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CHILDBIRTH CARE-SEEKING BEHAVIOR IN CHIAPAS

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I. INTRODUCTION

Birthing options are often multiple and have been the source of much discussion in public health and medical anthropology circles. The literature implies that deliveries attended by doctors in institutional settings is the norm and births assisted by traditional birth attendants (TBA) represent aberrant cases. In Mexico, for example, public health education and World Health Organization (WHO) policies reflect this trend. However, in poor areas of the world and also in certain highly "modern" cultures, births at home attended by TBAs are more common than hospital deliveries.[1]

In this paper, we present our findings concerning options available for childbirth care, preferences for the different types of care, and factors that underlie women's choices in the Border Region of the Mexican state of Chiapas. Our intent is to understand from the perspective of the women in this context what constitutes "good" birthing care. Our research reveals that TBAs are normally their first choice even when doctors' services are readily available. We propose that there are many aspects of TBAs that women value, making them the preferred attendants. On the other hand, the instances in which women are assisted by doctors represent aberrant cases, and the decision to be attended by a doctor is a function of perceived need. We hope that our findings contribute to promoting quality care for this critical moment in the lives of women and their babies.

II. OPTIONS FOR CARE DURING CHILDBIRTH

For childbirth, women in Mexico, including those in the Border Region of Chiapas, may seek care provided by doctors and/or TBAs. "Doctors" are medical personnel trained in the "Western" or "cosmopolitan" or "modern" medical techniques, and practicing in institutional settings, such as clinics and hospitals (either government-run or private). By "traditional birth attendants" we refer to women who attend deliveries in the laboring women's homes, using herbal treatments, massage therapy, and pharmaceutical products.

> *If we wanted to define* parteras, *we would have to start by saying that they are women who have had children (often alone, and that is how their midwifery experience began), generally from the community where they assist other women during the last months of pregnancy, childbirth, and the first few weeks after it... The care that they give during the pregnancy-childbirth-postpartum process is conducted via traditional medical practices that they may learn through "dreams" or from practice and experience, accompanying their mothers or other relatives.* [2]

Some TBAs have attended institutional training programs, as well.

Mexican health policy makers have been slow in recognizing and supporting TBAs. Sesia writes,

> *In Mexico, health policy makers ignored or blatantly condemned all traditional medical practices, including midwifery, well into the mid-1970s.... Since the late 1970s, and in response to a more favorable climate for the recognition of traditional medicine at national and international levels, Mexican health authorities have officially moved from denial and rejection to partial acknowledgment and acceptance.... Recognition by national health authorities of traditional midwifery in particular has been dictated by the magnitude of the phenomenon within Mexico. In the 1970s parteras attended well over two-thirds of all births in the country; according to more recent estimates by the national health sector, as many as 80% of all births in rural Mexico are managed by traditional and certified empirical midwives.*[3]

We have found that in the Border Region of Chiapas, TBAs refer complicated obstetrical problems to physicians and in fact do so frequently. Certainly some of the high maternal mortality reported in the regional hospital reflect the difficult problems referred there. However, even in the case of normal multipara pregnancies, doctors do not refer patients to TBAs, despite evidence that home births assisted by competent midwives are very safe.[4] It is not the policy of the Ministry of Education to refer patients to midwives.

III. METHODOLOGY

We developed a focused, open-ended ethnographic interview to address a wide range of issues critical to reproductive and sexual health, which we then applied along with a quantitative survey to a convenience sample of forty mestizo women in the region. The interview guide's format and the open-ended nature of the questions allowed the women we interviewed to speak at length and include spontaneous remarks. The forty interviews ranged from one to four hours in length. The sample included middle- and lower- SES women aged 19 to 62, living in rural and urban areas in eleven municipalities of Health Jurisdiction III. All of the women interviewed had at least one child. The majority of the interviews took place in the homes of the subjects. We also applied a closed precoded questionnaire in order to generate basic demographic and general health status information. This was the same questionnaire used in a random sample of 1600 women in the region.

Following data collection, we conducted data analysis of both the quantitative and the qualitative information. Survey data was analyzed using SAS. Statistical information concerning general sociodemographic data and care seeking for childbirth were obtained. We analyzed the qualitative data in two phases: an initial descriptive phase and, based on this, a second interpretive phase. The descriptive phase consisted primarily of data reduction and data display tasks. This included creating a database of demographic variables, producing a brief summary of each case, and generating a series of tables for displaying data. This phase entailed reviewing the transcription of each interview, the manual marking of categories and topics of interest, summarizing each case and transferring this information into a data base using EXCEL. The interpretive phase consisted of the searching for and substantiating patterns among the descriptive data through systematic comparison of the variables, the proposal of hypotheses related to the study objectives, and finally presenting our findings.

