unable to clearly describe

the frame negotiations of women whose partners dissuaded them from birthing at home. This would be an area for future further research.

Concluding Thoughts on Frame Negotiation

In the last three chapters on frame negotiation I have discussed the negotiation of choices and the making of decisions related to birthing at home. This negotiation process begins with a “liminal phase;” and involves the entrance into a transitional role of “pregnant person.” This role initiates a phase of “seeking a provider” to usher the woman through the transitional role, and fill the normative role of medical caregiver for pregnancy and birth as is customary in American society. Drawing on her birth frame alignment, as constructed through her experiences with frame foundations, her internalized knowledge and experience from frame bridging of information, she evaluates the birth model espoused by the caregiver. The process of “seeking out a caregiver” can be a radicalizing experience, motivating a woman to seek out alternates. For some this is a quick and easy process, for others it takes considerable time (perhaps over several births) and energy to locate a caregiver more in line with her adopted birth model. A few of the women had sufficient grounding in the holistic model that they were able to locate a midwife she liked initially. This process of “seeking out a provider” was constrained by structural and biographical constraints. As discussed in Chapter Ten this process of seeking a provider varied by time frame; with homebirth pioneers more likely to have experienced “friends helping friends” have homebirths,” and later contemporary women having the advantages of licensed and legal midwifery practice. The process of “seeking

a provider” is also mitigated by financial concerns in negotiating the plausibility of having a homebirth.

The second aspect of frame negotiation, as discussed in Chapter Eleven, are the motives or rationales that were motivational for the women in choosing and staying committed to homebirthing. These motivational collective action frames provided an interpretive footing for both deciding to birth at home and for interpreting events that occurred around birth. These motivational collective actions frames were adopted through the previous stages. They include the “reasons” and “rationales” espoused by homebirth advocates, and the homebirth literature that was important during frame bridging. It also includes a balancing or negotiation process between the holistic and technocratic frames. The area where this is most evident is in negotiating the concept of “risk.” In order to give birth outside the hospital, an individual must deemphasize the risks medicine and the majority of American society claim necessitates a hospitalized birth. The motives my respondents claim correspond with the information, statistics, rationales, narratives, and arguments provided in the majority of homebirth literature as presented in Chapter Five: Collective Action Frames. During frame negotiation, the motives that were of greatest saliency to the women in my study were crystallized. I identified six motivational categories that were central to the women’s frame negotiation process. First, a belief in the sufficiency of the natural process, and faith in the perfection of the natural process as designed by either or both nature and God was motivational for many. Second, a desire for control, authority, and personal responsibility were also central motivations for choosing homebirth, since hospitals are seen as limiting these. Third, in the section to “hike or drive,” I discussed the women’s belief in the value of

“going through the process” of birth un-medicated, which is easier to accomplish at home with a midwife. Fourth, women emphasized birthing at home as a better option for the safety and comfort of their newborn babies. Fifth, an emphasis on birth as a family not medical event that has a sacred quality was also stated motivations. Sixth, avoiding hospitals, doctors, and their common interventions and drugs, were important rationales and motivations for birthing at home. By choosing homebirth the women were able to control their environments and choices around the birth. Along with the motives they espouse for choosing homebirth, I also made clear how the women dealt with a sense of fear and risk of childbirth.

In the third and last chapter on frame negotiations-- Chapter Twelve, I discussed the women’s process of negotiating fears and concerns of friends, family, and themselves. Since homebirthing is out of the norm and general socially held to be a “unsafe” choice, almost all the women in my study described a process of negotiating and re-interpreting birth fears. This negotiation process focused on a belief in the natural process, education, and faith in their midwife’s skills which enabled the women to de-emphasize risk and reduce feelings of fear and anxiety. Frame Negotiation is the third conceptualized stage in the personal birth frame construction, alignment, and adoption process I am delineating within this thesis; we now move onto the fourth conceptualized stage, “Testing the Frame.”

CHAPTER THIRTEEN: TESTING THE FRAME

“I was so lucky to have had this absolutely epitome of the birthing experience.” Lucy

The fourth stage in the frame alignment process of birth models is testing the frame. Testing the frame consists of the woman’s actual birth experience. Birth is inherently unpredictable; spanning a spectrum of details from ranges of normal to shades of complications. The woman’s actual birth experiences either serve to confirm her birth model or challenge it. It is my observation that the idiosyncratic occurrences of the details of each birth are either interpreted within the holistic model or the model is reconsidered in the light of new experience. It is my observation that this process of testing the frame occurs in all birth settings. Research by Davis-Floyd (1992) has demonstrated similar observations. She studied 103 home and hospital births and found that women’s responses to their births could be categorized in three general ways: as leaning strongly toward the technocratic model, leaning toward the holistic model, and falling in between these poles. Of those leaning toward the technocratic model: 9% had full acceptance of this model of birth, expecting that the doctor would take care of everything; 9% also rejected biological groundings in favor of technology. For those with full acceptance of the holistic model of birth: 3% saw birth as a natural aspect of womanhood, and 3% saw birth as a spiritual process. For the women who fell between these birth models: 15% maintained conceptual distance from the technocratic model

through achieving natural childbirth in the hospital, 10% percent placed technology at the service of the individual, 42% had conceptual fusion with the technocratic model with cognitive ease. Lastly, 9% experienced cognitive distress (Davis-Floyd 1992: 239). In Davis-Floyd's (1992) research she found those who were unhappy with their birth experiences often exhibited several patterns. One of these was "further epistemic exploration through subsequent births" (Davis-Floyd 1992:249). This involves making different choices (such as providers) or further embracing technocratic birth (such as planned repeat cesarean section). In my sample, I primarily have examples of women seeking out different choices in their subsequent births, eventually bringing them to homebirthing. Of the thirty-five women in my sample five women experienced a realignment process with homebirth after experiencing previous births. To illustrate, Nasima had her first birth in a hospital but was so displeased she was propelled into homebirth midwifery and five of her own subsequent homebirths. Julie had her first child in a birth center where she was transferred to the hospital while pushing. She had her subsequent five children at home. Nancy had a similar experience but with more in-between stops along the way. Her first child was born in a hospital, her second in the Tucson Birth Center, and her subsequent five children were planned homebirths. Of these, two were transfers of care to hospitals for premature deliveries. Sandy Y. had a birth center birth, then three subsequent homebirths. Of the thirteen midwives in my sample, two gave birth to their children in the hospital, but ended up becoming homebirth midwives. One homebirth midwife planned two homebirths but ended up having all her deliveries in the hospital. Her first child was breech, and her second birth was to twins. She eventually went on to become a CNM and work in the hospital.

Another aspect of testing the frame is the level of childbirth satisfaction a woman holds after a birth. Childbirth satisfaction research has determined that most women come away from their births satisfied with their experiences. National research on women's experiences of hospital births, which overwhelmingly reflected high levels of interventions, found that women who had hospital births reported overall satisfaction (Declercq et al. 2002). The report states, "An overwhelming proportion of mothers were pleased with the care that they received noting that they generally understood what was happening (94%), felt comfortable asking questions (93%), got the attention they needed (91%), and felt they were as involved as they wanted to be in making decisions (89%)"(Declercq et al. 2002). The National Birth Center Study (Rooks et al. 1989), found that, of the women who had births in birth centers across the country and completed surveys, 99% were satisfied with their care and would recommend a birth center birth to friends. To date, I am unaware of any national level statistics on homebirth experience satisfaction, however all the qualitative research done on homebirth has demonstrated an overwhelming level of satisfaction described by researchers (Armstrong and Feldman 1990; Davis-Floyd 1992; Gaskin 2003; Klassen 2001; Tjaden 1983). It seems safe, given these studies, to assume these satisfaction scores would be at least as high as those found for other out-of-hospital birth settings (i.e. 99% satisfaction with birth centers). Satisfaction scores provide one picture, but complication rates provide a different picture.

Women may perceive their hospital experiences positively because a technological birth that reduced their pain level and is culturally perceived as safer was what they generally sought out; but in comparison to out-of-hospital births, hospital

births had appreciably worse outcomes for matched samples (Rothman 1983a). When matched for risk factors, socio-economic status, age and gestation, mothers and babies had more complications in the hospital (mostly due to intervention side effects), more septic workups, more cesarean sections, more meconium, and more Neonatal Intensive Care Unit (NICU) transfers. Transports from home to hospital were included in the home complication rates, and the outcomes remain worse in the hospital (Mehl et al. 1977; Sakala 1993). Olsen (1997) and Mehl (1977) found mortality rates for home and hospital are about equal, but morbidity is considerably worse in the hospital. Although high rates of general satisfaction are held socially regarding hospital birth, mothers and babies do not do appreciably better in the hospital. Despite evidence to the contrary, hospital birth remains the norm and the expectation of most Americans, and their childbirth satisfaction scores are reflective of these expectations. Davis-Floyd's (1992) data supports the assertion that relatively high levels of childbirth satisfaction are reflective of women's birth models and cultural trends, with this relationship holding for both hospital and out-of-hospital birth settings. Within my data, those women who experienced both hospital and homebirths were much more satisfied with their homebirth experiences. These women expressed the desire to educate more birthing women on the advantages of homebirth, so more women would find homebirth a desirable choice. Many women think if women had more education and exposure to homebirth there would be more support for this birthing choice. One respondent compared the differences between home and hospital birth and people's understandings of homebirth in the following way.

The positive experience overall with family, with the labor and delivery.
Overall, it's like night and day between the positiveness of the homebirth

vs. the strangers, the sterileness, the uncaring attitude that you get in a hospital. Those who have never experienced a homebirth have no idea you know. If somebody always lives in a desert, and they've never been to a beautiful green forest, or green area, they have no idea the beauty of going to the sequoias or the redwoods or the beauty of the nature there. They have no idea of it, and the peacefulness of going to that kind of place. If they've never been there and experienced, they have no idea. and its, its like the difference of being in the desert vs. being in beautiful area where there's a spring and I just, there's so much more beauty and relaxed feeling and atmosphere and caring atmosphere in a homebirth that you don't get in a hospital. Hospitals have improved. They've improved [since] when I used to work [as a nurse] and things, but I still say there's no comparison between what you experience at home and in a hospital.

Many homebirthers are profoundly affected by their varying birth experiences. This has motivated many to work to legalize, regulate, and support homebirth midwifery on both the interpersonal level and the political level. They have sought to keep open the birthing options available to other women and themselves and see the conceptual space of birth altered one woman at a time. This leads us to exploring the actual experiences of a sub-sample of the homebirth experiences included in my data.

Selected Birth Accounts

Of the seventy birth stories in my sample I will present four women's birthing accounts. This equals fourteen birth stories, including two of the eight transports to hospital from home or birth center in my sample, two of the fourteen planned hospital births, and nine of the forty-eight homebirth accounts. The accounts that have been included were chosen randomly to ensure inclusion of a wide variety of voices and experiences. As in the other quotes used throughout the thesis, I have modified the

quotes for readability, such as, taking out a lot of ‘ums’ and ‘you knows,” and my affirmative responses such as “a ha” and “okay.” We begin with Barbara.

Barbara

Barbara has her first child in 1980 at a hospital with nurse midwives and second child in 1985 at home with a licensed midwife (LM). Between her births she became a LM, and then later a CNM. She worked as a CNM at the Tucson Birth Center when I interviewed her.

NASIMA: So what were your birth experiences like?

BARBARA: My first one was with a lot of wonderful midwives and child educators up in Seattle, and Penny Simkin who was teaching up there and Kathy Carr was one of my midwives. There was a lot of neat people. My water broke at, well I never had a sono, I think early, probably what would have been 37 weeks and I went in labor and they started me on pit. I had a pitocin induced labor, drug free, but still pretty intense. Intense, and not what I was hoping for. Not natural. Had my baby and everything was fine with a nurse midwife and then I had a severe postpartum infection. I was in the hospital for 5 days with high fevers. [I] was checked about a 100 times in labor with ruptured membranes. I know where that came from. That was less than wonderful. I'm sure it could have been worse in a different situation. And then just in terms of the labor itself is once it took forever to get into labor and then once I got into labor I went from 4 to completely dilated in 20 minutes.

NASIMA: Wow.

BARBARA: Yah, it was really intense. Really intense and then basically with my second baby that I had at home with a licensed midwife five years later I only had about 20 minutes of labor. I repeated where I was laborless and labor then boom I had the baby. And so very rapid and very cool.

NASIMA: Your labor was so intense, what kinds of things did you do as your comfort measures

BARBARA: Well the first time I whined. A lot. That was memorable, and then swore at my husband which wasn't so good. The second time was more like that Aztec birth goddess that's just grimacing. I think I just grimaced for half an hour and the baby fell out. I had this fantasy or this, my only big wish was to in homebirth is that I get in the shower, but I had them so quickly, I got in the shower but they never got the water on. So I felt a little disappointed (laughing). I should have been more specific in what I wanted, not just to get a shower but I wanted to get wet, ya.
(Laughing)

NASIMA: So your birth at home, though, went really well, basically, except for being really intense?

BARBARA: you know he, we had thick mac [meconium], we had a little bit of that , he had good apgars, but our first, you know it was tumultuous when its that fast. It's just...I have hardly ever seen, I have been at a 1000 births... from me knowing it was labor to the placenta was 37 or 39 minutes. You know, it was insane and I think that stressed him out. We had thick Mac and we had [our] daughter came out a little shell shocked and barely got my midwife friend there and said, "you better check me before", she was going to a massage workshop and she did and I was about to deliver.

NASIMA: Good thing she came.

BARBARA: Umhum. It was good.

NASIMA: So you were pretty experienced at that point even if...

BARBARA: When its the other end of it, though, you know, when it's that quick its like the contraction never ends and its, you can't be very rational your just, you know. I just get paralyzed. I was just, I couldn't move, I couldn't do anything, I just. They put me in the bed, (Laugh) and that was it.

NASIMA: And you sort of rode it, is that right?

BARBARA: uhhuh. That was about it. Ya. So I did better just getting into it the second time around. Kind of 'Macho,' I can do anything in a short period of time, just do it.

Chris

Chris had all three children at home. Her first child was born in 1982, the second in 1984, and the third in 1986. After the birth of her first child she started assisting Holly at homebirths.

NASIMA: OK, how'd you get interested in the idea of homebirth?

CHRIS: (sigh) ... Well I've never been a big medical establishment person in the first place..... I think that a lot in those years a lot of us were in the natural mode movement ...and so that was a real natural part of life. And ... I guess there was just a lot of ... a lot of... noise going around and stories going around at that time about the c-section rate. Just starting to elevate. Not like it elevated after I had my babies.....but just really starting to increase there. And that bothered me... My husband and I just uh... It's hard to think back on this one...I guess we just both felt like if the birth was a really natural process, and I was really healthy, and if we had all good signs, that...it was a much more private and respectful way to have your baby...and we thought we'd get better attention and care...than being in a hospital environment, too...so that's... I think I just got there. Those kind of feelings, yeah.

NASIMA: How do you think you first heard about it, like that this was something you could really do?

CHRIS: Uh-huh. I don't remember that, because it's not something I grew up hearing...and it's not something like my mother put in my mind or anything... nobody that I knew personally had ever had a homebirth, so ... I'm not sure, but I think I must have just like heard around Tuscon that there were midwives and that it was a possibility....And it was something I sought out from there.

NASIMA: Do you think you were involved in anything that helped you to network with some of those people or hear some of those things. Were you doing health food, or doing yoga, or doing any of that kind of stuff?

CHRIS: Um... well I was a vegetarian...But I don't know that that had anything to do with it. No, I don't think so. I think I must have just... sought someone out at the time cuz that's the way I wanted to explore having the baby.

NASIMA: OK. So how did you find Holly?

CHRIS: I found a Naturopath that did homebirths with a midwife...
[Holly came along as a second assistant. She had just moved to town a few months before, and was trying to make connections and get licensed to practice in Arizona.]

NASIMA: Did you have an idea what you were choosing not to do? Did you have any idea what the hospital would have been like if you had chosen it?

CHRIS: mm-hmm. I had a very clear idea of what I thought that I was avoiding.

NASIMA: So why don't you tell me what that was.

CHRIS: Well I thought I would, I was avoiding unnecessary intervention, and I felt really strongly about that. I felt like I was supporting myself to have a baby in the way women were meant to have babies, and if there were no signs that anything was wrong, God made us to give birth just beautifully and wonderfully, and I really believe in that process very strongly. I was also a really healthy woman, and exercise and take care of myself, so I knew that my body could do it well.... we were really into the privacy of it and having our baby in a calm place where we had control of things and not other people telling us what to do... we were very careful that we felt we had good attendants who knew what they were doing and were, uh would call for backup if we needed it. They were very responsible and experienced, so we didn't feel we were putting ourselves or our baby in any kind of jeopardy at all... we felt at the time we would be putting our baby in more jeopardy to go to a hospital...than to have a homebirth by far and large. We really believed that. And I still do believe it...I feel so thankful that I had 3 homebirths.

NASIMA: Did you have to counter any flack, like "what if what if what if?"

CHRIS: Yeah, right, yeah. Probably a little bit of that, but I really think my family for the most part was pretty supportive, or, if they had some reservations, they didn't really vocalize them too much. They tried to support us or were quieter about it....And I know that I had people say, "oh, doesn't that make you nervous?" and I remember my canned response was, "it makes me nervous to think about going to the hospital."
(laughs)... It doesn't make me nervous about staying home.

NASIMA: OK Well then, why don't you tell me about your first birth story?

CHRIS: OK. Josh, then, my first baby... Oh, let's see, my water broke about 6 in the morning....so I knew he was on his way, and I had pretty

just easy contractions and stuff for most of the day. It seems like my [midwives] came... I can't remember when they first came to check me... Seems like it probably would have been... around noonish or something like that, when things started to pick up a little... a little stronger... And then I remember being, probably getting near dinner time because there was this great little Mexican food restaurant just around the corner from us with these real local people, and everything was going fine, and I was picking up, but I wasn't close yet... And so they, I mean literally you just had to go like 3 houses down, it was a real mom and pop operation. So they went over to get food, and the neighbors, we knew them, so they knew I was having a baby, and they were like rush them out of there with their food. (laughs) "Take this food and get out of here!" So they wanted them to have it, but it was like, "get back there," cuz they were nervous. I just remember that part. So, I say that because Josh was born about 5:30... So I'm thinkin' time frame wise, they were getting hungry, and I wasn't close. They got their food. They got rushed back, and then I think it was probably a couple hours when things started to pick up. Yeah. And um... (sigh) I think it took me about an hour of good hard pushing...pushing stage to push him out. And I dilated just normally and naturally, as you would pretty much anticipate. And I remember the last, oh gosh, probably 15 pushes seemed really hard, and I was changing positions and leaning against the bed, and ... kneeling on the floor with my hands against my bed and trying to use that to help me. I remember feeling like, "God, he's never gonna come out. I'm pushing soo hard, and he's never gonna come out!" (laughing) but finally he did, they do... You know, and he broke thru one time, and then out he came, and... let me see, yeah, I'm thinkin' he almost was gonna crown when I was down, and I quickly moved up into the bed, cuz I delivered him on the bed, yeah. But I was pretty much pushing that way for most of the delivery. And... he came out just fine. He was a big baby. He weighed 9-6. So he was good size, and he cried right away....he had good Apgars. And... everything was fine. We just loved the heck out of him. (laugh)

NASIMA: Did he go to the breast real quick?

CHRIS: Yeah, uh-huh, he just cried, they brought him right up to me. We let his umbilical cord you know the cord blood go thru until it stopped pulsing, and then Mike cut the cord and clamped it and everything, and the placenta delivered easily. It was nice and healthy, and they showed me and everything, and yeah, as soon as like he was kinda like breathing and pink and ready to do it, he latched right on and started nursing early, and ...best feeling in the world. Have your first baby there all healthy and beautiful.

NASIMA: And how 'bout Mike? What was Mike's reaction?

CHRIS: He was just very supportive the whole time...very right there for me, helping me with my breathing and calm and everything, and... he had total faith in the 3 women that were tending us, and... just cried when he was born and just was right there the whole time, and couldn't believe it, just great.

NASIMA: Do you remember anybody saying anything in particular?

CHRIS: I just remember myself feeling like, "Isn't he EVER gonna come out?" because those last, like I say you get down to those last 4 or 5 and they're right there. And they're not comin', and you're goin', "Uh! I can't push any harder!" You know, but then they do. They start to say, "here he comes, easy, easy," and they...held the perineum and supported that so I didn't tear. I didn't tear on my perineum. I didn't tear on any of my kids. Oh! To prep, Mike had done perineal massages for me, too, for all my babies, and I didn't tear on any of them, because I had a midwife who knew how to support that. And so that was really cool to... so my healing was just, I mean I was back and on my feet all 3 births really well...The bleeding was just good and healthy, not excessive, but the normal birth has blood... So I didn't have any bleeding problems or anything, so...

NASIMA: Do you remember what kind of comfort measures people did for you or that you did for yourself?

CHRIS: (sigh) I know I sometimes liked pushing on my back, and massaged my back, and rubbed my feet, and the women I know were just real supportive, telling me how good I was doing, how strong I was, and...I'm sure they told me how beautiful I was just cuz they're, that's the way, the kind of women they are...and just "you just, you look so beautiful giving birth," just those kind of statements that just make you feel "huh, you know, I can do this." Yeah, I had water and stuff available to drink, and...

NASIMA: Did you do the tub?

CHRIS: Um, not on Josh I didn't, but on my other ones I did... I think maybe I got in the tub real early with Josh, but no, I didn't stay in there a lot with him. I tried to walk around a lot with him I think is what I was doing in labor there.

NASIMA: OK. So what happened after you had Josh...you had a couple years in there. What were you doing during that time?

CHRIS: I was home with him. I took 7 years off with my boys when they were little, um...

NASIMA: What were you doing before you got pregnant?

CHRIS: I'm a teacher.

NASIMA: OK

CHRIS: Yeah, so I was teaching. Special Ed. And let me see, he was born in April and then that August I started a grad program because somebody called me and said, "we've got a really good grant. Would you like to do your Ed Specialist this way? It's a new program. You can study in 3 departments." And it was a full scholarship. It was people I had done my Masters with, so I wasn't planning on going back to school at all, but when we put it all together, it was a free degree in a really good program. There were only 6 of us that were invited to do it... And I had a babysitter who would come into the home for me. A lovely woman ...my first baby, and I thought, it won't get any easier, so... and I was planning on staying home anyway, and so it would work where I could kind of stay a little involved, but yet be home with Josh most of the time...So I did that, so I went back to school, so I went to graduate school for like a year and a summer to do my Ed Specialist. And then also Holly and I became friends....right after that, and um... so I actually started assisting her...And I'm thinking it was more like a few months later. Like I remember calling her after things calmed down a little bit, and talking to her about it, and asking her if she'd be interested in teaching me some stuff, and ...she said yeah, she was looking for an assistant. It just kinda all clicked in line, it's like, "you really are?" and she was like, "yeah." So I remember we're driving up to her house, and we just like connected, and so I started assisting her, too, and so... I was going to school and then started assisting Holly...It was, it's a pretty cool story. And we're still best friends. She's my best friend, and we've stayed best friends. We've raised our kids together, gone thru all kinds of stuff, had our babies together. Our second babies were born real close, and some stuff there I'll tell you about, so yeah, she's still my best bud. And she delivered my other 2 boys after that.

NASIMA: So this is something that fascinates me is how people with young children can do midwifery, because it seems so difficult...to balance all of those different things. And did that really work out for you? or was it very challenging?

CHRIS: No, it worked out, because I was home for one thing, and because I had good support. I had my babysitter Eve who came into the house and was a wonderful woman, and I think the biggest thing is I have a very supportive husband and father...And Mike totally supported me and Holly and the process of what we were doing for women all the way...So I'd say that was probably one of my biggest keys, beyond our

own motivation to do it, is like he was just totally there.. also just Holly was just practicing doing and getting her practice going, and her husband was supportive, although he had, has a business going, too, well, Mike did too, but anyways... I think the fact that Holly and I had such a good time doing it, as well as we supported each other doing it, that that really made it work. And we were both so motivated. I was so motivated to do it and be part of the process...

NASIMA: How do you think you got so motivated to want to do it?

CHRIS: ... cuz I had such a good experience...and ... it only takes you one birth (laugh) one baby...and boy, if you love babies, and you're just into that, it hooked me.

NASIMA: Hooked you. Had you ever thought of it before?

CHRIS: ...And I just wanted to be part of it. No. Hm-mm. It was after Josh was born, and I met Holly, and like I said, I just called her one day and said, "what would you think? Would you ever be interested?" And she was like, "Oh, I need an assistant. I'd love to talk to you about it."

NASIMA: Did you do prenats with her?

CHRIS: mm-hmm. Yeah, we did. I went to the office with her once a week, and, because that was part of we wanted the women to get to know us and bond with them really well, so I did prenats with her, and then I did postpartum visits, too. And then after I got good and knew what I was doing, I did postpartum visits by myself for Holly, too. So she would go to the first ones, and then I would do maybe second day, she'd do third day, I can't remember exactly what schedule we were on. It seems like... next day, and then we went to 3rd day if there were no problems, and then a one week, or... we had a schedule worked out....So I could, I would do somebody, if everything was going alright, some of those postpartum visits by myself.

NASIMA: So how long did you assist Holly for?

CHRIS: 4 and 1/2 years.

NASIMA: So pretty much the span of having your babies.

CHRIS: Yeah, because Josh was 4 and 1/2 when Colin was born, and pretty much when I had 3 kids to jump and run, it just got too crazy to try to do that. And so then I.. I did it probably for the next couple 3 years I would just do like repeat births of people who were really special to us. So maybe do 2 a year. Maybe 3 a year. But they were real planned. We

knew when they were. So it was easy for us to manage at home. But the jump and run at all hours and the staying for long times... cuz we used to stay with a woman a long time, that just got to be too crazy, so I needed to stop at that time, and then someone else stepped in.

NASIMA: OK. Well, OK, let's go ahead and go into Blake then. Is that another planned pregnancy, or was that...

CHRIS: Nope.. That was... yeah, more a surprise I think that was, yeah.

NASIMA: And was that a good pregnancy?

CHRIS: Yeah, uh-huh, yeah. Everything...same thing. I did the kind of same routine. Um... I was home. I wasn't working. With Josh I had worked till about um... 3 weeks before he was born. And uh so with Blake I was home, ...,and same thing. Exercised, did the same thing I told you about as far as my diet and everything. I was still a vegetarian. Then Holly was up and practicing, and I'd been doing births with her, so obviously, she was my midwife.....I had just seen Holly the night before like about 4:30 appointment, and she wasn't necessarily sure he was gonna come or not, , nothing for sure. But I went home, and... we had just moved into a rental house about a month before that cuz we were building. And... that night I had to put pictures on the wall. And it had to be done that night. So we were running around putting pictures on the wall, and my labor started during that night, so that was...(laughs)

NASIMA: That nesting had to happen.

CHRIS: Exactly, it had to have happened. Mike doesn't forget that one.Yes. So I went into labor with him sometime during the night. My water didn't break. I just was having contractions. I labored all night. He was born about 9:30 in the morning. And, um, my water broke someplace in that labor stage.

NASIMA: Do you remember what you did that time? Cuz you said you did some different things.

CHRIS: Um, same kinda thing walked around, changed positions...

NASIMA: What kind of breathing did you do?

CHRIS: Just slow and easy. No counting kind of... no (pants), except I panted when the head was crowning, but other than that just slow and easy breaths. Josh I remember being like somewhat hard labor...pains. Blake was a lot of pain.

NASIMA: Really.

