

THE PENNSYLVANIA STATE UNIVERSITY  
SCHREYER HONORS COLLEGE

DEPARTMENT OF WOMEN'S, GENDER, AND SEXUALITY STUDIES

FOCUS ON NEGATIVE OUTCOMES: WOMEN'S BIRTH EXPERIENCES IN THE  
UNITED STATES

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SPRING 2016

A thesis  
submitted in partial fulfillment  
of the requirements  
for baccalaureate degrees  
in Women's Studies and Sociology  
with honors in Women's Studies

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## **ABSTRACT**

The purpose of this paper is to explore the significance of maternal mortality in the United States as it affects women's birthing decisions and experiences. Maternal mortality is at an all-time high in the US; my research aims to understand the causes of the high maternal death rate. This research will allow me to explore how the causes of maternal mortality are significant to women, if maternal mortality is in fact a good measure of maternal well-being, and how the focus on birth outcomes impacts women's birth choices and experiences.

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## ACKNOWLEDGEMENTS

I would like to thank Dr. Jill Wood for her guidance and support throughout my thesis process. Her enthusiasm for women's health advocacy encouraged me to pursue maternal health as my main area of study. Our meetings became a highlight of my semester; I always looked forward to leaving her office with a backpack full of resources and a clear vision for my next steps.

In addition, I would like to thank Dr. Jennifer Wagner-Lawlor for her advisement throughout my Women's Studies academic endeavor at Penn State, as well as for her guidance during the thesis process.

I would also like to thank my family for their continuing support and encouragement, not only through the writing of my thesis, but also through my entire college career. Thank you to my mom for being my sounding board and for listening to me talk through outlines and arguments and for reading every single draft...over and over again. I would not have been able to complete this project without her help and my paper definitely would not have had nearly enough commas. Thank you for attending my research presentation and for participating in my event, I am glad I was able to share that experience with you. I am sincerely grateful for the support and encouragement that I have received; it has helped foster my passion for women's rights activism and has shaped me into the proud feminist I am today.

## Introduction

303,000 women across the globe died in 2015 as a result of pregnancy and childbirth. Of these women, 99% died of preventable causes and many lived in industrialized countries (World Health Organization). This overwhelming number, likely an underestimate, is collected based on “the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination per every 100,000 live births. This data are estimated with a regression model using information on the proportion of maternal deaths among non-AIDS women ages 15-29, birth attendants, and Gross Domestic Product” (The World Bank).

In an effort to eradicate this injustice, the United Nations has put forth the largest global movement in the form of the Millennium Development Goals (MDGs). In September of 2000, the UN Millennium Declaration was adopted at the largest gathering of world leaders in history. They adopted eight goals, each of which places a deadline on individual countries to reduce poverty, increase access to education, encourage gender equality, decrease maternal and child mortality, reduce HIV/AIDS, promote environmental sustainability, and cultivate global partnerships (Millennium Project). The fifth Millennium Goal seeks to reduce the maternal mortality ratio by three quarters in each country that adopted the document between 1990 and 2015, as well as achieve universal access to reproductive healthcare by 2015 (*The Millennium Development Goals Report* 38, 41). The Millennium Development Goals Report illustrated that, globally, there has been movement towards meeting this goal. For example, between 1990 and 2015, births attended by skilled professionals increased from 59% to 71% and since 1990, the maternal mortality ratio has decreased by 45%. Yet, in 2015, only 51% of countries have data on

maternal cause of death and globally the goal of reducing maternal mortality by 75% has not been met (*The Millennium Development Goals Report 38, 43*).

Tragically, the United States, a leader in science, technology, and medicine, is one of the countries that did not meet this goal. In fact, the maternal mortality rate in the United States has increased. This has happened in only seven other countries in the world between 2003 and 2013 namely, Afghanistan, Belize, El Salvador, Guinea-Bissau, Greece, Seychelles, and South Sudan (Kassebaum et al.). Relative to all of the countries in the world, the US has a low maternal death rate with an average of 14 deaths out of 100,000 live births (The World Bank). However, compared to countries with similar levels of industrialization, technology, medical advancement, and wealth, the United States has the highest rate of maternal mortality and ranks 46<sup>th</sup> in the world (The World Bank). Even countries considered “less developed” have fewer incidents of maternal death than the United States.

The aforementioned data demonstrates that change is imperative. The purpose of this paper is to explore the significance of maternal mortality in the United States as an indicator of maternal health. Moreover, a feminist perspective will be used to discuss how this conceptualization of maternal health influences U.S. women’s available birth options and their experience of childbirth. Three research questions will guide this project: What is the significance of the high maternal mortality rate in the U.S.? How does maternal mortality as an indicator of maternal health impact women’s available birth options and experiences? How can maternal health be improved through alternative birth options for women?

### **Culture of Childbirth in United States**

Childbirth has transformed over the past 300 years in the United States, making gains, as well as suffering setbacks. The current landscape of childbirth is littered with ignorance, mistrust, carelessness, and greed. However, this is modern childbirth and such problems did not always exist. Before 1760, midwives were the preferred attendants of childbirth. In fact, an all-female support system was commonly present during childbirth. (Leavitt 281) A midwife attended to women to offer advice, perform checkups, and resolve minor complications, with a physician only stepping in when the birth did not progress normally (282). In this way, women in a safe and supportive environment controlled birthing before 1760. However, there was a shift in focus from natural “social birth” to medicalized obstetrician attended birth due to the fear of maternal death and a desire for pain relief (Leavitt 282; Ehrenreich and English 5). Due to this shift, fewer women trusted midwives, viewing male physicians as significantly more capable of delivering a healthy baby with less pain and fewer incidents of maternal death. Male physicians were considered more qualified than midwives were because during the 1750s some physicians were trained in British medical schools, prestigious schools which denied medical education to women. A misconception developed from this opportunity: that men were better equipped to deliver babies than women because men were more educated. In reality though, not all physicians in the United States attended these prestigious medical schools or received adequate training (Leavitt 284). Although obstetrics grew as a field of study for men, modesty between the sexes remained thus, men were discouraged from looking at or touching female genitalia. Consequently, these men were taught theoretical lessons with manikins and drawings, never witnessing a real birth until they practiced after medical school. In contrast, midwives learned through hands-on experience (Leavitt 285). However, without medical degrees, instruments, pain

relief drugs and by virtue of their gender, midwives lacked credibility. In the 1700s and 1800s, interventions and pain medicines aided labor. Although these male-controlled interventions reduce pain and shorten labor, they also maintained the high rate of maternal mortality and morbidity in the United States (303).

Today, this shift from a female supported homebirth to a primarily male controlled hospital birth is a characteristic of the medicalization of childbirth. Medicalization is the process by which non-medical issues are defined, discussed, and treated as medical problems (Conrad 209). This sociocultural process, which feminist theorists have adopted, occurs on “the conceptual, the institutional, and the interactional levels” in order to construct medical problems (211). Similar to Judith Butler’s feminist theory of gender performance, which holds that gender is socially constructed, feminist perspectives on medicalization describe how social construction of illness has marginalized women (Weitz 49). For example, medicalization acts as a means of social control, an idea first shared by sociologist Talcott Parsons, but applied by feminists to women’s experiences including birth, menstruation, and intercourse (Conrad 210). Additionally, feminist theorists note that social control through medicalization is a historical phenomenon that has afflicted women for centuries: “Historically, women’s life experiences have been more medicalized than men’s” (Waggoner and Stults). Similarly, in *Complaints and Disorders: The Sexual Politics of Sickness*, the authors offer an understanding of the context in which women’s bodies and experiences are medicalized. The book explains that throughout history, the medical system has been one of the most powerful sources of sexist oppression over women. Medical sexism has justified the marginalization of women in education, work, public life, and personal life (Ehrenreich and English 5).



As a result of medicalization, childbirth for U.S. women occurs primarily in hospitals. In fact, hospital births make up 98.8% of the childbirths in the United States, which means that the vast majority, 86%, are overseen by physicians. This is the case even though 85% of hospital births are low-risk. Additionally, although the majority of childbirths are low-risk, 87% have continuous electronic fetal monitoring, 80% receive intravenous fluids, 47% have labor artificially accelerated with medications, 43% of first-time moms are artificially induced and the C-section rate is 32.2% (“Evidence Confirms Birth Centers”; Hamilton et al. 7). Hospital births also restrict 76% of women to their bed, prevent 60% of women from eating or drinking during labor, and encourage 92% of women to give birth while lying on their backs. These interventions have little benefit to women and are potentially harmful (“Evidence Confirms Birth Centers”). Although historically women shifted from midwife attended homebirth to physician led hospital births as a way to increase safety, the medicalized model has proven to have the opposite outcome and has led to an increase in maternal death (Coeytaux, Bingham, and Strauss; Wagner; *Birth Matters*; Every Mother Counts Staff).

### **Factors that influence maternal care/maternal mortality in the US**

The aforementioned statistics reflect a system that neglects acceptable standards of care for women in the United States. Various factors are responsible for the increase of maternal death and are exacerbated by futile efforts in the US to decrease maternal mortality. With an increasing maternal mortality rate and 50% of maternal deaths resulting from preventable causes, clearly the United States has not taken the proper measures to decrease maternal mortality.