In presenting our results, we found it useful to structure our data on the use of TBAs around five aspects of childbearing proposed by Oakley: 1) cultural definitions of childbearing (including pregnancy and delivery); 2) childbirth positions; 3) the intervention in birth and support network for the laboring woman; 4) the location of childbirth; and 5) who controls the delivery.[5] While our study was not specifically designed around these axes, the information volunteered by our subjects regarding preferences for TBAs lends itself to description in this framework.

IV. FINDINGS

A. Demographics

The 40 women interviewed are all mestizas (non-indigenous), and range in age from 19 to 62, with a median age of 32 years. Eighty-two percent are either married or living with their partner; the remaining 18% are either separated or widowed. They have from 1 to 12 children, with an average of 4.6. Forty-eight percent of the women have 0 to 6 years of schooling; 30% have finished primary school; 22% have finished secondary school or more. Of our 40 informants, 18% live in communities of fewer than 10,000 inhabitants, the remainder residing in semi-urban areas. Thirty-three of the women interviewed live in semi-urban areas, and 7 in small rural communities. (See Table 1.)

Table 1.

SUBJECTS	40 mestiza women
Age	19 to 62 years (median 32)
Marital status	82% married or living with partner 18% separated/divorced or widowed
Children	1 to 12 (average 4.6)
Education	0 to 6 years of schooling: 48% primary school completed: 30% secondary school or more completed: 22%
Size of community of residence	rural (fewer than 10,000 inhabitants): 18% semi-urban (over 10,000 inhabitants): 82%

Thirty-nine percent of the women we interviewed live in two-room huts of wooden plank walls, corrugated aluminum roofs, and dirt floors. Fifty-three percent live in larger, more sturdy cement block and brick structures. Almost all have radios and half had television sets, which they use both for entertainment and for keeping up national news. All of our subjects have piped water and electricity. Many who reside in rural settings live without proper drainage and cook with wood rather than gas stoves. Devices such as washing machines, dryers, dishwashers, electric stoves and microwave ovens are rare in this population.

The majority of our informants married in their late teens and immediately started having children. Most of these women live in the same neighborhood as their extended families, often living with their in-laws at the start of their marriage, and continuing to live nearby after establishing their own households.

B. Preferences for TBAs and the home setting during childbirth

Birth attendant

Our data indicate a higher prevalence for births attended by TBAs rather than physicians (see Table 3). The 40 women in this study reported a total of 176 pregnancies carried to term. Of these, we have data on who attended the birth for 150. Sixty-nine percent of the 150 births were attended by TBAs, 21% by doctors, and 10% by relatives (including husband, mother, mother-in-law, sister, or sister-in-law). Twenty-one women had been assisted by a doctor for one or more births, and 7 had been attended by doctors exclusively.

Place of birth

Our informants had the majority of their children in their own homes. Table 4 indicates that this preference is relatively unchanging regardless of whether the birth is the first or the most recent.

Table 2.

	Place of birth by birth number		
	First birth % N=40	Last Birth % N=40	Majority Births % N=40
Home	73	68	77
Govt.-run health service	18	22	16
Private health service	3	5	3
Other	6	5	4

Regarding information on the place of birth with respect to who had attended deliveries (see Table 2), the majority (91%) of deliveries attended by TBAs were homebirths. Almost all (90%) births attended by relatives took place at home, and the rest in hospitals (10%). Of those births attended to by doctors,

26% in the woman's home, and 62% in hospitals, and the remaining 12% in other places. The few births attended to by nurses or by noone at all occurred in the informants' home.

Table 3.

Birth attendant	Percent of all births reported (N=150)	Percent occuring in the woman's home
TBA	69%	91%
Doctors	21%	26%
Relatives	10%	90%

Contrary to our experience, distance and cost did not seem to influence the decision of choosing TBAs over institutional services, or vice-versa.[6] Our quantitative survey reveals that 48% of the informants live within 1 to 10 minutes of institutionalized health services, 15% within 11 to 20 minutes, 20% from 21 to 30 minutes, and just 10% over 30 minutes. This suggests that, even having services close by, the women we interviewed prefer to have their children at home, where the majority are attended by TBAs.