CHRIS: That's what I remember now. Blake was the most painful. And Holly's Orin, her second one who was born 6 months before Blake, he was the same way. He had been a painful birth, just the contractions hurt. And my big thing about Blake's is, I remember feeling like when it was getting close pushing, looking up at Holly, and I knew she... she couldn't and wouldn't do a thing for the pain... I was like, "Holly! Please do something!" Yk? That's how much I of all people knew it wasn't gonna happen, nor did I want it... but that's always like and she was like, "just one more. Just one more. OK." You know?... And then he came. And he was all fine, too. He delivered fine, normal kind of pushing stage. Probably a little shorter than Josh. Um... he was a big baby. He was 9-13.

NASIMA: Oh, you're good at these big babies!

CHRIS: I know I am

NASIMA: These big boys

CHRIS: I know! And everything worked out fine. Everybody was elated. My mom was real happy to be there to see that, and Eve felt really privileged to do that, too...and same thing. Placenta was fine, and I was feeling good, and....supported the perineum, no tears.

NASIMA: Do you have any special memories of that one...

CHRIS: He nursed right away... from his birth? Like the pain was brutal.

NASIMA: The pain.

CHRIS: I talked about that for a year. Holly and I both did. Those second babies. You don't forget that for a while!And then another one is just Josh, he was a couple years old, and he put his underwear on his head, little Jockey shorts, and he was running around like that! (laughing)

NASIMA: During the birth?

CHRIS: Being goofy. Yeah. During labor. And we have a picture of that. I don't know why he was doing that, but I remember that. And that was funny cuz he was cute.... And other than that, no, I just think I was pretty amazed that Blake was bigger than Josh like that, and... I was very thankful to have him out. He came out easier than Josh, but... ...the pain was more int... well, because it was a shorter labor. But the pain was more intense at the end. So, yeah.

NASIMA: [Inquire about her postpartum experience]

CHRIS: Yeah. Just my mom being there again. She stayed for another 6 [weeks], and that was really helpful, cuz now I had a 2 year old. ...a 2 and 1/2 year old and a newborn, and just having that support of her being there, Mike would sit up [with me], but he was working on construction at the time, so he'd be tired at night, too...and so after he would conk out, and need to go to bed, there's my mom sitting up with me while I was nursing. And I know we had a lot of good talks and times together then, even though I don't remember specifics. Just a woman being there, so she, cuz we were close, to support me like that, and... Blake um had a little bit of, he would nurse and nurse and nurse at that 10:00 feeding ...and then he'd spit it up. And it wasn't like projectile vomiting. It was a problem for him, it just, he'd nurse too much.

NASIMA: Right

CHRIS: It's like it's kinda hard when you're nursing to know how much they're getting versus a bottle. And I remember being confused like so is he all empty? Did he just throw up it all? But now should I let him nurse some more so that he can sleep for a little couple hours? Or did he just throw up enough so that he's just right, and he's still gonna be healthy? I mean I remember being in that quandary with him when he used to do that at times.

NASIMA: Did that last very long?

CHRIS: No, just a couple of weeks it seemed like, and not every night, but...

NASIMA: So then did you continue to help with Holly after that?

CHRIS: mm-hmm. Yeah. Right up until...

NASIMA: So how are you now balancing 2 kids...

CHRIS: So by this time too then, and I had helped at Orin's birth, which is her 2nd child's birth, 6 months before that. So I'd been there for hers. Now she's...at my 2nd...

NASIMA: So do you remember any cool things from Holly's birth when you were there with her?

CHRIS: mm-hmm, yeah. Just kind of the same thing of supportive atmosphere, good attendants. I think Lynn... I'm gues...I'm thinkin' Lynn and Terry delivered her baby Orin, yeah. She can tell you for sure, but...

NASIMA: I have it on tape, but I don't remember.

CHRIS: But I'm thinking, so, yeah. I don't know who else would have. And um... just she had a really good labor. I know she had a chair she sat in. I remember that.

NASIMA: hmm

CHRIS: Not a birth chair but just a comfortable chair to labor in, and I remember her being inside and outside and just ... it was a nice calm birth, too. Good feelings, and... she's just so great. Just the way she handled it, and...it was good.

NASIMA: It's interesting to hear from another perspective.

CHRIS: Yeah, I know, yeah. But, it was hard too for her at the end, like I say. Our second births, we both were... so I watched her do that too when it wasn't fun there for a while...as far as that pains go, but I don't think there were any complications that I remember with Orin or anything like that. He came out fine, as cute as he could be, and... there he was, so... Yep, and Steve was there, and... I think just the midwives and Steve and myself. I don't remember friends being there for that one.

NASIMA: You feel pretty good being friends with ... each other?

CHRIS: At Holly's birth? Oh, yeah. Definitely. Yeah, well I really looked forward to it as an event.

NASIMA: It was nice that you were there for that in return.

CHRIS: Yeah, it was very exciting, because we were doing it for all the women, so we were probably doing... seems like 3 or 4 births a month...

NASIMA: Pretty active practice.

CHRIS: Yeah, it was pretty active, for lots of months, not every month, but lots of months it seemed like. And then to just know that like gosh Holly was gonna do it, and since I was 3 months behind her. We were both pregnant at the same time for a while, too, so then we had the anticipation of me doing it and stuff, and... and we took Orin, she took Orin to births during that time. So then, and then after Blake was born, Orin and Blake went to births together!

NASIMA: If you had transferred to the hospital, was one of you responsible for the babies...

CHRIS: That usually was Holly went to the hospital, so I took the babies, yeah and I was nursing, so I could even nurse Orin a few times when he needed to be nursed, and Holly was comfortable with that and so was I because it was...we knew what each other ate and this and that and ... that he was being well taken care of, so couple times we needed to do that because she was ... you didn't know when people were gonna go off and running in that case... So... yeah, so I would just take Orin home with me and keep him until she was done and that really helped her because she was like totally knowing everything was fine and didn't have to think twice if she could really be there for the woman that she was with....and then come and get her baby when she was done.

NASIMA: Yeah. So... did you continue to practice just as much after you had the second?

CHRIS: Yep. mm-hmm. Yep I did. I continued to practice right until he was born. All as actively as that. And then I just couldn't jump and run with 3 of them.

NASIMA: So what was your 3rd?

CHRIS: Colin? He was trickier...Yeah, he is. Colin I started labor. It was interesting, my mom and dad were both out. He was supposed to be born on Thanksgiving Day...and he wasn't. He was actually due that day that Thanksgiving that year. So he was born December 2nd instead, and my dad left that morning before I went into like labor, because I didn't start till later after the plane had taken off, and I've always kind of wondered if that wasn't kinda... I wasn't gonna do that till my dad left or something, cuz he wasn't supposed to be there for the birth...necessarily...remember how that all worked out. Well, how could he have not, though, if he was, he came out first to visit, and, and he knew when I was due. I don't know. Maybe I take that back. Doesn't seem like we had planned that he would be. I don't know. Anyways, but my mother was definitely gonna stay. So I went into labor then about 11 o'clock that morning ...and Mike and Josh were out getting a new truck, and I was having no kinds of... it was just I knew I was in labor, but real easy contractions and stuff, and it was a beautiful day in early December. And I know I was sitting on the back porch, and my mom was getting nervous because it was getting to be about 3 o'clock and ... I was like, Holly was calling to see how I was doing and everything. I was like, "oh, I'm OK. You don't need to come, and they're real light and everything." And my mom was like, she's like too cool about this, and she's starting to get nervous, cuz Holly wasn't coming because I kept telling her she didn't need to be, and I felt very experienced, that I knew what I was doing and everything, and I had time with my other babies. But then I, I think the

story goes that my mom kinda talked to Holly when she called once and said, "why don't you come on out anyway?" So Holly, or somehow she intimated to her that she might want to. So Holly came out, and seems like by that time I was in the bath tub because I wanted to spend more time in the bath tub with him, for this, with that baby. I was in the bath tub more for Blake, too, I remember, too, especially for those contractions. I forgot about that. I tried to spend a lot of time in the tub with his pains.

NASIMA: Do you find that helps?

CHRIS: Yeah. It does definitely. And then with, with Colin I was gonna spend time, too, and my water, remember Blake's I had not broken...

NASIMA: Right

CHRIS: ...and his hadn't broken either. So when Holly got there, (sigh) um... I don't know if I was still sitting on the back porch, or if I had gotten in the tub at that ... in the tub was part of that, but... sometime shortly after. And I was in the tub, and I literally had no painful contractions until it was getting further along, so Mike called Holly and she said "you probably oughta head home." And he did, but there wasn't any rush about it, just ...come on home now, cuz it was a ways. So they came home, and when I got out of the bath tub, and Holly checked me the first time, and I had had no, I mean I was just... piece of cake... I was like 9 centimeters. And didn't even blink. I mean, I still probably wouldn't have called Holly. That's how little pain I was in....It was amazing. So she said, "gee, you're almost dilated," so I stayed out of the tub, and I went to 10 just like that, and um I mean it seemed like 3 contractions, and then they got strong when I went from 9 to 10 when I, at that point I was in bed cuz she was monitoring my heartbeat, out of the water and everything at that time. And I'm not thinkin' she broke my water, but I can't remember if it broke by itself, or she broke it at that point... But right in there my water would have needed to be broken if it wasn't, and ... then I pushed like one time, and he was right down there... I pushed another time, and he just started crowning. So he came out really quickly, too, like in, maybe it was more, but it seemed like 3 or 4 pushes. And then he was a shoulder dystocia. His shoulders were stuck, cuz he was 10-4.

NASIMA: Bigger and bigger every time!

CHRIS: I know! And so that was hairy. It was also interesting, because I knew what was happening, and so did Holly...[but not so much the assistant] she kinda didn't know what was happening so much, cuz she still... well I was still majorly the person practicing, so (sigh) we couldn't get him dislodged, and I flipped over real quickly and was on my [hands

and knees]...knees and trying to push him that way. He wasn't moving. We were... I felt like I was flipping like a fish trying to get him dislodged. ...but he did come out, and then she put him right on my lap, and we were working to get him breathing. I was assisting at that point. I was no longer the mom. I was the mom, but this baby was not gonna leave me... Holly was saying it, when this was happening in her mind as she was working, "this can't happen to my best friend." (laughs) "this is not gonna happen."...And we were working on the baby. We were talking to him, so I not only, like I say I wasn't the mother, but we were working together as a team, that this baby was...going to make it, yeah because I had kinda switched into my we gotta do something here mode, and so I was working with Holly on that, so that was interesting to have em there and doing this and that. And it really wasn't, like I say, it wasn't...it seemed long at the time...but we were watching the time. The time frames were OK. The assistant was calling out the time, how much time has passed, so we knew where we were. The paramedics [were called and] did show up, and he was fine by the time they did, so it was pretty quick, that tells you, cuz they were just literally down the road... And he pinked up and started crying as soon as she got him to take that breath, and then he was just fine, and he just went good from there, and his 5 minute APGARs were good. And he nursed right away. He was a healthy baby..The whole postpartum thing went just fine, and we were all out in the living room around the fireplace a little bit hours later.

NASIMA: You said you didn't have any tearing even with the shoulder dystocia.

CHRIS: Nope. Not with him either. Nope. Had a few scratches inside. I don't know if they were from Holly or from just baby moving thru... but nothing. Nope. I never had any that had to be stitched inside...on the side walls or anything like that. So nope, he didn't tear either. Even with that shoulder dystocia... And that made my mom very nervous. We have some pictures of she, she's holding Josh and like watching, and the looks on all 3 of their faces are just, they're just like picture perfect of what was happening...Really quite classic. And Mike... Josh definitely remembers, because he remembers hiding under the desk when the paramedics got there.... And showing them where the bedroom was. He vividly remembers Colin's birth, yeah. And my mother said that that was probably enough for her. She was quite concerned, although she felt, we knew what we were doing too and that we weren't gonna push it to a danger point, but dystocia happens like that, too. And Holly had tried to get me... I had watched my protein in my last trimester... I ate the minimum amount that I needed to be healthy and to have a healthy baby so that he didn't grow too big. And he's, we were trying to keep him around 9 pounds, and he still got bigger like that. So I guess it was just I have large babies, and I

still, I only ever gained like in that 25 to 28 pound range, but... big bellies. Big babies. 10-4

NASIMA: OK. And then just basically after that point you decided, "OK, I can't do this anymore."

CHRIS: Well, my husband always said he wanted 5 kids, but we felt so thankful that we had 3 healthy boys...And after having 3 boys, we felt sure we'd have a 4th boy...so we thought 4 boys is just really enough boys. That's 4 dirt bikes. You know, so we didn't think we really needed 4 boys, and we felt it, it scared... Mike particularly was scared at Colin's birth. He had a different feeling...at his birth than he did at the other 2 boys. They were real feelings of fear that something was gonna go wrong with his baby. Wasn't worried about me, cuz I was active and going and all that...but he was really afraid something was gonna happen. And so that scared him. He said to me right there when he was just on my breast and nursing within an hour, "I think we're just gonna stop here. This is just fine. We've been really blessed." And so I think that's kinda right where it stopped. Right there. We just knew we had enough then, and didn't have any more babies after that.

NASIMA: And so at that point you said you pretty well stopped midwifery...

CHRIS: yeah....but it wasn't because of the scare.If I would have gotten pregnant again anyways, I still would have had a homebirth. No doubt about it. And Mike still would have wanted a homebirth, too, so...

NASIMA: So you pretty much stopped right after ...

CHRIS: ... I can't really remember clearly...the whole end process, but it was pretty close after that that I just really phased out and said I needed to stop.

Sharon

Sharon had her first child, Anna, with Nasima as her "midwife" in 1974 and her second child in 1977. After Anna was born, she began learning midwifery from Nasima. She later went onto become first an L&D nurse, and then a CNM.

SHARON: Well, my first pregnancy was a surprise. It's kind of interesting. I don't think a lot of people plan their pregnancies, anyhow. (Laughs) George and I had just split up when I found out I was pregnant, so it was a real big surprise... Anyhow, I was living at a friend's house, and I was actually living in a tent in the back yard of a friend's house, when I found out I was pregnant. Really considered having an abortion because of the timing was pretty bad, and there weren't legal abortions happening at that time in AZ. You could go to CA and get an abortion. And so... one of my friends had told me that an herbal mixture you could drink to cause an abortion, and I went and bought the herbs, and then I... I came home and somebody else I was living with said, "Well, what if it doesn't cause an abortion, it just hurts the baby?" And it was like, "Oh! Well, I can't do that." I mean it's so bizarre now when I think about it, but it was like oh... it just sort of clicked for me something about that I didn't want to hurt this baby. And so I made the decision to keep the pregnancy, not expecting to be with George, which was kind of interesting, and he didn't put any pressure on me either way, and it wasn't until a pretty long time after words that he told me that he was glad I decided not to have an abortion. But... I didn't... I didn't include him in the decision, because I thought we were apart, and... um... so... It was quite emotional time for that pregnancy, but a lot of it was just all that was going on with our relationship...And also even then... pregnancy I think. I don't know for sure. Some of it I'm sure was pregnancy. I remember crying a lot. A lot. (Laughs) Most of the pregnancy crying. My memory. (Laughs) And I actually I didn't have what you call morning sickness with that pregnancy. I did have a lot of just being hungry. I never really... things just didn't taste good to me. Which I guess is not real common. Most people get hungry, or... either have morning sickness or get really hungry. And I... I think I generally felt pretty good. I did have... I can't remember now how I decided to go to a midwife exactly, except for that... I did start... the county had ... an old hospital down on old 6th Avenue then, and I went there for some prenatal care and really didn't like the doctors that I saw. And you would see a different resident every time, ... and I remember... it's like not wanting them to touch me. (Laughs) I thought, "Oh!" (Laughs) And then I heard about Nasima, the midwife, and I decided... I think actually I already knew her a little bit or a friend came to her, or... somehow I'd already known of her, but... decided that I would talk to her. And she gave me the name of an old doctor in town who had helped her some. Never come to do homebirths, but who had given them sort of some books to read and stuff like that. And I went to see him. And he was actually kind of a quack. He's... when I think back on it, but (Laughs)... He checked me and he then had to get out... He did a pelvic exam, and then he got out his book to see. He said, "Oh, well, I think you're kind of short from front to back, and he had to look up the measurement in this book, and (Laughs) had to get out this weird kind of

measuring thing to measure his hand, and I thought, "Now that is..." And now I'm thinking back on it, it was a little bizarre. And uh... but it was enough that he really worried me. And he also told me...he's looking thru his book to look up this measurement, and... there was a picture of a woman with these really big breasts, and he goes that was gonna happen to me cuz I wasn't wearing a bra. I mean, he was really bad! But he... he really laid a lot of fear into me about whether I could have a baby vaginally, but then I ... at the other extreme, I knew I didn't want to go see those doctors at the hospital, so I was really torn. But I did continue my prenatal care there, but I never told them that I was gonna... was planning a homebirth, just had my prenatal care there and set up with Nasima, who didn't even call herself a midwife at that time. She and her husband just would come help you because they had delivered their own children at home. And I think that around... I think I started actually feeling quite good around maybe sev... The first part of pregnancy was hard for me, cuz I'd always been a little bit on the heavy side.....and I felt like being pregnant made me just look fat.....and I... and again all the emotional turmoil in my relationship. And I felt like it was really hard for me. And then once I started looking pregnant and I felt good, I remember really enjoying it, feeling and looking pregnant. But.. it was a while. It was hard at first for me.....um... I think when I was about 7 months pregnant, George and I went back in together, and um... we lived in a little tiny trailer about the size of this front porch, and (laughs) it had a little porch attached to it that we spent a lot of time, cuz it was a roofed over porch. And we planted a really sweet garden there. We had lots of flowers, and we had planted the walls of the porch had 2 sides that were um open to the yard, and we put up trellises and planted morning glories..... so it was really beautiful. This little... it was like an extra little room with walls of flowers, and... um... Yeah, it was a really... when I think back on that time, it was a really wonderful time in my life. Really peaceful. Kind of nice in some ways. But we had this whole this turmoil, but then we had this whole sweet place we lived together. And uh... then... Trying to think of what... I did go over my due date quite far, and then was more and more afraid, because I thought well... and my baby didn't drop into my pelvis, and so I thought, "Oh that's, again, a sign that this baby's not gonna fit." ... and it's not gonna... So I had a lot of fear going into labor, based on that. Some of it was... And I remember when I was going thru my... the last weeks of my prenatal care, I'd ask, "Is there anything...?" Yk... about this fact that the baby hadn't dropped." And they would say, "Oh we won't do anything until you're in labor." And I'm glad now that they never did do any x-rays or anything. They don't do that now, but they used to do x-rays, and they don't... they don't really tell you that much useful... Yeah. so it was... I'm just as glad to know that they don't, but I um still went into it with a lot of fear, and except for it... I one time during my...This is kind of interesting. This was my first time I met Rachel.....my good friends that lived in... uh... Sue. Do you know Sue

James? And she... and they've been here... you've probably seen them here at some of my gatherings, but um... They lived out in St. David at that time. Some how thru them. I think that... and Quentin. They lived on Quentin Branch's property, and somehow Willy was connected. Somehow... I ended up driving to town with them one day. I'd been out to visit them, and we stopped at Rachel's house, which was right over here then... and Rachel had I think... I think delivered one... I think they delivered one child, their own child at home, or... no wait, I think before that. And somehow Rachel had done some reading and... Rachel um... I sort of shared with her that I was worried, and Sam just told me that he was there. I don't remember that. That... I don't remember meeting him. But I guess Trina and Sam were there also. And Rachel kind of put her... her hand between my sit bones and said, "Oh, no, your pelvis is plenty big." But I just held that in my head a lot, and I must be really grateful, cuz I felt like she was this voice of (Laughs) it's just such a lesson in how those things stay with women.....and that's one thing I think a lot of doctors don't get. The power of what they say to women. And how that influences what they think and feel, their fear, and... so... um... I'm being kinda slow here...(Laughs) OK. Um... so I went into labor with probably contractions about every 5 minutes. And Anna was born in August, so it was hot, and... I had like a... I think combined with my fear, I had some kind of quite painful contractions early on. But I wasn't really um making a lot of progress; still, I was just... So I was kind of a long time walking and hanging around, and Nasima would kind of come and go. And we went a couple days doing that. I didn't really sleep, but I just spent a lot of time in the bathtub and walked,... and another really wonderful thing I remember Nasima doing is she would draw a little heart on my belly where she heard the baby's heart beat.

And that... I watched it move down over time, and so I knew that that head was moving and that the baby was moving down. And so... that was really ...an amazing... the thing that stayed with me as something that gave me a lot of hope that things were working OK. And it was... uh... I also remember when things got quite intense, looking at Nasima, and thinking that she had had 4 children, so... somehow I would survive this, cuz I looked at her, and I knew that she had done it, and that she was sitting there calmly and helping me breathe, and... I did with ... with that birth I did do a lot of what I guess would be like a Lamaze technique. Which.... I had taken a childbirth class, and we had kind of gotten into fights trying to practice these exercises.....George would say, "Relax." I'd say, "I AM relaxed." (Laughing) We'd get in a fight about it. But I think it did help just having that knowledge base, but I... it was really in labor that I learned to do the type of breathing that they had, and um... part thru Nasima, and I remember Nasima telling me to focus on my breath just in the tip of my nose. It's this really "hmm" really such a delicate fine sense of things, and it really did help me deal with the contractions. I guess another thing that kind of went on over this period of time, we had an extended group of

friends that would come and stopped by and came and went, which ended up being very difficult for me, cuz I'm the kind of person that will try to take care of people when they're around, and... that... I think I learned a lot in terms of trying to protect women in labor from having a lot of people around. And some people actually do better with people around. And I think some people there, but... you have to really watch it closely, because I think that also kept my labor sort of at a certain level of not getting quite intense, cuz I couldn't deal with that on top of dealing with these people and figuring out uh... I was just too young and shy I guess to say, "You need to leave," to people! (Laughs) Finally, I think when my labor really kicked in and got strong was when everyone just kind of left or fell asleep, or.....somehow I was mostly by myself. And... what else do I remember about that?

NASIMA: When did your water break?

SHARON: I don't remember exactly when it broke, but it was quite a ways into labor. It wasn't... It was toward the end even. I may have even been pushing when it broke... And.. the other interesting thing was Nasima was very non-interventionist. She didn't even do vaginal exams at that time, so I'm not even sure at any point what I was dilated. I was having contractions, and we were watching the heart rate move down. And... I think she gauged a lot on just seeing what... how you were responding to the contractions. And at one point, she just told me to start it was time to start pushing. I didn't have an urge. And that was very difficult, because I pushed for a couple of hours without a real strong urge to push, and then finally did get up and walk around and push as I walked. Kind of did that together.... I can't imagine having ... I've worked as a nurse and taken care of people, and they're laying in a bed, I just... I just would never have done that. I... I don't think I ended up laying down most of the time I was in labor. With either of my babies, so I just can't imagine being expected to lay down... Yeah..And then I... So I pushed for a couple hours. And at that point, we were on the little porch, and it was night time, and we were outside, and... I also remember things of being in this real altered state of consciousness where I was very acutely aware of what was going on, but it was like I was watching from somewhere else, and things weren't bothering me, and I remember there was these flies flying around, and it was bugging everybody that these flies were flying around me, but it didn't bother me at all. (Laughs)... So...and it ended up being... I think I remember... what I remember as feeling this support, was there was my friend Jess was there, and her daughter had a baby 6 months before. I remember strongly feeling that sense of support from there, and them having gone thru this also. And also .. my friend Sue James, who hadn't had children yet, just her friendship, I remember feeling very strongly at that time when things were quite intense. And for the actual birth, I think there was a ... there was George's brother Frank was there,

and a good friend of ours Paul was there, and it's funny, I don't ... and there was another friend of ours, but I think he was sleeping in his... in his bus out on the street or something. (Laughs) And it's funny I wonder if there was somebody else there I don't remember. I never thought of this...

NASIMA: Lots of men.

SHARON: Yeah, that was a little odd. They were kind of an outside circle, and .. when I had my second baby, I was really clear that I didn't want a lot of people there after that first experience. It was real interesting to me. (Laughs)

NASIMA: You ended up though with quite a few, didn't you?

SHARON: Um... But it was all just the midwives, and... and your mom was there...People who had a purpose for being there [side conversation about Susie's daughter chocking on a apple while she was filming Sharon's second birth]...I think when Jenny was born. ... I can't tell you .. how incredulous I was that a baby had come out of me. (Laughs) I can't... I mean it was just like, "Oh! It's a baby!" (Laughing) You know I was like... I had just gotten so... The labor was so all-consuming to me that I had even forgotten why... what was happening, or what was going on, and it was just the most incredible experience in the world to me to see that there ... that was a baby that came out of me.....and I guess I didn't really... I didn't know it on that level until I saw it happen, and... um... I was just such an incredible. To have gone through such incredible pain, but none of it mattered as soon as I saw her. It was amazing to me that that was so... so completely erased as soon as I saw her. Um... and she ... I remember real vividly Nasima took her and was holding her over her arm and rubbing, drying her off, and Anna started pooping. And... Nasima said something like, "Oh, yuck, she's pooping on me." And I was just incensed that she was complaining about my baby. ...And I was like, "Will somebody take her?" And ...nobody was... and I was like, "Well, give her to me!" That's I was like... (Laughs) "How can you be upset about a little poop at this time?"...And so I don't even think I had delivered the placenta, yet. But we were just kind of... It was just amazing. And then... I did... I held her thru all my ... She started nursing quite soon. And then I remember we decided I needed to try and deliver the placenta. I was gonna sit up and squat to see if the placenta would come out. And I looked over at George, and I said, "Here George, will you take the baby?" and he... It was the first time I had again even focused outside of myself for so long, and I looked at him, and he was like totally blown away. And I said, "George, here you hold the baby." And he looked at me and went... (Laughing) He was scared to death. But he did, he took her and held her. (Laughing)... I have this wonderful memory of the look on his face. And um... gosh. And I remember I was just like

floating in clouds for a couple of weeks. And then I became ... I got kinda crashed and was really tired, but I remember so strongly, my life had been very unfocused up until that point. I had had a very .. dysfunctional family, had left and come here and still was kind of very unsure what I was doing and kind of floating around, and.... going wherever the swim took me, and... I felt so grounded and so... connected to the world after I had the baby. It was so different, and I remember one day sitting on the porch where Anna was born and looking, and I... I looked at this tree, and I felt like I just belonged here so much. Just like the tree belonged here... It was just... I don't know why that was really powerful for me. That feeling of like this was really a big ... this has really connected me to the world. ..And I was just... I just couldn't believe the whole birth experience had been such a... so empowering for me, that I had gone thru that and had done it. And...had this beautiful baby as a result of it. And I remember we didn't have a car at the time, and I would like ride the bus, and I would look at people with kids, and I would think, "She did it, too." I mean I just felt like I had joined this secret club that I didn't realize how, how immense this experience was... and I'd always felt... when I was in high school, I had never felt really good about how my body looked, or... and... you know breast feeding... I just felt like I felt good about myself for the first time in my life after giving birth. And my body had done this incredible thing, and it was making this wonderful milk, and... I don't know, I just really....there's a lot of... I was talking to somebody recently about how sexuality changes sometimes after birth, and I there's this certain percentage of women who say it's better, and I have to say it was for me, better after I had a baby. I just had... (Laughs)...yeah. Reconnected to my body... so... So that was Anna

SHARON:... And I had registered to go to nursing school right before I thought I was pregnant, and so... I kind of... All those plans changed... for me... and then decided after I'd had this incredible homebirth, that I was gonna... I offered to Nasima shortly, and I.. I would go visit her a lot... to work with you. And then at a point in time when Anna was about one, Nasima was due to have her fifth baby, and there was quite a few people coming to her asking her to help them, and so she gathered together anybody who had expressed an interest and formed this extended group of us that started studying together. And we would go as groups of 3 to deliveries... Usually 2 of us would go, and then Nasima would come towards the end, because she was the one who had...