One such measure is to ensure sexual health through proper education, yet the United States has the least effective sexual education system in any industrialized country. 87% of students are taught that abstinence is the most effective form of birth control and 1 in 4 are not taught about contraception (“Facts on American Teens”). If people are not taught to use contraception two problems arise that increase the chance of maternal mortality: poor spacing of pregnancy and unintended pregnancy. The United States Government has failed to ensure enough funding is allocated to budget family planning services. In addition, there are legislative restrictions that do not protect programs. Consequently, 50% of births in the United States are unintended, which often leads to worse outcomes than planned pregnancies. Additionally, women who have unintended pregnancy are likely to receive prenatal care later than women who plan to have a child (Logan et al. 3).

Moreover, the United States also experiences high levels of maternal mortality because the government does not identify at-risk women. Minority and low-income women in the United States have experienced a long history of ignored reproductive health discrimination. Amnesty International states:

In the 1970s, a pattern emerged of women on low incomes being coerced into accepting sterilization and threatened with the withdrawal of welfare benefits if they refused. Some doctors refused to deliver babies or perform abortions for black women on low incomes unless they first agreed to be sterilized. Between 1972 and 1976, thousands of indigenous women were sterilized when there was no medical necessity and without their informed consent (Amnesty International 19).

Consequently, there is significant distrust of medical providers amongst groups that have been experienced discrimination. This leads to fewer minority and low-income women seeking pre-

natal care, which in return leads to higher rates of maternal mortality for women of color. Low-risk women of color are four times more likely to die from birth related complications than are white women and the disparity increases for high-risk pregnancies. This disparity is attributed to the adverse effects of racism. Racism causes stress accumulation over a person's lifetime and negatively affect pregnancy (Dominquez et al. 201). Additionally, recent defunding of free clinics, such as Planned Parenthood, has reduced access to maternal care. Free clinics are the only source of care for some women, who are often women of low-income women of color (Chen).

Another key component to help decrease maternal mortality, and one which the United States fails to execute, is data collection. In the United States, many cases of maternal mortality are never recognized as such because death certificates are not mandated in all 50 states. Only 21 states are required to ask if the woman was pregnant in the weeks before she passed away ("Masking Maternal Mortality"). In states where this question is not asked, the woman most likely will not be classified as a victim of maternal mortality. The lack of proper questions for a death certificate is compounded by the fact that the rate of autopsy has dropped from 50% to 5% between 1960 and the present. Autopsies are not lucrative for hospitals and therefore are not routinely performed unless requested by the deceased's family ("Masking Maternal Mortality"). This lack of attention to the needs of women in the United States again relates to the lack of proper federal legislation and the business model of American hospitals. Underreporting and improper documenting impedes finding solutions to the high maternal mortality rate in the U.S.

As a result of inadequate focus placed on solving issues of maternal care and childbirth, women's options for maternal care are limited. Women's options for care are driven by the medicalized system of childbirth. Since obstetricians in the US "are trained to see pathology,

they often find pathology where it does not exist” (*The Business of Being Born*). This leads to unnecessary interventions including the use of Pitocin and epidurals, which often force the baby to fall into distress and leads to C-sections. One reason that obstetricians prefer C-sections because they are specifically trained as surgeons. In countries where the maternal mortality rate is much lower than in the United States, midwives oversee about 70% of the births, whereas in the United States as of 2014 9.1% of births were attended by all types of midwives (certified nurse midwives, certified midwives, certified professional midwives) (Midwives Alliance, Hamilton et al. 40). Notably, the midwife model often provides postnatal care, which eliminates post-birth complications that lead to death (American Pregnancy Association). Because of a low rate of midwife attended birth and a high rate of hospital birth, the United States had 13 straight years with an all-time high Cesarean section rate up until 2009 (32.9% rate) at which point the C-section rate decreased slightly. As of 2014, the C-section rate is 32.2% between (Hamilton et al.7). The World Health Organization deemed the appropriate percentage of C-sections to be less than (Department of Reproductive Health Research). According to Heathline Health News, women who deliver via C-section are three times more likely to die as a result of childbirth than women who deliver naturally (Levy). Despite this evidence, women have historically moved from midwife-attended birth to obstetrician attended hospital birth. Outrageously, this has led to worse maternal outcomes.

For some women, negative outcomes are not a result of the type of care that they receive, but instead a lack of care entirely. Because women in rural and urban areas struggle to obtain care, the government tried to implement medical facilities to reach underserved women. However, these Federally Qualified Health Centers were only able to reach about 20% of the people in need of these services (U.S. Department of Health and Human Services 9). The clinics

cannot run on the budget that they receive from the federal government, which forces them to rely on state and local governments as well as private donations. The supplementary funds that they receive are not enough to run the facilities, which leads to overcrowded and ill-equipped centers (Amnesty International 41). Additionally, in the United States, it is unusual to find government organized educational programs about nutrition, the effects of domestic abuse, ways to cope with mental health, and the dangers of smoking. Irresponsibly, this education is not provided in the United States where prenatal appointments usually do not allot time for extended counselling. Since maternal health facilities are run like businesses, they encourage a quick turnover to increase revenue (Amnesty International 63).

When facilities are available, the cost to obtain this care might be a restricting factor. A 15 minute ambulance ride in the United States can cost anywhere from a couple hundred dollars to a couple thousand dollars (“Think the E.R. is Expensive?”; Zamosky). Without government established local facilities or affordable transportation in the United States, women in rural America are prevented from obtaining care. Many rural women have reported that they lack a vehicle and the means to pay for gas. In addition, these women might have to drive “100 miles or more to obtain specialist care at a facility adequately equipped to handle potential complications” (Amnesty International 48). Urban women also face transportation barriers and often spend hours on public transportation getting to, and from, prenatal care appointments (Aved et al. 493-498). As a result, lack of transportation is an obstacle for pregnant women to ensure healthy pregnancies.

Additional expenses arise from the fact that the United States does not have universal health care, making maternal health expensive, especially for those without insurance. US health coverage is decided by the patient’s provider, economic status, race, location, and pre-existing

conditions. This is the reason why currently 33 million (13%) women ages 19-64 are uninsured, and of the women who are insured 24% are dependent on a spouse or family for their insurance. 47% of uninsured women in 2014 cited cost as the prohibiting factor in obtaining healthcare (The Kaiser Family Foundation 4). Without health insurance, pregnancy related costs are paid out-of-pocket by the patients. The average cost of a vaginal birth in a United States hospital is between \$7,455 and \$8,718, the cost of a C-section is between \$10,317 and \$12,175, and the cost of prenatal care and delivery is between \$4,350 and \$6,000. In addition, complications add to the cost of the birth (Thomson Healthcare 8, 10).

Due to exorbitant hospital expenses, midwife attended birth are an excellent lower cost alternative. Yet, United States has the lowest number of midwife-attended births in the industrialized world, an unbelievable statistic considering that United States has a shortage of healthcare providers (Garvey; Wilson). The United States' health care system fosters this deficiency because maternal care providers are subjected to costly malpractice insurance premiums. Providers also receive low compensation for women on Medicaid. Both of these financial concerns deter medical professionals from entering the field of maternal care, as well as providing care for low-income woman (Amnesty International 62). Additionally, pregnant women in the United States die due to a lack of pre-natal and post-natal care because it is an expensive service that not all women can afford. Midwives in the United States often include pre and post-natal care in their fee, which is much lower than the cost of a hospital birth. Yet, because the use of midwives in the United States is low, women do not receive this care (American Pregnancy Association).

## **What is the significance of the high maternal mortality rate in the United States?**

Examination of the status of childbirth and maternal death in the United States reveals conceptual and theoretical feminist issues of power and control over women and their bodies. Feminist theorists use power and control as a central concept in their analysis of medical oppression (Annandale and Clarke 19-20, 25). For instance, feminist epistemology aims to understand how people “know” what they “know” about sex and gender: “the greatest social control power com[ing] from having the authority to define certain behaviors, persons, and things” (Conrad 216; “Women’s Reproductive Health”). Through this lens, feminists argue that traditionally men’s bodies are the standard, adorned with venerable traits, while women’s bodies have been viewed in comparison to the standard male body (Annandale and Clark 19). For this reason, women have historically been described as defective males who are ill and able to pass their illness to men (Ehrenreich and English 5). In *Complaints and Disorders: The Sexual Politics of Sickness* the authors use the story of Eden and the teachings of Hippocrates to explain that women have been viewed as “‘misbegotten male[s],’ weak and incomplete” (6). Women’s ‘perpetual infirmities’ have cultivated a fear that women will infect men, an illustration of this is the fear that female menstruation can make others impure and dirty (6). Yet, the medicalization of women’s bodies has forced women into dependency upon the medical system, as well as stripped women of ownership over their bodily experiences (7). As such, feminist theories are useful to reject this essentialist view of the standard male body and to explain assumed knowledge of women’s bodies and experiences exist only in a patriarchal context of comparison and construction (Annandale and Clark 25). Unfortunately, this medical control has molded the health options (or lack thereof) presented to women today (Ehrenreich and English 8).