Informants reported that some doctors and hospital/clinic services charge a lot, some charge a little, and some are free (the patient often assuming the cost of transportation and prescribed medicine). The women mentioned that while some charge more than others, the TBAs always charge, but this does not diminish demand, and some women even send for TBAs who charge more than doctors and come from distances surpassing the distance from home to a doctor. The outpatient department of the Comitan hospital is often used by women to evaluate their condition; however, 95% of the names of women who attend the prenatal clinics do not appear on list of subsequent deliveries. Obviously, while doctor's services are known to, accessible, and solicited by these women, they utilize them to "self-triage" (possibly at the suggestion of midwives), but choose doctors' services for childbirth only if they perceive a specific need.

Education

With regard to level of schooling, our illiterate participants are more than twice as likely to give birth at home (93% had the majority of their children at home) than those who had completed secondary school (44% had the majority

of their children at home). Additionally, among illiterate women, there seems to be an increase in home births from the first to the last birth, while among more educated women, the tendency from first to last birth is to deliver less frequently at home. (See Table 4.)

Age

In terms of age groups, the quantitative data indicates that younger women more frequently deliver their babies at home. (See Table 4.) For example, women aged 15 to 19 had 96% of their births at home, while 76% of women aged 35 to 39 had the majority of their births at home. Thus, women seem to be using doctor's services less frequently. This is a surprising result as doctors' services have become more available.

Table 4.

Education	**Percent of births at home**
Illiterate	93%
Secondary school complete	44%
Age	**Percent of births at home**
15 to 19 years	96%
35 to 39	76%

In general, although the majority of deliveries take place at home and are attended to by TBAs, there is a slight drop in homebirths in the last births compared to the first births (from 73% for first births to 68% for last births).

C. Aspects of TBAs that women value

We propose that women prefer TBAs for a variety of reasons, including their openness to a variety of birthing positions, their use of techniques not employed by doctors, their promotion of supportive family intervention, their attending the woman in her own home, and their encouraging the woman to feel in control of the birth.

1. Cultural definitions of childbearing

The women we interviewed made comments that point to the extreme

importance of having children. For example, women commented that a woman with children has been blessed by God. Informants describe women who are visibly pregnant as very pretty. Bearing a child is not only essential to society's value of that woman, but often the most meaningful and valuable experience a woman could have. A woman who has none or too few children is often criticized. She is viewed as selfish and lazy, accused of wanting to pamper her body, or of having sexual interests beyond her husband, and especially she is characterized as a failure, not a real woman. One study participant commented, *People say that women who do not want to have children are bad mothers. They don't like having babies because is ruins their figure. They are women with a bad lifestyle; they run around with one man and then with another. Marimacha* was a term frequently used for women who willingly do not have children. Perhaps "masculinized" is the closest interpretation of the word, which by one person was paired with *mampo*, "effeminate", for a man who does not want children. Another woman told us, *People criticize women without children..., "she's a* marimacha, *she's incapable of having a child..., it must be God's punishment..."* Marimacha *means that she's a woman because she has a man..., but at the same time she's macho because she doesn't create a family.... There are couples in which the man mistreats the woman because he thinks that she is to blame.* Another commented, *A woman who does not want to have children is a lazy bum; she doesn't want to support them.* Such childless women - and even women with few children - inspire pity, compassion, and sadness. Comments ranged from remarks such as, *When a house has a garden, the house is beautiful. But a house without a garden is ugly.... A woman without a child is also ugly, having her children, well then they know she is a mother for her children,* to more extreme criticisms like, *Women who do not have or do not want children should not be women.* These comments indicate that, for our informants, children are a means for achieving worth on a personal and societal level, and that the subjects define a proper and esteemed woman, marriage, family, and home based on bearing children. Because there is such a high value placed on having children, giving birth is extremely important, as well, making the choice of birth attendant a crucial decision.

2. Positions and techniques for childbirth

Among this sample, women mentioned that the TBAs permit - and in some cases advise - women to squat instead of lie down for delivery. At least one woman said that on her back she just could not deliver. In addition to the flexibility regarding physical positions for the laboring woman, our subjects mentioned the broad range of tools and techniques employed by the TBAs. Study participants displayed their confidence in TBAs' knowledge and "tricks of the trade." One woman talked about giving birth with her midwife, *The partera*[7] *knew secrets. She tied a shawl around my waist and gave me a little bottle of oil to swallow. I took it and the placenta came out.* Another described a difficult birth, *The partera opened me*

up and checked. She said that the baby was stuck in a bag. She popped the bag that wouldn't let the baby through, and that's how she got the baby out. Noone mentioned doctors' training or knowledge as a factor.

