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Esta Con La Partera: A Qualitative Feminist Perspective of Women's Birthing Experiences in El Paso Texas

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ESTA CON LA PARTERA: A QUALITATIVE FEMINIST PERSPECTIVE OF WOMEN'S
BIRTHING EXPERIENCES IN EL PASO TEXAS

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Dedication

To all the women who have birthed & to all the women who someday will -
and to the midwives, thank you.

ESTA CON LA PARTERA: A QUALITATIVE FEMINIST PERSPECTIVE OF WOMEN'S
BIRTHING EXPERIENCES IN EL PASO TEXAS

by

ANESSA ANCHONDO-RIVERA, B.A.

THESIS

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day is a blessing to be with you in this world. To my husband Rick, team work to make the dream work! Thank you for being my rock, for sharing this life with me and walking down this path. I love you forever.

Abstract

The state of pregnancy is a political one, where women act within and from the social structures that can influence life choices. Through in-depth interviews, this qualitative study examines the choices of six women who birthed at the only birthing center in El Paso County, El Paso Texas. This research uses feminist standpoint theory and life course approach theory to examine how these six women interviewed negotiated their decision-making processes during their pregnancy and birth. Through the use of visual sociology, the research also uses the documentary *Catching Babies* as a secondary source to examine the services of Maternidad La Luz. This research provides a brief history of midwifery and obstetrics, the laws surrounding the practice of midwifery in the State of Texas, and research that shows the safety of midwifery assisted birth. This thesis takes a feminist stance that argues that women's experiences in birth are subjective simply because men cannot experience birth and thus their understanding of birth is created from an outsider and objective standpoint. Nonetheless, women's experiences in birth are an important for contributing to medical sociology and feminists' perspectives of women's birthing choices within a broader reproductive justice narrative. The experiences of the six women interviewed offer personal insights into how women feel about their experience, and of broader social structures that influenced their birthing choices. This research shows that for these women interviewed, birthing with a midwife at a birthing center offered them agency and power in their pregnancy and birth processes as well as higher satisfaction of care.

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Chapter 1: Introduction to the Study

1.1 Introduction

The choices a woman makes concerning her reproductive health are shaped vis-à-vis the social, cultural, and political world around her (Rich, 1986; Lorber 1997; Ehrenreich & English, 2010; Begley, et al., 2007; Foucault, 1979). Currently in the United States, women strive towards full reproductive agency and rights over their personal bodies. Full reproductive agency and rights over personal bodies includes access to comprehensive sex education, the unburdened access to abortion services, complete and adequate maternal health care services where women are the primary actor in her birth experience (Solinger, n.d.; Hessini, Hays, Turner, Packer, n.d.). As the Asian Communities for Reproductive Justice state,

“We believe reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our bodies sexuality and reproduction for ourselves, our families and our communities in all areas of our lives” (Asian Communities for Reproductive Justice, 2005).

The struggle for reproductive justice is particularly significant as women’s access to abortion is under attack on various levels of the nation-state. Most recently, in the case of *Whole Woman’s Health v. Hellerstedt* (2016) women’s access to abortion clinics is currently being revisited by the Supreme Court of the United States. In this case, the Supreme Court of the United States are going to decide whether or not Texas is placing an undue burden by enacting a law that will close 75% of clinics that serve women and their reproductive needs (Supreme Court of The United States Blog, 2016). Thus, women’s reproductive health rights include the decision to choose to have children or to not have children, as well as to choose where to birth one’s children.

Prior to making decisions about the birthing process, women's body are politicized through legislation; the figurative body of the woman has a long history of violence, neglect, oppression, and misconception associated with it (Foucault, 1979; Douglas, 1982; Bartky, 1990). Women's bodies have been historically politicized given their role in birthing citizens, as such, much is at stake in nation states and bureaucratic efforts to mediate and control the birthing process are in place. As social and political agents of their bodies, women also act within and from the social customs, traditions, laws and policies set forth by her culture and society at large (Douglas, 1982; Bartky, 1990). The body that births nations - either with freedom or through oppression - is a political body. Decisions and choices made in relation to prenatal care and birth are shaped by the social, cultural and political world (Davis-Floyd, 1992). The certification and the validation of the birthing process is thus no longer only in the hands of women, but also in the hands of the nation state apparatus.

Pregnancy is a political state of being, as a woman's¹ body is a landscape of rules and polices, customs and traditions varied by societies and between cultures (Douglas, 1982; Bartky, 1990; Selin, 2009). Pregnancy is situated knowledge, and as Haraway (1988) explains, situated knowledge requires that people be actors and agents in their authorship of unique objective knowledge (Haraway, 1988). "Birth everywhere is socially marked and shaped" (Jordan, 1997). In other words, women make decisions in response to the limitations within their social, cultural, and political world, and if she isn't exposed to certain ideas, or if some procedures or medical

¹ In this thesis, the terms woman/women/female/she/her are used, though it is recognized that trans men and non-binary people do in fact become pregnant and give birth. Because the participants identified as women and because the literature used in this thesis use the terms woman/women/female, this thesis uses those terms also so as to not create confusion.

professionals are not available to her because of laws, then she makes her choices within those limitations. As Bogdan (1990) explains:

“Women’s attitudes toward and behavior during birth are shaped and conditioned by the demands and expectations of family, peers, community, and often religion. What a woman expects from her childbirth experience, what she will do, what she will fear and not fear, how she will interpret what is happening to her, and what in fact *will* happen when she gives birth, depend in large measure upon how her society defines what birth should be and where she fits in the various hierarchies and value systems of that society” (p. 102-103).

This study explores ways in which the attitudes and behaviors of the birthing woman are shaped and conditioned by the demands and expectations of women’s family, peers, community, religion, and surrounding culture. One of the major decisions women and their partners must make is where to give birth to their children. Decisions influencing where to birth are mediated by cost and affordability, access, knowledge, and support (Miller & Shriver, 2012). Pregnancy and childbirth involve complex decision-making process. The experiences of the women in this study provide insight into how complex decisions about birthing choices are made in relation to one’s position in the world. Frost and Elichaooff argue that “women draw on cultural, historical, political, and personal constructs to make sense of themselves and their relations to the world they inhabit” (Frost & Elichaooff, 2014 p. 47). This research looks at how the participant’s draw on constructs in their personal lives and chose to birth at Maternidad La Luz.

Birthing involves choice and part of that choice is the ability to choose where to facilitate the process of birthing. This research examines women who chose to birth at a birthing center. While it may be assumed that birthing centers are not as safe as hospitals, studies show that birthing centers are safe places to birth. Several studies of birthing centers have demonstrated the safety of midwifery-led births performed at birthing centers. The most current research by Stapleton, Osborne, Illuzzi (2012) of a longitudinal study of 79 midwifery-led birth centers from

2007-2010 had zero maternal deaths, a 6% cesarean birth rate, and a fetal and neonatal mortality rate that is consistent with births among low-risk women in previous studies that also included hospital settings (Stapleton, Osborne, Illuzzi, 2012). This research by Stapleton et al., (2012) shows the safety of birthing at a birthing center with a midwife. Women express agency over their bodies during labor and delivery by seeking care from birthing centers as powerful spaces that encourage and guide women through the birthing process. Within birthing centers, midwives attend to women using the midwifery model of care which places the needs of the patient at the center. I will discuss the midwifery model of care and the safety of birthing centers in greater detail in another chapter of this study

The role of a *partera*, or midwife, is to guide women through her birthing journey with the least amount of bio-medical technological interventions as possible (Barnawi, Richter, Habib, 2013). Midwives accompany women through the journey of pregnancy and birth, providing encouragement, and comfort, in addition to safe medical care. This guidance helps to ease the uncertainty and fear associated with birth. When the uncertainty and fear is eased, women can open up both emotionally and physiologically, thus progressing their birth. Although birthing with midwives has been historically accepted in the U.S. and throughout other cultures, in the U.S. Midwifery-led birth has become an act outside of the accepted social norm.