Childbirth is a key example of the way in which a natural experience has been constructed as an illness and over-medicalized in an effort to control women's bodies. For instance, postpartum women are often viewed as disabled and in order to get six weeks of maternity care women may be required to take short-term disability or sick leave (Laurence). Yet, venerated midwife, natural birth advocate, and feminist Ina May Gaskin asserts "birth is a normal life experience, not a medical event to be feared" (Shapiro). Nonetheless, women have been indoctrinated to believe that pregnancy and childbirth are disorders that require medical attention and intervention (Waggoner and Stults). Currently, women's bodies are viewed as malfunctioning machines that can be fixed with the help of technological intervention and consequently are in need of constant surveillance to do so (Shaw 139). One theory, in the book entitled, *The Woman in the Body*, by Emily Martin, posits that a woman is seen as the "'laborer' whose 'machine' (uterus) produces the 'product,' babies" and that doctors are mechanics tasked to fix women (Martin 57). Breaking a woman into parts, like a machine, strips her of responsibility over her body based on the false propaganda that unassisted birth will lead to increased rates of maternal and infant mortality. Due to this fear, women have relinquished control of childbirth, relying less on the natural ability of their bodies and more on help from obstetricians. Due to medical propaganda, childbirth has become a significant medical event for women in the United States.

Due to the construction of women as ill and unfit, women have historically met with resistance, and even punishment, when they attempted to make decisions about their bodies and assert their reproductive rights. *Roe vs. Wade* is a landmark decision in which women gained the right to govern their bodies. This momentous decision introduced the term "choice" used in relation to abortion (Solinger 5). "Choice" was adopted in the 1970s in place of the term "right"



to make the abortion movement more palatable to the public; the word has since been associated with reproductive rights (5). Unfortunately, this term has been both problematic and empty in its promise. Rickie Solinger, historian, curator, and author of *Beggars and Choosers* discusses how the term choice, in relation to reproduction, encourages people to believe that certain options are asserted by, “bad women making bad choices” (8). Even further, in the wake of Roe vs Wade, politicians used their platform to describe “all women as bad choice makers” (14). Consequently, people who opposed them scrutinized women’s reproductive rights as personal choices; women who demanded human rights were demoted to “women shoppers selecting options in the marketplace” (5). Since women are viewed as consumers, women’s choices can be regulated in an effort to prevent them from making the “wrong choice.” In terms of abortion, women have to satisfy certain protocol such as meeting with a counselor or physician who would evaluate “the prospective candidate as a choice maker: is she ‘responsible enough to return for the necessary visits...to report complications?’” (33). In instances where a woman “seems unreliable,” the physician has the right to deny her abortion (33). Similarly, this patrolling occurs in childbirth. Physicians who view women’s birthing preferences as right or wrong, disregard women’s rights in favor of what they believe is correct.

Women did in fact attempt to reclaim control of their bodies and birthing experiences, with the publication of three Maternity Center Association reports, the first of their kind to explore the “attitudes, feelings, and knowledge” of women’s birth experiences, including pregnancy, labor, childbirth, and postpartum (Corry 61). The Maternity Center Association published recommendations based on these reports that would improve women’s birth experiences. The labor and delivery recommendations call for increased research into the necessity of birth interventions and the side effects of pain relief medication. Additionally, it was

recommended that a wide-range of options be made available for birthing women (61-63). These suggestions were ignored because women are deemed incapable and unqualified to make decisions related to their bodies, health, and childbirth. In this way, it is clear why maternal mortality “fits” as the indicator of birth outcome; women’s experiences are viewed as unimportant (“Thesis Draft”).

## **How does maternal mortality as an indicator of maternal health impact women's available birth options and experiences?**

Hard data with tangible outcomes (i.e. maternal mortality and maternal morbidity) is the standard that determines whether or not a birth is deemed healthy and successful (Hunter 120). Believing that this is the only determinant of a healthy birth entirely discounts the woman's experience. Maternal mortality and morbidity do not provide an entire picture of a healthy childbirth. Because of the current climate of childbirth, many women experience nightmares, intrusive memories, depression, anxiety, trouble bonding with their newborn, hesitation towards sexual intimacy, and a total avoidance of future pregnancy (Soet, Brack, and DiIorio 37). These problems can persist long past the experience of childbirth and may even lead to long-term issues with attachment to the child (37). This might seem like a rare phenomenon, however one study completed by Menage, found that of 500 participants, 102 or 20.4% of these subjects reported trauma related to childbirth (37). Of the women in this study who underwent an emergency C-section, 76% met the criterion in the DSM-IV for experiencing a traumatic event and 33% exhibited signs of posttraumatic stress reactions (not as severe as posttraumatic stress disorder) (37). Of the 500 people in this study, 30 women or 6% met the criterion for posttraumatic stress disorder (37). Creedy et al. found in their study that 33% of the women (with 499 total participants) described a stressful birth experience and traumatic symptoms, while 5.6% of the woman exhibited the symptoms of posttraumatic stress disorder (37).

Similar results published in other studies, all of which focused on hospital births and/or women who received obstetrical interventions (see: Ayers and Pickering; Czarnocka and Slade; Ryding). These studies indicated that roughly 20%-30% of women will experience trauma during childbirth and between 2% and 6% will meet the criterion for PTSD. In order to be

diagnosed with PTSD a woman has to meet the entire criterion outlined in the DSM-IV.

However, in a study conducted by Soet, Brack, and DiIorio they found that 30.1% of the women partially exhibited PTSD as a result of pain during childbirth, delivery of an ill or stillborn infant, hostile treatment by medical personnel, feeling powerless, inadequate information, a lack of consent, and increasing medical intervention (Soet, Brack, and DiIorio 36, 41). This research indicates that while an important outcome of childbirth is that the mother and baby are alive, it is not an identifier of well-being.

In addition to PTSD, women are increasingly developing tokophobia, which is the intense fear of childbirth (Bhatia and Jhanjee 158). Bhatia and Jhanjee explain in their case study that this is a serious disorder that can lead to depression, difficulty sleeping, loss of appetite, feelings of hopelessness, suicidal thoughts, withdrawal from sexual contact, and avoid pregnancy, even if the woman desires children (158). Yet, the pressure for women to have children makes it taboo for a woman to fear the process of childbirth (Nicholas). Therefore, this is a rarely discussed fear, but not a rarely felt one. A study performed in Britain revealed that 35% of women had pregnancy related fear or anxiety and estimates show for about 13% of women this fear leads to postponed or avoided pregnancy (Nicholas; "The Women Who Have A Pathological Fear").

Tokophobia is divided into two categories: primary or secondary tokophobia. Primary tokophobia is defined as having a morbid fear of pregnancy (caused by the idea of pain, intervention, or the unknown) without the firsthand experience of pregnancy ("The Women Who Have A Pathological Fear"). Dr. Shari Lusskin, a clinical professor of psychiatry in the Department of Obstetrics, Gynecology and Reproductive Science at Mount Sinai Medical Center in New York, stated that this fear might arise from a traumatizing experience as a medical patient in general; it also arises from hearing other women's traumatic experiences or from the negative

outcomes of childbirth (“The Women Who Have A Pathological Fear”; Nicholas; Bhatia and Jhanjee 158). Secondary tokophobia develops because of a traumatic childbirth experience in a previous pregnancy (Nicholas). This phobia proves that maternal health cannot be judged solely by maternal mortality, because women can experience trauma and fear related to pregnancy even before being pregnant. Additionally, women experience the onset of a crippling phobia as the result of birth experiences, even ones that do not end in death or physical injury.

Fear has significant effects on women, but some of the causes are preventable. Many women develop type one tokophobia from exposure to the negative effects of childbirth (Bhatia and Jhanjee 158). When childbirth is portrayed on television, for example, discussed with a physician, or described by other women, often the picture that is painted is one of pain, urgency, trauma, and anguish. These images make childbirth seem like a terrifying experience for all women. Childbirth educator and director of *Laboring Under an Illusion: Mass Media Childbirth vs. The Real Thing* Vicki Elson, theorizes about the influence of rituals, symbols, habits, opinions, morality, and commercialism on women’s ability to make decisions (Pincus 82). Her focus is on how the media’s consumerist culture influences women. Elson urges women to achieve feminist media literacy when consuming media about childbirth (82). Feminist media literacy is the ability to view and deconstruct what the media produces and how it stereotypes or discriminates against women (Decarvalho). This skill is important because the media “exaggerates fears and dangers related to childbirth mainly to sell advertising space, theater tickets, and magazine subscriptions. Broadcasting birth scenes is good for ratings...the laboring woman’s mad rush to the hospital, her fear, screams, and hysteria, the unbearable pain, the desirability, indeed necessity, of epidural anesthesia and the inevitability of a cesarean section”

(Pincus 82). A focus on the extreme situations of childbirth sells more tickets, but at a cost to women's birthing experiences (Pincus 82).

### **Women's Experiences**

Trauma, PTSD, and tokophobia are results of the poor experiences women endure during childbirth, which often results from a lack of control over their experiences. One unexpected source of pressure arises from supporters of alternative birth who believe there is excessive attention on the negative outcomes of birth and instead emphasizes the importance and sanctity of choosing natural birth. Still, the discourse surrounding this choice relates to the outcomes of birth, believing that women should choose natural birth because it is the safest option (Malacrida and Boulton 44). This "emphasis on choice does sit somewhat uneasily with the movement's pervasive and quite damning critique of the medical management of childbirth (What if women actively choose medical intervention?)" (Beckett 255). The expectation upon women to have a natural birth is equally as restrictive as the pressure to accept medicalization.