NASIMA: Right

SHARON: ...the most experience. Or Nasima and Daniel. I think Daniel actually stopped doing it fairly soon after we started working in that group. ..Yeah... He was present at Anna's, so it was Nasima and Daniel. And it's interesting... Daniel was very brilliant, but he's... he also didn't

have a lot... just couldn't relate to him. He was very in his head a lot, and so I think he was actually the one who knew the most about birth, but people wanted Nasima there because she's... intuitive. (Laughs) ... and so then I started going to births with Nasima. And fairly soon was doing quite a few deliveries, and well often on my... with other midwives, but often not with Nasima or Daniel, and just sort of they wouldn't make it there, it was just too much going on. And became very... very involved in that whole thing pretty quickly. I mean I think I had such a nice... Anna was a very mellow baby, and so she went with me in doing everything. Went to all my births with me. (Laughs) And...so I was by the time Jennifer was 3 and 1/2 years younger. I think it's about the same spacing for you guys... And so I had done a lot of midwifery by the time I had Jennifer...I had done a year's training at the free clinic that Margaret Pope had given us. A Certified Nurse Midwife. For prenatal care, and... it was a whole different experience going into that pregnancy. And then we had planned to get pregnant with that.....And... I was really clear that I didn't want to have an only child, so it was... planning the second one, and..... I felt miserable that pregnancy. I had lots of morning sickness. And I was also working. I was still doing a lot of deliveries. And I found it was very hard for me to do deliveries when I was pregnant. It was very hard for me to... to focus that energy outward. It was really interesting. I mean... Yeah. It was really... It was really interesting how different that was. Except for I really still loved doing prenatal care, and I never... even when I was really nauseous, I would go work at the free clinic one or two nights a week, and my nausea would just go away when I was working there. It was really kind of interesting. So...

NASIMA: Was it emotionally easier than Anna, cuz you were more settled...?

SHARON: It was in some ways, and in other ways it wasn't, cuz we had... we moved into this house with a group of people while I was pregnant with Jenny, and so there was that whole thing of getting used to living with this group of people, and it was three young guys. three guys again. So here I was for a while the only woman here, and it was... yeah, and then Sue James came with her kids and her husband, so she was here also, but it was just... It was really that was actually more stressful in some ways. It was kind of interesting. But.. less stressful in terms of my relationship with George. It was much softer, more serene... And the other thing that came up for me right at the end of my pregnancy, I learned that I could apply for a midwife... They were opening licensing... midwives in AZ at that time... and they would allow anybody to apply for that first group of licenses who had been practicing. And so if I took a test starting in January, she was born in December, I could get my license. And after that I would have to go through a program... kind of program.. So there was this sort of stress that came up of having to start studying and

do all this stuff to get my midwife license during my pregnancy. So... it was worth it, but it was still ... Jennifer, as a baby was so much more difficult for me than Anna....that it was... it was actually the time after she was born that was much more stressful. Really really quite stressful.

NASIMA: Cuz she was a lot more work.

SHARON: Yeah. She was just a real... Both of my girls had colic. They were very colicky for the first 3 months. But Jennifer was just also very persistent and very... She was just really different than Anna was a lot of it. Some of it was... she was just a different baby, and it took me a while to learn how to deal with that. How to love her in a different way. Well, she was not a baby that liked to be cuddled or hugged kind of thing....which was really different. You could hold her, but mostly just to nurse, and you couldn't like squeeze her. It's a lot of things I just had to learn about her and love. It's just her, a lot of it? Her... her level of wanting to take in sense stuff.

NASIMA: What was Jenny's birth like? [side conversation about if I remember Jenny's birth. I was four years old and what I remember of my sister's birth when I was three]

SHARON: Yeah. Well Jennifer's birth... She was, Anna had been 2 and 1/2 weeks late, and Jennifer was due the day before Christmas. And so I was sure that Jenny was gonna be 2 and 1/2 weeks late, too, and I had (Laughs) set up my team of midwives. And it was Nasima, and it was Angela, and it was Linda. Then Angela and Linda both called me the day before and said, "Well, what do you think?" It was Christmas, and they both wanted to go somewhere. Oh no, it wasn't Angela. It was Linda and Cherie. And they both wanted to go somewhere. And I said, "Nothing is happening. I'm not gonna have this baby right now." I mean it was so crazy. It was Christmas. I said, "I don't want to have my baby right now. So go ahead and go." So of course the next day I went into labor. (Laughs) And I had had some Braxton Hicks for a couple weeks with her. Contractions off and on. But life was just crazier. I lived in this big house. I had this three year old to take care of. I was doing midwifery. It was a lot more going on. I didn't ... just Christmas seemed a little overwhelming. And I thought, "I don't want to have her right now." But (laughs)...

NASIMA: She had other plans.

SHARON: I'd gone in for prenatal care and they said I looked different, and I'd had a contraction on the way where I felt ... I kind of held the steering wheel a little tight. Thought, "Hmm, that's interesting." Cuz I'd been having contractions for a few weeks, and I didn't know at any point

what ... what it was for sure. And then I went home, and I cooked dinner, and I noticed that as I was cooking I had to stop and just sort of stay still with the contraction, and that was different than it had been. So I think I did end up calling. It was about 9:00 at night, and I called just like, "Well, I think this is it." And I had some bloody show, and I decided to call the midwife and tell her. And I'd call her back. I thought something was happening. I'd call her back. And we set up a new birth team, because the team had gone out of town for Christmas that I had arranged to have, and then... I just sat up by the fire and told George to go to bed and Anna. I was expecting this long drawn out labor like I had the first time. And I said, "You go to bed." I just wanted that time by myself. And I sat in front of the fire, and it WAS pretty amazing to sit there by myself and deal with the contractions. But then I did get to a point where I felt like I needed help. I got in the tub for a while, and I... I did check my own cervix and sort of felt, "Well, I think I'm only about 4 cms." But they were getting stronger, and I woke up George, and then I think it was around midnight, 1:00 we called the midwives to come over. That labor was very strong, and I was very uncomfortable during a lot of that labor. And I had tried doing the breathing like I had done with my first one, and it didn't work, and I... I went into a chant. I did a chanting and rocking.....and it worked much much better for me. Kind of a moaning. And um... I ... I have found that I like that even better than breathing now when I'm helping people, and I try to move them in that direction. And unless the sound gets to be kind of a tight, freaked out kind of a sound, it's actually better to make sound... Anna when she was in labor said the same thing, that...she did... she did incredible, and she found that if she did the breathing, she could feel the contraction exquisitely but sort of maintain control. But when she was moaning, she didn't feel the contraction. She said it was just that different energy or something. (Laughs) Moving out of her ... I remember walking a lot in the yard and being more I could say intolerant of people, and they brought me warm honey water instead of juice. I was really mad. I said, "I'm not gonna drink that." (Laughs) And I remember being so indignant (laughs) with that it's ... I remember telling George to go get wood for the fire and then when he came back yelling at him for having left. (Laughs) So, that was a lot of that labor. I remember, I was working quite hard and walking around, and I was quite hot, and it was kind of a drizzly night. It was really quite nice out. It was this time of year. December. And the midwife and the assistants were sort of huddled around the fire, cuz our house was pretty cold, and (laughs) and they kept trying to bundle me up, too, and I said, "No, I'm hot!" (Laughs) And so,... I ended up... and then the midwife who had done..... who had been giving me prenatal care at the clinic I had gone to... she came over just to be a support person at the end, and I .. I really realized the connection I'd had to her, because she'd done my prenatal care, and how important that was. And what a difference that makes, and how... it helped me so much when she came in. That was real interesting.

We were trying a lot of things. We were all set up for the birth in the bedroom, and then... I was... we were sort of hanging around in the living room... I was sort of hanging on to people, trying to keep myself from pushing, cuz I felt like pushing for a long time. And I had a lip of cervix, and ...we were waiting for that to go away, and one of the times that Nasima was checking me, I laid down on some pillows right in front of the fire, and she checked and pushed on that lip, and it went up, and the head came down and crowned, all in that same moment, and everyone had to run for things, cuz everything was in here. And I told somebody to run and wake up Anna, my daughter, who's three, and I didn't want her to miss it. And she came out like, "Whoa! What's happening?" She went to bed, nothing was happening. Woke up, and all these people were in the house, and ... (Laughs) this funny thing coming out of her mom. So that part was very quick and easy and uh... I didn't have any tears with that. I remember real distinctly,... feeling... I mean somebody telling me at a certain point to relax, and I felt this stretching of the head, and I had done a lot of uh Kegel exercises when I was pregnant with her. And I felt like I was really in tune with those muscles in that part of my body. More so than I'd been the first time. And I remember I just did just let go, and I didn't tear or anything.....and I remember feeling afterwards, like looking... I felt like I had... like I couldn't tell I'd given birth. It was such a difference from my first delivery where I'd been swollen and sore and had a few stitches. And... so that was really interesting how much easier that part was. But then, as it turned out, I did have to go in... because her head had come down so quick, it had burst a little blood vessel inside my vaginal wall, and so I got like a blood blister that grew for a few days.....and it wasn't painful at first, but it got slowly more and more painful. And I went in to see the doctor when she was a few days old, and he had to drain it. Yeah. So that was kind of interesting.

NASIMA: What was your postpartum time like?

SHARON: I had a very difficult time postpartumpostpartum with Jenny. Part of it was it was hard for me getting used to having a second child, and I was so worried about Anna feeling left out, that I felt like I didn't really let go and let myself really love Jenny. And she was much, she was harder to soothe, and she was... She was just a different kind of baby. She was never one that you could bundle up tightly. She would scream. Or hug real tightly, and... so I had to learn a different way of being with her. And what finally really helped me, I remember, was... George's brother took Anna up to visit their parents for a week or part of a week....and it was real interesting because it gave me time to just be with the baby. And I felt kind of... fell in love with the baby at that point. And I was also, I was living in this house with a group of people, and... it was kind of stressful. I was trying to like... nobody was really taking care of me. It was really kind of interesting. And George...he was working as a truck

driver at that time, and I think Anna was just, I mean Jenny was just like a week old when he had to go back on the road, so it was not the ideal.

Nancy

Nancy worked as a pediatric nurse in a hospital in the early 80s. She also did some labor and delivery nursing at the same time. Nancy had given birth to seven children at the time of her interview. She had a hospital birth in 1984, a birth center birth in 1986, a planned homebirth that transferred to the hospital because of premature labor in 1988, homebirths in 1991 and 1994, a planned homebirth with a transfer due to prematurity in 1996, and another homebirth in 2000.

NANCY: Ok, I got married on my 28th birthday and then that was in 82, and then in 84, April of 84, I got married in September of 82 and then in April of 84, my first one was born... and I wanted as natural as I could get. So I went osteopath for the doctor and when I got to the hospital, it was, there were a lot of good things. I didn't, they didn't do the IVs and the, and it was natural and it was a birthing room and I had my brother and sister-in-law and my husband all with me and the nurses were great, but the doctors were cold. And I felt like I was not treated like a human being and he just talked really, I thought really rudely to me and it was, the doctor had the intern doing everything and so then when he came out, well one thing was I never had the urge to push and so it was very painful every time I pushed. The pain was worse than the contractions...so then m when he came out, the cord was wrapped around but it... snapped apart, so then the doctor stepped into help the intern clamp so he wouldn't bleed to death...And then I having been a nurse, having worked in labor and delivery, having worked postpartum, knew what kinds of things should be done and then the positive was they let me, they said I could go home in 2 hours if I wanted to, but I thought, I've got this gourmet meal if I go home, I will miss out on. So I stayed, but then the care was really bad. They never checked me to see if I was hemorrhaging. They forgot, the doctor forgot to write orders on me and so as, I felt like I might as well have gone home with the mount of care that they gave me. I knew what needed to be done more than what was being done for me.

NASIMA: [Inquired about how she first became interested in natural/homebirth]

NANCY: OK, well I was born and raised in Mexico of missionary parents, and then I went to, I went to high school in California and then I went to college in California and got my nursing degree there. And that's actually, while I was in Nursing school, that I first heard about homebirths... Cause we watched a video, a movie in our nursing class done of documenting a doctor who did homebirths. And I was very impressed with what I saw with homebirth that this doctor was doing and so that was my first experience with that and then when I graduated from college I worked in a hospital in a teaching hospital for seven years, kind of off and on...

NASIMA; When you were in nursing school and you saw the video on homebirth, how did, do you remember how other people reacted to that or did anybody else say anything or was it sort of talked about in the positive or in a negative way at all in nursing school?

NANCY: I don't think it talked about it negatively, it was talking about it as an option, another way and I know another fellow nursing classmate. She went osteopath and it was very natural and when she wrote letters to me and told me about it, it was very positive, and when I hear that compared to what I'd seen in my hospital nursing experiences, I really liked it and it sounded so much better to me and so that's why I went osteopath.

NASIMA: Ya, and it didn't work out quite like you expected.

NANCY: No, and I had asked them now don't, you'll make sure, cuz he had talked about too how I had, I don't know, I had read plus remembered from that you don't always have to have an episiotomy....And it, if things are done right, you shouldn't need one and that was one of the things I said to the doctors and they did nothing to help prevent episiotomy. They just cut, and I had a very bad experience with that and it didn't heal right, then they, five months later they re-cut me open and redid it and it never did heal right, ever. And, um, so that was when I decided that I'm going to start looking another way. And I heard about homebirth, they do things like that here in Tucson, but I wasn't quite ready for it, so I went to the birthing center with my next one....So I went to the birthing center and had midwives and at that point I had also read in some journals that, that in Europe they have four stages instead of the 3 stages that the US teaches, and one of those stages is the urge to push... And you don't rip if your, if your on your side and different things and so when I went to the birthing center I talked to them about doing different ways of doing it and could I do it on my side and they said, yes and my experience with them was very positive. [side conversation about birth center midwives]

NANCY And ah, and it was right in there time when they were they got bought by Thomas Davis and it was right in that time and that was a lot more positive experience. The, my bag of water broke early, 17 days early and so I wasn't even expecting it, so I didn't have anything out and my contractions hadn't started so I went out and got all my baby clothes and started washing them and doing different things and then they said that if I hadn't started labor and was going that by 4'oclock to be at the clinic so that they could check me, so anyway they, one thing I appreciated was they use natural means to help labor get started.

NASIMA What did that mean?

NANCY They gave me an enema, cuz I know labor had started cuz my bag of water had broken, and they confirmed that it was the bag of water had broken and so they then they gave me an enema and then they told be to just, to go off somewhere and play with my nipples. And so we didn't, since we lived clear out here in Catalina, we went to a friends house and, so I am sitting there visiting with them and once in a while play with my nipple and a contraction would come. And after a while, they started kicking in on their own and so...trying to remember, we went in at 4 or 6? Cuz at 6'oclock is when I remembered that labor, must have been 6 and then I went in and was checked and I was only 6 cm, so they told me to walk, go away. Now that was a disappointment to me, because they had always talked about they're with you and they'll be with you and all, and she sent me away and I felt that the reasons, cause she had a party she was wanting to be at...And so we went, so we just went and sat in the parking lot and I went into full fledge transition there in the parking lot and then my husband had a hard time getting the answering company to believe him that I was really in labor, since I was early, in order to contact her and so by the time they got a hold of her and they got me back to, got me back to the clinic, I couldn't even walk. It was 10'oclock at night and the transition, I was well into transition and but once I got in there, they were helpful and really good ...

NASIMA What kinds of things did they do for you?

NANCY Well, they, I was still only 6 cm and so finally she said m she said to go ahead and give a push. It was, I had the urge to push but I'm still only 6 cm, so she, I think I must of had like a cervical lip or something, now looking back, cause she told me go ahead and push and she did something and I opened right up to 10 and so I went in at 10 and at like 10:20, she was born.

NASIMA So you didn't push very long, either?

NANCY No, and I did it on my side and... I felt positive about it. My husband helped hold my leg up and I did it on my side and she was born fine. There were no rips nor tears or anything, so to me that was the most wonderful... and I felt so good afterwards and my parents arrived from California like I don't remember if it was a half hour or an hour later and Larry was able to carry her to the door of the birthing center and say here's your granddaughter and the care was very good and it was nice and relaxed, so it was like night and day to me, the experience and I felt so good that the next day, I felt like being up and about and doing everything, which I had never felt with the other one.

NASIMA How had those early pregnancies been, both Nathan and Elizabeths, had they both been pretty positive pregnancies, did you have any complications?

NANCY Nathan's the one I had a lot of problems with constipation with Nathan and that was a real, I struggled with that through out the pregnancy which I'd never had before and that was part too of some of the problems with episiotomy and after I had that problem, after he was born and I was still having problems, they finally told me about taking calcium and magnesium, and I began to take that and they said to take the same amount and just up it until your stools get loose and then, and I had not any problems. If I start to have any problems I just make sure I am taking calcium and magnesium and it really works. But I had used all the unnatural methods before and nothing had worked and so it was nice to find out that something natural like calcium and magnesium works better for your body.

NASIMA: [Inquire about how first birth began]

NANCY: It lasted 20 hours and it was just little cramps at the beginning until it got more frequent and more and more and so he was born 8 at night and so I started probably, I don't know, 20 hours before that, but I went in to be checked like in the morning and they told me to go off and eat breakfast, which in a typical...they told me go off and eat breakfast, that's what I really liked is because with the osteopathic, they didn't have the IVs and when I would start to loose strength during the labor, they would give me apple juice or any juices that I felt like to drink and that would just give me that little extra energy to keep going and I appreciated that, and you don't have all the monitors on you, all the invasive things. In a lot of ways, that was one of the things that was very positive, cuz I just, all the invasive things are so distracting when your trying to work through contractions and I think in a lot of ways its more harmful to the child to have them putting the monitor inside you and to monitor the baby and just different things that rather than it being natural, its invasive and I think

that in a lot of ways, a lot of problems that babies have, that end up in C-sections is due to the invasiveness that they do in hospitals.

NASIMA: I understand. I'm gona just go back here a little bit, ok, when you were an L&D nurse, or floated, doing the what you did what was the standard of care that you generally saw for in labor and delivery?

NANCY Well...

NASIMA What happened to most women in labor?

NANCY Well, they all got this monitor strapped on them. Some of them had the internal monitors put in them. Ah, they weren't allowed to get up and walk around. They all had the IVs. It was all the protocol things, and then right when they're in the transition, just ready to deliver, the hassle in their the pain and everything they are going through, to be moved to a labor and delivery room just seemed cruel to me. After seeing both I look back and I go what a cruel thing to do to women to move them in that most crucial and most painful time. And then to be strapped down in the labor room... On your back and strapped and it, they were uncomfortable, it didn't matter that's the position they had to be in and doctors barking at them. Rather they need the gentle caring at that time instead of doctors barking at them. And the sterileness of it all, I mean to me it was just like a very cold like pushing cattle through or something. I don't know. Its just, I didn't...I felt like more compassion for the women and I wished that it would be more compassionate toward, for them then it was. And people wouldn't believe the women when they'd say things, oh no it will be hours from now or whatever...

NASIMA: Did you have to work through a feeling of how there are so many what ifs?

NANCY: Id just figured it was going to be ok. The what ifs came after Id had a premature.

NASIMA Oh, ok.

NANCY Then the what ifs came. When I, with my third one, they I'd just felt everything's was going to be fine. I had no problems and then at 29 weeks, my bag of water broke and the we were in Mexico and so then the what ifs came because ah I had already worked in neonatal and seen all the horrors of the little babies and all that could go wrong and all the just the vital...I can't think of the word...how just they're right on the edge. Ya, right on the brink of did they lived or not live, what could go wrong with them and so I envisioned this premie with all these problems and I felt that no way down there, would they know how to care for that kind and so I

came back to the United States and thankfully I lasted 3 weeks before labor started and the doctor in Mexico they gave me, they worked prophylactically with me. They gave me antibiotics to prevent infection. They gave me steroids to mature his lungs faster and they gave me something to prevent contractions. I got up here and they quit all that. They stopped all that and they say, we don't do that anymore and but they just kept an eye on me and did non-stress tests and at 32 weeks, then I went into labor and I envisioned what all could have happened and what could happen in things, so I was really nervous about it, but they, there we had big battles in the hospital with the doctor.

NASIMA: so how did you have it planned out what your birth was going to be like. Were you going to go back to the birth center?

NANCY No, that was going to be my first homebirth.

NASIMA Oh, it was. Ok. So how did you go about preparing for it. Obviously you didn't get it, but...

NANCY Well at that, it was so early I hadn't really started preparing for anything except that I was going to a midwife before we went to Mexico. Holly.

NASIMA Ok, how did you find Holly?

NANCY Through the birthing center, actually.

NASIMA Oh you did?

NANCY Well, no, I had heard about her at the birthing center, but also through the crisis pregnancy center, that's where I got her name. The crisis pregnancy center had given me her name. I called them and asked them ...I had, I asked various people and she was the highest recommended one.

NASIMA Interesting.

NANCY Of all the midwives. And that's how I ended up calling her and going with her.

NASIMA And did you do most of your prenatal with her?

NANCY Yes. I had been doing that but I hadn't had very many yet because we'd go back and forth to Mexico and Tucson, so I had one with her and everything was fine, we went to Mexico and while we were down there, that happened and I called her like at two in the morning, so and

said, I think my bag of waters broken and I was feeling pretty frightened cuz, since that was what had happened with my second one, the bag of water broke. I knew how it felt and what was happening, so...

NASIMA: what did she do for you?

NANCY Well, she was going to, she recommended I go to the university hospital when I got backup here and she was going to be there for me when I went into labor but I don't remember the whole thing but she didn't get to a really participate with that one. Probably maybe things would have been better if she had, but...

NASIMA Ok so when you come up from Mexico after they have given you some of this prophalactics stuff to try to keep you from going into labor did you actually stay in the hospital or were you just checking in or what were you doing?

NANCY Well, ... I check in and I was in for I think three days and they let me come home. They let me come home because well the doctor understood my mission organization and because they knew that I was a nurse, so they knew what signs, I knew what signs to look for. So they let me come home and be with my family and I was on strict bed rest and then I'd just go in like every three days for non-stress tests... And they did a sonogram and said that 80% of the water was gone, but as my body would try to replenish it, it would just go out, so it never did more than that. And I felt that I would have lasted longer, but the last time I'd gone in for stress test, the nurse started trying to manipulate, move, get the baby moving cause she wanted to see more movement, which is, and I think that's what got the labor started cuz then that night my labor started. Cuz I wasn't supposed to be moved or touched in more than necessary to try to get the baby to stay in as long as possible, but they told me that it would be quick and fast because he was premie but it wasn't. With Elizabeth it was 6 hours, with him it was 12 hours labor and...

NASIMA: Do you think part of that was because it was so stressful, I mean do you think that was part of it?

NANCY: I don't know, but we had to fight the doctor.

NASIMA: How did you choose the doctor?

NANCY: Well I ended up with the doctor on call.

NASIMA: Oh, ok.

NANCY: And I had already had problems with her once before when I had gone in to be checked. They gave me, they sent her in to my room instead of the doctor that was... supposed be in and she wanted to, she wanted to do an internal check, which I knew could promote labor, and I, and we said no, that's not to be done, and she got really mad at me and kind of huffed out and so then when she was the one on call when I actually went into labor and my doctor was gone for two days, so he wasn't there and she because of what my episiotomy looked like, it freaks doctors out. I don't know how that all fit, but anyway, she wanted to do another episiotomy on me, and I said no. And Larry said no. I go, this ones a premie, this ones going to be smaller and there's no need. My last one, I didn't need one, and I did fine and I didn't tear. I don't need it. And she was going to insist. And she turned, and Larry and I both firmly told her no, she was not to do an episiotomy, and she turned around to get the instrument to do it anyway and so that got me, so when the contractions came while she was turning around, I pushed him out and ah so then she was really mad at me and bawled me out, right after he came out, he had a bruised eye. She blamed that on me, and they often can have bruised eyes, thats just part of the labor process. It can happen, but she blamed me for the bruised eye because I pushed him out before she could do what she wanted to do and it was a very negative experience. Very negative.

NASIMA So then what happened to your son?

NANCY Then he was taken to neonatal intensive care...

NASIMA Was he breathing?

NANCY Yes, and he, I think because of the care that we had had at the very beginning...[in Mexico]. He had no lung problems. His Apgar scores were good, and he was just, he was 4 pounds, 5 ounces...and he did really well but they kept him in. He had, didn't have the suck reflex yet and they kept him in for 22 days before they let me take him home.

NASIMA: Was that because they were feeding him?

NANCY; Ya, but in some ways I felt that I could have fed him better than they did, too, because, but they wouldn't believe me, but I told my husband, we can just let them do what they want to do, because you can't buck the system.

NASIMA: So did you, were you just pretty much living there, too, as well or...

NANCY: Well, I went there some, but I had two children at home. We went everyday, never missed a day, and I pumped, I rented a pump, a breast pump and pumped it and took milk to him all the time and they wouldn't let me try to breastfeed him...the first time they let me try to breast feed him was the day before I brought him home. And he was 21 days old. That was the first time they let me.

NASIMA: And was he able to?

NANCY: At that point, yes, because they wouldn't let him go home until he was able to suck and that was very different. Their philosophy, from what I had seen at neonatal intensive care where I had worked in California, and because they wouldn't, if you wouldn't suck on a pacifier, they wouldn't let him try to nipple feed and where as when I worked in California, we would put the bottle up in them and we would just kind of let a little bit of the milk drip in so they would get the idea that there's milk here and really want it. To give them the desire to want to suck, where as their philosophy was the opposite, don't do it unless they are already sucking, so I found that a little hard to handle and so...

NASIMA: When he came home, he was ok?

NANCY: He was fine. Fact they told me don't breast feed him very much when you get home. Bottle feed him and he hadn't gained much weight and my other two had gained weight really well at the beginning, and so when I got him home I just breast fed him and he gained right away and did really great after I got him home. He didn't do well there, but once I got him home, he just started thriving and gaining weight, doing really well and I didn't have problems with him at all.....

NASIMA Ok, alright, so on to number 4 I guess.

NANCY Ok, so then since I didn't make it with number 3 to have a homebirth, we then planned again with number 4 to have a homebirth and we went with Holly again, I mean the pregnancy went great when it was time, then I called her and she came and...

NASIMA; What was that labor like?

NANCY: It was much more relaxed. Much easier to me and I found being able to stay home, it was like in the middle of the night and my, I didn't have to get a baby sitter. My children slept and it was just much more relaxed and she came and we were, I was still at home in my own bedroom. I found labor easier to handle, I found the progress quicker, much quicker and, and then just natural ways and she was just caring, I felt like she cared. I felt like she knew what she was doing. I felt like

very confident in her, which I did not feel with the doctors at all, and like I felt like she cared about my well being and the baby's well being more than just getting her job done, which doctors its like, lets get this process over with you know and lets go to my convenience rather than she just gave me her time and she gave me suggestions of ways to make it through when transition came... like, growling like a bear kind of, I forget, she kind of called that.... just getting a deeper sound and feel to kind of uhhh, kind of a bear like thing and it really got me back in focus and got me to be able to handle it better, and then it was just very relaxed and it just went so much better and the transition lasted much shorter because of it I think and she was born just really so much easier and...

NASIMA: What kind of things did you like to do when you were in labor, did you like to walk, did you like to sit, did you like to be in the tub? What did you do?