This thesis explores the experiences of six women - four self-identified as Mexican American, one self-identified as Native American-Mexica Chicana, and one self-identified as white/Caucasian, who have birthed at Maternidad La Luz, one of the only birthing centers with midwives in El Paso County, El Paso Texas and the most highly valued midwifery school in the United States (Rooks, 1997). In addition to the interviews, through the use of visual sociology I reviewed the documentary *Catching Babies*. *Catching Babies* is a 2011 film about Maternidad

La Luz that features midwives, clients, and all the different services provided by the clinic. Through the use of visual sociology, I used the documentary as a tool to compliment my research. Guided by feminist research methodology, feminist standpoint theory and by a life course theory approach, this thesis examines several factors related to women's decisions about where, how and [with whom] to birth.

Feminist standpoint theory comes from feminist epistemology and is defined as “knowledge that reflects the particular perspectives of the subject or situated knower” (Anderson, 2000). Feminist standpoint theory according to Harding (1987) and Smith (1987) is crucial when examining systemic oppression in societies where a woman's knowledge is not valued. Feminist standpoint centers the experiences of women and it is crucial when examining systemic oppression in societies where a woman's knowledge is not valued. This work addresses both the cognitive/decision making process and the emotional responses the women in this study provided about their birthing choices and experiences. This thesis offers future policy implications that can help re-center birthing towards a women-centered care model, thus helping to shift how we view birthing locally in El Paso and in the broader nation-state. Understanding women's birthing choices is also important for those in the medical community who seek to provide better care. Statistics of childbirth in any given community do not provide a full account of the issue. Examining pre-natal practices, labor and delivery practices from the personal standpoint provides a more holistic account. This study aims to create a space for readers to learn from the birthing stories of six women in El Paso who discussed what mattered most during their labor and deliver and what they considered to be the most important factors contributing to their choices to birth at a midwifery center rather than at a hospital. The research participants'

experiences describe how they navigated their care in relation to social factors influencing their agency.

Guiding Research Questions

Through the use of qualitative interviews, I interviewed the women about their birthing experience at Maternidad La Luz in El Paso, Texas. The qualitative elements of this study is grounded in the following research questions:

O1: What factors influenced women's decisions to birth at Maternidad La Luz?

O2: What were women's experiences during labor and delivery at Maternidad la Luz?

O3: What post partum reflections did women in this study have about birthing at Maternidad La Luz?

After completing the qualitative interviews of each woman, each interview was then transcribed and analyzed the interviews through a grounded research approach that led to the identification of several emerging themes. In seeking to address the first research question, in this work, I found that women in this study identified the importance of familial support, past birthing experiences, and the affordability of health care as influential reasons for choosing Maternidad La Luz. For the second Objective, the analysis of women's experiences during labor and delivery at Maternidad La Luz, I found that women referred to embodied knowledge in knowing when to trust themselves during labor and delivery and being respected to trust themselves, and having a sense of agency in deciding where to birth their children as significant factors that helped shaped the experience in labor and delivery. For the third Objective, what post partum reflections did women in this study have about birthing at Maternidad La Luz, the research participants overall had positive experiences birthing at Maternidad La Luz, due in great part to the midwifery model of care that Maternidad La Luz practices.

This qualitative analysis contributes to the fields of medical anthropology and sociology, women and gender studies, and reproductive health justice by exploring decision-making in their birthing process. This study also considers the roles that women's familial and social networks play in the women's decision-making process. This study contributes to broader issues of reproductive justice through a focus on midwifery led birth as I examine how women feel about their experience birthing at the only birthing center in El Paso County, El Paso Texas. Thus, this study contributes to what Haraway (1988) refers to as situational knowledge of women's narratives as testimonies of their agency in the birthing process that alters the ways women are viewed as passive consumers of care in a western medical framework. This also contributes to a body of work focused on women's birthing narratives as a feminist practice.

1.2 Birth as Experience

Giving birth is one of the most profound experiences, physically and emotionally, that a woman's body can undergo. Having a positive birthing experience can lead to numerous benefits (Larkin, et al, 2007; Beech & Phipps, 2004) such as self-affirmation, self-realization (Murphy-Lawless, 1998), and maternal psychological well-being (Bailham & Joseph, 2003). Negative birth experiences may define or alter future pregnancies affecting women's reproductive decisions (Waldenstrom, et al., 2004). In addition, women in the birthing process who express feeling empowered indicate they have an increased ability to feel control, to have strength in their bodies, feel a greater sense of satisfaction and reassurance, and have greater pain management (Nilsson, Thorsell, Wahn, Ekstrom, 2013). These feelings of empowerment among women in the birthing process are linked to trusting relationships developed between women and their healthcare providers, while inadequate support could lead to a negative birth experience involving feelings of neglect, abandonment and not feeling prioritized (Nilsson et al., 2013).

Perceptions shape the childbirth experience. Perceptions about childbirth affect views on labor, obstetric complications, interventions, and birth (Stoll & Hall, 2013). Women who have a low fear of birth view birth as a natural and normal event, while women with high fear of birth view birth as painful and as a frightening ordeal (Stoll & Hall, 2013). How women view and perceive the birthing process affects their own birthing process and any future births they may have. High fear can lead to tearing, higher use of pain medication, and cesareans (Stoll & Hall, 2013). Therefore, having a low fear view of birth can lead to better outcomes. Midwives using the midwifery model of care work to reduce the perceptions of fear and pain all through out the pregnancy in preparation for the birth.

1.2.1 Cross-cultural Perspectives on Birthing

Cultures and societies all over the world have different traditions, rituals, customs, and rules surrounding the birthing process (Jordan, 1997; Davis-Floyd & Sargent, 1997; Mead & Newton, 1967). As Patrisia Gonzales explains in *Red Medicine* (2012), Indigenous-rooted people, Mexican-American Chicanos are asserting their cultural knowledge in traditions practiced by their ancestors. For example, some indigenous cultures in the Americas practice cord burning, where the umbilical cord is not cut with a knife or scissors, but rather burned off using two candles (Gonzales, 2012), a practice performed by many who are reclaiming cultural knowledge. In some cultures, it is appropriate for mothers to consume a placenta or bury the placenta such as the Mixtec of Oaxaca as part of a tradition or ritual (Gonzales, 2012), practices that are embraced and promoted among the midwifery community. Some cultures practice a post-partum resting period lasting anywhere from 10 to 40 days, known as *la cuarentena* in Mexico and among Mexican origin populations in the United States (Gonzales, 2012; Selin, 2009). During this resting period, women are expected to stay away from heavy housework to

spend quality time with their infant while developing a bonding relationship. During this time, breastfeeding is highly encouraged while sexual relations are put on hold (Nunez-Mchiri, 2015 personal communication). This resting period is crucial for both the woman and the newborn baby. The resting period allows for healing from the physical and emotional toll that is labor and delivery.

1.2.2 Birthing in The United States

In the United States, birthing has become a somewhat homogenous experience. In the United States, women are predominately expected to see an obstetrician for prenatal health care throughout the 9 months of gestation, labor and deliver vaginally or via cesarean section, with the use of anesthesia in a hospital, and do follow up visits with the obstetrician (Miller, 2005; Bogdan, 1990). More often than not, women who birth in a hospital do so because they have state subsidized or private insurance. The uninsured cost of birthing in a hospital can cost between \$14,000-\$30,000 depending on the type of birth, in what state/county the birth occurred, and whether or not anesthesia was used (Childbirth Connection, 2014). It is not common for someone to pay out of pocket for a hospital birth, although county hospitals do provide payment arrangements for women who have no choice but to pay out of pocket.

Women in the United States experience barriers to quality maternity care due to a lack of insurance and money to pay out of pocket for services ranging from hospital care, prenatal care, private doctor, doula, and/or midwife (van Teijlingen et al., 2009). One of the results of quality of maternity care issues in the U.S. involves women facing greater mortality and neonatal mortality risks due to socio-economic inequality due to uneven wealth distribution compared to women all over the world (van Teijlingen et al., 2009; United Nations, 2015). Furthermore, there are racial and socioeconomic disparities in the inequality of prenatal and postpartum care for

African Americans and Hispanics born in the United States, and low-income people (Roth & Henley, 2012, p. 208). In general, racial and ethnic minorities and low-income people have less access to health care. Low socioeconomic status is linked to bad health and a higher mortality rate, and income is the highest indicator of health care access (Roth & Henley, 2012, 2008; Teijlingen et al., 2009).