These supporters believe that medical intervention takes away women's natural abilities and a natural birth is the gold standard to which women should aspire. Problematically, women who are unable to achieve this gold standard are given little attention. For example, women, who cannot have a natural birth due to a high-risk pregnancy, may feel like failures because they are unable to achieve a natural birth (Malacrida and Boulton 44). Additionally, women who can "achieve" a natural birth but may choose a medicalized birth are looked down upon and even told that they are not fully experiencing their child's birth. This is a consequence of the

alternative birth movement labeling un-medicalized births as “natural;” it implies that there also exists the “unnatural.” In this case, the unnatural is the medicalized birth (Beckett 257, 258).

Although the rhetoric of the alternative birth movement encourages women to choose natural birth, the medical community, the environment in which most births take place, perpetuates a greater source of rhetorical judgement, value and pressure. Feminist theorists often focus on language’s ability to shape women’s experiences, to the extent that language socially controls women because it is a male construction which refers to male concepts as the norm. (See: Moulton; Kitzinger). For instance, certain words are changed when they describe a female i.e. female doctor or manageress (Saul). This type of language suggests the unlikeliness of women to be involved in certain groups, especially in positions of power (Saul). In childbirth, there too exists language that situates women in inferior roles. Childbirth follows the biomedical model of science, which emphasizes pathology through the Cartesian principles (Hunter 120). These principles state that the mind and body are separate entities, that the body is a machine, and that science is based on the language of logic and reasoning (120). The medical language of childbirth places women in an inferior role because it is difficult for a non-medical person to understand. Nonetheless, feminists argue that the language has alienated women because it is heavily male controlled. For example, Evelyn Fox Keller who is a physicist, author, and feminist explained the differences in “language between the dominant masculine paradigm, which are objective, reasoning, mechanistic, and rational versus the alternative feminine paradigm of language which is subjective, emotional, intuitive, artistic, and in tune with nature” (120). Childbirth as a science favors masculine language, which has contributed to the exclusion of women’s experiences in childbirth (120). Multiple studies of nurses’ and obstetricians’ language concluded that the language used in labor and childbirth is often abusive, accusatory, and hostile

in an effort for professionals to “control the agenda” (121). For instance, Richard Miles, a proponent of holistic medicine, conducted an open forum with obstetricians and parents about the opening of a birth center. Obstetricians used words that implied the need for control including risk, protections, costs, proof, management, standards, efficiency, and death (121). But it is not just the language that doctors choose to use that implies a focus on negative outcomes and the need for control over women, the medical terms themselves are derogatory. Some examples include “value-laden language” such as lazy uterus, failure to progress, or untried pelvis, while other language encourages a power imbalance: client, patient, restrain, confinement (121). In order for women to feel a part of their birth experience once again, there must be a shift in language to encourage a more welcoming and supportive environment.

As a result of an emphasis on communication during childbirth, women may opt to use a birth plan to insert their voice into their experience. A birth plan lays out the desires of the woman, from where she would like to give birth, to who she wants present during labor, to which interventions she will accept (The Society of Obstetricians). Rhonda Shaw, explains in, “The Ethics of the Birth Plan,” that in an “increasingly technologically oriented body politic” she hoped that creating a birth plan “would enable [her] to retain a significant measure of personal autonomy, optimal choice, control and responsibility” (Shaw 135,136). Additionally, women feel that the birth plan offers the opportunity to take control of an otherwise unpredictable medical condition, and with this control, gain better birth experiences and safer outcomes (136). For instance, knowing that having an episiotomy can lead to infection, women may express their rejection of such an intervention in their birth plan. However, as Shaw alludes to in her article, the birth plan is often considered a “privileged self-indulgence readily dismissed when bureaucratic expediency necessitates” (143). This mentality has worked to discourage women



from creating such a plan because they know that the plan is frequently disregarded by doctors (Malacrida and Boulton 50; Stockill 571). For instance, Stockill explains that directly against her birth plan and without her consent, her pubic hair was shaved, she received an anal suppository, a fetal monitor was attached to the baby's head, and an episiotomy was performed (572). Often, even when women attempt to gain control over their birth experiences, they are met with resistance.

Women's voices are also ignored when the need for informed consent is ignored. Medical control and intervention interrupt the natural birth process and is often administered even if the woman is not in favor of such treatment. Clare Stockill, writes to this point, saying of her own birth experience, "I was 'informed' of what was happening, but given absolutely no space to make choices" (572). This, by no means, meets the requirements of informed consent. In this context, informed consent refers to the reception of adequate information, an understanding of this information, and most importantly, agreement. Autonomy, which is the ability to make independent choices with adequate information and knowledge, is closely linked to the concept of informed consent. The third aspect of informed consent cannot be met without a respect for the autonomy of a person (Scott et al 44, 46). It is not acceptable to inform the birthing woman of what decisions are being made; she must be an active and autonomous participant in the decision-making process in order to comply with informed consent. However, Stockill's experience is not an exception to the rule; a large community of unhappy women has echoed her experience. In a study of 22 women conducted by Professors Claudia Malacrida and Tiffany Boulton, one woman desired a C-section, the other 21 women desired intervention-free birth experiences. However, 11 of these births resulted in C-sections, and all but two women received some type of intervention. The interviews from these participants revealed "many of the women

were unable to make meaningful decisions regarding medical intervention” (Malacrida and Boulton 51). For instance, Carmen, a woman in the study described her induced labor saying, “I didn’t have any other choices presented to me” (51). I was told nothing else would work...I realized that the C-section wasn’t really a choice by then.” Because Carmen was not informed of her choices, she was stripped of her autonomy and experienced a highly medicalized birth against her wishes, making it clear that her doctors did not take her experience and responsibility into consideration.

In some instances, dissimilar to Carmen’s experience, women may be informed about the immediate options that they have, but not how that affects future decisions. Without full disclosure about the consequences of immediate decisions, doctors are violating informed consent practices. For instance, some women in the Malacrida and Boulton study were made aware of medical induction, but were uninformed that choosing this option increases the likelihood for other interventions to occur. Shirley, a natural birth-seeking participant, who had a C-section, describes her experience by alluding to the cascade of interventions. She explained, “You can’t really just leave it once you started [having an induction] and I didn’t realize that. And [the doctor] didn’t really explain that to me ... I thought you could just try it ... but I didn’t get that option, because once I started it he came in and said, ‘Ok we’ll break your water next’” (Malacrida and Boulton 52). According to Childbirth Connection, “Many maternity care interventions have unintended effects during labor and birth. Often these effects are new problems that are ‘solved’ with further intervention, which may in turn create even more problems. This chain of events has been called the ‘cascade of intervention,’” a term which was popularized by Marsden Wagner (Childbirth Connection). Often the cascade of intervention begins due to a lack of informed consent; Shirley agreed to induction but was unaware what

would happen as a result. Without full disclosure, Shirley endured an undesirable birth experience. Because obstetricians focus on the outcome of birth, they may disregard the need to receive informed consent and force women into an unpleasant birth experience.

Women's choices are also ignored for capital gain. *The Business of Being Born* highlights the capitalist birth system that arose from a focus on the outcome of birth. Hospitals are businesses that require a high turnover rate to make a profit. C-sections are faster, more lucrative than natural vaginal delivery, and are accessible because women are birthing in hospitals (*The Business of Being Born*). This means their most important focus is on delivering babies as quickly as possible. Consequently, hospitals are more interested in capital gain than in ensuring a positive birth experience for women. Realistically, childbirth for many women is not a fast process. Ina May Gaskin points out that not all women follow the pre-determined hospital timeline: "some women are stuck at two or five or seven centimeters for hours, then quickly they move several centimeters," she said (qtd. in Shapiro). Gaskin has determined that birthing in a hospital slows labor due to the upright positions, bright lights, lack of eating and drinking, and frequent vaginal exams (Shapiro). To this end, medical staff will encourage and even pressure women to submit to interventions, thereby increasing profits. Thus, women often feel like their childbirth is timed and in fact, it is. Prolonged labour or "failure to progress" "is most often defined as onset of regular, rhythmical painful contractions accompanied by cervical dilation where labour is longer than 24 hours;" additionally, the women should be dilated to 4cm by the eight hour point (International Confederation of Midwives 17). To determine if a woman is failing to progress in labor, previous interventions, which can cause contractions to slow down and reduce in intensity, are not considered. After this allotted time expires, doctors will suggest further medical interventions, even though non-medical activities like walking, resting, changing

positions, squatting, standing or taking a warm bath can help labor progress (“Friedman’s Curve and Failure to Progress”).

The women in Malacrida’s and Boulton’s study expressed this rushed feeling, which impeded their ability to positively experience childbirth. Rita, who desired a vaginal birth, but instead underwent a C-Section, believed that if she was allowed to have more time to labor naturally, would have experienced the birth she wanted (Malacrida and Boulton 18). Susan, another participant in this study, shared that a C-Section was presented to her as an “option,” but she did not have time to think about her decision. She explained that, in this pressure-filled moment, she did not think to ask for more time (18). The emphasis on turnover compromises women’s birth experiences in an effort to secure capitalist gains.