NANCY: Well, mostly sit, probably um some of them I walked. The last one I walked a lot because it kept stopping, but with that one it just kept progressing with and so I would try to, Id lie down and try to rest between contractions and Larry was always with, hes been with me with every one and helped me to maybe put a wash cloth on my forehead or get me a drink or see what he could do to help and get me focused and look me in the eye and encourage me that it would be ok and they both were that way. ..., he's been very, he's always been very supportive and very absolutely sure that he always wants to be with me and always be part of the process and hes also cut the cord each time that we've had a homebirth and I think they let him at the birthing center, but I dont remember now, but but the hospital ones that never, its always been the doctor doing everything, so, he's cut the cord and he's been there and then as soon as Ester was born, he went and woke up the children and brought them to see her, so she was just minutes old in fact, trying to remember with Ester, whether he had them come and watch him cut the cord or whether it was just right after. I don't remember. I know with the second one that was born at home, we invited them to watch and cut the cord, and I think with Ester too.

NASIMA: So you went with Holly again after you had another good pregnancy?

NANCY: Yes, with Holly again, had another good pregnancy and another just even better yet experience with the delivery.

NASIMA: So how long were you in labor and stuff?

NANCY: That one was I believe three hours.

NASIMA: Wow, thats getting better and better.

NANCY: So, and that one was three hours and lets see...it was it was just very positive and Julian and Larry were and Holly, between the three they were there for me and helping me and encouraging me and it was and then again it happened at night or early in the morning. Well lets see Ester was born at six in the morning. Anna was born at three in the morning, or was it one in the morning, and and that time the children were awake, and they sat in the hall and Julie opened the door and called them just as the head was coming out, so they came and saw that last push out, and...

NASIMA How did you feel about that?

NANCY I felt ok. I've had people really criticise me for it.

NASIMA Why.

NANCY They felt that I was showing them private things that shouldn't be, but I felt and they never had any negative response or they've never said anything that would indicate that it would have been harmful or negative for them. I think when something as miraculous as a birth is happening, thats the focus not, the focus is not a mothers bottom, its on the miracle of what's happening, of this new sibling coming into the world. Its so beautiful of an experience that it was frightening. Elizabeth expressed some negative feelings about having heard me crying some at the end during the last little bit, when the transition is so intense and the heads just coming, but that was the only thing, but the actual birth watching was very exciting and just that last little bit.

NASIMA Do you think for your daughter that was a very important experience for her to have for the future?

NANCY: Yes. The last one she did watch and that was in, she actually did watch for sure that one, ya, and that one was exciting for her

NASIMA: In Anna's birth, so, what you were saying it was 3 hours of labor and the kids came in, so did you push pretty quick too, did that...

NANCY; Yes, that one was not a real long transition either. I pushed and just a few pushes and she came out ok, so, ya the pushes had not been, with the homebirths, are much quicker, I dont have to push very much.

NASIMA: Are you also, what kind of position were you in that time?

NANCY: On my back. The only one I did on my side was the second one. And the others were on my back and propped up pulling my legs up and it was ok, with that.

[Side conversation about Holly stopping practicing and Nancy finding another midwife. She ended up going with Nancy Aton, who a friend recommended.]

NANCY I never did talk to Amy at that point. M so then my checkups were fine every time I went and we had to go to Michigan for a wedding and according to my dates, I was due the end of May, but according to according to a sonogram Id had in California, he was due in June, June 20.

NASIMA Wow, thats quite a difference.

NANCY: Ya, and so since the sonogram showed him as due June 20, we decided to go ahead and fly to Michigan to a wedding. My sister in law was getting married, and she wanted the whole family there, and so I had my checkup the day before. I went in then everything was fine and we went to the wedding and while we were in Michigan, I noticed the baby wasnt moving anymore. I hardly felt him move and when we got back, Nancy was gone and so my next appointment, my first appointment with her was the 21 of May. Well, that morning I went into labor. And, she said, well your not, your not 37 weeks yet. Your not even quite even 36 weeks, so I can't deliver you. And so I kept hoping that labor would stop cuz I wanted a homebirth so bad. I did not want another hospital birth and so when it didn't, it kept progressing and a friend of ours got off work across the street, she came over to watch the kids, then we left.

[Side conversation about doctors and amniocentesis]

... I had to sign waivers and also our insurance company was giving us a hard time about having a midwife instead of a doctor, and they asked my age. I said I don't care if I were 50, I would never let a doctor touch me with a ten foot pole. This is a natural thing that god has created and I won't go to a doctor unless there is a problem and I feel very confident that the midwives are careful and if there is a possibility of a problem, they will just like with Nancy, with Daniel, he wasn't at a safe age yet gestation wise, so she wouldn't deliver me at home. And so I feel very confident that if there is a problem, the midwives are aware and they are not going to want to risk and so then they will send me to a hospital if its needed...and so at this time, I kept praying, god I don't want to have this one in a hospital, so God decided to be humorous and so he was born in the car on the way in. (laugh)..And I was so grateful that he was born before we got there.

NASIMA So who was in the car with you?

NANCY Just my husband and me and I was in the front seat of the Astrovan with the seat probably at 45 degree angle, yes, and I had really stretchy pants on, Maternity pants, and as we're going along, I go, well his heads out,...in my pants as I'm sitting there and then as he's driving into

the parking lot, I go well the rest of him is out, and he's sitting there in my pants and my husbands honking, trying to get attention, and he runs into the emergency room and nobody would believe him.

NASIMA: So what did you do?

NANCY:I, being the dunce, selfish person, just thankful that the worst parts over with and I'm not even thinking to check him and they finally sent a nurse out, just to get them off their back, and they open the door, pull my pants down, there was the baby, and she freaked out and said, "Oh, he is born, bring the kit and so they brought a kit, and they had nothing, nothing with her. We had to get the suction bulb syringe out of our suitcase to suction him out, cause they had brought nothing out, and then they finally brought something to clamp and run off with him, they took off with him...and then finally brought a gurney to take me in.....they took me in to emergency room and Larry kept saying, telling them to page Nancy, and they weren't doing it, and so then I delivered the placenta in the emergency room and finally Nancy showed up and she showed up because she heard them talking up in labor and delivery that somebody had delivered down in the car, and she figured it must have been me, so she came down to check, and she was very much my advocate. She stepped right in and was there for me and Daniel. He was small, he was very shocked to find out that he was a small as he was. He was 4 pounds, 5 ounces, just the same as my 32 weeker and he was almost a 36 weeker. And, his apgar scores weren't real good and I, I feel, it was in May, so we had, I feel like looking back, if Nancy had delivered him home, he would have been better off because he would have been cared for immediately plus we weren't thinking. We had, I was in the front seat. We had the air conditioner blowing and I wasn't checking to make sure he was breathing, so by the time they came out, he was blue and his apgar scores were not good. He had been stressed by the cold and by not being cared for immediately, and so I really feel that if Id had him at home, he would have been better off.....he would have gotten immediate care and he would have been better off. He was kept in for 10 days, but this time the neonatal experience was better. They let me breast, try to breast feed him every day, and that was good.

NASIMA: Did he?

NANCY: He would petter out and it was the first time when I could visually see why they say 37 weeks. When he reached 37 weeks, it was like he woke up and became a normal baby and began to suck normally, began to do everything normal and, so that first week, he was very lethargic, very, just wanted to sleep all the time. Didn't want a, he kept falling asleep and where as my mothers stories of how it was when she, that's the way they were, because the mothers were drugged. [side

conversation about NICU and Nancy advocating for her to stay at the hospital] I just lived there, and whenever it was feeding time around the clock, they'd call me and I would go in and feed him, try to feed him anyway, I would, till he fall asleep and then we'd finish it with whatever was needed. And I can pump there and then I could go back and sleep and then when the kids came, Larry brought the children the next day, then they let me take the baby out to the little parenting room and so the children could see him and, so it was very, very positive and if it hadn't been for Nancy, I wouldn't have had that positive experience, and then finally I came, I went home when, because I needed to be with the other children and then I made trips back.

NASIMA: Do you feel like Nancy did a very good job of being your advocate?

NANCY: Very, excellent job of being my advocate. Excellent job, and I'm very grateful and so then I had a miscarriage between, I've had 2 miscarriages and I had a miscarriage between the two boys and after Daniel and Nancy was good about taking care of me ...and she just let me do it the least expensive, just do the bloodwork and see what the count was and confirm and things and answer my question and thought, even when I' not pregnant or what ever, if I've had a question, the midwives are very good about being willing to answer your question on the phone, and where as the doctor, they want you to come in, pay them some money. With a midwife they are caring people and they're not out for the money, they are out because they care about the women and the mothers and the babies and there's a huge difference in attitude overall. [side conversation]...Yes, but Nancy has been fine and so I went with Nancy with this last one and the pregnancy, I was wiped out and exhausted throughout the pregnancy again.

NASIMA You were 43 at that point or

NANCY No, I'm, I was ah 45, no, ya, 45. I turned 45 in this last pregnancy, so...

NASIMA Think this might be your last one?

NANCY I don't know. I kind of hope so, but, but I don't know, cuz we've decided to let God choose the size of our family. We feel god knows better than we do and he's the one in history that opens and closes the womb and who am I to tell God not to bless me. They are a blessing, even though it's a very difficult job to be a parent. Its the hardest job in the world, but...they are a blessing and theres many things about it that its well worth it and the children want more all the time. I go, I tell them that that's why I keep having them, because they keep praying for more

<Laugh> about the time they keep bugging me about when are we going to have another one and I find out I'm pregnant, so I go it's their fault.

NASIMA So, but you were wiped out during that pregnancy.

NANCY; Ya, I felt very wiped out, very, just hard time, just keeping going throughout the pregnancy and because of my history of prematures, we came home from Mexico earlier than we would have. We only stayed down there short period of time and he was, and we just, she said we had to reach, 37 weeks before we just praying that we'd make it to that and I tried to be more careful with taking naps and being, Holly recommended that I take Vitamine E to strengthen my placenta because that might be why Daniel had had problems and came early and why he was so small, they said that was because maybe my placenta was starting to give out early and that's why his growth slowed way down and his movement slowed way down. If I had gone to term, he might have been stillborn, so it was actually a blessing that he was born early. And I had high blood pressure on the day he was born and for months afterwards, but this pregnancy again, my blood pressure was fine, everything went fine. Its just that I felt wiped out all the time, and I rested more. I took Vitamine E to try to help the placenta to be stronger and healthier and my bag of water broke at 37 weeks exactly and he was born here at home and Nancy came and after she got here, my labor stopped, so I had to walk around a lot, but she was very good about just being relaxed. She sat down and played games with the kids and while I'm walking around and doing things, she would suggest little things and...

NASIMA What did she suggest?

NANCY To take a bath and she encouraged me to walk around, trying to remember now. I had a lot of people here this time. That wanted to see the birth. Julie was here again and then ah her friend Marilyn who wants to study midwifery. She's done a correspondence course on it and her daughters done the correspondence course. Her daughters 17 and my daughter wanted to watch it and then I had another friend in town who had never seen a birth who really wanted to watch, and so I had all these people her and...

NASIMA Were they all there, too, when your labor was slow?

NANCY; They all came and they all visited and wanted, I was, when it got to where I was starting to get into hard labor, it did bother me to have so many people. They were all sitting there in the room watching me and that kind of, I felt like I was in a, I was in a cage being watched or something, at that point it, I found it disturbing and Julie was sensitive to that and she kicked everybody out and so then, although Marylin stayed

in, but she was in corner, I didn't even notice her. It was fine, so it was just Larry and Nancy during the hardest part. Then I was kind of frustrated that I was in transition but yet I wasn't feeling the urge to push yet and so Nancy had me turn to the Knee/Chest [on all fours with head down, butt up] position and it must have been another cervical lip at that point and then she did some massage to help and then that, then it came and at that point it was so intense, I didn't want to flip back over so anyway they called everybody in to say I was ready. They called down the hall, those that, and my one friend from Tucson didn't make it in time to see the birth, but Elizabeth and Julie and Marilyn and Cory all made it in time to watch the birth and even though it was an awkward position and I kept thinking, I shouldn't be in this position, I'm going against gravity, but it pushed fine. He came out...it was so intense at that point, it was too hard to move and, but Elizabeth was just excited. She was so thrilled to have seen it.

NASIMA How old was she?

NANCY 14, She wasn't quite 14 yet, but so she was 13 and half and she was just ecstatic, she was just so thrilled to have seen it this time and then we called the rest in to see, to watch the cord I flipped over and then we, they watched the cord be cut by Larry and we got pictures and so it was a very, it was positive, that's the only, the only hesitation I have is just that I wish I had been in a different position.

NASIMA Right.

NANCY But other than that, but it went fine. Everything went fine.

ASIMA You didnt tear, you...

NANCY I didn't, ya everything went great. So, and I did have a small tear with one of them that Holly delivered, but it was so small, she said stitching it wouldn't matter and it was, and with everyone of my deliveries that have been done by midwives, I have felt wonderful afterwards. I have felt like I could be up and do anything I want and go anywhere I want right away afterwards, and it was hard to stay down and with one of them, the first one that Holly delivered, the next day I went to a concert, because I felt so good and afterwards and I think... not having a episiotomies makes a huge difference and the care, and then the olive oil they can use to massage and things, just is very helpful where doctors don't even care to try and using natural means to get labor going. If I had been in a hospital, they would have hooked me up to pitocin and gotten labor going using chemicals that, it's not good for the body and instead using not natural means and to me that is, it's healthier for the mother, its healthier for the

baby to use natural means... I would always recommend homebirth over hospital. Always.

As the birth accounts of Barbara, Chris, Sharon, and Nancy H. show, the particulars of birth varied greatly. From Barbara's forty-minute labors to Sharon's much longer labors, from premature to overdue babies, from experiences with hospitals to homebirths, these women demonstrate a large range of experiences. These experiences are pivotal events, which affect their future feelings, lives, and birth frames. Much like the "liminal phase" of finding out one is pregnant, the actual births serve as turning points which create situations in which experiences need to be interpreted and frames tested in the light of lived experience. This cycle of testing the frame can occur multiple times as is evident in Nancy H.'s birth accounts, in her case strengthening her belief in the holistic model. We'll further explore the effects of testing the frame in the next stage in the frame alignment process, frame transformations. The next chapter on frame transformations will discuss the effects of these pivotal experiences on the women's lives and senses of self.

CHAPTER FOURTEEN: FRAME TRANSFORMATIONS: “BIRTH COMPLETELY CHANGED MY LIFE”

The last frame alignment process I will discuss is that of frame transformations³⁰. Sociologists have long understood that the birth of a child is an important transition in a woman's and a family's life cycle (Kornblum 1994). Birth creates transformations in roles, responsibilities, and self-image (Renzetti and Curran 1999). Also birth, as a rite of passage, is a heightened phase of enculturation (Davis-Floyd 1992). Birth is a transformative experience wherever or how ever it happens to occur. How a woman is transformed by her birth, and how this experience is affected by her birth attendants and her birth setting, is emphasized within the homebirth movement's rhetoric (e.g. Arms 1996). For example, research by Oakley (1980) has illuminated the link between postpartum depression and birth setting, with higher rates associated with interventionist hospital births. Empowerment through the birth experience is an often-mentioned motive in homebirth literature. For my purposes here, I focus on the transformations birth brings to those women who have gone through the frame alignment process of the holistic birth model and homebirthing. These transformations represent changes in the status quo, whereas hospital birthing generally reinforces the cultural status quo as discussed in previous chapters. These frame transformations occur after a woman's birth and refer to changes in attitude, self-confidence, perception, support for the homebirth movement

³⁰ I specifically am focusing on the transformations that occur for those 'lining up' with the holistic frame of birthing. See Davis-Floyd (1992), for research on solidification and transformations of medical model birthers.

and collective action frames, and life goals that shift for individuals after going through the frame alignment process and having a birth. It also refers to the transformations in frames that occur for birth attendants, both those events that bring them into attending births, and those events which lead them out of homebirthing.

For birthing women, this process can occur repeatedly with each subsequent birth, creating new interpretations and alignments. Subsequent births can create experiences that provide new interpretations of previous births as well. Within my frame alignment process model, I observed women drawing upon their frame foundations of experience, parental influence, and socio-political attitudes to make choices prior to their births (such as finding a provider). Frame bridging provides information both from media (such as books) and interactions with others. Frame foundations and frame bridging provides information in which women draw rationales and motives from for their birth choices. The births test their adopted frames of reference. Frame foundations and frame bridging also serve to provide points of interpretation of the women's lived experiences. Lastly, drawing on all the above stages, the last stage, frame transformations occur. It is what David Snow et al. (1986:475) have termed a global transformation: "what is involved in essence, is a new kind of thorough going conversion that has been depicted as a change in one's overall sense of ultimate grounding."

This conversion process is a significant component in micromobilization for the homebirth movement. Through these transformations women act as movement actors and contribute to the movement's framing and survival. In other words, as they have become cognitively liberated through these framing processes they have become

micromobilized. These women support and seek out alternatives and changes to the status quo of standard hospital birthing and the medical model. Essentially these framing efforts occur within the realm of “life politics.” Building on Taylor’s (1996) work on postpartum depression and self-help, I argue that “life politics” are becoming a major focus of modern movements. “Life politics” are readily applicable to issues of the self, the body, and the life of individuals. This focus is in contrast to the more traditional concerns of “emancipatory politics,” of traditional social movements. The homebirth movement as a member of the constellation of medical self-help movements has many of the components Taylor (1996; Taylor and Van Willigen 1996) identified as making self-help “count” as a social movement. As Taylor (1996:190) states, “In self-help, organizations are not the main actors. Rather, the movement is found in the ideas, discourse, identities, and life changes of participants.” The homebirth movement operates primarily in this fashion. A limited national level organization exists, with numerous diffuse local small grassroots efforts to encourage or provide legal support to midwives and homebirthing parents, but the primary components of the movement are ideas, discourse, identities, and life changes of participants, and these are my focus within this chapter on frame transformations.

For most homebirthing women “life politics” are experienced as a diffuse, personal type of participation: personal but also political. Women who birth at home internalize the collective identity of “homebirther,” and provide discourse with other women, hence acting as movement actors to perpetuate the ideas of the movement. Taylor (1996) found a similar pattern among the postpartum support movement. This is a different kind of participation than protesting in the streets, but its value to movements

should not be devalued (Melucci 1988). Within the homebirth movement, both emancipatory politics and life politics are present and are seen in the micromobilization of homebirthers and their advocates.

I have identified five types of micromobilization present in the data. First, *intrapersonal* refers to support for the movement within the confines of a woman's personal experience and thinking. For my respondents intrapersonal support usually involved homebirthing herself. This support level may also include persons who support the ideas of the movement, but who did not or could not birth at home. This also involves providing financial support to the movement's practitioners, the midwives. This level of participation is reflective of a woman's collective identity and life politics.

Second, *interpersonal* support for the movement comes in the form of talking and sharing information on the homebirth movement's collective action frames and sharing personal experiences of homebirthing with others, basically "talking up" the movement with friends and acquaintances and thus providing frame bridging.

The third type of micromobilization is that of *practitioners*. Midwives are the main public actors of the movement. They deal with the issues, joys, and constraints of practice and the movement's effects on birth every day.

Fourth, *public support* by both activists and practitioners represents an active role in the movement such as providing financial contributions to organizations, going to meetings, distributing flyers, doing fundraising, presenting websites, and talking to the media.

Lastly, the traditional level of *leader activists* who participates in the movement's various social movement organizations (SMOs), who publish books, hold

conferences, distribute newsletters, collect and disseminate statistical research, and organize SMO activities and framing. In order to explore the above types of micromobilization, we will discuss four types of frame transformations and their impacts on micromobilization.

Within my data I have identified four types of frame transformation paths. Two represent a solidification of the holistic model and two represent a challenge or break with the holistic model and/or homebirthing. The first frame transformation path occurs in those clients who have had successful homebirths and who tend to have their model/frame confirmed and solidified through their birth experiences. This is the case for the majority of my sample population. Sometimes this solidification occurs after multiple births. The second path represents a crisis. Whether the woman planned a homebirth or a hospital birth, the experience occurs in a way which “shakes her belief in herself and the world” or is interpreted in a way that suggests “a better way.” Her transformation is characterized by a reinterpretation of her choices and experiences. For some this leads toward greater support for homebirth and the holistic model, for others (especially homebirth transports) it may make them question and reevaluate homebirthing and the experiential credibility of the movement’s CAFs. The third path represents a heightened solidification of the holistic model to the point of sending women into becoming midwives, doulas, midwives’ assistants, childbirth educators and natural birth advocates. Lastly, “burn out” or a change of career path for birth attendants represents the last frame transformation path I have identified. All four paths affect the women’s micromobilization and movement participation. This will be explored in the

following sections. Figure 14: Frame Transformations and Movement Support graphically displays these frame transformations and movement participation levels.

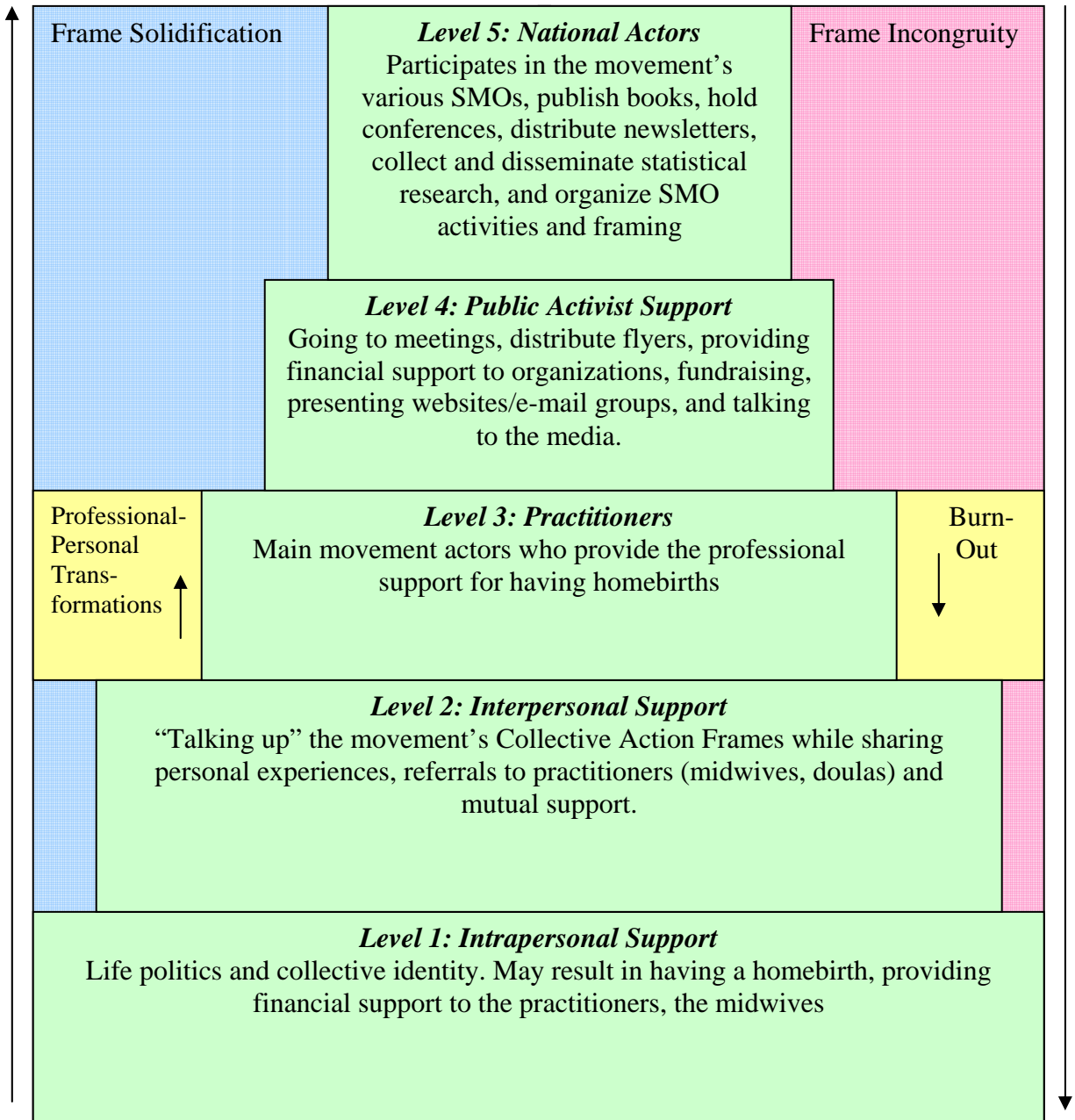


Figure 14: Frame Transformations and Movement Support

Solidification of Homebirthing

Generally, for those who had successful homebirths, these births serve to confirm their adopted holistic model and solidify their frame alignment process in favor of homebirthing. They become further mobilized in favor of the movement and they further adopt the movement's collective identity. This solidification may span the spectrum of micromobilization, from intrapersonal support to acting as movement leaders. The birth process tends to transform the way they see the world and themselves. This transformation through the birth experience provides the women with a sense of accomplishment and self-confidence. Within my sample population, I have no examples of women choosing to birth in hospitals after birthing at home unless they were "risky" such as for premature labor or twins. The importance of coming through the challenges of homebirth was clearly transformative and important to all the women in the study. Since many of the women took on homebirth as a personal responsibility, they reaped additional psychological rewards from their successful birth experiences. This success is often seen in contrast to epidurals or other drugs that change the woman's experience of coping with birth and how active she can be in the birth process. Homebirthers also reap the reward of a hormonal birth high after a natural birth (Buckley 2002b). In the narratives, birth is often equated with a physical endeavor such as a marathon. Zimmer (1997:4), explored this topic and framed it in the following way, "Women face other challenges in their lives (running marathons, for example) by not focusing on the pain but by welcoming the challenge- to see if they can do it or how far

they can go....rarely has childbirth been viewed as one way of knowing and coming to terms with our bodies, of discovering our physical and psychic resources.” This framing of birth as a challenge often plays out successfully which leads the women to feelings of accomplishment and success. Lucy recalled, “I enjoyed birth, it was an athletic endeavor I could be good at... I was so lucky to of had this absolutely epitome of the birthing experience.” This after all was part of their motivational rationales for desiring homebirth, to be “empowered.”

The sense of accomplishment is clear in the homebirth accounts. Although national research has demonstrated that most women are fairly satisfied with their childbirth experiences (Declercq et al. 2002), the qualitative research on the cultural constructs and self-images internalized by women varies greatly between out-of- hospital and hospital settings (Armstrong and Feldman 1990; Davis-Floyd 1992; Martin 1987). Women at home emphasize their strength, coping abilities, awe of the natural process, and empowerment more often than do hospital birthers (Armstrong and Feldman 1990). This sense of awe and accomplishment also served to diminish the woman’s sense of pain at home. Sharon said, “It was such an incredible pain but then none of it mattered as soon as I saw her. It was so amazing to see her... it was so completely erased as soon as I saw her.” These women rarely emphasize the pain but instead speak volumes to the ecstasy and joy of delivering their children. They acknowledged the sensations of birth, but moved past them. Sandy recalls, “I was so grateful that all had gone well and I had this beautiful baby. I had had confidence and it had worked out that way.” Damiana commented, “I mean... that space of pushing out a baby is ... it's just the most incredible space. I mean it is such and absolute gift of being a woman. And it blows me away that

people want the mind-body disconnection, and they miss that.” Sandy stated, “I think birth is so empowering...I remember just thinking, I could do anything it made me feel like I can find out what I need to know and I can make intelligent decisions that are best for my family without doing what everybody else thinks I should.” Carolyn, when asked if the homebirth had changed her thinking in any way, responded, “Really positive. You know, I feel like it's a way for woman to kind of take charge of their lives.”