Changes in Birthing Methods in The United States in the Last 100 Years

Birthing methods that were once considered traditional are now viewed as alternative (Ehrenreich & English, 2010). In the past, traditional birthing involved women giving birth at home with the help of midwives. Over time, this tradition has been replaced through the institutionalization of birthing in medical clinics and hospitals, or as Robbie Davis-Floyd calls it a technocratic birth (Davis-Floyd, 1995). The concept of the current birth trends as traditional is quite new - a trend gaining popularity barely 100 years ago (Bogdan, 1990). Birth that is now considered alternative (as described above) is how women have birthed since history documented, and how many women continue to birth around the world (Ehrenreich & English, 2010). Over time, women have chosen not to birth in the technocratic way as described above, instead have chosen to birth in what is referred to as an “alternative” way through a midwife either at home or with a midwife at a birthing center.

Navigating Choices of Care: Women’s Agency in Birthing

Pregnancy is a period of time in a woman’s life where there are multiple decisions to make in regards to the new life developing within her. Decisions and choices can be overwhelming and confusing. Decisions such as whether to breastfeed or formula feed, or to use disposables over cloth diapers can cause anxiety. Choosing where and how and with whom to birth adds to the decision making process in pregnancy. For some women, choosing an

obstetrician physician is an easy decision. For other women who want something different, the alternative can add additional stressors.

Factors influencing where women will give birth involves a number of factors. Women, more importantly Mexican-American women, deal with a considerable amount of stressors such as a lack of insurance, financial instability, and discrimination, during pregnancy (Flores et al., 2008; Hamilton et al., 2006; Ramirez & de la Cruz, 2002). Choosing to birth outside the traditional system can leave a woman open to a myriad of questions by family and friends that in turn can cast doubts about whether or not her decision to birth with a midwife at home or at a birthing center is safe, even though research and studies have shown that it is safe to birth with a midwife at home or at a birthing center if the pregnancy is low-risk (Stapleton et al., 2013; MacDorman & Singh, 1998). When coupled with familial/social/cultural expectations and financial instability, or lack of monetary resources, making choices and negotiating prenatal health care can be complicated and stressful.

Pregnant women are far from simply being passive actors in their birthing choices, rather, they are actively trying to navigate many aspects of their pregnancies, the best way they can, with the resources that are available to them. Ultimately, having options, having the ability to *choose* is what is most crucial. Women make decisions about pregnancy health-care based on risk and safety, and “women in different societies act in ways that they believe will maximize safety and minimize risk in childbirth, but these actions occur within a broader structural and cultural context” (Miller & Shriver, 2012, p. 710). Exercising agency is important because it is a part of the decision making process; nonetheless these choices are constrained by larger social structures such as the medical industry, laws, regulations, and so on (Miller & Shriver, 2012). Historically women have been excluded from opportunities such as higher education, obtaining

medical licenses, from researching female health and body, and have been treated as second-class people (Lorber, 1997; Ehrenreich & English, 2010; Bogdan, 1990; Harding, 1991). Women want to be able to exercise choice- to choose to have a child, to choose which type of medical professional will assist in delivering their child, to choose where to birth, how to birth, what to do during birth, and how to celebrate the birth. These are all choices women desire to make or choices *not* to make.

“How have women given birth, who has helped them, and how, and why? These are not simply questions of the history of midwifery and obstetrics: they are political questions” (Rich, 1986, p.128).

1.2.3 Birthing in El Paso County, El Paso Texas

In El Paso, there are a few options of where a woman can birth. The city of El Paso has five private hospitals², one military hospital, Texas Tech Medical School in connection with the county hospital University Medical Center, all serving a population of 833,487³. If a woman has private insurance or Medicaid she can birth at a private hospital, or at the county hospital University Medical Center (UMC); if she is a military officer or a member of a military family, she can birth at William Beaumont Army Medical Center as well⁴. UMC in partnership with Texas Tech University provides women with access to Certified Nurse Midwives (CNM) for low risk births. This re-introduced service allows women to birth with a CNM in a hospital setting. Other than UMC, Maternidad La Luz is the only other formal place where women can birth with a staff of midwives in a woman centered care approach. Pregnant women in El Paso have other options for alternative birthing and can hire private midwives to deliver at home, and often these midwives travel throughout the metropolitan area to assist women in birth.

² Private hospitals, Sierra Providence Health Network has 3 hospitals, Del Sol Las Palmas have 2 hospitals.

³ United States Census Data 2014 for El Paso County.

⁴ William Beaumont Army Medical Center does have a joint obstetrics, gynecology, and midwifery services program available to active military personnel and family.

It is important to understand the demographics of women in El Paso County. Women comprise of 51% of the total population in El Paso, Texas according to 2012 Census Bureau data (Census Bureau, 2012). In El Paso, 62.9% of employed people have insurance, though 6.6% rely on public coverage, and 37.1% have zero health coverage (Census Bureau, 2012). Of those unemployed, 62.7% of have no health insurance, while 14.3 have public coverage, and 26.1 have private health insurance (Census Bureau, 2012). Of female householders with no husband present, 37.2% live below the poverty level, with 47.4% with children under 18 years of age and 44.5% with children under 5 years of age (Census Bureau, 2012). Females with no husband present householders present the largest group who live below the poverty level in El Paso Texas. High poverty and low insurance coverage affects decision making processes. Women in El Paso who live below the poverty level as head of household with no husband present have limited options when it comes to making health care decisions. Limited options such as inability to make time for doctor appointments, or the ability to be able to afford health care services can hinder a woman's agency and choice options.

1.3 “The Harvard of Midwifery School⁵” Maternidad La Luz

Maternidad La Luz is a community-based birthing center that also serves as a midwifery school. Maternidad La Luz opened its doors to the community in 1987 and has attended over 13,000 births since then (Maternidad La Luz, 2012). From the outside, Maternidad La Luz looks like a home, the trim colored in a warm peach with white walls. A short set of stairs leads to the peach colored front door. A large sign hangs from the banister and it reads “Maternidad La Luz Parteras Tituladas MIDWIVES The Birth Place.” A cheery sun on the left side of the front door greets visitors, and underneath the windows sit benches for resting. The rooms inside

⁵ A term coined by participant Carla.

Maternidad La Luz are clean, simple, and modest, with figures that depict birthing women adding to the decorations. The clinic is a building that was once a home, as are many businesses in El Paso downtown South El Paso area. Historically, women have birthed in their home, or at the home of their partera. Maternidad La Luz connects women back to that long history of birthing in a “home.”

Maternidad La Luz is the only Midwifery Education and Accreditation Council accredited school that provides all necessary clinical and academic requirements on-site for the North American Registry of Midwives (NARM) Certified Professional Midwife credential (CPM) (Maternidad La Luz, 2012). Furthermore, their academic programs are based from the Midwives Alliance North America (MANA) Core Competencies and the clinical programs are based from the Texas standards and North American Registry of Midwives (NARM) requirements (Maternidad La Luz, 2012).

The certification and oversight of the midwifery process is critical for helping to validate birth centers as safe and reliable places to birth. Two major organizations have played a critical role in the education of midwives in the U.S. The North American Registry of Midwives (NARM) is an organization whose mission is to provide a process to evaluate the routes to midwifery education and training and support the best practices for the diverse independent midwifery community, while providing a way to publish and distribute certification and examination materials (North America Registry of Midwives [NARM], 2015). Midwives Alliance of North America (MANA) is a professional midwifery organization. Established in 1982, MANA strives to promote “excellence in midwifery practice, endorses diversity in educational backgrounds and practice styles, and is dedicated to unifying and strengthening the profession, thereby increasing access to quality health care and improving outcomes for women, babies, families, and communities” (Midwife Alliance North America [MANA], 2015). MANA is committed to “promoting an evidence-based midwifery model of care, addressing health

disparities, and achieving optimal outcomes through normal physiologic birth and healthcare across the lifespan” (MANA, 2015). The standards and qualifications for MANA are quite extensive, ensuring the highest evidence-based information available so that the best care can be given to the woman and her newborn. Maternidad La Luz follows guidelines developed by MANA, including the midwifery model of care.