Although the well-being of the patient and infant should be paramount in childbearing, greed and fear taint the judgement of healthcare professionals. In the current climate of childbirth, in which obstetricians control childbirth, the decisions and recommendations made by these professionals alter the course of a woman’s birth experience, and potentially her life. With the ability to impact women’s experiences, it is imperative that obstetricians have women’s best interests at heart. Nevertheless, obstetricians do not make delivery choices purely to ensure the best experience for women. Obstetricians, who are trained surgeons and not experienced in natural birth, fear complications associated with vaginal birth (Fuglenes, Øian and Kristiansen 48.e1). They also fear that these complications could result in litigation, preferring to perform C-Sections and employ other medical interventions to deliver babies. The article entitled, “Obstetricians’ choice of cesarean delivery in ambiguous cases: is it influenced by risk attitude or fear of complaints and litigation?” discusses the risk attitude among obstetricians to determine if it influences their decisions regarding labor and delivery. Risk attitude is defined in this article

as, “a person’s preference for different levels of risk” (Fuglenes, Øian and Kristiansen 48.e1). In this context, the article examines the extent to which medical professionals are willing to “accept an outcome that is not necessarily the best...in exchange for avoiding a poor outcome” (48.e1). An example is choosing to perform a C-Section to avoid a vaginal birth, which might lead to fetal injury and legal actions. The article concluded that fear of litigation (risk) does in fact influence the obstetrician’s choice of delivery method.

This conclusion was echoed in an article entitled, “Effect of Fear of Litigation on Obstetric Care: A Nationwide Analysis on Obstetric Practice.” This study found that in states with higher malpractice premiums, C-sections are more common than in states with a relatively low malpractice premium (Zwecker 281). These studies offer insight into the reasons why the maternal mortality in the United States is the highest in the industrialized world. Doctors do not trust women’s bodies to deliver a baby without intervention and therefore with a focus on negative outcomes of birth and self-preservation in mind, they make choices out of a fear and greed.

Since medical professionals do not trust women’s bodies to deliver a child safely, they manage the entire childbirth experience. Unfortunately, the pressure doctors feel, combines with narrowly focused obstetric training. According to *The Business of Being Born*, obstetricians have little to no experience with vaginal birth. Unfortunately, the doctors explain how natural birth is not something they were exposed to in their training because obstetricians are surgeons trained in performing C-Sections, administering Pitocin, and controlling epidural. This reliance on medical intervention, to prevent negative birth outcomes, harms more women than it helps and severely restricts women’s birth options.

### Limited Options

Women endure poor childbirth experiences due to pressure, derogatory language, disregard for their desires, capitalism, fear, and limited obstetric training. Further, women are barred from achieving positive experiences because their options in childbirth are limited as the emphasis continues to be placed solely on the outcome. They may undergo birth intervention because of a lack of consent, or they may accept these interventions because they do not feel qualified to make their own decisions.

Women have been told for centuries that their bodies are not their own to control (see: Annandale and Clark; Martin; Lothian; Weitz). In order for women to feel as though they are autonomous they must be respected, valued, and understood to be the authority on their own bodies (Lothian 36). But women have never exercised power over their bodies because they have always been told that their bodies are sick. Maintaining the sickness of women has worked to preserve patriarchy in two ways: “to disqualify women as healers, and, of course, it made women highly qualified as patients” (Ehrenreich and English 23). Women are also perfect patients due to their socialized obedience and submissiveness to authority (24), in the patient role; women feel that their options are limited.

Many women feel that they are the “patient” under the supervision of a professional and are ill equipped to make decisions regarding this highly medicalized and fearful process. Shirley, previously mentioned in the Malacrida and Boulton study, felt this way about her doctor’s suggestion to induce labor. Once the doctor recommended this intervention, Shirley “didn’t feel qualified to question that” (18). This “doctor knows best” mentality was a theme that recurred throughout the experiences of the women in this study; this mentality prevented them from asserting their desires and making decisions. “Medicalization precipitates disempowerment,”

because normal processes, such as childbirth, become medical problems that only professionals can solve (Waggoner and Stults). This too reflects the narrow focus that women, in addition to doctors, have on the outcome of their birth and not upon their experiences. Because childbirth has evolved into an “unpredictable and risky medical procedure,” women feel the need to rely on the expertise of the medical professional (Stockill 572). The issue of safety is the determining factor of power and decision-making and because childbirth is considered a medical condition, doctors determine what is safe and normal, and therefore, “hold the keys to safety” (Lothian 36). Consequently, women may willingly surrender control of their birth experience to medical professionals who seem more qualified to birth the child than the woman herself.

Conversely, the midwife model of care encourages women to be present in their own experiences, an appealing reason to choose midwife style care once again (American Pregnancy Association). Women increasingly recognize that low risk births do not need the care of an obstetrician; one woman filmed in *The Business of Being Born*, said that using a midwife was a “no-brainer” because of the extensive personal care that they provide. Another woman interviewed in an *Atlantic* article echoed this sentiment; she too said that due to a desire for personalized attention and prenatal care she turned to the midwife model of care. The article reports that this woman “is part of a small but growing minority of American mothers opting for midwives over obstetricians: In 1989, the first year for which data is available, midwives were the lead care providers at merely 3 percent of births in the U.S. In 2013, the most recent year for which statistics are available, that number was close to 9 percent” (Cruz). Dr. Ashton, an OB-GYN contributor for ABC News, stated “women are growing more and more dissatisfied with what’s being offered by their doctor, by their board certified OB, or even in some cases, by a certified nurse midwife, and it’s pushing them to seek out these more extreme birthing

experiences” (Chang, Soichet, and Effron). While feminists would refrain from describing any woman’s birthing choice as extreme, they would agree that women are dissatisfied with their birthing experiences at hospitals and with obstetricians, and therefore, are seeking different birthing options.

Although women are turning to alternative methods of childbirth, their search for midwives is difficult, another limiting factor in their options for maternal care. For instance, women who choose to birth with a midwife face problems with their insurance providers. Mayra, featured in *The Business of Being Born*, describes how her insurance company asked for her obstetrician’s name and the hospital in which she was receiving care. Her responses about a midwife and homebirth were met with confusion. She expressed her frustration with people who “were treating her like she had a third eye” when she explained her birth preferences (*The Business of Being Born*). Mayra was confused by the resistance from her insurance company, who did not want to cover her homebirth. Midwife attended natural births are significantly cheaper than hospital births, she noted. Thus, insurance companies should prefer midwife attended births. This is exemplified in a *The Atlantic* article entitled, “Call the Midwife,” which reveals that many people, like Mayra, were infuriated when denied insurance coverage. Companies claim that midwives are “unauthorized services,” meaning that homebirths, as well as delivery in birthing centers, which are most often run by midwives, are not covered by insurance (“Getting Insurance to Pay for Midwives”). Yet, insurance companies do pay for childbirth if a physician performs it in a hospital, even though hospital births are thousands of dollars more than midwife attended birth (“Getting Insurance to Pay for Midwives”). Not readily receiving the support of insurance companies for cheaper birth options “makes you wonder what their agenda is” (*The Business of Being Born*). An article from the *New York Times* entitled, “Getting



Insurance to Pay for Midwives," also agreed "at a time when the United States is looking for ways to rein in its runaway medical spending, a surprising glitch is preventing American women from choosing the low-cost option: Many insurance plans do not have midwives in their provider networks, or do not cover midwife care at all." Marsden Wagner, the former director of Women's and Children's Health at the World Health Organization helps clarify this "glitch," which is in fact not a glitch at all. Wagner explains that insurance companies are part of the capitalist system of childbirth, when they seek information about childbirth they ask obstetricians. This information reflects the opinion that childbirth is a dangerous medical condition unsafe under the control of midwives. Accordingly, insurance companies choose not to cover home births and thus maintain birth is a medical condition.

This restriction on coverage is additionally problematic because midwives are unable to provide services in private practice. Eugene Declercq, a professor at the Boston University School of Public Health, explains that insurance is so complicated and restrictive for midwives that this often results in midwives having to work for a hospital or an obstetrician ("Getting Insurance to Pay for Midwives"). Consequently, midwives are relegated to helpers. Midwifery clinics, private practices, and midwife run birthing centers are forced to close because they are unable to financially support their practices. *The Business of Being Born* provides footage of a midwife on the phone with her insurance company. The woman quips, "It's like I'm begging you to get paid, your members did not have to beg us to get treatment" (*The Business of Being Born*). As a result, the midwife was forced to close her practice. Forcing midwives out of practice and eliminating women's choices surrounding birth works to maintain control over women's bodies and cultivate the capitalist hold over childbirth.

It might be tempting to jump to the conclusion that the United States needs to spend more money on healthcare. On the contrary, the United States spends more on healthcare than any other country in the world. According to the Peter G. Peterson Foundation, which compiled statistics from the Organization for Economic Cooperation and Development (OECD) August 2015 Health Statistics, the United States spends \$8,713 per capita on healthcare. This is more than double the average for the OECD countries, which spend an average of \$3,453 per capita (Peter G. Peterson Foundation). This exorbitant healthcare spending also places the United States at number one for maternal healthcare spending (Coeytaux, Bingham, and Strauss). Nevertheless, the problem remains: the United States has the highest rate of maternal mortality of all of the OECD countries who spend significantly less on maternal health (Coeytaux, Bingham, and Strauss). Evidently, it is not the amount of money spent on women's health, but instead, whether or not the money is spent to better women's experiences.