Beyond the birth itself, the experiences following their homebirths transformed many aspects of the women’s lives. Sharon recalls,

I felt so grounded and so connected to the world after I had the baby. It was so different. I remember one day sitting on the porch looking, looking at a tree. I felt like I belonged here. It was really powerful for me. This has really connected me to the world. I couldn’t believe how, so empowering the birth experience had been for me, and I had gone through that and I had a beautiful baby as a result of it, I would ride the bus and see women with kids and I thought she had done it too. I had joined this secret club.

The birth transformed not only her sense of empowerment, but her sexuality and body image also improved. Sue experienced a similar transformation. She learned to live at a more organic level, to slow down, and to open up sexually. She said the birth was a “transforming experience for me all the way around.”

Sue’s transformation also included a professional shift that included beginning “Ladies and Babies.” This was a class/group that got together and danced, sang, and played with their infants and children. This was in large part an extension of the group of women who were homebirthing together in the early days in Tucson. The group helped maintain connections between women who shared similar experiences. As they had their second and third children, the group helped them adjust to additional children. Sandy stated “ [a friend]linked her to Ladies and Babies- which made an enormous impact in

my life. It developed friendships, friendships that have lasted till today.” Other circles of homebirthing women formed in similar ways. Chris, Holly, and another circle of friends developed and was instrumental in their lives. Chris described,

..friends that we had one and two and three babies with. You know things like that. And then these people I told you all their kids were born at home. They actually knew Holly in North Carolina before I did. Their husbands went to chiropractic school together. So I met them thru Holly, and ... then going and delivering Mary's babies with her, and we just had real connection as women, even prior to the birth. You know, some ceremony stuff we did to welcome the baby ahead of time, and those were really special, to know that they were our friends we would do it with, too. So those were really good births. And then Annie's sister Liz had babies with us, so we delivered Liz's babies after that. So we got to know them. There's this real circle.

Homebirthing tends to create a feeling of solidarity between women. It is my observation that women who share birthing in other ways also create bonds through hospital birth experiences, but the primal, exposed nature of sharing homebirths seems to create very strong bonds between women. Part of this solidarity is also an increased commitment to homebirthing, including seeking improvements in maternity care and working toward greater popularity and legitimacy of homebirth.

Through the frame transformations that solidify people's commitments to homebirthing, more advocates for homebirth are created. Women who tell others of their positive homebirth experiences act as movement actors, providing interpersonal micromobilization. These women also support the movement's practitioners or main actors, the homebirth midwives, by providing emotional and financial support. Some women may provide public physical labor, such as helping to hand out information at events, or helping with administrative work. Most, however, support the movement by “life politics,” or intrapersonal micromobilization. Building on the feminist principle that

the “personal is political,” by birthing at home these women express political and personal change in our culture and institutions. They provide living examples of change to existing cultural structures. They then act to provide frame bridging of information and interaction with subsequent birthing women.

This occurs through a process of internalizing a collective identity, that of “homebirther.” In the interviews, many women mentioned the importance of homebirthing to their lives, who they “are,” and the importance of sharing their stories with others. Kathryn Shrag of the Tucson Birth Center commented on the importance of out-of-hospital birthers sharing their stories,

there was somebody in the [childbirth] class the other night who had been born at home. And somebody whose husband had been born at home. I mean, that's such a powerful experience, you know, so it's, I suspect the power of a out-of-hospital birth experience is disproportionate to the power of a hospital birth experience, so that even if only 2%, and I don't know what the numbers are...I mean birth center numbers are not going up nationwide...So, I mean, even if there's only 2% of people having out of hospital birth, I bet their voice is equivalent to 10%....because they're empowered by it. It's life changing.

Women shared their quiet forms of activism. Patty represents both interpersonal and practitioner micromobilization in her role as a doula. She related the following,

The people who have had homebirths, we tell our stories to a lot of people. We are like this very quiet network. [Laughing] And people don't really ask, but if they ask, we are like, what kind of birth, well where did you have your baby. At home. Really, and people, women love to hear it. Love to know that it really worked and its really ok and its a possibility and those are the pieces, its the continue to talk about it that I think will keep it alive, too.

When asked about the homebirth movement’s social effect, Kathy a homebirth mother shared her experiences of interpersonal micromobilization.

I think its very difficult. Like anything like that, I think if all grass roots

and grass roots is slow and its weak. It really is and its unfortunate. I don't know what the alternatives would be to educating more women about homebirth except ... to talk about those experiences more. I mean I do try to encourage people with homebirth whenever they seem even remotely interested. And I send people to Nancy whenever I can and to my acupuncture guy who likes her too... there are a circle of people who all support each other that way. So I sent someone to my acupuncturist and maybe he sends somebody to Nancy.

This type of word of mouth education is what most women explain as their major part in continuing the homebirth movement. Some however do move beyond "life politics" and the interpersonal level of micromobilization to have a more public role in supporting the homebirth movement.

Public support by both activists and practitioners represents an active role in the movement such as going to meetings, distributing flyers, doing fundraising, presenting websites, and talking to the media. Sue experienced a frame transformation that brought her into active public support of the movement: "I had so much preoccupation with supporting homebirth that somebody at the university ran into me and assuming I had become a midwife." Trina also was active with the midwives. She acted as a coordinator for the group of midwives in the New Beginnings birth group. She helped answer calls and match midwives with clients. Sandy helped work at the street fair to raise money for the midwives. This represents micromobilization. In all likelihood, the women's partners also experienced a frame transformation, but the effect on their micromobilization is unclear from the interviews. The women rarely mentioned partner participation in any of the homebirth movement activities with the exception of Daniel Lomax, Nasima's husband, who helped run the Arizona School of Midwifery.

These women generally experienced "global transformation" of their birth frame. The holistic approach to birth and childrearing, to large extent, engulfed their lives after

their homebirths. Out of their experiences and the interpretive work of the frame construction, alignment, and adoption process the women acted to support the motives and the movement behind their belief system. I'll now move onto the effect of incongruity of birth frames and the effect of these experiences on movement participation and/or support.

Incongruity with Birth Frame

The second path represents a crisis. Whether the woman planned a homebirth or a hospital birth, the experience occurs in a way, which “shakes her belief in herself and the world” or is interpreted in away that suggests “a better way.” Her transformation is characterized by a reinterpretation of her choices and experiences. For some this leads them toward greater support for homebirth and the holistic model, while for others, especially homebirth transports or those with serious complications, it may make them question and reevaluate homebirthing and the movement’s CAFs.

For most of the women in my sample who had hospital births before homebirths, these hospital experiences provided frame transformations that brought them further in line with the holistic model and the core collective action frames of the homebirth movement. Those in my sample who wanted homebirths but had hospital births due to risk factors found these experiences further confirmed their holistic birth frames as well. These unwanted hospital births are interpreted as being incongruent with their models and frames of birth. Nancy represents multiple revolutions of the frame alignment process, as illustrated in the Testing the Frame chapter; first she had a hospital birth, then

a birth center birth, and then she planned homebirths. Her initial birth experience in the hospital produced an incongruity with her birth frame. This experience led her to further support natural birth and to have her next birth at a birth center. She then moved on to wanting homebirths. Her subsequent hospital births occurred as a result of premature births. These hospital experiences further confirmed her commitment to homebirthing and homebirthing's core collective action frames.

She recalled for her first birth,

I wanted as natural as I could get. So I went osteopath for the doctor and when I got to the hospital, it was, there were a lot of good things. They didn't do the IVs and the, and it was natural and it was a birthing room and I had my brother and sister-in-law and my husband all with me and the nurses were great, but the doctors were cold. And I felt like I was not treated like a human being and he just talked really, I thought really rudely to me and it was, the doctor had the intern doing everything

After the birth she considered going right home but instead decided to stay to be fed and cared for. She recalled, "So I stayed, but then the care was really bad. They never checked me to see if I was hemorrhaging. They forgot, the doctor forgot to write orders on me and so I felt like I might as well have gone home with the amount of care that they gave me. I knew what needed to be done more than what was being done for me." During this delivery the doctor cut a large episiotomy, which didn't heal properly and was recut a few weeks after her first birth. It never did heal correctly. This hospital experience was incongruent with the care and birthing experience she had hoped to have. In later births, after having really good birth center and homebirths, she ended up in the hospital again with a premature baby. This experience was again incongruent with her birth frame. During this birth the doctor refused to listen to her wishes. As she states,

We had to fight the doctor...I had already had problems with her once before...they sent her in to my room instead of the doctor that was

supposed to be in and she wanted to do an internal check, which I knew could promote labor, and I, and we said no, that's not to be done, and she got really mad at me and kind of huffed out and so then when she was the one on call when I actually went in to labor and my doctor was gone for two days, so he wasn't there and because of what my episiotomy looked like, it freaks doctors out...she wanted to do another episiotomy on me, and I said no. And Larry said no. I go, 'this ones a preemie, this ones going to be smaller and there's no need. My last one, I didn't need one, and I did fine and I didn't tear. I don't need it.' And she was going to insist. And she turned, and Larry and I both firmly told her no, she was not to do an episiotomy, and she turned around to get the instrument to do it anyway and so that got me, so when the contractions came while she was turning around, I pushed him out and so then she was really mad at me and bawled me out, and right after he came out, he had a bruised eye. She blamed that on me, and they often can have bruised eyes, that's just part of the labor process. It can happen, but she blamed me for the bruised eye because I pushed him out before she could do what she wanted to do and it was a very negative experience. Very negative experience for us.

The way her first birth occurred, with a "cold" doctor and a large episiotomy that she felt was unnecessary, reinforced her desire to seek out "a better way" to birth. After birthing at home her hospital experiences of having to fight the doctor continued to solidify her alignment with the holistic model and the movement's CAFs.

Negative birth experiences that were incongruent with Betty's birth frame also affected her frame transformations. She knew after her first birth there had to be a "better way." She recalls her first experiences in the early 70s,

Well, the first one was horrendous, in a way because they, like I said, um... it was at Davis Monthan and it was an Air Force Hospital. And they pretty much put me in a room, told my husband to go do whatever he wanted to do (laughs) so he went home and waited. And um... and they never came in except to do heart tones once in a while with a fetal scope. They didn't have those external fetal monitors like they have now, and the internal fetal monitors. But that part was a blessing, because I'm the kind of person that doesn't... I like to be left alone. So, in that way, even though it was lonely, it was a blessing, because I was not being interrupted. And I could, I could just was able to just go into my own thing. I had to holler for them when they... when I thought it was close to the birth. "Somebody out there? I think I'm having my baby!" Very strange

Through the transformations of her first birth she sought out a more natural supportive birth the second time. She explains,

And then my second one, I decided, "uh, no this is gonna be different." So when I heard about St. Joseph's, I found the right doctor that would let my husband come in, and 2 years later things were changing anyway, and the Air Force Hospital was a little bit behind anyway. They're still behind by about... mmm... 20 years. (laughs)... No maybe not, 10 maybe... so I had my second one in a rooming in situation, doctor that let my husband be there, and... for the delivery, but even then they were, "Yes, your husband can be at the delivery, but he has to put masks on and things..and stand over there, and don't fall on the instruments. They just assumed men would faint. They just had this whole different attitude. But it was nice. I mean both births... were... wonderful... in a way, because they were the birth of my children.

As Betty's closing words illustrate, women treasure their births because they are the births of their children, but many find their frames transformed through their birth experiences, some seeking out different situations to improve future experiences.

Barbara, a CNM, explains women's varied responses to birth experiences, which reflect the variety of birth frames held by women and the interpretations that occur after the births based on these frames of reference.

I think there's a lot of smart, conscience people out there. There has to be or we're all in big trouble. I think there's enough people that have had a first experience to see the emperor doesn't have any clothes on, I think. Well, this epidural made my back hurt, and they kept sticking tubes in me and have to have all these antibiotics and my baby wouldn't nurse and they didn't pay that much attention to me in the hospital. I was in a bed with a room with 4 other women and, you know, I sat there bleeding after words and then my family, and then they would start thinking, this wasn't so great. You know, what's the big hype about all this medical stuff being so wonderful and people start questioning it. We have a lot of people come for their second or third babies or they have had really disgraceful, somewhat assaultive deliveries, you know, yank the baby out, I only pushed for 15 minutes and came and pulled it out with forceps because he was on his way home or we hear these incredible stories that you just go, oh my god, you know. Some women will give that same story and say that it was so, it was great because I was pushing so hard with the epidural and I just couldn't get the baby and the wonderful doctor so and so delivered

and somebody else would say, well, you know, I had a fourth degree tear, it was miserable, my baby had bruises and it would, dadada. So it, some of it kind of goes with how educated the woman is. You know, some people still, they know what's going on. You can't completely fool all the people all the time.

Amy, another homebirth midwife, shared how many of her clients come to her after having births in hospitals that were incongruent with what the women were wanting for their births.

Sometimes it's because they've had a birth or two, in the hospital, and they've had a horrible experience. Or they know people that have had horrible experiences. Or they had an OK experience at the hospital, but they know it would be better at home... They've been there. They've decided, and now they're at this decision that they're... whereas if you get first timers you really have to kinda sometimes pull them in and really educate educate educate.

These experiences provide women with opportunities to interpret their births and come closer to the holistic model of birth. As such their frame transformations bring them to making different choices for their subsequent births and greater ideological support for homebirth. Unfortunately, however, birth is unpredictable, and sometimes those who plan homebirths have complications that necessitate transport to the hospital. Often this transport experience is rather traumatic, and the women grieve the loss of their “ideal” homebirth. Within my sample I only have three examples of transports in labor (with the above account of Nancy’s transfer of care for premature labor representing a slightly different situation). Any conclusions I can draw from these accounts are of course very preliminary, but given the familiar patterns to other accounts I have read of other transports, I feel they are worth exploring.

The following accounts of Alicia and Whitney represent two paths to similar transport experiences. Alicia was traumatized from her transport and became more

cautious about homebirth than she had been before her transport experience. She later decided to birth her second child at a birth center instead of having a second homebirth. Whitney was transported but came away from the experience feeling that she would try a homebirth again the second time around.

Alicia's birth had a very slow beginning with her water breaking and then very light contractions for many hours that did not produce dilation. She and her midwife decides to go in to the hospital because the midwife's backup doctor was available but not for long. If they had stayed home but then needed to transport, they would have had to go to a different hospital where the midwife had had bad experiences before. At the hospital they started pitocin and Alicia slowly dilated. She tried a position she dreamed about and that quickly takes her to complete dilation. She recalled,

I started pushing, and I was kind of concerned. I didn't want to push too hard because I didn't want to tear so I was just sort of trying to hold on to it and at one point I was just was like screaming cause it burned so bad, it hurt so bad, and I remember specifically nurse asking me if I wanted something for the pain, and I said no, I mean even in all that pain, in that moment I said no and I was really proud of myself... And I was very determined, very, very determined to have a natural birth. And as natural as can be in a hospital. And, um, so the baby was born and he, um, in that first hour he nursed and stayed on me the whole time and bundled him up and my husband took him and he kind of went back and forth...

During the delivery she tore badly and two varicose veins made the repair difficult. She also lost a lot of blood which caused her vital signs to drop. She was pumped up with fluids to stabilize her, which created further complications. Later she ended up having an anxiety attack and becoming unable to move. She came away from this birth feeling like she hadn't "done her best." When asked about her feelings about homebirth in general and her choice to not homebirth again she responded,

I wasn't afraid of having a baby at home at the time, I don't think I was in touch with the negative aspects of things or the positive. I think I was more naive than, more naive about the situation, and just really wanted to stay on the side of being really confident that everything's going to go ok. So I didn't look at the other possibilities, and the reason why we chose a birth center was cause it felt like a real nice, happy medium, and we have, its cozy like a home but if something were to happen, which it can, and because of what's gone on in my last case I felt like, let's be on the safe side and lets go with the happy medium and, if we need any intervention than its right there. So, that's how we kind of came to our decision about the birthing center as opposed to homebirth or the hospital.

... um, my husband was really well set too. He said that birthing center or hospital and I said birthing center. I would like to do homebirth but I think because of my last experience I was having some fears about birth as well. Ya, so it wasn't, it was not that hard of a decision here. I didn't feel like I was giving much up. I felt like I was making a compromise for myself. Ya, but when, when I found out that I was pregnant again and I told [my mom], I said we were going to have the baby at the birthing center, and she's like, I'm so relieved. She was, my mom was just really happy. I described to her about the birthing center and she said, "I have no problem with it. I have no problem at all. I am just really glad that your going to have, you know, that you will be so close to help if you need it." A lot of that for them, too, is fear based. Like it is for a lot of people. Really scared of the what ifs...I even I have a little bit of that, which is why I am not going. Otherwise I would be going to a homebirth again. ...Even though, ok, so what I said was that this is the difference that I want to have in this next birth and that is when I look back at my last birth, even though, you know, I think on a one level you can say it was a successful birth, you know, I'm healthy, the babies healthy. There wasn't any, we didn't have to be resuscitated or anything like that, or we didn't have an emergency C-section or that. Um, I still came away from that experience not feeling like I had done my best, or that I had really known my body and known what to go with any experience. I had little clues and I had the dream and, you know, stuff like that, but it was still very ambiguous to me. So this time around, I'm really trying to learn what it means, first of all, to be really in touch with your body as a pregnant woman and to listen to signals ...And I had a real trust in, in life and in the natural process of life. Um...I think that that belief really got shaken when I went through what I went through. Um, in kind of rebuilding that took some time. But, just a real belief and trust...that there is a higher being, a higher power at work and it isn't, it isn't all, it isn't all in my control.

When I inquired what the central reason she wanted a birth center birth, she responded,

Um, well, kind of goes hand in hand, wanting to have that peaceful environment as opposed to an institution, but then the safety component, because of what happened in the last, my last birth. I think if I would have

had a birth that I didn't tear, I didn't bleed, [if] it was a successful homebirth, I'd definitely do a homebirth again. But, under the circumstances, because I did go through some of those things, and because I still don't have some of these issues resolved in myself....So, I think that we are just being practical in choosing the birth center, wanting that home loving environment, but having the safety of having immediate care.

Alicia represents a frame transformation away from homebirthing. Her birth experience made her more cautious. She still values the core collective action frames of the movement but found that birthing at home was too scary for her after her first birth experience.

Whitney also had a homebirth transport, but its course proved less traumatic for her. She labored at home comfortably with her midwife Nancy and family in attendance, but then her pushing was ineffective due to a big baby with a malpresentation of the head. They decided to transport to the hospital. In the hospital she was given an epidural which did not work, and then due to concerns about needing a cesarean section and Whitney's back pain level they gave her a spinal, which did work. They then manually turned the baby's head and used forceps to pull her out. I first asked Whitney why she had wanted a homebirth and she stated,

Well, I just thought that, you know, I figured that it would just be that I would have to deal with my baby might get introduced to drugs because, you know, through the labor that I had there. They always do that anyway now, it's not anything all natural, so you know, I figured that, and then also just that it's not a personal thing that my husband would have to be, and my family would have to be, all working around all of those strangers that are there, and you know, I mean, it's not that bad, but it's just not the way I wanted it to be, you know, And I figured I had my little nieces, who are 12 and 11, and I said they could come if they wanted to watch, and everything like that, and my sister's a massage therapist, she was there to help me, and my mom was there, I figured you know, and my husband was there, and it would all be real easy right here in our house. And we

had planned on having a birthing party and do all that fun stuff, but the party didn't go as planned.

She explained why they decided to go to the hospital and how the birth went.

I was, you know, ready to keep working at it and doing everything, and I didn't yell at anybody and be nasty like they say that you are sometimes. So, it was like you know, I was getting very discouraged at the end, and she [Nancy] said if it doesn't work, if nothing happens in the next half hour I think we better go to the hospital, and I was just like, I'm just getting so discouraged of pushing and nothing happening, I want to do something different, because I'm afraid if I go for another hour or two, I'll be dehydrated because we don't have air conditioning, so that was kind of hot, and I hadn't been able to eat anything or keep anything down, so it was like... I got sick the first thing in the morning, and then I tried to eat something else, and it just didn't stay down, so I hadn't eaten anything, so I was just, I was getting concerned with that, you know, mostly my mental state because I was just like getting so discouraged. I was just like what, what, we tried every position, we tried in the bathtub, we tried everything before we left here. So that was that. And I don't think if I would have stayed here for two days she would have come out because her head was turned wrong and they had to get the forceps and stuff...and it just kept on, I mean it was 6 hours of back, low back pain here, and then another when they were making up all their decisions of what to do. We tried an epidural and that didn't work, and then they said, well, we can do the spinal now just in case you have a C-Section then we'll be ready for it, so I was like okay, whatever. I'm here at the hospital, which is not what I wanted, I didn't want to do drugs, but I'm here, so let's do whatever we have to do now. So that's the way it was. It was fine. I mean, once they gave me the spinal, I was like, I didn't feel any of the pain anymore so I could push, and I pushed hard and everything happened then.... but it took them a couple of tries to get it, get the forceps at the right place and even then they left a mark on her head. So that was a scary situation. But I was so happy, you know, I wanted a girl and I was so happy I got a girl. And my husband...I didn't hear her cry for like, you know, like 3, you know, it seemed like a long time. They just took her right into the other room and measured her and got the stuff out of her throat and nose. And I didn't hear her, and I was like sitting there looking at my husband, go in there and see what's happening with our baby.... and that's another thing that I was looking forward to, you know, because you see all the homebirths and they get to be all up close to their baby right at the beginning. I mean, you know, to me it was like, that's was just the way it was. And my husband didn't get to cut the cord and stuff because it was kind of all real quick at the end, you know. And she did real good, though because her heart rate didn't change at all throughout the whole day of all that stuff. You know,

she was just, she was just fine. It wasn't like we were worried about her really, but....

Although the hospital birth wasn't what she wanted, she ended up feeling positive about the experience. She talked about her hospital experience,

...the experience I did have at the hospital when we had to go, we went to UMC and I was like me and my husband wrote him a really nice thank you letter because it was like, it was like a vacation stay at a hotel for a weekend. We got our own room, and I don't how that happened. It was luck, I guess. And then, you know, we wanted to nurse her so we had her in the room with us pretty much the whole time. And if we didn't want her there we'd just tell them, you know, you can take her down there, and so it was nice. And they let my husband stay and he had to sleep in this little roll out chair; it wasn't the most comfortable for him, but he was really happy that he got to be with us. And because I had the, I had the thing with the forceps, they had to push really hard on my bladder and do all this stuff, they put a catheter and stuff and they wanted to make sure everything was right when they took it out, so I had to stay for two days. Usually you don't have to, just one day, but...and the drugs that they gave me during that lasted all the way to the next day, so I stayed for two days, and it was just really nice. I mean, they took really good care of us. All the people that night really explained everything really well to me, and you know, and all the decisions that we had to, had to be made that night, it was really nice. All the doctors and everybody were really great.

I then asked her about where she would like to give birth to her next child, and she stated,

I would try again with the midwives first. My husband already promised her [Nancy] our second child; I'm like, you promised her? Wait a minute, I have some say in this. I don't think we're going to give her a child, let's just give her the money instead [laughing]...., she says it is [also easier the second time]. And I do believe it is. I mean, like the tape that we saw that Nancy gave us about other homebirths. All of them were second child homebirths because they had their other little children there. And they were all pretty quick and they seemed a lot easier. So, I'm looking forward to the second one being, you know, the whole thing done at home the way I planned. Soft candlelight and nice music... I just wanted a little bit...I wanted it to be quiet and I wanted it not to have any strangers and, of course, I wanted it here because I trust the environment as far as it being healthy, safe, and clean, you know.

Despite things going differently than planned, Whitney was able to come away feeling that she had been able to deal with the pain of labor well, and coped with the changing situations, which were things she valued and felt proud of. She also retained her commitment to wanting to try homebirth again for her next child. She remained committed to the central collective action frames of the homebirth movement.

For women who had birth experiences that were out of alignment with their birth frames or models, Davis-Floyd (1992) found three psychological tendencies: compartmentalizing, intensifying toward the holistic model, or intensifying toward the technical model. I found a similar pattern in the accounts of my respondents as well. Davis-Floyd (1992) found that women tended to “compartmentalize” the birth experience if it occurred in a way that lacked correspondence between their reality models and self-images they wished and needed to hold. This meant placing it completely outside their everyday lives. Phrases such as, ‘its over and done, and life goes on” or “[it’s] what you have to do to have a baby,” convey this compartmentalization. On the other hand, another group of women who had experiences that made them “uncomfortable” or made them feel like “failures” tended to intensify their exploration of birth issues. This category applies to Alicia. Her birth has made her reconsider her choices and further explore other options. It is my observation that her birth left her fearful that complications could occur again for her second birth. Davis-Floyd (1992) found for some this meant a further confirmation of the technocratic model (i.e. coming to realize that the cesarean section they had was medically necessary). For others the opposite is true, further epistemological exploration leads them to greater concordance with the holistic model. Davis-Floyd (1992) found those who had the most

intense of experiences either good or bad tended to be very involved with birth issues.

For those with bad experiences further epistemological exploration may also bring them into working with birth issues. Davis-Floyd (1992:248-249) states,

Those women who seemed most deeply touched-with grief or joy- by their birth experiences (if they did not compartmentalize) seemed to be the most likely to pursue their search for meaning through intensifying their involvement with childbirth as a social and individual process- a pattern readily identifiable among many of the past and present leaders of the national consumer movement for childbirth reform (e.g. Arms, 1975; Cohen and Estner 1983; Hazell 1976; Karmel 1965; Noble 1982, 1983; Rothman 1982). Those who had traumatic births wished to empower others to avoid such psychological devastation; those who had joyous births wished to empower others to do the same.

This desire to be involved in birth issues is the next area of frame transformation in my frame alignment model. Due to experiences both personal and professional, women become drawn to birth as a vocation and so become to the homebirth movement activists.

Professional Transformations: The Personal –Professional Link

Women today become midwives, doulas, and childbirth educators through a number of routes. Some come to these vocations before having children, deciding these are desirable jobs. Others come to these vocations through personal transformations and lived experience. This personal-professional link will be the route that is most useful for elaborating the professional details relevant to my frame alignment model. The focus of the following section is the experiences that bring women into homebirth midwifery, and other related vocations, and those experiences that lead them out of these vocations. This

is important to the frame alignment model because midwives and other birth professionals represent the main activists of the homebirth movement. Their personal transformation are part and parcel to the movement. Those who have personal experiences which transform their professional lives represent the most dramatic form of frame alignment transformation. Birth not only changed the way they felt about themselves, but it transformed their vocations. This transformation is similar to the experiences of other movement leaders. Taylor(1996) traced similar vocation/activist roles to those involved in the postpartum depression movement, illustrating the links between personal experience, collective identity, and micromobilization. Davis-Floyd (1992) also clearly illustrated the link between birth experience, either positive or negative, and women's involvement as movement leaders and practitioners.

This process is readily apparent in the frame transformations of many of my respondents. Of the thirty-five women in my sample seven of the thirteen midwives came to midwifery after they experienced their own births. Nasima is a case in point. After her unhappy hospital birth she had an unassisted homebirth and started helping other women have homebirths as well. Her transformation was so large that she was instrumental in starting the Arizona School of Midwifery. Sharon shared that she had been very unfocused before the birth, thinking she might become a nurse, but she quickly became focused on becoming a midwife after her first birth. This professional transformation also occurred for Rachel, who began attending homebirths after her first homebirth in the 1970s. Joanne also stated, "...you probably hear these kinds of stories I guess from everybody...Well... giving birth to my own kids is definitely what turned the clock on for me..." Barbara also stated,

I was young, had dropped out of school for nursing, RN program here at Pima and wanted to do something more alternative women's health... and then when I became pregnant with my own daughter [I] started searching around for an alternative type of women's health care provider and found out more about midwifery and ah jee this would be an interesting thing to do and so it all kind of came together when I got pregnant myself.