1.3.1 Midwifery Model of Care

The Midwives Model of Care is a different type of care than that of contemporary obstetrics (MANA, 2015). This model of care is described as being nurturing, hands-on care prenatal, during birth, and postnatal; trusting care that is built with the client that results in a caring supportive labor and delivery (MANA, 2015). The Midwifery Model of Care is extensive, and is time intensive, however this model ensures that women and newborns receive care that is culturally relevant, family centered, and fully supportive (MANA, 2015) during the momentous journey that is pregnancy and birth. This model of care functions on the premise that pregnancy is not pathology (illness), but rather, pregnancy is a natural process that the body undergoes.

1.3.2 Payment Arrangements

Maternidad La Luz does not accept Texas Medicaid or private insurance. Women seeking services must pay out of pocket and the cost depends on several factors. If paid in full upfront, the cost is \$650, however a payment system can be arranged where women are asked to put a \$200 deposit down to pay in full the total amount of \$795.00 by the 36th week (Maternidad La Luz, 2012). If a woman happens to come to the clinic while in labor, having never visited before, the cost is \$995 (Maternidad La Luz, 2012). Maternidad La Luz does offer a refund policy if the woman is transported to a hospital before the baby is born and does not deliver at Maternidad La Luz, or if for some other reason, the woman does not birth at the clinic. The refund policy still charges for prenatal care received at the clinic. The registration and initial

appointment fee of \$400, and the \$45 prenatal appointment and labor check fee are non-refundable as well (Maternidad La Luz, 2012). The clinic also has a \$150 facility fee that is charged once a client is admitted for labor, and this fee is also non-refundable (Maternidad La Luz, 2012). If the client and baby are transferred to a hospital postpartum none of the fees are refundable at that point, however, Maternidad La Luz will still see the client and baby for postpartum appointments for no additional fee (Maternidad La Luz, 2012).

1.3.3 Services Provided

For the cost of birthing at Maternidad La Luz, the following are services covered under the total amount: initial appointment fee; prenatal appointments; laboratory tests such as blood work, pap smear, gonorrhea and chlamydia testing, plasma glucose test; nutritional counseling; childbirth education; labor and birth, including water birth and vaginal birth after cesarean (VBAC); immediate postpartum care; postpartum appointments; and preparation of birth certificate if baby is born at the clinic (Maternidad La Luz, 2012). Services not covered include: additional laboratory fees; any consultation with a physician; hospital costs; ambulance costs; pediatrician costs; sonograms (Maternidad La Luz, 2012). However, there are services that may be needed, they are at an additional cost to the total fee, and these services are: suturing which costs between \$50-\$100; RhoGAM which costs \$200; baby cord blood sample if the client is Rh negative which costs \$75; and IV therapy which costs \$50 (Maternidad La Luz, 2012). Maternidad La Luz serves the El Paso and Ciudad Juarez community and acknowledges that 95% of the women who chose to birth at Maternidad La Luz predominately speak Spanish (Maternidad La Luz, 2012). Maternidad La Luz strives to provide affordable, high quality maternity care to pregnant women regardless of their nationality or residency status (Maternidad La Luz, 2012). Maternidad La Luz is essential to the El Paso community because it is the only

birthing center available that provides woman centered care with a holistic approach at an affordable price. Compared to the cost of birthing in a hospital, the cost of birthing at Maternidad La Luz is much more affordable option.

1.3.4 Different Types of Midwives: The Professionalization of a Traditional Profession

There are two levels of midwives, professional and traditional. Professional midwives are those who are certified on various levels within the field. These levels are Certified Professional Midwives (CPM), Certified Nurse-Midwives (CNM), Certified Midwives (CM), and Direct-Entry Midwives (DEM) (MANA, 2014). Certified Professional Midwives receive accreditation through the North American Registry of Midwives and is the only credential in midwifery that requires knowledge and experience within the hospital and outside of the hospital setting (MANA, 2014). Certified Nurse-Midwives and Certified Midwives both receive their accreditation through the American College of Nurse-Midwives (MANA, 2014). A Direct-Entry Midwife is an independent practitioner who is educated through self-study, apprenticeship, a midwifery school, a college, or university-based program separate from nursing, and Licensed Midwives (LM) and Registered Midwives (RM) are DEMs (MANA, 2014). Traditional midwives are persons who chose to not become certified. In the state of Texas, a person may not practice midwifery unless the person obtains a license to practice midwifery. Faculty midwives at MLL are CPM licensed midwives (Maternidad La Luz, 2015). Certification legitimizes the profession of midwifery. Certification can also build trust between patients and midwives because certification establishes that midwives are knowledgeable about their profession and practice.

In El Paso, Maternidad La Luz provides affordable services for women who otherwise might not be able to birth with a midwife. Using the midwifery model of care, Maternidad La

Luz provides services for women who want a natural vaginal birth. This introduction of Maternidad La Luz serves as a backdrop and setting to contextualize the experiences of the participants in this thesis. Understanding the cost and services, provide insight to why someone would choose Maternidad La Luz. In the next chapter I will discuss the history of the midwifery and obstetrics, and I will review the literature associated with this research.

1.3.5 La Partera

In Mexican and indigenous-rooted communities within Mexico and in The United States as well, midwives are known as *parteras*. Parteras are lifelines to medicine and health care in rural areas and within predominately indigenous communities (Gonzales, 2012). Parteras are not simply caregivers, but rather, they become part of the family they assist, and sometimes, newborn babies are named after the beloved partera (Gonzales, 2012). Parteras offer guidance during pregnancy, support during labor and delivery, and post partum the partera is there to aid the woman during her rest-in period following birth (Gonzales, 2012). The partera have historically been considered lay/traditional/community midwives (MANA, 2015), women who lack the institutional education or certification to attend births, though a licensed midwife (who is not lay/traditional) can be/is referred to as a partera within Mexican and indigenous communities (Gonzales, 2012; MANA, 2015).

1.4 Organization of Thesis

Chapter 1 briefly discuss the framework for this thesis, and I introduce and describe the location where the women gave birth through the help and support of midwives at Maternidad La Luz in El Paso, Texas. Chapter 2 discusses the current state of maternal health in the United States and the history of midwifery and obstetrics more broadly. It is important to discuss the history of midwifery and the birth of obstetrics in order to understand how laws, and the history

of midwifery and obstetrics shapes the decision making processes for women and their birth choices. Chapter 2 also covers details the conceptual definitions of birth and midwifery, research on midwifery in the United States, social assumptions about the safety of birthing centers with midwives, as well as as well as issues in maternity care. Here, I introduce the theoretical frameworks of life course approach concept and feminist standpoint theory. Chapter 3 presents the methods, research and portion of the thesis. In addition to birthing narratives this work includes a critical analysis of a documentary titled *Catching Babies* (2011), which focuses on other women's experiences at Maternidad La Luz to further complement my own data collection. Through a visual Sociological analysis, I examine the significance of midwifery centers as birthing spaces for future midwives as medical practitioners and as training/educational/transformational spaces that help reproduce alternative providers of care. Chapter 4 discusses data analysis the results and findings of the research conducted. Chapter 5 is the discussion and conclusion portion of this thesis.