Based on an expenditure breakdown of the US health budget, as of 2013 the United States spent 180 billion dollars on "Other Programs" (National Center for Health Statistics 319). One of the roughly twelve programs included in the "Other Programs" portion of the budget was Maternal and Child Health, which equaled roughly 15 billion dollars (under the assumption that each program included in this category received equal funding) (320). Additionally, the category of "Research," which includes all areas of research not just Women's Health, received 46.7 billion dollars (304). Even though these sums of money make the United States the number one country in maternal care spending, the money is not reducing the incidents of maternal death and poor birth experiences. This is a result of poorly allocated funds. As of 2011, the United States government spent 86 billion dollars on hospitalized childbirth per year, significantly more than the amount allocated to women's health research and programming combined (Coeytaux,

Bingham, and Strauss). In effect, the government pours money into one type of childbirth experience, the one that has the worse experiences and health outcomes.

## **How can maternal health be improved through alternative birth options?**

Emotionally, mentally, and psychically the medicalized system of childbirth is failing women in the United States. The medical focus on the outcome of childbirth is restricting women's options and leading to poor experiences. Yet, there are options outside of medicalized hospital births that, although restricted in the ways previously discussed, are better options for women in terms of cost, comfort of mother, satisfaction with experience, pre-natal care, and maternal and infant mortality rates.

Feminists are conscientious not to persuade or control women's choices and instead ensure that women are aware of and have access to all of their options. The following section offers information about alternative birth options, including midwife care at home and in birth centers. I have chosen to highlight these options because they promote positive outcomes for woman, as well as focus on the holistic birth experience.

### **Midwifery**

The midwife model of care is a philosophy of care that affirms that pregnancy and childbirth are normal and safe processes. Midwives ensure that the woman remains the focus of care by empowering her and meeting her reproductive needs and desires. One way midwives empower women is by encouraging them to believe in their body's natural abilities. As a result of this philosophy of care, midwives aim to minimize unnecessary interventions (American Pregnancy Association). Additionally, the midwife model of care encourages midwives to monitor a woman's physical, psychological, and social well-being, offer education/counseling/pre and post-natal care, provide attention during labor and delivery,

minimize interventions, and identify women who need to be transferred to a hospital for obstetric care from out-of-hospital settings. Some midwives can also perform gynecological exams, provide family planning, newborn care, breastfeeding support, and menopausal aid (American Pregnancy Association).

Although all midwives base their care on this model, the specific services that a midwife can provide depend on the midwife's certifications and licenses. Midwives who have a nursing license can provide the most comprehensive care. Certified Nurse Midwives (CNM) are licensed in nursing and midwifery, which means that they have both a bachelor's degree and are certified by the American College of Nurse Midwives. In addition, Certified Midwives (CM) are trained and certified in midwifery but not nursing, they are required to earn a bachelor's degree and certification from the American College of Nurse Midwives (American Pregnancy Association). The vast majority of midwives are CNMs or CMs, and as of January 2012, there were 12,622 CNMs and 73 CMs in the United States (American College of Nurse Midwives). Although this is the most common type of midwife, there are also Certified Professional Midwives (CPM) trained in midwifery and who meet the criteria of the North American Registry of Midwives, but come from various educational backgrounds. The final two types of midwives are Direct-Entry Midwife (DEM) and Lay Midwife (LM). Direct-Entry Midwives are independently trained through apprenticeships, self-study, midwifery school, or a university program. Lay midwives are not certified or licensed as a midwife, but have informal training (American Pregnancy Association).

No matter the type of midwife, the benefits stem from their philosophy. In the previous chapters, I discussed over-medicalized childbirth, which originates from sexist deconstruction of the female body. Midwives, on the other hand, demonstrate that childbirth does not need to be

medicalized to be successful. They believe that when women's bodies are trusted and women are empowered, the mental, emotional, and physical outcomes of childbirth are more positive.

Herein lies the greatest benefit that midwives offer women, a benefit which is supported by statistics, facts, and testimonials. Midwives aim to provide the type of care that women desire.

For this reason, there are many options of care available for women to birth with a midwife. A common myth associated with midwives is that they only attend homebirths. However, midwife care can be at home, in a birth center, or in a hospital.

As of 2014, 91.2% of midwife attended births were overseen by CNMs, but only 5.8% of these births took place out-of-hospital, which includes births at home, a birth center, a doctor's office, or in other locations (Hamilton et al. 50). Midwives who deliver in hospitals are often part of the labor and deliver teams, a type of care facilitated by an agreement between The American College of Obstetricians and Gynecologists (the College) and the American College of Nurse-Midwives (ACNM).

The College and ACNM believe health care is most effective when it occurs in a system that facilitates communication across care settings and among providers. Ob-gyns and CNMs/CMs are experts in their respective fields of practice and are educated, trained, and licensed, independent providers who may collaborate with each other based on the needs of their patients (College Executive Board).

Although the vast majority of midwife-attended births are performed by CNMs in hospitals, of all midwife attended births roughly 12% were out-of-hospital births (Hamilton et al. 50).

According to Ina May Gaskin, and reiterated by The American College of Nurse-Midwives, women who are in generally good health, desire an out-of-hospital childbirth experience, understand the responsibility of their choice, are fully informed of all childbirth options and have

knowledge of what this option entails are eligible for out-of-hospital births (“Question”; “Normal, Healthy Childbirth” 2). Midwives are available for different types of births and encourage women to understand and choose the option with which they are most comfortable.

Midwives offer complete care in diverse locations, which allows them to reach underserved women. For example, the Frontier Nursing Service is a service that embodies the midwife model of care. Since the 1920s, Frontier Nursing Service has been providing nurse-midwife care to underserved areas. Now called the Frontier Nursing University, they offer off-site graduate programs. This allows midwives, no matter where they live, to become certified nurse-midwives (FNU Board of Directors). One graduate of the university said that “Frontier was the way [she] could finish [her] education from home because it is a four-and-a-half-hour drive to the nearest university offering a degree in certified nurse midwifery” (Morris 8). This midwife works in rural Wisconsin where care is difficult to obtain. She points out the importance of community care in such areas and explains that her degree in midwifery allows her to provide critical medical assistance (Morris 8). Midwives are often the main care providers in rural areas. For example, a study compared physicians to non-physicians in rural areas of California and Washington to determine which type of care provider most commonly aids the underserved population. The study found that CNMs provided care to more women on Medicaid living in rural areas of California than obstetricians. Certified nurse-midwives had a mean of 43% of their patients insured by Medicaid, compared to obstetrician-gynecologists who only had 14% (Grumbach 101). Furthermore, a report published in 2010 by the Institute of Medicine (IOM) concluded that nurse-midwives have improved primary health care services for underserved women. For this reason, the IOM recommended that nurse-midwives should be offered the

opportunity for more responsibility in women's health (Committee on the Robert Wood Johnson Foundation 56-58).

Midwives can also reach underserved women because their care is more affordable than obstetrician attended birth. Childbirth is likely the most costly health experience of reproductive age (Fetters). Although costs range widely based on insurance coverage, multiple sources have shown that midwife attended care is cheaper for both the woman and her insurer (American College of Nurse Midwives; Lincoff; Newhouse 246; Angood et al. S26). The expense of a hospital birth is costly because hospitals are interested in capital gain, use expensive interventions, and charge additional fees for pre-natal and post-natal care. Yet, midwife care can be a fraction of the cost because midwives include the facility charge, pre/post-natal care, and delivery services in their fee (*The Business of Being Born*). The average costs for vaginal birth are approximately 50% lower than those for cesarean birth (Thomson Healthcare 7). The Office of Technology Assessment analyzed nurse practitioner and nurse-midwife practice at two different points in time and found that they provided medical care that was equivalent to or exceeded physician care at a lower total cost (*The Cost and Effectiveness of Nurse Practitioners; Nurse Practitioners, Physician Assistants and Certified Nurse-Midwives*).

In addition to midwifery care reaching underserved women, another benefit is improved physiological outcomes. Studies have shown that the midwife model of care has similar if not better fetal and maternal outcomes in childbirth than do hospital physician-led care. Numerous studies compare midwife-led care to physician-led care and indicate positive outcomes including lower rates of: C-section, induction and augmentation, severe perineal tears, anesthesia/analgesia, intervention, episiotomy, preterm birth, antenatal hospitalization, neonatal death, maternal mortality and higher rates of: breastfeeding and breastfeeding initiation,



spontaneous vaginal birth, average labor time (Newhouse et al 245-247; Sandall et al. 2; Sutcliffe et al. 2381-2383; Oakley 402-405; Snowden et al. 2649). Statistics reported by the American College of Nurse Midwives support these findings. The published material boasted significantly reduced levels of intervention. For instance, a study they cited of 90 midwifery practices found that the average rate of episiotomy for midwives was 3.6% compared to the national average, which is 25%. This study also found that 78.6% of women achieved breastfeeding initiation, compared to the national average of 51%. Moreover, the C-section rate in this study showed a 9.9% rate, which is tremendously lower than the national average of roughly 32%. (American College of Nurse Midwives). With the recent rise in the C-section rate, it is crucial that studies are identifying providers who practice this delivery method less frequently. For example, according to the Centers for Disease Control and Prevention's National Center for Health Statistics, the lowest rate of C-Section in the United States is in New Mexico, which is also the state with a higher than average rate of CNM attended birth (one-third of all births are attended by CNMs in New Mexico) (American College of Nurse Midwives). Midwife-led care has proven in numerous studies to provide positive outcomes for women and babies in childbirth and postpartum.