The women we interviewed described how a variety of techniques employed by TBAs helped during delivery. For example, they prescribe herbal remedies, such as teas and baths, *The day that I was going to give birth, the partera sent me to bathe with sour orange water... as hot as I could stand. My goodness! She'd make you sweat. But I think that it's good that way because it makes the delivery quick. And she would always give us chamomile tea.* They use injections and prescribe aspirin and other pharmaceuticals, as well. Women speak positively of this combination of herbal and pharmaceutical treatment. TBAs also use manual therapies, such as rubbing and massaging the mother's abdomen and maneuvering the baby into the right position. This is especially important when *the midwife has detected a breech or transverse baby. On the other hand, doctors, they say, do not position the baby, The doctor checks with an apparatus to see how the baby is doing inside, but I don't feel that they help in that.... well, I had to be attended by parteras because they help to see if the baby is badly positioned. They help to put it in the normal position with their hands. Many informants indicate that the TBA offers more complete care for both the mother and the baby after birth, as well, The partera cared for me until I got well. She tended the baby, and she left me all cleaned up.*

3. Intervention in birth and the emotional and social supports for the laboring women

In our study, an often mentioned factor is that the TBA allows others to participate in the birthing process, facilitated by the fact that the woman is in her own home. There, the laboring woman enjoys the care provided by other family members, and her husband and mother often play a critical role in the delivery. Husbands, in-laws, siblings, and parents all participate in a variety of activities from calling the TBA, to preparing teas for the woman, to helping to hold her while she squats and pushes in the final stage of delivery. As one woman told us, *My husband helped hold me so that I could push.* In all but one case, the TBA allowed the husband to assist her and witness the birth. Subjects criticized the hospital services for excluding relatives from participating: *When you give birth at home they hold you, not like in the hospital where you just have to put up with the pain.*

Adding to the confidence in the TBAs orientation, the midwives in this region tend to be women, and doctors tend to be men. Our informants mentioned that they are ashamed to be seen by a male provider, which may influence their choosing TBAs.

4. Location of childbirth

As mentioned above, the women we interviewed had the majority of their children at home. Even having services close by, they prefer to deliver in their own homes, where the majority are attended by TBAs. We have seen that family support and privacy is important for the mother, and birthing at home helps to ensure it.

5. Who controls delivery

Who controls the delivery is implicit in the previous discussion on childbirth positions, location of childbirth, intervention, and the support network. That women giving birth at home have access to a wider range of techniques and benefit from greater family involvement in fact implies more control over the delivery for the mother, whether attended by a TBA or other relative. Undoubtedly, there is even more control when attended by relative or of course by no one, and a significant number of our respondents fall into that category.

C. Preferences for institutional care in childbirth

Despite strong preferences for TBAs, informants mentioned opting for doctors at times. This decision to be attended by a doctor seems to be a function of perceived need, as they mention two situations. First, they turn to doctors for obstetric complications; secondly they look to hospital care when they want a tubal ligation at the time of delivery.

1. Obstetric complications & referral

If there are no complications identified beforehand, the majority of women prefer the TBA's delivery services. A study participant explained, *I went to the clinic beforehand so they could see how everything was going. If it seemed necessary, they were going to take me to the clinic for the delivery. But because there wasn't any need, it was born here at home with a partera.* In the event of complications identified (by TBAs or by doctors) during the pregnancy, such as a very large baby or twins, women seek doctors' services. One woman noted, *If it's a good birth, then they have it there at home. When the woman begins to feel the pains, they attend her at home. But those that aren't good, well, they have to go to the clinic.*

Complications come up during the course of labor, as well. Most commonly mentioned are prolonged labor and poor position of the baby. In most of these cases, the TBA refers the woman to a doctor.