Chapter 2: History, Review of Related Literature and Theoretical Framework

2.1 Women's Health Paradigms and Ideologies

The institution of medicine and research in health, stem from patriarchal ideologies; the objective stance in medicine and health research hides and sometimes rejects patient's subjective experiences. It does this because it functions from a framework that excludes the lived experience as part of the health paradigm, and women's subjectivity is a deviation from the scientific paradigm in medicine. One's social position of privilege is determined by the intersectionality that constructs an individual. Women are "excluded" from the health paradigm because their health issues are treated as pathology (Lorber, 1997). Social divisions occur based on gender, race and socio-economic class. Women of color experience divisions that are 3-fold or more. Women of color have been historically "excluded" from the health paradigm (Fraser, 1998), and poor women have been "excluded" from the health paradigm within the United States at large because it focuses on the patient's ability to afford insurance (van Teijlingen et al., 2009). Exclusion is oppressive; it denies access and it creates barriers. "Unintentional" exclusion of women's voices and agency in birthing choices is oppressive because it denies that there is even an issue to research, uncover, and discuss. This happens in hegemonic paradigms where whiteness, being male, and heteronormativity, are the standard. Women are more likely to be poor and economically and socially powerless, therefore, "women's health cannot be divorced from international political and economic structures" (Lorber, 1997, p. 101). The literature review in this thesis focuses on elements in the prenatal care and birthing process that contributes to negative or positive perceptions of experience in childbirth. How a woman feels about her labor process and experience can in turn affect her "maternal role attainment" and her self-conception (Larkin et al., 2007; Callister, 1993). The literature also reflects the descriptions of the birthing experience of participants in this research.

Currently in the United States, women are still working towards reproductive agency and rights over personal bodies. “Gender is thus one of the most significant factors in the transformation of physical bodies into social bodies” (Lorber, 1997, p. 3), this is especially true in when it comes to women’s reproductive health care. Women’s bodies are viewed as social bodies, available to objectify, ridicule, for titillation, speculation, and patriarchal protection. Women’s bodies are a *gendered* body – a highly regulated body vis-à-vis legislation. As feminist essayist Adrienne Rich (1986) notes in her book *Of Woman Born: Motherhood as Experience and Institution*

“The woman awaiting her period, or the onset of labor, the woman laying on a table undergoing abortion or pushing her baby out, the woman inserting a diaphragm or swallowing her daily pill, is doing these things under the influence of centuries of imprinting. Her choices - when she has any – are made, or outlawed within the context of laws and professional codes, religious sanctions and ethnic traditions, from whose creation women have been historically excluded” (p.128).

It is important to now briefly review the history of midwifery in the United States in order to clearly understand why the current practices and restrictions exist.

2.2 Brief History of Midwifery⁶

“In reading the history of childbirth, we have to ‘read between the lines’ of histories of obstetrics by contemporary medical men; we can also examine the passionate debate-by-pamphlet that went on between those who opposed and those who argued for the female midwife. But it is important to remember that the writers were by no means disinterested, that they were engaged in both a rhetorical and a political battle – and that the one group whose opinions and documentation we long to have – the mothers- are, as usual, almost entirely unheard-from” (Rich, 1986, p.130).

Women have assisted women in childbirth since the beginning of documented history (Rooks, 1997). In every culture throughout history, women have guided women during pregnancy, and during labor and delivery, using techniques to lessen pain, to change the

⁶ The word *midwife* is “derived from *mid* which means “with” and *wif*, which means “wife” or woman. The term was used as early as 1303” (Rooks, 1997, p. 3).

presentation of the baby, herbs to aid in the process and so on (Gonzales, 2012; Ehrenreich & English, 2010). It is important to discuss the history of midwifery, woman centered care, medical education, and obstetrics, in order to understand the process today. Biases, exclusion, and misconceptions have shaped the birthing process within the United States. Birthing with a midwife (or female attendant) was the way birthing traditionally happened, “for centuries the art of midwifery was the exclusive province of women (Donegan, 1978, p. 9). Now birthing with a midwife is considered an alternative form of birthing, while hospital births are considered the traditional way to give birth. Furthermore, while midwives consider a birth without the use of anesthesia to be a natural birth, an obstetrician physician may consider a vaginal birth, with the use of anesthesia, to be a natural birth. This is just one small example of the disconnection between midwifery practices and obstetrician practices in birth.

The Enlightenment period in 16th century France sought to understand the natural world, childbirth included (Bogdan, 1990). As the development and use of hospitals began to grow, women were willing to participate in order to receive care (Bogdan, 1990). What physicians knew at the time about female reproductive anatomy was restricted to what was derived from human and animal autopsies (Bogdan, 1990). Having women in hospitals allowed physicians to learn more about the female reproductive anatomy, though physicians were limited by the codes of morality during this period of time (Bogdan, 1990).

In the 17th century Europe, surgery was the last option and only used in extreme cases where the labor and/or delivery were stalled or abnormal. Women attended to women during childbirth at home, and through this practice of attending the labor and delivery of other women in their communities, women learned about the occurrences of childbirth (Bogdan, 1990). During this period within Colonial America, women were married by the time they were 21

years old, and they would immediately start the reproductive cycle of conception, pregnancy, birth, nursing, weaning and then conception again; continuous cycles that lasted for up to 25 years (Bogdan, 1990). Childbirth and pregnancy were a part of everyday life so much that it steered the activities of women, affecting her travel, gardening, harvest, and so on (Bogdan, 1990).

It was during the 18th century when women became more literate and began to write more about their daily lives and domestic responsibilities which included childbirth (Bogdan, 1990). These writings helped researchers better understand how the 18th century woman viewed the world and their social position in their world, however by the mid 18th century, female expertise was questioned (Bogdan, 1990). The Enlightenment heralded the domination of nature and natural laws (Bogdan, 1990). Doctors recorded births and used observation and measurement methods in order to further understand the nature of birth and the natural laws that surrounded the birth (Bogdan, 1990). During this time in Europe, having access to the “desperate poor” in the hospital beds, doctors began to scientifically medicalize the birthing process and in turn, “doctors both implicitly and explicitly trivialized and degraded the traditional, experience-based knowledge women and midwives had about birth” (Bogdan, 1990, p. 109).

In essence, it is this “birth” of science that championed the avoidance of superstitious ideas and practices, including those that surround birth (Bogdan, 1990). Ehrenreich and English (2010) contend that the male dominated medical profession emerged from the suppression and murder of women healers after centuries of witch hunting and killing, so that 85% of the millions of people murdered were women, and wise-women, healers and midwives. Ehrenreich and English (2010) show a history of Christianity having a negative view of women’s bodies as dirty and unholy, forbidding men to associate with a woman’s naked body outside of matrimony, so

that male physicians knew little of the female body, an issue that remained until the 20th century (Ehrenreich & English, 2010). Midwives and women healers were already considered lowly, but degradation for their practice occurred greatly when the male dominated medical profession began to expand from which women were barred. While women's bodies were considered dirty and midwives were considered lowly, the spread of puerperal fever in hospitals is linked to the obstetric practice by men and the man-midwife⁷ (Finney, 1930). It wasn't until the 17th century that a physician named William Harvey dissected a female body and noted that the post partum uterus was "an open wound" yet, the connection between the bacteria laden hands of the male physicians in the unsanitary hospitals was not made (Rich, 1986). Germ theory wasn't widely accepted until the late 19th century early 20th century (Davis-Floyd & Cheyney, 2009).

As the shift took place, and spread through Europe and to the United States, men traveled from the United States to the U.K. in order to study obstetrics, thus learning these new scientific ways of birth (Bogdan, 1990). Upon returning, these men would set up practices, assist in middle to upper class births along side midwives, though midwives were soon completely replaced (Bogdan, 1990). Judy Barrett-Litoff's research on midwifery from 1860 until the late 20th century found that by the end of the 19th century, middle and upper class women in the United States did not use a midwife (Litoff, 1990). These doctors would also establish medical schools, thus creating an academic culture around the cultural ideas of the Enlightenment (Bogdan, 1990). There was a shift from being cared by woman who had experienced birth and was experienced in childbirth - to the expertise of a person who was most likely male, with a medical education in childbirth. Though it must be noted that during this time until after 1910, medical education as not by any means, standardized. Medical education was still in the

⁷ Indeed, Mary Wollstonecraft died of puerperal fever or "childbed fever" in 1797, as did countless other women who labored and delivered in the hospitals (Rich, 1986).

developmental stage and would not become more rigorously standardized until the 20th century (Rooks, 1997; Borst, 1990).