Yet, not only do midwives offer better physiological outcomes, but women have better experiences when they choose midwife care. Satisfaction rates are in the 91-95 percentiles because women are so pleased with the care that they receive from midwives (Shaw-Battista 664). High maternal satisfaction is reported in relation to information, advice, and explanation women receive from their midwife (Sandall et al. 20; Sutcliffe et al. 2383). In addition, women noted high satisfaction rates with the venue of delivery, preparation for labor and delivery, options surrounding pain relief and professionalism offered with midwife-led care (Sandall et al.

22). Because women are treated as equal participants in their birth experience, women report feeling more confident in their provider and they feel more in control of their birth experience (Sutcliffe et al. 2383). This feeling of support and empowerment continues through labor and delivery because women who use midwives are more likely attended by the midwife they know, as opposed to physician-led care, where women were more likely to deliver with someone that they do not know (Sandall et al. 22). Midwifery care provides higher satisfaction for women because according to Sandall, author of the comprehensive new study published in the Cochrane Review, “having someone who is there for you, who is going to be there at your birth is important...because women know their midwives, and they’re often easier to get in touch with them, midwives are picking up any problems sooner and helping women get the right specialist input as early as possible...” (“Midwifery Benefits?”). She explains that the way in which midwives treat birth as a social and clinical event, positively influences the outcomes of childbirth (“Midwifery Benefits?”).

### **Homebirth**

Because a midwife’s view of birth is more social and less clinical than physicians, midwives provide the option of homebirth. Homebirth is just as safe, if not safer than a hospital birth (see Zielinski, Ackerson, and Low; Snowden et al.; Fullerton, Navarro, and Young). Yet, because childbirth is erroneously considered dangerous, even for low-risk women, only 1% of all births in the US occur out-of-hospital. 66% of these births take place at home, and are primarily attended by direct entry midwives and certified professional midwives. Luckily, homebirths are on the rise in the United States, although still far behind many other similarly industrialized

countries (Cheyney et al. 17). There is disagreement in the medical and research community about the fetal safety of homebirth and fierce disagreement between the obstetric and midwifery communities about homebirth safety in general.

However, a recent study in the *International Journal of Women's Health* explained “while some studies suggest a small but significant increase in neonatal death and adverse outcomes the majority of studies across a variety of countries have shown no increase in neonatal morbidity and mortality for planned homebirth. Additionally, maternal outcomes are consistently better for planned homebirth, including less interventions and fewer complications” (Zielinski, Ackerson, and Low 374). Some of the misconceptions are based on outdated or unreliable information. There had not been a peer-reviewed study published on the topic of homebirth outcomes since 2005, this stretch without research was broken in 2014 with a comprehensive study on this subject (Cheyney et al. 17). The study reviewed 16,924 homebirths to understand the outcome. Of these births, 89.1% were delivered at home. The majority of transfers were a result of failure to progress, but upon transfer only 4.5% required oxytocin and/or epidural. Of the 89.1% of the women who delivered at home, 93.6% delivered via a vaginal birth, 1.2% had an assisted vaginal birth, and only 5.2% required a C-section (Cheyney et al. 17). This study also found that only 1.5% of the newborns had a low Apgar score (below a 7 out of 10) and the intrapartum, early neonatal and late neonatal mortality rate were extremely low (1.30, .41, .35 per 1000 respectively) (Cheyney et al. 23). Due to low emergent rates, postnatal transfers to hospital were rare for both the newborn and mother. In addition, because the midwife model of care aims to provide women with the type of birth experience they desire, many midwives will accept women who want a vaginal birth after Cesarean (VBAC) at home. Of the 1,054 women who wanted a VBAC, 87% were successful at home. Therefore, even such deliveries, usually deemed high-

risk, were successful at home with a midwife. Overall the study found “excellent outcomes” for planned homebirth (Cheyney et al. 21, 23).

Women are not only choosing homebirth because of the positive physiological outcomes, but also for the positive experiences. Various studies have reported maternal satisfaction with homebirth (see Zielinski, Ackerson, and Low; Lindgren and Erlandsson; Janssen, Carty, and Reime). Many women choose homebirth after previously birthing at a hospital. A study found that two factors primarily influenced the decision to switch from hospital to homebirth. These factors include too many interventions and interruptions and the desire to avoid pain relief drugs (Zielinski, Ackerson, and Low 373). Women who switched reported feeling that birth is a natural process and the interruptions of unfamiliar people walking in and out of their room disrupted their labor. Additionally, women felt disrespected by their care providers and the lack of discussion before administering interventions (Zielinski, Ackerson, and Low 373-374). Therefore, women choose homebirth in order to have control and empowerment. Women had better experiences at home than in the hospital because the familiar environment provided more control, a feeling that encouraged women to make decisions with the midwife. Women also believe in their body’s ability to birth. Women also cited the comfort of being in a familiar environment as helpful in coping with labor pain (Zielinski, Ackerson, and Low 374) Another study, in which 75% of 1025 birth took place at home, reported that pain was rarely mentioned during the birth experience. Women reported more positive pain management experiences because they felt prepared by their midwife to cope with various pain management techniques (Lindgren and Erlandsson 310). Midwife-led care at home is a safe and satisfying experience for low-risk women who choose an out-of-hospital birth.

## Birth Center

Although home birth offers many benefits to women, not all women are comfortable with giving birth in an entirely non-clinical environment. Freestanding birth centers provide a compromise between clinical and non-clinical childbirth. Freestanding birth centers are defined under federal law as services furnished to an individual at a freestanding birth center, not a hospital. These births, planned away from home in a licensed center, offer prenatal, labor, and postnatal care (H.R. 3590). As of 2014, only .46% of births in the United States took place in a freestanding birth center and of these births, midwives attended 92.47% (Hamilton et al. 50).

Even though so few births take place in birth centers, they offer positive outcomes and a multitude of ways to customize the pregnancy and birth experience. The American Association of Birth Centers, “the nation's foremost authority and resource on birth centers,” explains the difference between hospital provided care and birth center provided care (“American Association of Birth Centers”). Birth centers have a commitment to educate and prepare women for the childbirth experience. To fulfil this commitment, they offer prenatal care appointments that are time-intensive and build provider-patient partnerships, hold formal classes, maintain a book and video library, and host speakers. Birth centers also offer non-traditional hours, satellite locations (medical offices, schools, businesses), as well as group care options (“American Association of Birth Centers”).

The midwife model of care is incorporated into birth centers because most often births in this location are attended by midwives. Therefore, care in a birth center focuses on labor support and pain management with a philosophy of “high touch, low tech.” This is facilitated by emotional support, the freedom to move, aromatherapy, relaxation and breathing techniques, hypnobirthing, massage, and acupuncture (“American Association of Birth Centers”).

More clinical options are also available, and range from pharmaceutical analgesia, sterile water papules, transcutaneous electrical nerve stimulation (TENS), and hydrotherapy (water birth). Birth centers also offer excellent mother and baby combined care through time-intensive couplet care, extra time to remain in the center (4-24 hours, it is usually 4-8 hours in a hospital), birth centers also offer 1-2 week postpartum visits and postpartum mom and baby groups ("American Association of Birth Centers").

The most comprehensive study recently published about birth center outcomes is the National Birth Center Study II (a follow-up to the 1989 National Birth Center Study) which sampled 15,574 women planning birth center birth at 79 different midwife led births. 84% gave birth at a birth center, 12% were transferred after admission and 4% were transferred before admission, although of the transfers only 1.9% were emergent (during or after birth). Due to the low number of emergencies and transfers, the C-section rate of women who planned to birth at a birth center was only 6%. Not only were the maternal outcomes better, but the fetal and newborn mortality rates were similar to low risk hospital births at roughly .47/1000 and .40/1000 respectively (Stapleton, Osborne, and Illuzzi 3, 7- 9). Another study comparing out-of-hospital birth to hospital birth echoed a low emergent transfer rate, reduced C-section rate, and similarly low infant/newborn mortality. This study adds that induction and augmentation in birth centers was 1.9% and 1.1% respectively, compared to the 30.4% and 26.4% they found in the hospitals they surveyed (Snowden et al. 2649). In addition, out of 84,000 women who birthed at birth centers, there were no reported maternal deaths. As a result of the positive findings of this study, the authors recommended that policy makers should consider supporting the birth center model as a strategy to improve maternal outcomes (Alliman and Phillippi 48).

Positive physiological outcomes are not the only reason that women found satisfaction in birth center care (“Ongoing relationships with a personal focus”; “Normality and collaboration”). Similar to homebirth, women are reporting higher levels of satisfaction in birth centers than in hospitals (see Esposito; “Ongoing Relationships with a Personal Focus”; Palmer; Pewitt; Phillippi, Myers, and Schorn; Waldenström and Nilsson; Walsh; Overgaard C, Fenger-Grøn M, and Sandall). A study by Alliman and Phillippi reviewed all of these studies to understand why women preferred birth center care. Women report that not only are they more satisfied with birth center care than with hospital care, but that they would use birth center care again and recommend it to a friend. The study found that contentment with the environment was a common source of satisfaction for women in both homebirth and birth center studies. They valued the comprehensive personal care fostered positive relationships with their care. Women also felt equal to their care provider and were encouraged to participate in birth related decisions. Accordingly, they also felt empowered to take on challenges and felt that they were more confident parents.