An additional three of the thirty-five women went on to become doulas or midwife assistants. These women had positive birth experiences of their own and wanted to be more involved with birth. As Chris, who became Holly's assistant explained, "cuz I had such a good experience...and ... it only takes you one birth (laugh) one baby...and boy, if you love babies, and you're just into that, it hooked me." Chris also felt she reciprocated the care she was given at her births to other women, "I always used to really be... be really feeling like I was there to support that woman, and... tell her how beautiful she was and how strong she was and all that stuff like people had done for me..." Sara also became Holly's assistant, and it was the contrast between witnessing a horrible hospital birth and a peaceful homebirth which brought her into being a birth assistant. She stated,

I went to a birth in Martinas, California to a friend of mine's birth, and she never interviewed the doctor. She just like went, and was really young, and had no clue, had her baby in the county hospital in Martinas, California, and it was the worst birth I had ever seen in my life...it was horrifying. They had her start pushing before she was fully dilated. Her cervix swelled, and then she couldn't get him out. They used every intervention, and that was back, you know, they screwed the thing on the baby's head, and then they did forceps, and then the doctor...the doctor had the plunger on the baby's head, and her foot on the table, yanking the baby's head, and yanking it, and cut her front, cut her back, yanked some more, and they finally got that baby out, and his head was this long from the plunger, and the suction, and the trauma, and I just flipped out. And then, on top of that, there was heroin moms and crack babies and you know, screaming crack babies, and a heroin mom that kept coming in and out of the delivery room while we were in there, and it was horrifying, and I thought, this is a nightmare. And I had already been to my sister's birth of her two children where it was a homebirth, it was peaceful, it was

gentle, and just the extreme of that, and you know, I think this was the second baby this doctor had ever delivered. She was on a time schedule, she was just really...it was sad.

These contradicting experiences motivated Sara to be part of homebirthing and to have her own successful homebirths.

All the midwives and birth assistants talked about how having children either before or after coming into practice deepened their understanding of birth and postpartum experiences. Joanne talked about how she feels she brings a lot of knowledge and experience to helping women breastfeed after her own experiences. She stated,

I went to League meetings. I breastfed twins for 3 years, my son for 2 and 1/2 years... I'm really thankful for that experience now, because I'm...probably even of our group of midwives here, I'm probably the most experienced, but also just the most knowledgeable from a personal standpoint of all kinds of complications from plugged ducts, mastitis, nursing strikes, whatever... and I'm very proactive with teaching women and getting them thru humps...with breastfeeding, so... So um...that's kind of my own experience, but really impacted me a lot, and it, and if you let it impact you, and you get called to further developing of those skills.

Damiana also explained how her own births informed her midwifery practice,

I felt like what really changed was my experience of being a mother and having a baby. I felt like all the postpartum stuff, all the nursing stuff, all the um joys and difficulties with being a new mom, like I just had my own experience that I could bring into my practice...So that, that that really changed. And I do feel like ... I had these intense lessons with my 2 pregnancies and births about fear and trust

Her first birth had been thirty-three hours of difficulty with a baby who ended up in the hospital for five days. She stated,

...I felt like with my first delivery in '88, I totally operated from a place of fear...I think it was just where I was in my life, and I just...I didn't come from a place of surrender. I think that's what it was. I think I was really dealing with issues about control...Totally afraid of losing it, and that's what birth is, you know? I mean it's totally what it is.

It took her four and a half years to have another child, and in that time a lot changed. She explained,

I was just in this very trusting, ready to let go, ready to (grunts) ..be in this primal space. I kind of viewed it as this is my next and only opportunity to heal, and go with what I really learned last time. So I mean it was just my dream. I mean it was my everything I wanted....It was like 6 hours and 45 minutes compared to 33 hours ...just getting into it and letting go and ... um... I loved it.

She expressed that these lessons helped her help clients move through their feelings of fear and anxiety and help women let go and surrender to the flow of the birth process.

I think one thing was I could really work with people to the point where they would, they could trust me...so that they could surrender... in a different way than I had before...cuz I feel like... I learned that that's really important, that you have to be able to, to turn yourself inside out in front of somebody else and make noise and, I could grunt with people, and scream with people, and ...just allow them the space to be that open and surrender and let go and be more hands on uh.. I feel like I really.., I had read about it before I had actually gone through it, but you can't help people go through that in the same way.

All these experiences helped inform and transform these women in their roles as midwives and assistants. The flip side to this level of personal experience, and practicing in a way that is very personal, means there are few boundaries in their lives. The intensity of practice, having small children, partners, and the politics of homebirthing and midwifery often took a toll on the lives of these women. The last frame transformation I will present is “burn out.” These are the events that push midwives and assistants away from homebirthing and acting as direct movement actors.

Professional Transformations: “Burn Out”

Burn Out represents multiple levels of frame alignment revolutions experienced by midwives. They are the movement’s foot soldiers. They deal with the beauty and challenges of birth every day. Their frames are tested over and over through professional practice. They are the one’s that deal with the disapproval of the medical community when they transport a woman. They are part of the failed homebirths. Also there is an emotional and energy cost to midwifery. Most homebirth midwives have solo practices meaning they are on call 24/7. This level of restriction to their lives tends to take a toll on their families, relationships, and energy. In addition midwifery seldom pays very much. Midwifery is also based on a philosophy of “connection” and “care,” which often translates into high levels of emotional labor on the part of midwives. This is often rewarding, but it also has its challenges. In addition to being available all the time, midwives also report feeling responsible to the “movement.” This responsibility to a stigmatized setting tends to also take an emotional toll on birth practitioners.

This burn out factor is a common problem for activists and has been identified as being associated with the nature of collective action frames a movement espouses (Benford 1993; McAdam 1989). It’s difficult to constantly defend your practice and the philosophy of homebirthing. Burn out is also common with other medical practitioners (Maslach, Schaufeli, and Leiter 2001; Raiger 2005) but the stigmatized nature of homebirth midwifery may additionally aggravate burnout. Damiana explained why she quit homebirth midwifery to become an L&D nurse. She stated,

I became weary of searching for clients. I became really weary of somehow like feeling like I was like fighting this cause instead of that...this was already established and yeah like I somehow...I just did not

feel the energy anymore in the same way that I had to promote the cause. I did not feel like I wanted to be politically involved anymore, with the rules and regulations and I don't know. I think that was how I felt was I just grew weary of the fight. And I no longer wanted to fight the fight. I wanted to really like um go...I wanted to like go with something that was like going instead of feeling like I needed to always be making something happen.... Yeah it was draining. And I didn't feel like it was supposed to be that way. I felt like it was supposed to be gaining momentum instead of losing momentum, and I mean all the midwives in Tucson started doing less and less. It was like "what's...what's happening here?" I mean I would go to conferences, and people would say the same thing.

Joanne also commented about the drain of midwifery politics:

I was burnt out with the politics. It's like no matter how good your outcomes are, they're never good enough... You're gonna have to fight the medical model mentality forever... This is not going away ever in your lifetime. And I don't feel like being on call 24/7.

The longest lasting homebirth midwife in Tucson is Betty Kibble. She is often described by others as a loner and unpolitical. However it seems that her decision to stay out of the “politics” of birth and simply stick to helping women have empowering homebirths has been a successful survival strategy for her. This type of practitioner level activism is equally important, since if all the midwives burned out there would be no one left to serve the women who are the backbone of the homebirth movement. They are creating change through “life politics.” Betty stated, “I never ...and I still have people calling me trying to get me to go to meetings. I have never been political, and I have never got into that. I suppose from the very beginning. I decided I am not going to be doing this number thing. And so I've kept to myself, and um ... I don't go to the meetings.” Some expressed disappointment that more midwives weren't as politically active as they once were. One stated,

There needs to be... We used to call ourselves... We used to say the LM stands for Loud Mouth. We used to be out there talking. Talking to reporters. Talking to them on the radio. And now... people aren't doing

that anymore. They'll have an article... like the Sunday paper had that story. They were following those women with birth a few months ago. Following them thru their pregnancies. And they were all basically high-risk people. And they were all... had like bad things went wrong, and modern science medicine came in and saved the day, and... It's like years ago we never would have let that go by. We would have demanded equal time with that. No one does that anymore, and I feel like someone, maybe someone needs to do that. Maybe that's what I need to do. We need Loud Mouths. There needs to be Loud Mouths out there going to the schools, making the presentations like we used to do. And no one does it now.

All midwives expressed the challenges of balancing their vocations, their lives, and the drain of political activism.

The drain on children and marriages is also a significant factor. Almost all the midwives described the deep challenges of balancing small children and homebirth practice, which could take them away for days at a time. This conflict between activism, midwifery, and small children led Nasima out of midwifery in the early 1980s. When Nasima left in the early eighties her five children barely knew her. Nasima had hoped the Arizona School of Midwifery would continue without her, but the school folded a few years later. She explained,

I've lived with a certain guilt about that, but at the time I had to weigh that my children were only going to be children one time in their life and they needed me, they needed their mom. At this point I had five children myself. I was so constantly at either a home visit, at a birth, at a post birth, or at a class, and my own children were hardly ever seeing me. They were always somewhere being watched by someone else. And it was starting to weigh heavy on my heart that my own children hardly even knew their mom and that is a bit of an exaggeration, but not really. It was just that I was so busy with everybody else.

Amy also recounted the challenges she faced as a single parent in midwifery school,

It was not easy... I got her in school and daycare there so I could be in for 24 hours...She lived with another family that only spoke Spanish. And so that was traumatic for her. She doesn't really remember it with happiness, but we were together no matter what. And so, and we were a team, and

we still are, and so, I think she'll... she weathered it pretty well. She was still nursing the entire time we were there, and I kept thinking she would quit cuz she was 4, and getting close to 5. She kept it up.

Midwives also recounted the challenges of telling their kids “we can do XYZ,” but only if I don’t get called to a birth. If they were called to a birth then often midwives would take their children with them until someone could come get them. Although families and midwifery are difficult to balance, some arrangements worked out well. Holly recounted her arrangement with her assistant who also had a baby within a few months of her.

My assistant had her baby in September, at home, so there were 2 of us taking our babies, and if we transported I couldn't take my baby upstairs at the University Hospital, so she would take the baby. Babies. And um either sit with them in the waiting room, and if one got hungry, she fed it. If the other got hungry, she fed it. Which was perfect! And I trusted the woman, I mean she was a very good friend.... and in an emergency it was great. She would take the boys home, and put them in the bath together, and nurse them, and put them to bed 'til I could get there.

On the other hand one midwife came to midwifery in the 1970s before getting married or having children and she now wonders where her life went. This may be related to the biographical effects of high cost/risk activism, which has been linked with a greater likelihood of being divorced or not married (McAdam 1989). She stated,

I still have some regrets, cuz I felt like I gave my young years when I should have been socializing, and getting married, and having my own family. Instead of doing that, I was doing midwifery...It doesn't work to try to meet people. It just doesn't. I mean.. I was always on call. I couldn't go places.... I remember going out to dinner with this man, and my beeper goes off. They just brought our food, and I had to leave. So now that... I'm not doing midwifery, when I realized that Nurse Midwifery wasn't gonna happen for me... what happened to my life, you know? What happened to my own husband and family? .. I guess they were victims of midwifery.

Because of the stresses of solo practice, low incomes, and family needs, many homebirth midwives “go medical,” becoming labor and delivery nurses or certified nurse midwives. They often report this as very challenging. It is hard to become part of a system that you have spent so much time criticizing and providing alternatives to. Midwives who “go medical” often find the ethical and culture shock pretty severe, but the compensation of a steady paycheck and time off seems to be a needed trade off. Most stay within their field, building on their already accumulated knowledge and practice base, by becoming Labor and Delivery nurses and /or Certified Nurse Midwives. As CNMs, they also feel “less in the social norm, but more legitimate than LMs.” They have greater legitimacy. Joanne commented about her experience of working in hospitals as a CNM after doing homebirth midwifery.

My biggest biggest issue...was that I really felt like I wanted to bring the midwifery model of care to the 98-1/2% of America's women who are delivering somewhere other than home...And that bringing that mentality into a setting such as this [hospital]...is only gonna benefit women. You know? I wanted to do the other side of it, and the thing that was really a challenge but really fun to do was to see people, whether it's like a 14 year old who gives birth standing/squatting...and delivers a 7-1/2 pound kid intact [perineum] you know breastfeeds within the first hour, I run into her a year later, she's still breastfeeding, she's cleaned up 3 years of high school....and she was empowered by this birth...That if she would of just gone to some Joe Blow doctor, she would have been episiotomies, and who knows forceps, maybe she was induced at 40 weeks, who would...but she didn't have that with me...And so I have now impacted this young girl...at an early age, and this is cool...This is really good.

Sharon also talked about the differences between being an LM and a CNM,

NASIMA: What do you think the most drastic differences are in either the way people relate, or the way you relate to the patients

SHARON:... I did homebirth on such a personal level with people. that was very difficult uh and in a way I miss that ...I try to maintain a lot of that, but there's a certain aspect like where... I just may not be on call the day that you come in. And that was never the case as a homebirth midwife. So that's quite different. But at the same time, it's something that

protects me from burning out, and... I need that in my life, too,. so it's just sort of a balance... Um... that just has to be kind of reached in some way or some point.

Before finding this balance many of these women have to first adjust to their new roles and the medical system. Culture shock is a real factor for midwives. They often discuss being ethically challenged, but finding ways to make it work. Their frames and models of birth are incongruent with the environment in which they are working, and they are forced to find ways to adapt. One midwife commented,

I got totally stressed out for one thing. It was... I mean I... there are so many things that nurses know because they've been nurses. Like... scheduling... they have a special language. Not an official language that you learn in nursing school, but a language that you learn when you've been around a hospital for a while...It's not just basic nursing, in other words... and we were doing high risk stuff...it was depressing and upsetting,.. and I had fear about it. Where these babies were coming out and wouldn't suck. Epidural babies. Nubane babies... for 12 or more hours or sometimes 18 hours, you put something in their mouth as big as a finger that they can't ignore, and they just don't. They were awake, and alert but...no suck reflex. Like, what's wrong with these babies. I've never seen this And...women who couldn't figure out breast feeding. I'd never seen that either. Give the baby to the mom. She takes it in her arms. She knows to use, knows how to do it. And.. in the hospital it'd be like...they'd get the baby by the head and... that kind of thing. I'd say, "well... cradle your baby." It was like they'd never held a baby in their lives. I don't know, but it was totally foreign to me

One adaptation strategy is using their roles in educating women to share information congruent with their birth models. One referred to it as “sneaky power.” Another got a folder of information on the risks/problems regarding circumcision approved and was able to find openings for educating patients. Others also report finding alternative ways to help women through the process of having children. Damiana again stated,

I can sit there and just be who I am and help them be who they are which is really what you do as a midwife, and help them get what they need. If they don't have baby clothes... I feel like I can just like... help people be honest about and not be ashamed of who they are and what they're going

thru and so I kind of feel like, "Oh, I've found a way to be a midwife, and a midwife is not about catching a baby. I've never felt that way. A midwife is just being with that person, and helping them go through that space.

Through the multiple revolutions of frames alignment, women take on roles as midwives and are transformed through this process. In the midst of the medical system they find their way to bring a bit of midwifery into the hospital. This involves its fair share of compromises, but from the inside out they make their small contributions to adding greater humanity and change to the medical system. Interestingly, despite their process of medicalization, and being softened to the more medical model of hospital practice, not one of the midwives interviewed regretted having homebirths, and they all continued to support homebirthing as a wonderful and safe option for childbearing women. They retained their commitment to the core collective action frames of the movement but they generally moved their participation to modifying the system from the inside out, instead of the outside in. Half these midwives represent a frame transformation process, which brought them into homebirthing through their own births; they served as practitioners for other homebirthing women to experience generally positive transformations, which solidify the holistic model and CAFs of the homebirth movement, and then through the stresses of this vocation were transformed again into other more medical birth roles. They did not lose their underlining belief in the CAF but exhibited a modification of how they are applied and how they vary by setting.

In conclusion, birth is transformative no matter where or how it occurs.

Sociological research (Oakley 1979) has illustrated how roles, responsibilities, and self-image are altered through the process of becoming a mother. However, it has been illustrated that how birth occurs does affect the way women feel about themselves and

their capabilities (Davis-Floyd 1992). Within this discussion of the homebirth movement and my respondents' frame alignment process, birth serves to transform women's birth models, either solidifying their frames or providing experiences that are incongruent with these frames. As I have illustrated in this chapter for many of my respondents incongruent hospital experiences brought them more fully in line with the CAF of the homebirth movement, whereas those homebirthers who had complications and transports may experience a transformation that takes them further away from homebirthing. This drift away from homebirthing also occurs as burn out for midwives. Even within these transformations, we still hear a commitment to the central principles of the movement, but a need to compromise due to life strain and experience. Lastly, transformations occur to provide micromobilization. Women support the movement by intrapersonal support by having homebirths, and the effect of "life politics." They also provide interpersonal support to the movement by talking to other women. They are motivated to spread the CAFs of homebirth movement to other women through the telling of their own birth stories and information about homebirthing. They provide networking and frame bridging for the movement in this capacity. Lastly, some are transformed sufficiently by their experiences and their beliefs in the holistic model and homebirthing to provide public activist support, through events, clerical labor, etc. Lastly, practitioners emerge as the movement's main actors. For half the midwives in my sample and two women who became midwife assistants, their personal experiences with birth transformed them into seeking out vocations which supported the core CAF of the homebirth movement and providing care to the women who go through the frame alignment process and seek out homebirthing. These personal experiences informed their practices. As I have illustrated

throughout this chapter, the transformations women experience after births vary, but most are motivated to support the movement, at least in thought if not in action. Overall, women expressed the sentiment that their homebirths empowered them and made them stronger. And therefore they were motivated to keep homebirth a viable option open to women.

CHAPTER FIFTEEN: CONCLUSION

As homebirthing women have come through the frame alignment and construction process, most have been motivated to support the movement at a variety of levels, ranging from the intrapersonal level to activist or practitioner levels of movement support. From the 1970s to the present day, what has this support (or micro-mobilization) resulted in? Where do things stand nationally for the homebirth movement in America?

The homebirth movement has grown from a few isolated individuals in the 1970s birthing alone or with friends, such as Nasima, Sharon, and Rachel in my interviews; to small enclaves of midwives and interested women, such as Ina May Gaskin and the Farm Midwifery Center in Tennessee; to advocacy groups, such as Tucson's Committee for Midwifery (COFAM) slowly making inroads at the state level to develop licensing of homebirth midwives; to the publication of numerous articles and books supportive of the care that midwives provide and/or critical of the care that is standard in maternity care in most hospitals.

Midwifery has continued to take on a more professional and national scope. In 1982 midwives developed the Midwives Alliance of North America (MANA), a national organization supporting midwifery across America and Canada. They organized around four goals: 1.To expand communication among midwives; 2.To set educational guidelines for the training of midwives; 3.To set guidelines for basic competency and safety for practicing midwives; 4.To form an identifiable professional organization for all midwives in this country. They published the MANA News to facilitate communication

and put on yearly national conferences. Midwives codified their knowledge through publication of standards of care, ethics, and books used in midwifery education. Schools were started; some have survived for over twenty years, such as the Seattle School of Midwifery in Washington (Rooks 1997).

In the late 1980s, midwives began working toward increasing standards for practice and education. One way they began to redefine themselves was by slowly replacing the term “lay midwife” with the term “direct-entry midwife” (DEM), as a reflection of their ever-increasing levels of knowledge, experience, professionalization, and as a way to position themselves more in line with European non-nurse paths into midwifery³¹ (Davis-Floyd 1998). One of the outgrowths of MANA was the North American Registry of Midwives (NARM), that in 1994 began a process to certify experienced direct-entry midwives, and then expanded to beginning-level midwives in 1996 (Rooks 1997). The written exam developed by NARM was quickly picked up by midwifery organizations and state agencies looking for an exam to use in licensing or certification of midwives. This led NARM to become a full-fledged testing and certifying agency, responsible for certifying, designing, developing, and implementing the national credential of Certified Professional Midwife (CPM). The CPM was a particular success for homebirth midwifery because it was based completely on the knowledge base of homebirth midwives. A comprehensive practice survey was mailed to MANA members, who filled out a survey on the skills needed to practice homebirth midwifery. The results

³¹ In Europe midwives who go to three year formal midwifery programs, use the term Direct-Entry Midwives because they do not have to become nurses before becoming midwives as CNMs traditionally have in America.

represented an amazing consensus among homebirth midwives on the skills and knowledge needed to practice direct-entry midwifery. The national test was then based partially on this survey, expert advice, and midwifery books (Davis-Floyd 1998; Rooks 1997). Eventually with the help of Citizens for Midwifery, they contracted with a competency-based education and testing agency in Ohio that improved the process and exam and gave it greater credibility (Davis-Floyd 1998; Rooks 1997)³². The first CPM was certified in 1994, and by June of 1998 there were 400 CPMs certified (Davis-Floyd 1998). Today in 2006, there are 1112 CPMs nationally (Pulley 2006) See APPENDIX E: CERTIFIED PROFESSIONAL MIDWIVES GEOGRAPHIC DISTRIBUTION MAP for further numerical and geographic distribution of CPMs. The CPM reflects competency-based proficiency. It does not require a college degree. This reflects the importance in the midwifery community of maintaining multiple routes to certification, including the traditional route of self-study and apprenticeship. In addition to this respect for traditional routes into midwifery, there was also increasing interest in accrediting schools of midwifery and establishing standards for DEM education.

In 1991, the Midwifery Education Accreditation Council (MEAC) was established; it set standards, goals, and requirements for accreditation (Rooks 1997). It began accrediting schools in 1995. MEAC is now a recognized accrediting body approved by the US Department of Education, and there are ten MEAC accredited schools of midwifery in eight states: Washington, Florida, Oregon, Maine, Texas, Utah, New Mexico, and Vermont as of August 2005 (www.meacschools.org/ 2005). As

³² For a detailed discussion of the process of NARM and the CPM see Rooks, Judith Pence. 1997. *Midwifery and Childbirth in America*. Philadelphia: Temple University Press..

accredited institutions, these schools are eligible for financial aid (Tritten 1998). This financial support has allowed many women to enter midwifery through formal routes who may not have been able to afford this education otherwise.

Communications between midwives, professional groups and consumers has also increased. Newsletters, bulletins and e-groups are supported and distributed from midwifery organizations. Consumer groups, such as local Friends of Midwives, and other statewide consumer organizations, as well as the national consumer group Citizens for Midwifery have continued to work to support midwifery. Citizens for Midwifery began in 1996 to provide national-level networking for local midwifery advocacy groups.

Out of these consumer and practitioner efforts, the *Midwives Model of Care* was defined in 1996. The definition states, “The *Midwives Model of Care* is based on the fact that pregnancy and birth are normal life processes. [It involves] monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle; providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and postpartum support, minimizing technological interventions; and identifying and referring women who require obstetrical attention. The application of this woman-centered model of care has been proven to reduce the incidence of birth injury, trauma, and cesarean section” (Midwifery Task Force 2005 quoted in www.cfmidwifery.org 2005). The midwifery model of practice is autonomous, community-based care, and incorporates the principles of continuity of care, informed consumer choice, choice of birth setting, collaborative care, accountability and evidence-based practice.

This concept has been influential in the development of the mother-friendly childbirth initiative (MFCI) seeking to improve maternity care in all settings. The Coalition for Improving Maternity Services (CIMS) is a collaboration of individuals and organizations with concern for the care and well-being of mothers, babies, and families. Their mission is to promote a wellness model of maternity care that will improve birth outcomes and substantially reduce costs. Among other things, they seek to educate consumers, facilitate evidence-based care, and designate birth centers, hospitals, and homebirth services which meet their standards for mother-friendly care (www.motherfriendly.org 2005).

Direct-entry midwifery is also legal in more states than ever before. As of April 2006 there are thirty-four states where direct-entry midwifery is legal by statute, judicial interpretation, or licensure, certification, registration, documentation or permit. It is alegal in six states because it's either not prohibited but not legally defined, or it's legal by statute but licensure is unavailable. It is illegal in eleven states. This represents a change in twelve hard-won states that are now legal instead of alegal; five states that have changed from illegal status to legal status, and one state that has changed from illegal to alegal; and four states that have gone from legal to illegal/alegal since 1985³³. Today,

³³ Change in state legal status derived from Baechler, Mary. 1985. "Would You Like To Become a Midwife?" in *Mother Earth News*. and Midwives Alliance of North America. 2006a, "Direct-Entry Midwifery State-By-State Legal Status", Midwives Alliance of North America, Retrieved 4/10/2006, (www.mana.org/statechart.html).. Illegal to legal change seen in CO, DE, LA, NY, PA. A-legal to legal (CA, IL, KY, MA, MI, MN, MS, MT, NJ, RI, VA, WI. Legal to illegal (WY, SD, IA). Legal to a-legal (NE). Illegal to a-legal (OH).

nine states provide Medicaid reimbursement for DEMs and a few insurers provide coverage in a few states (Midwives Alliance of North America 2006a; Tritten 1998). For further information, a map and table See Figure 15: Map of Direct-Entry Legal Status by State, 2006 and APPENDIX C: DIRECT-ENTRY MIDWIFERY STATE-BY-STATE.

Over the years midwifery has developed a greater understanding of the need to be evidence-based, and increasing amounts of research literature have demonstrated the advantages of midwifery care such as reducing cesarean sections rates, improving neonatal mortality, reduction in use of interventions, and significant cost savings (Anderson and Greener 1991; Anderson and Anderson 1999; Anderson and Murphy 1995; Berg 2005; Bruner et al. 1998; Burnett 1980; Declercq et al. 1995; Durand 1992; Enkin et al. 1995; Gaskin 2003; Goer 1995; Issacson 2002; Johnson and Daviss 2005; Koehler et al. 1984; Mehl et al. 1977; Murphy and Fullerton 1998; Olsen 1997; Remez 1997; Rooks et al. 1989; Rooks 1997; Sakala 1993; Sullivan and Beeman 1983; unknown 1987; Wagner 2000; Walsh and Downe 2004). New research by (Johnson and Daviss 2005) has provided the most robust evidence of the safety, good outcomes, and low use of interventions in the care provided by CPMs in out-of-hospital birth settings. Just one such example is the reduction in rates of cesarean sections. In 2000, homebirth CPMs had a cesarean section rate of 3.7% versus 19% for comparable lower-risk births nationally (term, singleton, vertex births) (Johnson and Daviss 2005). The specifics of common obstetric interventions, and the homebirth movement's arguments against their overuse, was presented in detail in CHAPTER FIVE: BIRTH OF A MOVEMENT-COLLECTIVE ACTION FRAME EMERGENCE AND DIFFUSION subsection "Framing Technology and Birth Interventions."

The movement has also seen the publication of articles (Beech 2000; Buckley 2002b; England 2000; Fuchs 2000; Gaskin 2001; Griffin 1997; Issacson 2002; Jukelevics 2004; Mothering 2005; O'Mara 2003a, c; Simkin 2000; Stahmann 1991; Wagner 2003) and books (Arms 1996; England and Horowitz 1998; Gaskin 2003; Harper 1994) for the general public detailing the dangers of standard care, the advantages of midwifery care, and homebirthing accounts that provide motivational frames. These have articulated and disbursed the movement's diagnostic and prognostic CAFs. As detailed in Johnson and Daviss (2005), CPMs in out-of-hospital settings with low-risk patients had a rate of intrapartum and neonatal mortality of 1.7/1000 excluding congenital anomalies, which is consistent with the neonatal/intrapartum mortality rate for low-risk births in general and previous studies of out-of-hospital births. In fact, when they compared crude mortality across studies for intended homebirths and intended hospital births for comparable populations and employed indirect standardization and logistic regression to compensate for variations in risk profiles, both methods found a slightly lower risk for intended homebirths.