In the 19th century, interventions soared as more and more woman chose physician attended births in the United States and the U.K. (Bogdan, 1990). Anesthesia use such as chloroform and ether were used, sometimes to the detriment of the mother and the fetus (Bogdan, 1990). Chronic infection after childbirth, vaginal and perianal tears became common (Bogdan, 1990). After 1880 came an influx of immigrants from Southern and Eastern Europe who still practiced midwifery, creating a resurgence of midwifery (Litoff, 1990). Social-economic status, race/ethnicity, as well as citizenship status impeded a midwife's ability to reach a "respectable status" (Litoff, 1990). In addition, Litoff (1990) argues that geography, language and financial barriers restricted women from creating a solidarity network with other midwives outside of their community.

Donegan (1978) examined the paradox between the rise of man-midwifery during an era of prudent female modesty. Donegan (1978) found that despite the notion of females as the delicate and modest sex, proponents of man-midwifery were persuasive and advocated "new obstetrics," thus attracting middle and upper class women to their practice. The rise of the male attendant at birth provided a transition from all female attendant birth, to a birth where the male attendant assisted in the birthing process. This practice was much more common in England and in other countries under the English flag such as Australia (Donegan, 1978). This introduction of a male attendant in childbirth started the process of legitimizing the practice of delivering babies. Man-midwifery paved the way for the new field of obstetrics⁸.

⁸ Obstetrics is derived from *obstetrix*, a Latin term for midwife (Rooks, 1997, p. 3).

The birthing practices of women in the 19th century, according to Janet Bogdan (1990) varied depending on who attended the birth. If a midwife was the main attendant, the woman may have experienced the use of herbal teas to soothe, and the midwives would have provided endless encouragement, whereas a physician would rely on interventionist methods, drugs and instruments to unnecessarily manipulate the labor and delivery (Rooks, 1997; Bogdan, 1990). At this point these methods, drugs and instruments were used for show rather than actually useful in progressing labor.

At the beginning of the 20th century, the new bio-medical and scientific direction in birth sterilized the birthing process. The new direction also erased and encroached upon women's decision-making processes. Although the poor were the first to utilize hospital care, over time middle and upper class women began to use physicians for birthing. In the United States, middle and upper class women set the trend for physician attended birth use in either a hospital or within the home of the laboring woman (Bogdan, 1990). Physician attended births set a distinction between the socio-economic classes, between the wealthy and the poor women or poor immigrant women who still used midwives (Bogdan, 1990). Urban poor women increasingly began to use physicians in birth, a move away from midwifery (Bogdan, 1990). This movement away from midwifery-assisted birth towards male physician assisted birth also ushered techniques that altered the way women birthed. Physicians preferred laboring women to be on their backs or on their side so that the physician could have better access to the vagina for examination or forceps use. Since the majority of the women using physicians were middle and upper class women, they also adhered to codes of modesty and behavior that dictated they respect and follow the views of the physician and be as bodily modest as possible in front of a man who was not their husband (Bogdan, 1990). This shift was not a natural shift- the shift was

a human construct that began to seep into decision-making processes and real behaviors. Birth went from an all-female attended event, where women supported, assisted, and guided one another in natural birth, where women held the knowledge of birth practices – to a practice where knowledge of birth was of constructed birth performed by a physician or as Bogdan (1990) states, “knowledge of birth gained through education rather than experience,” (Bogdan, 1990, p. 110). Powerful female relationships, as well as real knowledge and experience of pregnancy and birthing was downgraded and male dominance was asserted.

In the 20th century, birth became heavily medicalized and non-midwife attended and women were experiencing increasing hospitalization and alienation (Bogdan, 1990). This type of birth became the new normal and was no longer viewed as abnormal. This alienation over time caused a certain mystification to fall upon the process of childbirth (Bogdan, 1990). While physician intervention care in a hospital caused a rise in birthing complications, physicians convinced women that the safest place for childbirth was a hospital because they were closer to medical technology (Bogdan, 1990).

Other literature such as theses, articles and books on the topic of midwifery existed however they were not widely printed or distributed (Litoff, 1990). Eugene Declercq studied of immigrant midwives in Lawrence, Massachusetts and from his research, Declercq was able to place midwives in three categories of different types of midwives: 1) Generalist midwives who helped a diverse population; 2) Active ethnic specialists who concentrated on one ethnic group; and 3) Granny midwives who attended births on occasion (Litoff, 1990). Charlotte Borst also researched midwives in Wisconsin at the start of the 20th century and found that midwives in that area could also be placed into distinct groups: 1) Native American women who sometimes attended the birth of a relative or friend; 2) Apprenticed trained midwives who were also born

within the United States who learned midwifery from older midwives and physicians; 3) School-educated midwives who were 1st or 2nd generation immigrants (Litoff, 1990). Borst also supports Declercq's findings that there was much cooperation between midwives and physician/obstetricians (Litoff, 1990). It seems as though the role of the midwife shifts and changes depending on medical perspective at the time of the shift. Nancy Schrom Dye's research found the opposite was true for the New York Midwife Dispensary from 1890-1920, as dispensary doctors and immigrant midwives did not collaborate (Litoff, 1990). Collaboration varied greatly across the United States between different socio-economic groups of physicians/obstetricians and midwives.

During the early 20th century, the field of obstetrics was struggling to be recognized and respected as a legitimate field during the same era when the institution of medicine in the United States was being rebuilt (Borst, 1990). General practitioners in 1900 had cared for pregnant women and delivered their babies, and family doctors argued that this was an integral part of their practice and service however, by the 1980's obstetrical specialists were accused of using operative obstetrics to shorten or conclude births; now it seems that obstetrics intervene excessively (Borst, 1990).

Licensing of physicians in the United States is an outcome of physicians who trained in European medical schools in the early part of the 20th century. Medical schools were reformed and only these schools could provide licenses and degrees in medicine. The focus shifted from preventative care and environmental social concerns of health, to a science-oriented disease-focused field. With this change in medical school licensing, women, African Americans, Jewish men and Catholic men were excluded from participating (Lorber, 1997, p. 37). The state reinforced the physicians' authority by allowing only licensed medical doctors to prescribe drugs

and to perform surgical procedures, while limiting what other licensed health/medical practitioners such as midwives and physician assistants could practice in medicine (Lorber, 1997, p. 38).

A social shift occurred during WWII when more women entered the workforce and left the domestic sphere behind. When more women entered the workforce, they also created a space in which they could become negotiators in their consumption and decision-making choices. This is important because it is also during this time that the decline in midwifery use began. The decline of midwives was due to many factors such as the decline in immigration following WWI (Litoff, 1990). Following this period, progressive women began to demand improved care, which led to the further decline of midwives (Borst, 1990; Litoff, 1990). Birth became managed rather than attended or dominated and was carefully controlled via monitoring with the fetus gaining chief concern over the woman's wellbeing (Borst, 1990; Arney, 1982). By the end of the 1940's, the profession had changed into a profession that brought about social control over women, pregnancy and childbirth by fully replacing midwives with physicians (Borst, 1990; Arney, 1982).

In the 1960's research looked at pregnancy and childbirth as a social phenomenon rather than just a medical phenomenon. Pregnancy and childbirth were examined through the intersecting political, social, economic, and race paradigms in order to obtain a better understanding of the processes and meanings to different women (Bogdan, 1990). During this period of time the United States was experiencing a social cultural shift with the Civil Rights Movement, and the Women's Liberation Movement (Rooks, 1997). It was during this time that women began to re-examine their roles in society (i.e. mother, wife, worker etc.) and women

became stronger agents of social change and leaders pushing back against patriarchal control of their reproductive matters (Rooks, 1997).