## Conclusion

Feminist research is conducted and reported through a range of approaches and methodologies. This interdisciplinary, multi-method approach allows the research to meet the needs and interests of the participants as well as the researchers (Im 135). Although there are various approaches to feminist research, feminist research typically includes common characteristics (e.g. Im 135; Lather 257; “The Experience and Meaning” 6). First, feminist research examines epistemology; how a topic is researched, viewed, and known. It considers the construction of male paradigms and male ways of knowing, both of which ignore women’s experiences (Ackerly and True 465). Rationalist research does not examine epistemology in this way therefore, women’s experiences with social and political occurrences are often omitted from scientific research. Similarly, this lack of focus on women’s experience in research echoes the medical focus on maternal mortality instead of women’s birth experiences and satisfaction. Conversely, feminist researchers understand the importance of acknowledging women’s voices and including women’s experiences in their research (Im 135; Ackerly and True 465; Brayton, Ollivier, Robbins). Women’s voices are imperative to research because, as feminists have come to understand through social and political movements, and especially during the second wave of feminism, the “personal is political” (Ackerly and True 465). Feminists recognize that what women think, feel, and experience cannot be separated from the political and social agenda. Instead, women’s “individual” problems are not always so individual, and often require political solutions (Lather 265). As a result of this intertwined understanding of women’s personal lives and the politics that surround them, feminist research also doubles as a piece of consciousness raising activism (Ackerly and True 465; Brayton, Ollivier, Robbins). Due to its political charge, feminist research raises awareness of women’s experiences in an effort to achieve equality



through social change. This is the final piece included in feminist research, argues Wood, which has the potential to change women's lives. Research can achieve this through the sharing of information between the feminist that conducted the research and the research participants. This reciprocity communicates to participants that their contributions are valued thus, reframing the participant-researcher hierarchy (Lather 263).

Due to my understanding of feminist research as a means to raise awareness, as well as my commitment to feminist activism, I initiated social change based on the findings of my research. My research taught me that women's birth options are limited due to sexist power dynamics and constructions of the female body. I learned that women can offer ways to improve their own and others' birth experiences, but their suggestions and desires are not being heard. Due to a lack of female voices, women's right to be satisfied with their childbirth experience is stripped from them. I wanted my research to help improve childbirth experiences. Consequently, I developed and organized a project at Penn State for the State College community by providing a forum for women to share their birth experiences and offer suggestions to change the birth experience in Centre County.

To execute this project, I collaborated with a Certified Nurse Midwife who works at a local hospital. I have discussed with her the birth options that are available to women in Centre County. As per our conversations, I learned that women's options are limited due to a low level of available midwife care and the distance to the nearest birth center. Consequently, many women feel forced into a hospital birth. Some women leave the area to find more options for childbirth, specifically to take advantage of birth centers in other areas of Pennsylvania. I was curious to see what women wanted, a local birth center? Homebirth? More midwives? Access to

doulas? Therefore, I hosted a film screening and discussion to hear what options local women prefer.

Luckily, I had the support of the Penn State Planned Parenthood Generation Action club. This is a new student organization, for which I serve as the Vice President. The organization was excited to support my interest in a birth related event at Penn State. Because of this collaboration, part of the mission for this event was to demonstrate that Planned Parenthood supports a wide range of women's health issues. Additionally, working with this organization framed the topic as an issue of reproductive rights. My research, as well as my involvement with the organization helped me to understand how organizations, like Planned Parenthood, offer women diverse and often otherwise unattainable services. These services range from health screenings to counselling, as well as advice with birth options and maternal/fetal care. Yet, with recent defunding of similar clinics, women health options are being restricted. I was thrilled that my research could act as a piece of reproductive rights activism.

Yet, the point of this event was not to sway opinions or present any birth option with bias, but instead offer women the opportunity to speak up for their reproductive rights. To this end, I selected clips that represented various birth options, birth locations, and birth professionals. The topics covered in the films included elective C-section, free birth (unassisted childbirth), home birth, birth center birth, water birth, birthing with a midwife, birth led in joint midwife-obstetrician care, and birth assisted by doulas. After each section of film, there was a moderated discussion. It was important to me that the conversation remained a safe place for women to speak about their options, as well as medical professionals to voice their opinions. Therefore, I selected a moderator who was not affiliated with my research. This moderator was

Paula Milone-Nuzzo, the Dean of the College of Nursing. She is an educator and academic, nurse, as well as a member of Mount Nittany Health.

Through this moderated discussion, I had the opportunity to share my research as well as learn more about childbirth directly from local women. What I heard at the event supported my thesis findings. There were three main ideas that came from the event: lack of options and support, a desire to share suggestions, and an enthusiasm to continue the conversation. Attendees voiced their disapproval with the options that Centre County has to offer expecting moms. Some of the women at the event told stories about leaving the area to give birth in counties with more options or feeling pressured to choose a hospital birth because there were no other options offered to them. Women felt that this was due to the low level of support for women who opted for alternative experience such as homebirth or hypno-birth.

Based on their unsatisfactory experiences the women had suggestions to offer. Often suggestions focused on improving communication and collaboration between ob-gyns and midwives. Many women echoed that they wanted support from multiple care providers, but did not want to be pushed to accept certain types of care. This topic manifested into a discussion of needing to expand medical practice to include more techniques of midwifery. Women expressed the desire for both clinical and non-clinical care, but found the medical options too rigid. In order to improve the clinical environment, women suggested small improvements to the hospital that would enhance the experience. Recommendation included allowing doulas to accompany women into the operating room for C-section, using the laboring tub for delivery, using less controlling rhetoric with women. These suggestions were practical and implementable, but a more complex proposal did arise, the idea was to open a birth center. I was curious to know if women would be interested in a birth center in State College and if they would consider this option of care. When

this idea was voiced, there was wide spread agreement that a birth center in Centre County would be an excellent and well-utilized option for women, especially since many of the women who left to birth elsewhere chose to do so at a birth center. The women agreed that a birth center backed by a local hospital would be the preferred type of birth center, again in order to facilitate the collaboration of midwives and physicians.

The women who attended the event were more than willing to share their experiences and explain reasonable ways to solve the problem. The women exuded passion and excitement at the opportunity to better the childbirth experience. As a result, the women asked how they could be a part of the conversation moving forward. Due to this overwhelming support and interest in pursuing reproductive justice, there will be a newly formed local organization called Friends of Midwives. This group will support diverse birth options and methods of maternal support. At the event there were about 30 people who signed in and showed interest in supporting this organization. This organization represents women's voices and experiences that are left out of the current landscape of childbirth.

At the onset of writing this paper, my goal was to initiate change and be the impetus for others to further this consciousness raising. I am thrilled that my research and passion for activism allowed me to bring women in the community together to share their experience and offer suggestions in an effort to eradicate this reproductive injustice.

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# Academic Vita

## Olivia Pecora

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### EDUCATION

**The Pennsylvania State University** - University Park May 2016  
**Paterno Fellows Program | B.A. Women's Studies | B.A. Sociology**  
**Study Abroad:** Dublin, Ireland and Zagreb, Croatia Summers 2014 & 2015

### HONORS

**Schreyer Honors College**  
Spring 2016 Interdisciplinary Student Marshall  
Phi Beta Kappa Honor Society | Triota Women's Studies Honor Society

### EXPERIENCE

**Women's Studies Department** - Penn State University, PA Spring 2016  
*Research Assistant Supervised by Jill Wood*

**Library For All** - New York, NY Summer 2015  
*Business Development Intern*

- Researched and analyzed the psychology of philanthropy to create Monthly Giving Program.
- Secured sponsorships, corresponded with partners, and organized large scale fundraisers.
- Wrote and presented partnership proposals to the Business Director and the CEO.
- Generated ideas in business development and problem-solving meetings with directors.

**Women and the Criminal Justice System** - Penn State University, PA Spring 2014  
*Teaching Assistant*

- Collaborated with the professor to structure course.
- Guided students in the completion of final project.
- Acted as a liaison between the students and the professor.

**Malini Foundation** - Remote Summer - Fall 2014  
*Information Session Panelist/ Legal Project Manager Intern*

- Established the foundation as a state non-profit and as a federal tax exempt organization.
- Conducted research to identify donors and non-profits with whom to connect.
- Communicated weekly with the organization's founder to present research findings.

### LEADERSHIP

**Planned Parenthood Action Generation** Spring 2016  
*Vice President*

**One Team International** Spring 2013 - 2015  
*Founder and President*

- Led meetings and advocacy events to support girls' athletics in Mumbai.
- Formed partnership with Goal Programme, Naz India.
- Organized fundraiser supported by the Penn State Men's Basketball Team.

**Penn State Dance Marathon (THON) - Largest Student-Run Philanthropy in the World** 2012 - 2014  
*Family Relations Chairperson/Family Relations Captain*

- Planned and managed events for families affected by pediatric cancer.
- Communicated with THON families biweekly to accommodate their needs.
- Strategized improvements including efficient fund allocation and board meeting productivity.

### AWARDS

- The Laura Richardson Whitaker Memorial Undergraduate Award in Women's Studies Spring 2016
- Citizenship and Service: Partisan Award Spring 2015
- Outstanding Undergraduate Student Award Spring 2015
- Kean University Human Rights Institute: Outstanding Human Rights Student Activist Award Spring 2012

### ADDITIONAL ACTIVITIES

- Competitive Ballroom Dancing. Fall 2014-Present
- Penn State Lion Scout tour guide. Fall 2014-Present