CPMs utilize significantly lower rates of interventions compared to a relatively low-risk national comparative group. Intended homebirths had lower rates of electronic fetal monitoring (9.6% versus 84.3%), episiotomy (2.1% versus 33.0%), cesarean section (3.7% versus 19.0%), induction of labor (2.1% versus 21%), augmentation (2.7% versus 18.9%), and vacuum extraction (0.6% versus 5.5%) (Citizens for Midwifery 2005b; Johnson and Daviss 2005). As discussed in much greater detail in Chapter Five, these interventions are associated with higher rates of mortality and morbidity. Cesarean sections alone have a two to four times

greater chance of maternal mortality (Hall and Bewley 1999; Harper et al. 2003; Petiti 1985; Petitti et al. 1982). When truly used to save a mother and child, these risks are of course offset; however, when as many as 50% of cesarean sections may be unnecessary (Menacker 2005; World Health Organization 1985) the risk does seem significant³⁴. It seems unconceivable to defend a 2004 national cesarean section rate of 29.1%, when other countries with lower infant and maternal mortality rates have cesarean section rates of 10% or lower, high rates of midwife-attended births, and state supported homebirths (ICAN 2005; Wagner 2003). Declerq (2002) found that compared to women who had a vaginal birth, women who had a cesarean section were less likely to “room-in” with their babies and be breastfeeding at one week. They were also more likely to experience health concerns such as abdominal pain, bladder and bowel difficulties, headaches, or backaches. Declerq et al. (2005) found that primary “no indicated risk” cesareans had increased 67% between 1991 (3.3% of all births) to 2001 (5.5% of all births). For older primiparaous women the odds of having a no risk indicated cesarean section were almost 50% higher in 2001 than in 1996. This very low-risk group represents a clear indication of the casual attitude cesareans are getting in American medical practice and society. These numbers are likely to

³⁴ Healthy People 2010 guidelines set a target of 15 percent for cesarean delivery of low-risk mothers (singleton, term, vertex) and 63 percent for repeat cesarean delivery Menacker, Fay, Dr. PH. 2005. "Trends in Cesarean Rates for First Births and Repeat Cesarean Rates for Low-risk Women: United States, 1990-2003." Centers for Disease Control and Prevention, U.S. Department of Health and Human Services.

rise in 2006 as “elective” cesarean sections have been “approved” by ACOG and are on the rise (ACOG 2003; Declercq et al. 2005).

The literature has demonstrated that episiotomies cause increased postpartum pain, slower return to sexual activity, and are not necessary in more than 5%-20% of women (Wagner 2000). Epidurals are associated with double the risk of death, and “anesthesia complications” are documented as one of the leading causes of maternal mortality in America (Wagner 2003). Epidurals are associated with hypotension, headaches, backaches, and rarely paralysis. Epidurals also put women in bed, attached to a monitor, eliminating or reducing the body’s natural neuro-hormonal feedback loop that intensifies labor. These “side effects” commonly result in a slowed or sluggish labor, and to “fix” this slow down, more technology- the administration of pitocin to augment the body’s natural labor hormones- is employed (Griffin 1997). Pitocin either for augmentation or induction of labor has its own accompanying risks. Pitocin and prostaglandins can cause contractions so strong that they compromise the blood supply to the infant and are even capable of rupturing the uterus. Electronic fetal monitoring has been found to be associated with a doubling of primary cesarean sections (Rooks 1997). Epidurals are also associated with as much as a ten-fold increase in cesarean sections overall (Rooks 1997). Epidurals also cause changes in the infant, such as fetal heart rate irregularities, neonatal jaundice, a reduction in sucking reflex and other neuro-behavior changes, which adversely affect the initiation and continuance of breastfeeding (Goer 1995). Other painkillers such as narcotics (e.g. Demoral) are known to have a depressive effect on neonatal respirations (Brackbill et al. 1974; Mehl et al. 1977). Inductions, augmentations, and epidurals all require the use of electronic fetal heart rate monitors

(EFM) since they have the potential to compromise the infant. Continuous EFM is itself associated with a doubling of the primary cesarean section rate (Rooks 1997). It is clear these interventions are being used more and more for non-medical reasons. As these statistics and research make clear, the effect of life politics and increased frame bridging is ever more important to improving maternity care in America.

The Maternity Center Association (Declercq et al. 2002) study on women's experiences with birth in America found that 93% of women had fetal monitoring, 85% had an IV, 67% had their water broken, 63% had an epidural, 44% had an attempted or successful induction, 53% had their labors chemically augmented to speed up or intensify their labors, 35% reported having an episiotomy, 7% had vacuum extraction, and 24% reported having a cesarean section. Declercq (2002) also found that while 20% of mothers indicated that they used no medications for pain relief, there were virtually no "natural childbirths" among the mothers surveyed. Fewer than 1% of the mothers gave birth without at least one of these interventions, and almost all of these came from the less than 1% of homebirths in their sample (Declercq et al. 2002). This same research found that most women found their caregivers to be polite (93%), supportive (89%), understanding (87%), but rushed (16%). Women surveyed felt generally positive about their births, stating they generally understood what was happening (95%), felt comfortable asking questions (93%), got the attention they needed (91%), and felt as involved in decision-making as they wanted to be (89%). When asked if "birth was a natural process that should not be interfered with unless absolutely medically necessary" only 45% agreed with this statement, with 31% disagreeing, and 24% undecided. Clearly, many women

agree with the medical model and “definition of the situation” that defines birth as risky and should be medically managed.

So the majority of women aren't complaining about their maternity care or the very high rates of interventions, more women and babies are dying or having complications based on these interventions, and we are nationally approaching the point where one third of babies are delivered by major abdominal surgery with all its attendant risks for the mother, baby, and her future pregnancies. So what good has come from the activism and experiences of homebirthing parents and natural birth advocates?

Certainly a main advantage for parents who choose to birth at home is the increasing support from national groups, and the knowledge base and experience that homebirth midwives in general now have. Homebirth's legal status is slowly improving, and access such as Medicaid coverage, although not what it needs to be, is also slowly improving. In terms of larger policy and social changes, many feel the changes are small, given the above statistics. However, some of these changes are significant. Women are no longer strapped to tables with leather bindings without partners, friends, or other support. Women are generally not drugged to the point of unconsciousness, their babies pulled from the womb with forceps and large episiotomies, emerging limp, blue, and slow to breathe from the drugs their mothers have received. Most women no longer labor in shared labor rooms and are then rushed to a delivery suite for delivery during the hardest part of labor. Consumer pressures and concerned practitioners have asserted pressure on standard maternity care and some successes have been gained. Partners, family, and even children are “allowed” to accompany the mother through her labor and birth. Most partners are even allowed to stay with the mother during a cesarean section. Birthing

rooms have become common, where the mother stays in one room during labor, delivery, and perhaps postpartum as well. Many of these rooms have been “decorated” with matching furniture and décor, certainly making the surroundings more pleasant than they were forty years ago. Babies spend more time with their mothers than they used to. Rooming-in is much more the norm than it was thirty years ago. More nurse-midwives also practice and deliver more children today than ever before. Today’s mothers enjoy the policy changes brought about by activists seeking to improve maternity care, including homebirth parents and activists. Homebirth was one important part of the pressures that brought about birthing rooms, and rooming in. Homebirth still serves as the small social and medical laboratory where truly “natural births” occur and provide the opportunity to see the good outcomes possible from direct-entry midwifery and births with low rates of interventions. Although homebirthers are often marginalized or seen as a curiosity in the press, their rationales questioned, their interaction with the medical community often hostile, they have served as a radical flank pushing the mainstream toward change and in the process mostly experiencing beautiful, satisfying, safe births for themselves.

So what is the direction of policy change yet to come? Certainly it seems that a congressional or governmental level examination of our national cesarean section rate and rates of interventions and complications, including increases in maternal mortality, is in order. Reducing these rates is part of the Healthy People 2010 program, but since the rates are moving in the opposite direction to these goals, it seems appropriate for a larger investigation of this trend. Consumer and practitioner groups are discussing ways to encourage such an investigation. Continued work on increasing the number of states in which homebirth midwifery is licensed and legal, third payer equity, and malpractice

insurance for direct-entry midwives are other areas of activism and policy efforts. Continuing efforts are also underway to increase cooperation between CNMs and DEMs. Groups continue to work to increase consumer knowledge about natural birth and homebirth, hoping to motivate more women to choose homebirth or more natural birth choices and eventually become consumer activists. They have focused on actions such as writing a letter a week to media outlets or policy makers or creating a local Birth Network.

It is my hope that this research will further these policy goals and provide insight into how and why women decide to have a homebirth. In the realm of sociology, I have added to the field's understanding of framing, cognitive liberation, and collective identity. It is useful to understand the processes I have described. They may help activist groups focus on the areas that women report as important to them- the areas that are resonant to increase their education efforts in that direction. I have provided data on the framing efforts of the homebirth movement and how some of these framing efforts came to be. I have presented the movement's diagnostic, prognostic, and motivational frames and how these became part of individual women's process of birth frame alignment and construction, including processes of collective identity and cognitive liberation. Overall, my research fills in several areas of the sociological literature.

Within the sociology of birth, I have added to the literature on women's birth setting decision-making and the micro-level processes described in my frame alignment and construction model. I detailed the development of some of the homebirth movement's collective action frames from the lived experiences of early leaders. I have

also further elaborated on the linkages between macro-constructions and micro-alignments and reconstructions of birth models (framing).

Within the social movement literature, I have added to our understanding of a health-related social movement. Brown et al. (2004) and Benford and Snow (2000) have highlighted the need for more research in this area, and my research adds to this discourse by bringing to light the diagnostic, prognostic, and motivational frames employed by the homebirth movement, and showing how at the micro-level these arguments were “processed” and “utilized” within individual birthing choices and framing. My model of “Birth Frame Construction, Alignment, and Adoption” elaborates on several key framing efforts that have been highlighted as in need of further study, especially within the health-related arenas (Benford and Snow 2000); these include frame bridging and frame transformations. I have added to the framing lexicon with the concepts of frame foundation, frame negotiation, and testing the frame. I have also illustrated the process of cognitive liberation, utilizing Nepstad’s (1997) elaboration of this concept to describe how individuals become “cognitively liberated” through the effects of framing. Cognitive liberation involves three steps: first, individuals no longer perceive a system as legitimate or just; second, those who once saw the system as inevitable begin to demand change; and third, those who normally considered themselves powerless have come to believe that they can alter their lot in life. When individuals have moved through all three stages, they are “cognitively liberated” and able to organize, act on political opportunities, and instigate change (McAdam 1982; Nepstad 1997). I have shown how homebirth movement actors have presented diagnostic collective action frames that detailed how the US maternity system has been unjust to birthing mothers and their

infants by increasing, not decreasing, the risks of complications, and by practicing in ways that are not evidence-based and that are often disrespectful of women's wishes. Consumers began to demand changes, some of which have been effective. Lastly, homebirthers have found that they are empowered to make decisions, find alternatives, and advocate for social change individually and in groups.

Through this process of cognitive liberation, a collective identity has developed (Kebede et al. 2000). Homebirthers generally share a set of ideas, beliefs, and values based on some shared understanding of identity. This identity is both a means to and a goal of micromobilization. Taylor (1996; Taylor and Van Willigen 1996), has illustrated how collective identities can occur through framing efforts in self-help and political movements, and my research affirms this assertion.

Again affirming Taylor's (1996; Taylor and Van Willigen 1996) and Brown et al.'s (2004) assertion that "life politics" is politics, I have demonstrated how the homebirth movement, as an embodied health movement with a self-help component, has presented collective challenges to medical policy and politics, belief systems, research and practice; including an array of formal and informal organizations, supporters, networks of cooperation, and the media. I have demonstrated how health and self-help movements represent challenges to political power, professional authority, and personal and collective identity. Homebirth midwifery has provided a way for individual women to express their political discontent with the current maternity system and a means to achieve an alternative route to practice. Homebirthers, although very divergent in characteristics, do hold the central collective action frames of the movement as important; their collective identity can be explored through these shared beliefs, attitudes,

and behavior. They share a “definition of the situation” that reflects their shared understanding of the movement’s collective action frames (Owens and Aronson 2000).

These social psychological and meso-level theories of framing processes, collective action frames, and their related concepts of collective identity and cognitive liberation, have helped sociologists recognize the importance of the interpretive processes at work in collective action. They have helped to illuminate the micro-level processes involved in movements and how these interpretive processes take place in different movements, providing a link to macro-level processes. Linking these levels together has been a major goal of this thesis.

The central research purpose of my thesis has been to illuminate the experiences, motives, and organizational process of a cohort of homebirthing women in Tucson, Arizona, who embody the holistic reframings of the national homebirth movement. In so doing, I have discussed the national homebirth movement’s framing of an alternative paradigm of holistic birth that developed in opposition to the medical model of birth, as well as the frame alignment processes, micromobilization, movement participation and growth of the homebirth movement. This thesis has further elaborated the link between micro- and macro-levels of social movements, detailing how movement processes are reflexive at both the individual and group level. To accomplish these purposes I have described a birth frame alignment and construction model that is composed of five components: frame foundations, frame bridging, frame negotiations, testing the frame, and frame transformations.

In detailing frame foundations, I have discussed how women’s childhood experiences, their mothers’ stories, their social milieu and lifestyle, and their prior

experiences with doctors and hospitals influenced their interest in and receptivity toward the collective action frames (CAF) of the homebirth movement (HBM) and deciding to homebirth themselves.

Through frame bridging, women connect with sources of information about homebirthing. This occurs through books, magazines, and other media, and through interpersonal networks, and more formal channels of childbirth education classes. Frame bridging occurs throughout the process of frame construction and alignment.

As I have illustrated, frame negotiation is the next component of the frame alignment and construction model that deals with making choices and navigating social obstacles such as finding a midwife, balancing financial concerns, and dealing with questions of risk. It also involves cognitive liberation, a process of assigning blame to a social system (e.g. medicalized childbirth) and identifying practical opportunities for change (e.g. trying to birth at home) A lengthy part of this discussion also involved the prognostic, diagnostic, and motivational collective action frames that women espoused as important to their homebirthing decisions. I have also discussed how concerns are moderated through faith, education, and a deep trust in one's caregiver.

Frame negotiation leads to testing the frame; this component represents the culmination of decision-making, internalization of CAFs, and micromobilization. This chapter presented a sampling of individual women's idiosyncratic experiences with birthing.

Last, the chapter on frame transformations presented the effect of women's birthing on their birth frames. Some found their frames, derived from the other stages in the model, confirmed through their birth experiences, reinforcing for these women the

“rightness” of their choices and their underlining frameworks derived from the CAFs of the homebirth movement. Some, however, found these frames lacking in the face of experience and found themselves reanalyzing their commitment to this model of birth and the movement itself. Many referred to themselves as a “homebirther,” which I saw as reflective of their adoption of a collective identity linked to the homebirth movement. Additionally, most ended up supporting the movement through various levels of micromobilization, from simply talking to friends and sharing their experiences, to becoming a midwife or public activist. These transformations were further affected by subsequent births or years as a birth practitioner and/or activist.

This process varied some by decade. As the national homebirth movement evolved and changed, individual women’s expectations, structural and social support, and legal and economic frameworks affected their processes of frame construction and alignment. The early pioneers in the 1970s had no structural support for their homebirthing, and many birthed with minimally experienced “midwives.” This was seen in the stories of Nasima, Sharon, Rachel, and other homebirth pioneers such as Ina May Gaskin. These women would go on to build the structural support today’s homebirthers enjoy. Ina May’s book *Spiritual Midwifery* had a far-reaching effect and introduced many of the movement’s emerging CAFs, and her midwifery service has represented a model of successful out-of-hospital midwifery. Nasima, Daniel and all the others who were instrumental in interfacing with the state authorities and successfully revising Arizona’s licensing of homebirth midwifery paved the way for licensed midwifery in Arizona. Without these individuals’, and many others, birth frame processes and eventual transformations into activists the stories of the contemporary homebirthers in all

likelihood would not be possible. The contemporary women experienced this frame alignment process with the lessons of the pioneers as the bedrock of their experiences. Today's homebirthers have the advantage of thirty years of legal midwifery in Arizona and the mounting evidence of its safety and success for those who embrace it. Although homebirthers represent only 0.66% of births in Arizona, their passion and desire to see changes in maternity care both for themselves and others is powerful. Kathryn Shrag, director of The Tucson Birth Center at the time of our interview, stated to me she thinks the power of out-of-hospital birth is ten times stronger than hospital birth. It's hard-won and it's beautiful and it makes people want to share their experiences and work for change.

A woman's choice to homebirth is reflective of her process of cognitive liberation, an adoption of a collective identity, and the process of frame alignment and construction. These culminate in the reflection of her "life politics." These political expressions, through women's birthing choices, are the building blocks of the larger homebirth movement. Every birth is political. Klassen (2001:213) stated,

Giving birth in contemporary America is an act laden with political meanings, whether a woman articulates them or not. Childbirth is political because it has to do with negotiations of power: a woman's power to bring forth new life and a midwife or doctor's power to help her do so (or hinder her). Furthermore, childbirth is embedded within a wider cultural and political discourse, including a legal discourse, that sanctions or censures a woman's decision about how best to accomplish her task of birth

I hope I have succeeded in bringing the reader from the micro-experience of movement pioneers, to the macro-articulations of movement leaders, back to the micro-level of my respondents' processes of birth model construction, alignment, and adoption;

and then back up again to how social policy and “life politics” is changing birth culture in America.

Building on these findings and additions to the body of research on homebirthing and also social movements, I see several avenues for future research. First, building on my existing research framework, further interviews with mothers who chose birth center or hospital births with CNMs would be useful research to gauge alternative birth setting decision-making. I’d like to research why women who appear to have an interest in midwifery care and natural birth do not go the extra step of having a homebirth. Additionally, further interviews with fathers/partners would allow me to fill in men’s/partner’s process and contributions to their wife/partner’s frame alignment and construction process. How do partners either encourage or discourage women in their birthplace decision-making? How do birthing women negotiate these issues with partners?

A second avenue of future research revolves around a more thorough recounting of the history, accounts, and politics (internal and external) of midwifery organizations and activist efforts, perhaps on a state-by-state basis. There is still a good deal of information and detail on the framing efforts of the homebirth movement yet to be explored by a social scientist. Also, the “mothers” of the homebirth movement are reaching their 70s, and their stories are close to slipping from history. Future research to document in detail their contributions to modern midwifery care would be valuable and timely research. Learning how past women became activists is one step toward increasing political involvement for new generations of women.

A third avenue of future research involves quantitative data collection on why homebirthers choose to homebirth. There are several studies (Davis-Floyd 1992; Klassen 2001; Pfaffl 1999; Tjaden 1983) and my current research that provide in-depth qualitative data on women's motives and rationales for homebirth, but as of yet there are no quantitative studies producing hard data on the main rationales for homebirth. There are several barriers to this type of research, as I discussed in my methods section, but as data collection through MANA and other state sources is improving, some of these barriers may be more easily overcome. Having statistics of this nature could have policy implications and be useful in arguing for direct-entry midwifery. It would also quantitatively define areas in which the homebirth movement has been most resonant with its CAFs. Hence, this research could help the movement focus on areas of education that are the most resonant for the most women. It may also be used to help identify problems with empirical credibility in the movement. This would have further research policy implications because it would aid activists in understanding how to better connect with and/or educate the public about midwifery care.

I am hopeful that the most lasting contribution of my thesis will be its focus on "life politics"- a focus on how each person's individual choices affect the big picture. I was asked, "What are the implications of your work?" I think the best answer to that is that women and society come to realize that each woman, each birth, each choice matters. It is my hope that this work facilitates women's sociological imagination, the knowledge that the choices that they make in their lives, and for their birthings, are not just a reflection of society, but are the creations of society. Each choice each individual makes adds to the whole, and as such is greater than the one. Each woman who births with an

epidural and sees this as acceptable and the norm reinforces the social status quo. Today that is the majority. But the value of women who hold open an alternative conceptual space are just as powerful. Women who birth naturally, and those who birth at home especially, are affected by strong experience. Because they are hard won, they hold considerable charge. Sometimes for our lifetimes the effect seems invisible and purely personal, but we must not forget that each of us is a drop in the social bucket and enough drops and the water changes color. That said, changes have already come to pass through consumer pressures. Although change is slow, we must use the lens of history to see the shifting sands. There is hope. In the interviews I experienced women's frustrations over and over again. Why don't more women choose this, why isn't homebirth more accepted? Why is the movement not gaining momentum? I kept hearing sheer frustrations and sadness. To them I say your personal choices matter, they make a difference, and every person who you encourage and tell your story to, and every midwifery organization you financially support, these things matter; you are the backbone of the fight and don't forget it. Our numbers may be small, but never forget this quote by Margaret Mead: "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has."

APPENDIX A: CONSENT FORM

You are invited to participate in an in-depth interview for the research study, “ Born at Home: Exploring the Home Birth Movement, and the Experiences and Motives of Home Birthing Parents” being conducted by Nasima Pfaffl, a Masters Student in the Department of Anthropology and Sociology at the University of Central Florida. Her thesis committee includes Dr. Lin Huff-Corzine, Dr. Karen Baird-Olson, Dr. John Lynxwiler, and Dr. Shirley Keeton, all from the from the Department of Sociology. This research study will further the understanding of the home birth movement and the motives and experiences of home birthing parents.

This research project has two components. First, audio and/or video interviews will be used to write the Masters Thesis. Second, parts and/or whole video interviews will be used to create a video compilation of home birthing stories. Below you are given the opportunity to designate which components of “ Born at Home” you are willing to participate in. If you choose only to participate in an audio interview, you may designate if you wish your identity to be kept confidential. If you wish your name to be kept confidential only Nasima Pfaffl, Dr. Huff-Corzine, Dr. Baird-Olson, and Dr. Lynxwiler, and DR. Shirley Keeton will have access to your identity, and they are all bound not to disclose this information. If you participate fully in the video and audio interviews, your identity will not be confidential and you will have no rights to the end video product. The interview will take one or more hours. Your participation is very valuable to the researcher, and your time and willingness to participate is greatly appreciated.

Please check one box below and sign at the bottom.

- I choose to participate in both the audio and video components of this study.
- I choose to participate in only the audio component of this study.
- I choose to participate in only the audio component of this study and I wish my identity to be kept confidential.

I, as signed below, understand that participation in the interview is voluntary and I may refuse to participate, or refuse to answer specific questions if I so choose. I understand no money or other compensation will be provided for my participation. I understand I will suffer no penalties or losses for my participation in the study. I understand if I have checked the box indicating my desire to be included in the video portion of this research project: I grant Nasima Pfaffl, permission to use, reproduce, publish, broadcast, and distribute photo(s) and/or video(s) either complete or in part, alone or in conjunction with written materials pertaining to the study “ Born at Home” I understand that any works created by Nasima Pfaffl, or any licensees and assignees concerning, based on, related to, or suggested by her, in any media, whether known or later invented, though out the world are her property. If you believe you have been injured during participation in this research project, you may file a claim against the State of Florida by filing a claim with the University of Central Florida’s Insurance Coordinator, Purchasing Department, 4000 Central Florida Boulevard, Suite 360, Orlando, FL 32816, (407) 823-2661. By signing this informed consent form, however, you acknowledge that the University of Central Florida is an agency of the State of Florida and that the university’s and the state’s liability for personal injury or property damage is extremely limited under Florida law. Accordingly, the university’s and the state’s ability to compensate you for any personal injury or property damage suffered during this research project is very limited. Information regarding your rights as a research volunteer may be obtained from Nancy Marshall, Institutional Review Board (IRB) University of Central Florida (UCF), 4000 Central Florida Boulevard Adm Building, Suite #350, Orlando, Florida 32816-0015 at (407) 823-2482. I understand that if at any time in the future I have questions regarding this research I may request information from the researcher, Nasima Pfaffl at 321-733-6156, the Committee Chair, Dr. Huff-Corzine 407-823-2227. I may also contact Chris Grayson of the UCF Office of Research, 12443 Research Parkway, Suite 207, Orlando, Florida 32826-3252 at 407-823-2000. By my signature below I hereby indicate that I agree to participate in the above described research, and that I have been provided with a copy of this consent form.

Researcher’s Signature : _____ Date: _____
Signature : _____ Date: _____
Address : _____

Researcher’s Copy

**APPENDIX B: TRANSCRIPTION CONFIDENTIALITY
FORM**

Transcription Confidentiality Form

I, as signed below, agree that in my capacity as transcriber I will hold all information pertaining to the transcription materials in strict confidence. I will not disclose any names, dates, events or other information to a third party either currently or in the future. Upon completion of all transcription and/or per Nasima Pfaffl's request, all audio and text files will be deleted from my files. I agree to not keep a copy of the data (audio or text) after my service as transcriber is completed. I also agree to restrict access to these data files for my use only. This includes services such as Napster or other peer-to-peer file sharing technologies. I understand that these data are the sole property of Nasima Pfaffl.

Signature: _____ Date: _____

Address: _____

Phone: _____ E-mail: _____

**APPENDIX C: DIRECT-ENTRY MIDWIFERY STATE-BY-
STATE LEGAL STATUS, 4-10-2006**

Table 10: Direct-Entry Midwifery State-by-State Legal Status-Last Updated 4-10-2006

STATE	LEGAL BY:			LEGAL BY:	PROHIBITED BY:	CPM	MEDICAID REIMBURSEMENT
	Licensure (L) Certification (C) Registration (R) Permit (P)	Judicial Interpretation or Statutory Inference	Not legally defined, but not prohibited	Statute, but Licensure Unavailable	Statute, Judicial Interpretation, or Stricture of Practice		
AL					X		
AK	L					CPM	X
AR	L					CPM	
AZ	L					CPM	X
CA	L					E	X
CO	R					CPM	
CT			X				
DC					X		
DE	P					CPM	
FL	L					E	X
GA				X			
HI				X			
IA					X		
ID		X					
IL					X		
IN					X		
KS		X					
KY					X		
LA	L					CPM	
MA		X					
MD					X		
ME		X					
MI		X					
MN	L					CPM	
MO					X		
MS		X					
MT	L					E	
NC					X		
NE			X				
NH	C					CPM	X
NJ	L					CPM	
NM	L					CPM	X
NV		X					
NY	C					*	
ND		X					
OH			X				
OK		X					
OR	Voluntary-L					CPM	X
PA		X					
RI	C					*	
SC	L					CPM	X
SD					X		
TN	C					CPM	
TX	L					CPM	
UT	Voluntary-L					CPM	
VT	L					CPM	
VA	L					CPM	
WA	L					E	X
WI	L					CPM	
WV			X				
WY					X		

 Legal

 Illegal

4/14/2008

E - State uses NARM Exam as part of licensure process

CPM - Reciprocity of CPM credential or CPM plus state specific requirements accepted for licensure, certification, documentation or registration.

* - Certified Midwives (CMs) are direct-entry midwives certified by the ACNM Certification Council.

For more information on direct-entry midwifery, visit MANA's web site. <http://www.mana.org> or contact Debbie Pulley, CPM at 888-842-4784 or legislation@mana.org

*** Information for this chart was provided by the Midwives Alliance of North America (MANA), the Midwifery Education Accreditation Council (MEAC), and the North American Registry of Midwives (NARM).