In the 1970's with the resurgence of feminism also came renewed interest in midwifery. Prior to the 1970's knowledge of childbirth was mainly taken from the writings of medical historians, and these writings emphasized the necessity of the advancement in medical technology (Bogdan, 1990). Social historians were able to emphasize customs and traditions that dominated women's lives throughout the centuries and these writings are what helped researchers better understand the role of pregnancy in women's lives (Bogdan, 1990). The history of midwifery in the United States was tied to the histories of medicine and obstetrics and these histories greatly emphasized the victories of medical science in improving the health of pregnant women (Litoff, 1990). Much of the medical academic literature prior to 1964 characterized midwives as ignorant, superstitious and educationally inferior (Borst, 1990). For example, Borst (1990) discusses Harold Speert's *Obstetrics and Gynecology in America: A History* in which he asserts that midwives were ignorant, superstitious, and illiterate, and "clearly needed by American mothers was protection from incompetence and superstition" (Borst, 1990, p. 200). From the colonial times to 1910, midwives attended one half of all births, however by 1970 the number drops to 0.05% of all births. Women returned to the midwifery tradition in the 1970's in order to reclaim agency over technological interventions and procedures during childbirth.

2.3 Midwifery Along the United States - Mexico Border and the State of Texas

In this section a brief summary of the long history of midwifery use in Texas and along The United States-Mexico border will be given. Along the border between the United States and Mexico, the use of parteras has had a long history, long before the creation of the border in 1848 after a long war in which portions of Mexico were annexed by The United States. People now

lived along a border, though the use of parteras did not diminish. Parteras, generally considered to be traditional lay-midwives, have served rural, poor, under-served communities along the U.S Mexico border, and in 1978 only two-thirds of the 7,500 midwife attended births in Texas were of women with Spanish surnames (Seaholm, 2010). Between 1906 and 1924, 73 percent of practicing midwives in Texas were black, while 22 percent were Mexican (Rook, 1997). A State Bureau of Child Hygiene survey from 1924 had an estimation of 4,000 practicing midwives in the state of Texas (Seaholm, 2010). In Texas, 1,500 registered midwives delivered only 2.3 percent of all lives births in 1970 (Seaholm, 2010).

During the 1970's registered nurses gained specialized training in childbirth and were certified by the American College of Nurse Midwives thus becoming CNMs (Seaholm, 2010). Franciscan nun Angela Murdaugh was a Certified Nurse Midwife who established the first Certified Nurse Midwife birthing center called Su Clinica Familiar in Raymondville, Texas in 1972 (Barnett, et al., 2008). Soon birthing centers would open up along the border (Barnett, et al., 2008). In 1976, a lay midwife named Shari Daniels opened The Maternity Center at El Paso in order to offer a space for traditional lay midwives (parteras) to gain experience in multiple births, and to give women an opportunity to birth with a midwife (McCallum, 1979). By 1981, Texas had the largest number of direct-entry midwives (Rooks, 1997). In 1981, Certified Nurse Midwife Carolyn Rutledge together with Texas Tech Health Sciences Center at El Paso opened a midwifery service at Thomason Hospital (now University Medical Center⁹) (Barnett, et al, 2008). In 1987 Maternidad La Luz opened its doors (Maternidad La Luz, 2015). It was through the policies and laws in Texas that created a need for a school like Maternidad La Luz along the

⁹ Though this program has closed over the years, it has re-emerged yet again as part of the Texas Tech University Health Sciences Center in El Paso as part of the graduate program in nursing (Texas Tech, 2015).

border. Other birthing centers would open and close in El Paso Texas, leaving Maternidad La Luz to exist as the only birthing center option in 2015.

2.4 Laws, Rules, and Regulations for the State of Texas and El Paso County

In this section I will briefly discuss the legal aspect of birthing choices in the State of Texas, and El Paso County. Laws, rules, and regulations shape the types of choices that are available to women in regards to reproductive health and pregnancy. Vedam (2012) posits that the malpractice environment and legislation contribute to variation in available birth setting options (Vedam, 2012, p. 67). Laws, rules, and regulations surrounding childbirth are meant to protect the fetus first, and to protect the medical establishment from lawsuits, secondly. In 1983, the Texas legislature passed the Texas Midwifery Act, which regulated licensed midwifery, whereas prior to 1983 midwives were not regulated by the State of Texas (Department of State Health Services [DHS], 2014). Faculty midwives at Maternidad La Luz are licensed midwives. A licensed midwife (direct entry midwife) assists only in normal childbirth, does not perform caesarean sections, does not use forceps or surgical instruments for any procedure other than cutting the umbilical cord or providing emergency first aid during delivery, does not perform an episiotomy, does not remove the placenta by invasive techniques, does not advance or retard labor or delivery by using medicines or mechanical devices, does not assist at childbirth other than normal childbirth except in emergency situations that poses an immediate threat to the life of the mother or newborn, does not administer a prescription drug except as an agent of a physician licensed by the State of Texas (other than eye prophylaxis for the newborn and oxygen in accordance with board rules) (DHS, 2014). These rules and regulations are meant to regulate the practice of licensed midwives. The Lay Midwifery Board was established in 1987, however by 1991, the word “Lay” was dropped and it was now called The Midwifery Board (Rooks,

1997). Licensed midwives are required to renew their licenses every two years, and The Texas Midwifery Board helps to set standards of practice, complaint review processes, and educational standards (DSHS, 2014). Certified Nurse Midwives have a different set of rules and regulations set forth by the Texas Board of Nursing (DSHS, 2014).

2.5 Reframing the Role of Midwives in Birthing Practices

Midwives have assisted the labor and delivery of women in their communities, they have been a source of comfort, and they have provided traditions and customs to support the woman during her labor and delivery. Midwives have been a part of every culture or group in the United States (Litoff, 1990). The shift away from female-led and midwifery-led births towards a bio-medical physician attended birth has more than one cause. Over the course of the history of midwifery and obstetrics in the United States, social, cultural, and legal aspects have created this shift. The shift from home to hospital, the legitimization and medicalization of childbirth in medicine, declining birth rates during the 1920's decreased immigration post WWI, as well as women themselves who wanted improved birthing care, all contributed to the shift from midwifery use to obstetrician use. Women were mostly excluded from obtaining higher education in many fields of science and medicine, and in turn, their participation within medicine was marginalized (Rooks, 1997; Litoff, 1986). The most powerful aspect of the shift comes from the legitimization and medicalization of childbirth within the institution of medicine. Furthermore, through the legitimization and medicalization came laws and legislation, licensing and rules that created a paradigm which shaped midwifery in the United States.

The role of the midwife, the guide during pregnancy and the birthing process has been reclaimed and re-taken. The Women's Liberation Movement created space in which women could reclaim another piece of their reproductive health. Though there are many areas of the United

States where the practice of midwifery is very limited, there are many counties and cities where Certified Nurse Midwives practice their service in the hospital setting along with obstetricians; these hospitals tend to have lower rates of cesarean sections and University Medical Center in El Paso is an example (Cesarean Rates, 2015)

2.6 Catching Babies: Documentary About Maternidad La Luz

In 2011 the hour long documentary *Catching Babies* was released. This documentary features midwives and clients at Maternidad La Luz. *Catching Babies* artfully shows the type of relationship that develops between the midwives and the clients of Maternidad La Luz. The clinic is shown in a stream of busyness, between educational classes for the student midwives and tending to clients, Maternidad La Luz is bustling (Lucero & Qaasim, 2011). As Deborah Kaley explains in the documentary, the student midwives squeeze three years of midwifery work into a year and a half at the clinic (Lucero & Qaasim, 2011). Because Maternidad La Luz is busy with clients from both sides of the border and with student midwives, it is considered one of the highest output midwifery schools in the United States (Lucero & Qaasim, 2011). This is important because people studying midwifery must attend a certain number of labors as part of obtaining their license to practice midwifery as explained in the documentary,

“To get licensed in the united states in most states in the united states and you have to have been in at least 100 births and have to have 20 primary which is when you catch the baby, so the clinic is great for that because you get to go to class and learn all the textbook knowledge about midwifery but you also get your numbers for your exam” (Lucero & Qaasim, 2011).