2. Tubal ligation

Nearly half (47%) of the informants had used some form of contraception in the previous month. Tubal ligations are extremely popular in this population; of this group, 20% had had a opted for the tubal ligation (as opposed to 20% use of temporary methods, and 7% "traditional" methods).14 Of the women who opted for have gotten tubal ligations, 62% delivered their last child in hospitals and clinics, while only 38% delivered at home. In contrast, the women who had used other forms of birth control, only 21% delivered in institutional settings, and women who had never used birth control methods also reported a lower percentage (24%) of institutional deliveries. (See Table 5.) There are at least two plausible explanations for this trend, including the possibility that over time women become more "modern" and hence have more children at hospital, as well as the possibility that many women choose to give birth to their last babies in the hospital in order to have their tubes tied during the same visit.

Table 5. Place of last birth by type of contraceptive method used

	Never used contra. %	Former contra. user %	Use modern method %	Uses other method %	Has had tubal ligation %
Home	76	73	74	100	38
Govt.-run health service	22	14	18	0	44
Private health service	2	0	3	0	0
Other	0	13	5	0	0

It seems that women choose to deliver in institutional settings because they want to have a tubal ligation performed. Their comments indicate that this is a premeditated decision, rather than one made in the hospital following the delivery. For example, one study participant explained, *Sometimes what they do in the hospital*

is operate on the women to get the baby out. Then a lot come to the hospital and they operate on them so that they won't have anymore children. Another told us that, *The same partera helped me with my first three children, but not with the last one because I went to the hospital to get a tubal ligation.* Thus, the second major impetus women mentioned to deliver with a doctor is to have the tubal ligation performed immediately following the birth, and "kill two birds with one stone".

V. CONCLUSIONS

We have seen that, in our study population, the majority of births have been assisted by TBAs, rather than by doctors. This choice does not seem to be a function of distance to providers, nor of the cost of the care. Rather, our informants expressed their marked preference for the TBAs' style over that of physicians, and mentioned a variety of characteristics of the TBAs that they value. These include the TBAs' openness to a variety of birthing positions, their use of techniques not employed by doctors, their promotion of supportive family intervention, their attending the woman in her own home, and their encouraging the woman to feel in control of the birth. In fewer cases, deliveries have been assisted by doctors, and the women's comments indicate that the decision to deliver with a doctor's aid is based on perceived need in cases of obstetrical complications or the woman's desire to get a tubal ligation immediately following childbirth.

Recent literature reflects some of the issues around the childbirth care preferences. Sakala, for example, contrasts medical personnel versus TBAs:

> *Medical personnel tend to be oriented toward pathology and dysfunction, to emphasize the dangers of birth and to believe that birth should only occur in hospitals. Their general orientation is that women are likely to lack resources to safely and effectively birth their infants. By contrast, midwives focus on birth as a "normal" and "natural" process, and they emphasize the ability of the great majority of women to give birth vaginally and without excessive interventions. The midwives believe that the birth attendant can do many things to keep the course of labor and birth within a normal range. Their general orientation is that women are likely to be able to safely and effectively birth their infants in supportive low-technology environments.*[8]

Sakala discusses other differences, as well. For example, physicians tend to adhere to action and treatment, while the TBA's role is oriented toward watchfulness and patience. In general, the TBAs exercise a more diverse and flexible range of options than medical personnel.[9]

Cordero Fiedler mentions that giving birth at home - the most common scenario when the attendant is a TBA - is an important element in the laboring woman's authority. The physical location of birth is reflects and creates social territories, which affect the physical processes of labor and birth and the woman's experience of those processes. For example, homebirth reflects birth as natural and healthy, and the mother's control and authority over her body and the situation. Hospital birth reflects control of the doctors, technology and their authority over women (and midwives).[10] Jackson and Bailes reflect,

> *A woman laboring and birthing at home retains increased authority. She is the central figure for and by whom all intrapartum plans are made. When the mother leaves her home to birth, her centrality is diminished, even if she is going to an institution designed to support her natural efforts. When she remains at home, the responses to labor's demands can flow from the needs of the woman rather than the needs of an institution.*[11]

Various authors have identified the attention provided by TBAs as an important source of power for women. Powell Kennedy found that, with a midwife,

> *the woman, as an individual, determines and directs her care. The process of being cared for by a nurse-midwife validated the woman's ability to determine and direct what happened to her. Actions that the nurse-midwife took seemed to empower the woman to take charge of her own care.... A philosophy of practice that emphasizes that women have the right to determine their care communicates a message of responsibility that is shared between the woman and the midwife. Shared responsibility indicates shared power.*[12]

The preferences discussed here highlight the fact that childbirth is not simply the culmination of biological reproduction, but much more: *...Birth is almost never simply a biological act; on the contrary, as Brigitte Jordan has written, "birth is everywhere socially marked and shaped". It is ...an ongoing social process that builds and reflects contested power relationships and cultural values....*[13] Childbirth care highlights a series of social factors critical to the health and well-being of women, including the quality of health care, the right to choose methods and practitioners, collective (family) and individual roles in health care, control over contraception and sexuality, and gender relations (woman-male doctor, woman-female midwife). The incorporation of this perspective - that is, of childbirth as a social process - is crucial in the development of health policy and program planning to promote quality care during childbirth.