**APPENDIX D: MAP OF DIRECT-ENTRY MIDWIFERY
LEGAL STATE-BY-STATE STATUS, 4-10-2006**

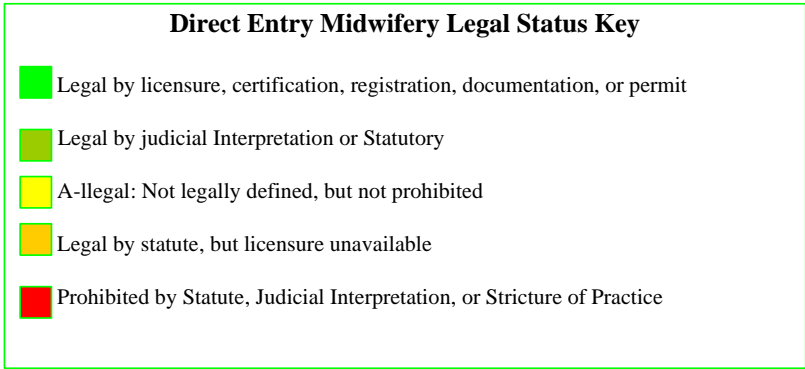
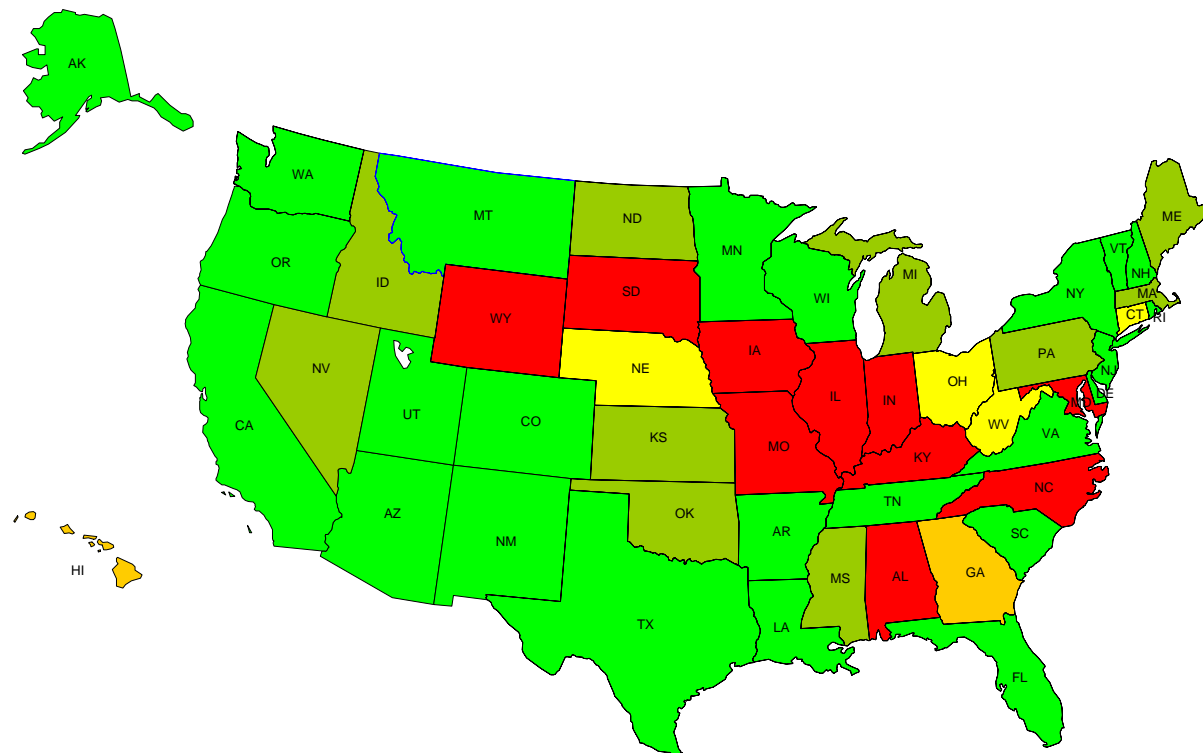


Figure 15: Map of Direct-Entry Legal Status by State, 2006

**APPENDIX E: CERTIFIED PROFESSIONAL MIDWIVES
GEOGRAPHIC DISTRIBUTION MAP**

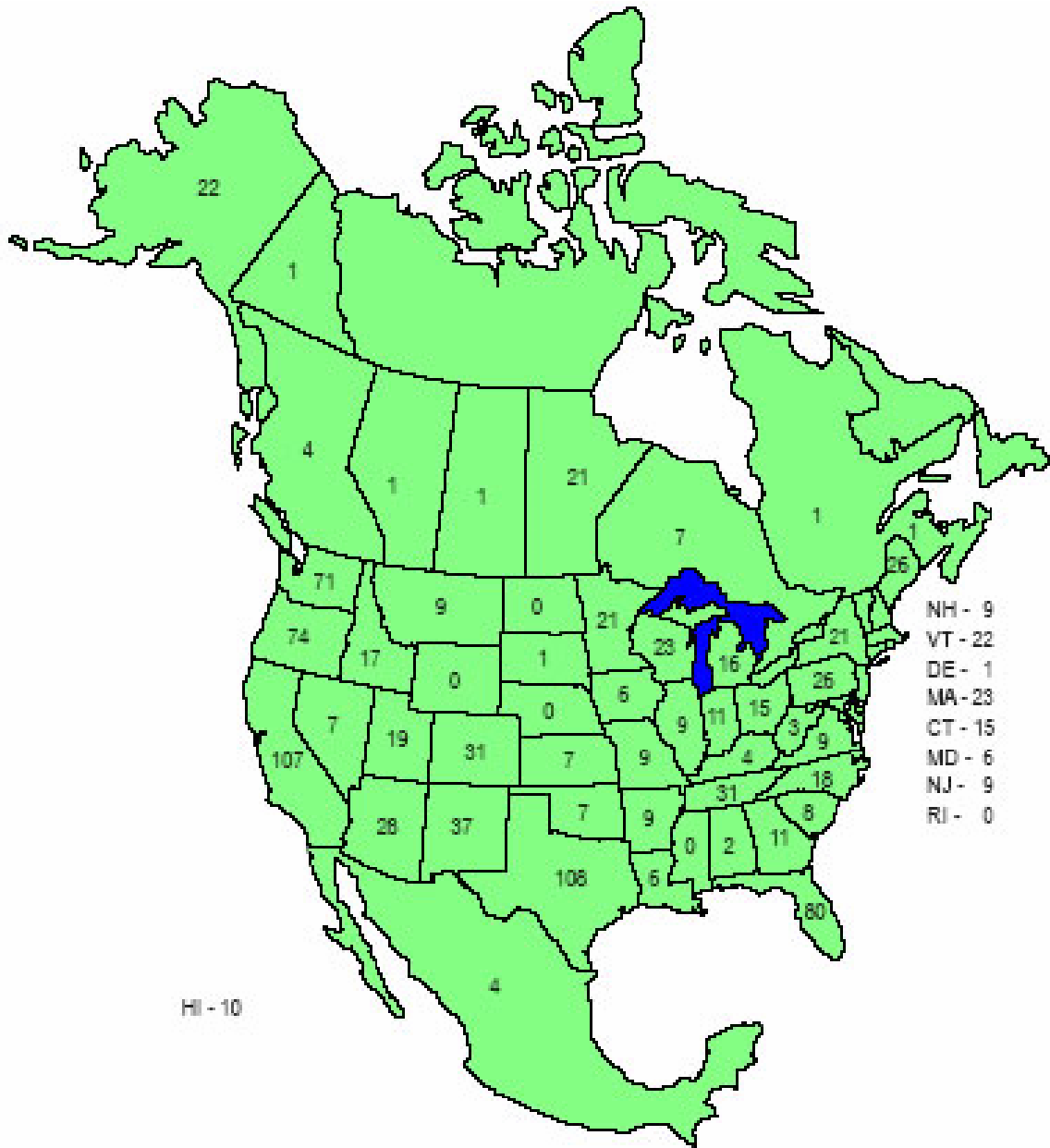


Figure 16: NARM CPM Geographical Breakdown Map, March 2006

**APPENDIX F: STATE-BY-STATE CESAREAN RATES BY
RACE**

Table 11: Percent of live births by cesarean delivery by race and Hispanic origin of mother: United States, each State and Territory, final 2002 and preliminary 2003

Area	All races ¹		White total ²		Non-Hispanic white ²		Black total ²		Hispanic ³	
	2003	2002	2003	2002	2003	2002	2003	2002	2003	2002
United States ⁴	27.6	26.1	27.4	25.9	27.7	26.2	29.2	27.6	26.6	25.2
Alabama	29.6	28.7	29.4	28.6	29.9	29.0	30.3	29.1	22.8	23.4
Alaska	21.3	19.5	24.2	22.0	23.8	21.2	27.1	22.5	21.7	17.9
Arizona	22.2	21.3	22.2	21.3	23.7	23.2	24.7	23.8	20.8	19.3
Arkansas	29.5	29.1	29.2	28.9	29.7	29.4	31.3	30.2	24.4	24.8
California	27.9	26.8	27.8	26.6	28.6	27.4	31.1	30.2	27.2	26.1
Colorado	22.2	21.1	22.1	21.1	22.9	21.6	24.4	21.2	20.6	19.9
Connecticut	27.2	26.1	27.3	26.2	28.1	27.1	27.9	26.4	24.0	22.4
Delaware	29.0	27.3	28.4	26.9	28.5	27.4	31.2	28.6	27.4	24.2
District of Columbia	27.4	26.5	28.6	24.9	29.0	26.7	26.9	27.6	20.1	21.6
Florida	30.8	28.5	31.0	28.9	29.8	27.9	30.2	27.8	33.3	30.8
Georgia	27.3	25.9	26.9	25.5	28.4	26.8	28.1	26.9	21.0	19.9
Hawaii	22.0	21.4	21.3	19.5	21.1	19.2	20.7	16.9	22.3	22.1
Idaho	21.2	19.7	21.1	19.5	21.0	19.4	*	22.3	21.6	20.5
Illinois	25.7	23.9	25.5	23.8	26.5	24.8	26.2	24.1	23.1	21.4
Indiana	25.6	24.8	25.5	24.7	25.5	24.7	26.2	25.5	25.3	24.5
Iowa	25.4	24.8	25.5	24.9	25.4	24.9	26.9	24.8	26.6	24.4
Kansas	26.5	24.8	26.6	24.8	26.9	25.1	27.2	27.3	25.1	23.4
Kentucky	30.1	28.0	30.2	28.0	30.3	28.1	29.4	28.6	27.9	27.3
Louisiana	31.7	30.4	32.8	31.3	32.8	31.3	30.3	29.3	32.9	30.0
Maine	26.3	25.7	26.4	25.6	26.3	25.6	25.0	24.1	30.5	28.9
Maryland	28.5	27.5	27.3	26.5	27.7	27.0	30.9	29.5	24.2	23.6
Massachusetts	29.3	28.0	29.4	28.1	30.0	28.7	29.6	29.2	25.8	24.5
Michigan	26.4	24.9	26.6	25.0	26.7	25.1	25.8	24.6	25.1	23.7
Minnesota	23.3	22.2	23.6	22.7	23.8	22.8	24.0	22.9	22.2	22.4
Mississippi	32.3	31.1	32.8	31.5	33.0	31.7	31.7	30.9	24.2	24.4
Missouri	27.3	25.7	27.4	25.9	27.6	26.0	26.5	25.0	24.0	24.1
Montana	23.7	22.9	23.2	22.5	23.1	22.5	*	*	24.0	23.4
Nebraska	27.7	26.7	27.9	26.9	28.2	27.4	25.4	24.4	26.6	23.8
Nevada	27.6	25.7	26.9	25.0	29.5	27.1	31.6	31.1	23.6	22.3
New Hampshire	26.5	24.2	26.2	24.2	26.4	24.4	33.6	25.6	25.6	21.1
New Jersey	33.1	30.9	33.0	30.9	33.6	31.5	34.4	31.7	31.8	29.7
New Mexico	20.3	19.1	20.9	19.6	21.8	21.2	21.2	20.7	20.4	18.7
New York	28.4	27.1	28.5	27.3	29.1	27.7	29.1	27.6	27.1	25.9
North Carolina	27.4	26.4	26.9	26.0	28.1	27.1	29.2	28.1	22.0	21.0
North Dakota	24.3	23.1	24.3	22.9	24.1	22.8	21.1	*	30.4	27.5
Ohio	25.1	23.6	24.9	23.5	25.0	23.5	25.7	24.4	23.1	23.2
Oklahoma	29.4	28.1	29.1	27.7	29.8	28.0	32.7	30.0	24.8	25.4
Oregon	24.9	23.4	24.7	23.3	25.1	23.6	30.1	25.9	22.8	21.7
Pennsylvania	27.9	24.8	28.1	24.8	28.2	24.9	27.1	25.2	26.2	23.6
Rhode Island	28.3	26.2	29.1	26.8	30.4	28.3	26.0	25.0	26.2	23.4
South Carolina	29.7	28.6	29.6	28.4	30.0	28.5	30.2	29.2	26.1	26.3
South Dakota	25.4	24.6	25.6	24.7	25.8	24.7	23.0	20.4	20.2	21.3
Tennessee	28.6	27.5	28.9	27.7	29.3	28.1	27.7	26.7	24.2	23.1
Texas	30.2	27.9	29.8	27.7	31.1	28.5	33.2	29.9	28.9	27.1
Utah	19.2	19.1	19.0	18.9	18.5	18.4	27.2	27.4	21.9	22.2
Vermont	22.6	20.9	22.4	20.9	22.4	21.0	*	*	*	*
Virginia	28.3	26.8	28.0	26.3	28.4	26.6	28.3	27.9	25.0	24.3
Washington	27.4	24.0	27.2	23.9	27.4	24.4	28.7	27.0	25.4	21.6
West Virginia	31.6	29.3	31.5	29.2	31.5	29.2	34.0	32.1	28.3	26.2
Wisconsin	21.9	20.6	22.2	21.1	22.3	21.3	21.2	18.1	21.1	19.6
Wyoming	23.8	21.1	24.0	21.1	23.9	20.8	*	*	24.4	23.3

*see www.cdc.gov/nchs/data/nvsr/nvsr53/nvsr53_09tables.pdf for complete footnotes and information

**APPENDIX G: MAP OF CESAREAN SECTION RATES BY
STATE, 2003**

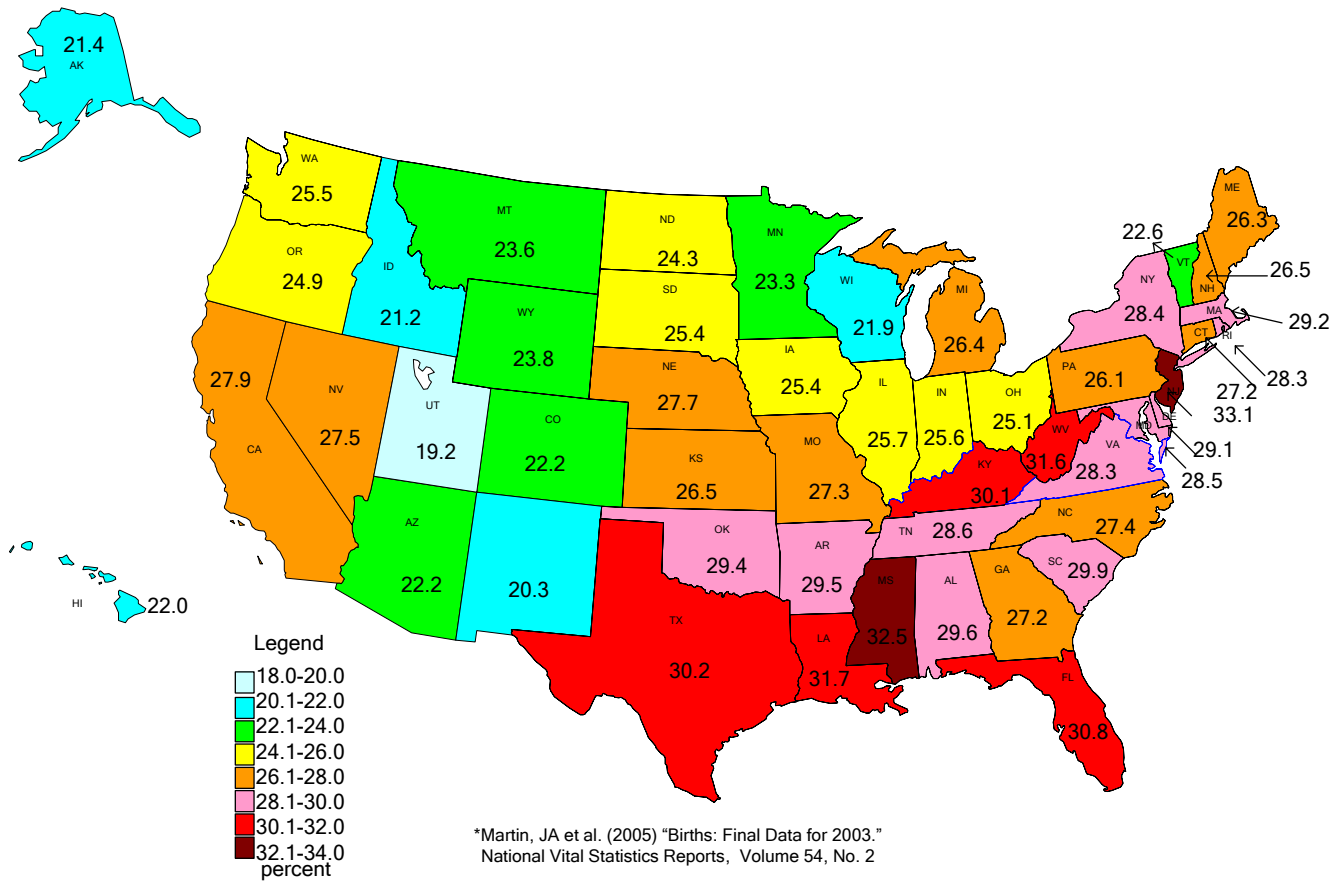


Figure 17: Cesarean Section Rates by State, 2003*

**APPENDIX H: INSTITUTIONAL REVIEW BOARD
APPROVAL LETTER**



Office of Research & Commercialization

November 1, 2000

Nasima Pfaffl
1224 Coventry Circle
West Melbourne, Florida 32904

Dear Ms. Pfaffl:

With reference to your protocol entitled, "Born at Home: Exploring the Home Birth Movement and the Motives Experiences of Home Birth Parenting," I am enclosing for your records the expedited, executed document of the Assurance of Protection of Human Subjects form you had submitted to our office.

Please be advised that this approval is given for one year. Should there be any addendums or administrative changes to the already approved protocol, they must also be submitted to the Board. Further, should there be a need to extend this protocol, a new assurance of Protection of Human Subjects form must be submitted for approval at least one month prior to the anniversary date of the most recent approval and is the **responsibility of the investigator** (UCF). No notification will be sent from the IRB.

Should you have any questions, please do not hesitate to call me at 823-2901.

Please accept our best wishes for the success of your endeavors.

Cordially,

A handwritten signature in cursive script that reads "Chris Grayson".

Chris Grayson
Institutional Review Board (IRB)

Copy: IRB File

APPENDIX I: COPYRIGHT PERMISSION FORMS

Nasima Pfaffl
1224 Coventry Cir
West Melbourne, FL 32904
npfaffl@cfl.rr.com

March 7, 2006

Debbie Pulley
MANA Legislative Chair
legislation@mana.org

Dear Ms. Pulley:

I am a graduate student in Sociology at the University of Central Florida. I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000. I would like permission to reprint in my thesis your Legal Status of Direct-Entry Midwives Chart. It nicely illustrates the status of midwifery across the country and as such I would like to include it.

The requested permission extends to any future revisions and editions of my thesis, in both print and digital media, including non-exclusive world rights in all languages, and to the publication of my thesis by UMI. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above- described material.

If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. If you have any questions or concerns please don't hesitate to contact me: 321-733-6156 or npfaffl@cfl.rr.com. Thank you for your attention to this matter.

Sincerely,

Nasima Pfaffl

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By Debbie Pulley, CM

Debbie Pulley
MANA Legislative Chair
legislation@mana.org

Date: 4-3-06

Nasima Pfaffl
1224 Coventry Cir
West Melbourne, FL 32904
321-733-6156

July 20, 2005

Anna Pope
Book Publishing Co
P.O. Box 99
Summertown, TN 38483
888-260-8458

Dear Ms. Pope:

This letter is a follow up to our e-mail exchange. To reiterate, I am a graduate student in Sociology at the University of Central Florida. I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000 and through books, such as Ina May's pivotal and seminal book *Spiritual Midwifery*. Her book's importance is mentioned repeatedly in my interviews and I would like to be able to show examples of the photos, personal accounts, and information included in this important book in my thesis. I would like your permission to reprint in my thesis excerpts from the following:

Spiritual Midwifery, third edition 1990, by Ina May Gaskin, I would like to include scans of the following pages from the third edition: pg 38-39, pg 96-97, pg 181-183.

These pages predominantly include photographic material. I have attached photocopies of these pages for your approval. Please note within my thesis I have modified the size of the images so they can be combined on pages together.

This request is for purely educational purposes. At this time I do not foresee any financial gain to be made from this work. The requested permission extends to any future revisions and editions of my thesis, in both print and digital media, including non-exclusive world rights in all languages, and to the publication of my thesis by UMI. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you or The Book Publishing Company owns the copyright to the above- described material.

If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. If you have any questions or concerns please don't hesitate to contact me: 321-733-6156 or npfaffl@cfl.rr.com. Thank you for your attention to this matter.

Sincerely,


Nasima Pfaffl

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By Anna Pope, Book Publishing Co.

Book Publishing Co
P.O. Box 99
Summertown, TN 38483

Date: 7-29-05

Nasima Pfaffl
1224 Coventry Cir
West Melbourne, FL 32904
321-733-6156

August 28, 2005

Raven Lang
530 Ocean Street
Santa Cruz, CA 95060-6602

Dear Ms. Lang:

Thank you for speaking with me on the phone. I have revised this copyright permissions letter to reflect the changes we discussed to create a very limited permission for use.

To reiterate, I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000 and through books, such as your pivotal and seminal book *Birth Book*. Your book's importance is mentioned repeatedly in my interviews and I would like to be able to show examples of the photos in the book. These photos clearly depict your books central rationales for homebirth in such a clear and concise way and as such are important exemplars of the seeds of the homebirth movement's efforts to provide family/women centered and empowered maternity care in America.

I am requesting permission to utilize photos included in *Birth Book*. Please note in the attached pages that I have modified the size of the images, cropped some images to make them less revealing, and selected images from various pages so they would fit more compactly on a single page. I would like your permission to reprint in my thesis selected photos from the following:

Birth Book (1972) Selected images from approximately page 45 and pages 67 through 74. (Please see attached pages to clarify which images I am referring to)

This request is for purely educational purposes. At this time I do not foresee any financial gain to be made from this work. The requested permission is for print, microfilm and PDF publication of my master's thesis with UCF, for print, microfilm and PDF publication of my thesis by UMI. Any future revisions or editions will require separate and additional permissions to be granted. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above- described

Page 1 of 2

material. If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. Thank you for your attention to this matter.

Sincerely,



Nasima Pfaffl

P.S. Please contact me if you have any questions or concerns: 321-733-6156 or npfaffl@cfl.rr.com

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By Raven Lang

Raven Lang
530 Ocean Street
Santa Cruz, CA 95060-6602

Date: Sept 20, 05

NASIMA, Images 5-7 are too closely cropped. I give you permission to use those delivery photos in their original state, bec they are easier to perceive by an untrained eye in their full images.

Raven Lang

good luck. Please send me a copy of your work.

Page 2 of 2

Nasima Pfaffl
1224 Coventry Cir
West Melbourne, FL 32904
321-733-6156

July 20, 2005

Suzanne Arms
Birthing the Future[®]
P.O. Box 1040
Bayfield, CO 81122
970-884-4090

Dear Ms. Arms:

I am a graduate student in Sociology at the University of Central Florida. I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000 and through books, such as your *Immaculate Deception*. Your book's importance is mentioned repeatedly in my interviews and I would like to be able to show examples of the photos, personal accounts, and information included in this important book. I draw textual excerpts from your 1975 original book, but I am requesting permission to utilize the photo collages you included in the 1994 book since they nicely combine images from the original together. I would like your permission to reprint in my thesis excerpts from the following:

Immaculate Deception II: Myth, Magic, and Birth (1996) pgs 104 and 105. Which are primarily composed of photos. I have attached photocopies of these pages for your approval.

This request is for purely educational purposes. At this time I do not foresee any financial gain to be made from this work. The requested permission extends to any future revisions and editions of my thesis, in both print and digital media, including non-exclusive world rights in all languages, and to the publication of my thesis by UMI. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above- described material.

If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. If you have any questions or concerns please don't hesitate to contact me: 321-733-6156 or npfaffl@cf1.cc.com. Thank you for your attention to this matter.

Sincerely,



Nasima Pfaffl

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By Suzanne Arms

Suzanne Arms
Birthing the Future*
P.O. Box 1040
Bayfield, CO 81122

*This permission
is only for use
in your thesis*

Date: Aug. 6 '05

Foot wishes!

914 476-0090

Nasima Pfaff
1224 Coventry Cir
West Melbourne, FL 32904
npfaff@cfl.rr.com

March 21, 2006

Shannon Mitchell
ICAN
infoservices@ican-online.org

Dear Shannon Mitchell:

To reiterate from our phone conversation, I am a graduate student in Sociology at the University of Central Florida. I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000. I would like permission to reprint in my thesis your "Cesarean and VBAC by Year" chart from your website. Your chart nicely puts together information from multiple years of National Vital Statistics Reports. Although I realize that NVSR are not copyrighted, and are therefore open for public use, your organization's presentation of the material on your site is covered by copyright, and as such I need specific permission to include it with attribution. See below a copy of the chart I am requesting permission for.

The requested permission extends to any future revisions and editions of my thesis, in both print and digital media, including non-exclusive world rights in all languages, and to the publication of my thesis by UMI. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above-described material.

If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. If you have any questions or concerns please don't hesitate to contact me: 321-733-6156 or npfaff@cfl.rr.com. Thank you for your attention to this matter.

Sincerely,

Nasima Pfaff

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By Tonya Jamois
Tonya Jamois, President, International Cesarean Awareness Network

Date: 4/12/06

Nasima Pfaffl
1224 Coventry Cir
West Melbourne, FL 32904
npfaffl@cfl.rr.com

April 10, 2006

Debbie Pulley
Director of Public Education & Advocacy
The North American Registry of Midwives
info@narm.org

Dear Ms. Pulley:

I am a graduate student in Sociology at the University of Central Florida. I am writing a master's thesis entitled "Catching Satisfaction: Personal and Political Framings in the Home Birth Movement, 1970-2000." I focus on the development of the home birth movement through the birth stories of 38 women who predominately gave birth in Tucson Arizona from 1970-2000. I would like permission to reprint in my thesis your Certified Professional Midwives Geographic Breakdown Map, 2005. It nicely illustrates the distribution of CPMs across the country and as such I would like to include it.

The requested permission extends to any future revisions and editions of my thesis, in both print and digital media, including non-exclusive world rights in all languages, and to the publication of my thesis by UMI. These rights will in no way restrict republication of the material in any form by you or by others authorized by you. Your signing of this letter will also confirm that you own the copyright to the above- described material.

If these arrangements meet with your approval, please sign this letter where indicated below and return it to me. If you have any questions or concerns please don't hesitate to contact me: 321-733-6156 or npfaffl@cfl.rr.com. Thank you for your attention to this matter.

Sincerely,

Nasima Pfaffl

PERMISSION GRANTED FOR THE USE REQUESTED ABOVE:

By  _____

Debbie Pulley
Director of Public Education & Advocacy
The North American Registry of Midwives
info@narm.org

Date: 4-13-06

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