VI. RECOMMENDATIONS

Here, our goal is to elucidate when and why women in this region prefer TBAs' services, and when and why they opt for institutional services. It is our hope that the following suggestions, based on our findings, help to develop better childbirth services, whether provided by TBAs or doctors, or TBAs and doctors cooperating and combining TBAs obstetrical practices with biomedical practices.

- Recognize, respect and support the knowledge and experience of midwives.
- Increase the number of female gynecologist/obstetricians.
- Facilitate referrals from midwives to doctors and from doctors to midwives.
- Train medical personnel in ethno-obstetric practice, benefits and rationales and "humanize" hospital care in obstetrics encouraging alternative birthing techniques and family participation.
- Facilitate transportation between communities and hospitals and enable and encourage midwives to accompany the women to the hospital throughout the medical consultation or during the clinic stay, and then bring her back home.

ENDNOTES:

[1] In Holland, for example, home births are very common. See *Medical Anthropology Quarterly*. Vol. 10, No. 2, June 1996.

[2] Cadenas Gordillo, Barbara & Leticia Pons Bonals. *Las Parteras: influence de su saber en las relaciones de poder al interior de la comunidad indígena.* San Cristóbal de Las Casas. Marzo de 1992. p. 15. (Translation: Namino M. Glantz.)

[3] Sesia, Paola M. "Women come here on their own when they need to: Prenatal care, authoritative knowledge, and maternal health in Oaxaca." In *Medical Anthropology Quarterly*. Vol 10, No. 2, June 1996. pp. 122-123.

[4] Jackson & Bailes, Ibid.

[5] Oakley 1978:18 as cited by: Lindenbaum, Shirley & Margaret Lock, Eds. *Knowledge, Power & Practice. The Anthropology of Medicine and Everyday Life.* University of California Press. Berkeley, 1993. p. 10.

[6] Economic accessibility is cited as a principal reason for the choice of TBAs over medical personnel in: Castañeda Camey, Xochitl, et. al. "Traditional birth attendants in Mexico: Advantages and inadequacies of care for normal deliveries." In *Soc. Sci.*

Med., Vol. 43, No. 2, pp. 199-207, 1996, and in The Center for Health Research, Consultation and Education (CIAES) MotherCare Project. *Qualitative Research on Knowledge, Attitudes, and Practices Related to Women's Reproductive Health*, Cochabamba, Bolivia. Working Paper No. 9. July, 1991, p. 20.

[7] *Partera* is Spanish for *midwife*.

[8] Sakala, Carol. "Midwifery care and out-of-hospital birth settings: How do they reduce unnecessary cesarean section births?" In *Soc. Sci. Med.*, Vol. 37, No. 10., pp. 1233-1250, 1993.

[9] Sakala, Carol. "Midwifery care and out-of-hospital birth settings: How do they reduce unnecessary cesarean section births?" In *Soc. Sci. Med.*, Vol. 37, No. 10., pp. 1233-1250, 1993.

[10] Cordero Fiedler, Deborah. "Authoritative knowledge and birth territories in contemporary Japan" In *Medical Anthropology Quarterly*. Vol 10, No. 2, June 1996. p. 195.

[11] Jackson, Marsha E. and Alice J. Bailes. *Home birth with certified nurse-midwife attendants in the United States: An overview.* In Journal of Nurse-Midwifery, Vol. 40, No. 6, pp. 493-502, 1995.

[12] Powell Kennedy, Holly. "The essence of nurse-midwifery care: The woman's story." In *Journal of Nurse-Midwifery*, Vol. 40, No. 5, pp. 410-417, 1995.

[13] Davis-Floyd, Robbie & Carolyn Sargent. "Introduction". In *Medical Anthropology Quarterly*. Vol 10, No. 2, June 1996, p. 111, 114.