2.6.1 Midwives Voices from the Border Region

As discussed in the film, some of the midwives working at Maternidad La Luz came to the midwifery after experiencing their own birth journey. As Deborah Kaley explains,

“I came to El Paso to study to be a midwife I had been living in Nova Scotia Cape Breton and had had a baby in the hospital and really wanted to become the midwife I wanted for myself, that was the goal. I fell in love with what I was doing. I fell in love with women and I also fell in love with teaching other

students. Maternidad la luz it's a very intense experience. I think its overwhelming in a sense because there coming here to el Paso which is a very different place for most people. They have to learn midwifery but they have to learn it through another culture and another language. People are coming away form home, often without partners or family. They're investing a lot of money and then they have to really put in 3 years of energy into one year. That is really what is being asked of them. So all of those things make it hard. Its hard, its really hard and I think, transforming" (Lucero & Qaasim, 2011)

Another midwife featured in the documentary, Diana Zanelli describes her path to midwifery,

"So I decided to be a midwife when my daughter was born. She, I always say that when she was born she brought me two gifts, the gift of herself and discovering my passion in midwifery. It was really the most empowering thing I have ever done, giving birth naturally. And saying that doesn't mean that it was the easiest thing I've ever done. I just really really started opening my mind to what it is to give birth in a different way than in a hospital and fears came up for me of course and it things I had to work through like my fear of pain, and fear of what if something goes wrong, these really deep set fears that I think girls and women are succumb to all their lives because of the way our society views childbirth and so I really did a lot of emotional psychological and spiritual work in my pregnancy to shed all that. Then when my baby was born, it was a really loving environment I got to have her in my arms immediately and we laid down in the bed myself and her dad and it was just really loving and family like and warm and really wonderful and I really felt empowered as a woman afterwards, like wow I did a huge thing" (Lucero & Qaasim, 2011).

Kennasha Roberson, another student midwife reflected about her role as a midwife and what it meant to her to be able to help women,

"I just wanna be able to educate them about natural birth and different options that we have because a lot of people I deal with as soon as they are pregnant they go to the hospital like they broke their arm and I just want to let them know that there are options to birth outside of the hospital, you don't always need medication there's different ways to eat and think and just live. There are other options and I feel like they don't know that" (Lucero & Qaasim, 2011).
Catching Babies

2.7 Conceptual Definitions

In this section I will discuss the conceptual definitions related to the research in this study. Childbirth experience, embodied knowledge, support, agency, and control are all different terms that were expressed in the interviews.

2.7.1 Childbirth Experience

The research in this thesis focuses on the childbirth experience, therefore it is important to discuss the conceptual definition of childbirth experience. Researchers Larkin, Begley, and Devane (2007) analyzed three databases related to labor, childbirth, and experience. The authors found that there is little consensus on the conceptual definition of childbirth experience, however they were able to identify four main attributes of the childbirth experience as individual, complex, process, and life event (Larkin, et al., 2007). Larkin et al., (2007) state

“Through this concept analysis, the experiences of labor and birth is defined as an individual life event, incorporating interrelated subjective psychological and physiological processes, influenced by social, environmental, organizational and policy context.”

The design of my interview guide drew on these concepts of childbirth experience. Through the interview process each participant described the four main attributes during their birthing experience at Maternidad La Luz. The term ‘individual’ encompasses concepts such as unique, special, and idiosyncratic (Larkin et al., 2007). “Although childbirth is a universal phenomenon, women’s experiences are subjective, personal, and particular. The broader social, moral, and cultural contexts of childbirth are experienced in many ways” (Larkin et al., 2007; Miller 2005). Larkin et al., (2007) found within the literature the terms ‘complex’ and/or ‘multidimensional’ as associated with feelings changing from positive to negative and back again, and though a negative feeling seems contradictory, negative feelings are a part of the labor process, especially during intense pain and right before the final stage (Waldenstrom, 1996; Lavender et al., 1999; Larkin et al., 2007). ‘Process’ as described in Larkin et al., (2007) is “the experience of childbirth characterized by the beginning, labor, with movement or activity towards a goal, that of giving birth, and a transformative process to motherhood” (Larkin et al., 2007 p 54-55). The process of childbirth is described in the literature as an unpredictable journey, and a sequential

physiological process that involves work (Gould, 2000; Halldorsdottir & Karlsdottir, 1996; Larkin et al., 2007). Lastly, Larkin et al., (2007) found that the phrase “life event” was described as profound, significant, important life experience, and a pivotal life event (VandeVusse, 1999; Lundgren, 2005; Matthews & Callister, 2004; Larkin et al., 2007). Thus the childbirth experience is defined by this compiled list of concepts and definitions.

2.7.2 Embodied Knowledge

Browner and Press (1996) describe embodied knowledge as “subjective knowledge derived from a woman’s perceptions of her body and its natural processes as these change throughout a pregnancy’s course” (Browner & Press, 1996, p. 141). The concept of the body is both socially constructed and material that appear, endure and live within highly gendered regulatory systems (Butler, 1993), however, as Harris, Connor, Bisits, and Higginbotham (2004) argue, “embodied experiences are no less real than any material or political reality” (Harris, Connor, Bisits, Higginbotham, 2004, 10). Furthermore, Browner and Press (1996) argue during pregnancy and labor within a hospital in the United States, women are typically accepting of biomedical authority rather than their embodied knowledge because the power of biomedical authority has in the institution of medicine. Within this study, women discussed ways in which they experienced embodied knowledge during pregnancy and labor.

2.7.3 Support

Another conceptual definition is support. Support in birth provides benefits, and intrapartum support seems to provide benefits for women and their baby (Halldorsdottir and Karlsdottir, 1996; Ogden et al., 1998). Intrapartum support may help women from long term childbirth related negative experiences (Lundgren, 2005). In addition, support was also recognized by women in the literature as a caring presence, and giving of emotional support (MacKinnon et al., 2003). Support was also recognized as treating women as adult individuals

(Fraser, 1999; Lundgren, 2004; Larkin et al., 2007) with comfort and privacy (Ogden et al., 1998), and dignity and respect (Matthews & Callister, 2004). Establishing a relationship with one's medical caregiver in birth is crucial for good outcomes in the birthing experience. When the relationship with the medical professional/caregiver was supportive, communicative, and sensitive to needs during labor, it contributed to women feeling satisfaction with their birthing experience (Green et al., 1990; Waldenstrom, 1996; Brown & Lumley, 1998). Having an interpersonal relationship with a medical care professional who involves the laboring woman in decision making processes, who guides the laboring woman based on her own terms, who can contribute to pain relief in labor, can further enhancing the birth experience (Corbett & Callister, 2000; Homer et al., 2002; VandeVusse, 1999; MacKinnon et al., 2003; Larkin et al., 2007).

2.7.4 Agency and Control

Women's experiences with decision-making processes regarding pregnancy and birth involve the notion of control and include the woman's agency over her body and the processes of her birth. Control is a key part of birth. Control is a multifaceted subjective concept that has diverse meaning for women and it can mean something different for each woman (Namey & Lyerly, 2010). Control in scholarly journals is rarely defined and there is no agreed upon definition, therefore control is looked through certain aspects and facets, agency is one facet of control (Namey & Lyerly, 2010). "A third definition of control as self-determination relates to agency. Agency in this context refers to the women as 'the birther,' the person experiencing labor and bringing the baby forth" (Namey & Lyerly, 2010). Green and Baston (2003) also researched different aspects of control that are present in birth, which are, feeling in control of what staff does to you, feeling in control of your own behavior, and feeling in control during contractions (Green & Baston, 2003). Control is an important part of birth, and *how* control is exercised and by *whom* it is exercised, can make a difference on the outcome of one's

experience; feeling that they were cared for rather than having care being something that is done to them, makes a difference in how control is perceived, which in turn contributes to a positive birth experience (Green & Baston, 2003). When women are in an environment where they are respected as individuals by considerate staff, they felt more comfortable and ‘in control’ during their labor and their pain during contractions (Green & Baston, 2003). Women, in an attempt to increase their feeling of control during labor and birth, have chosen particular birth environments including laboring in water (Hall & Holloway, 1998), home birth (Andrews, 2004), birth centers (Berg et al., 1996) and, in some cases, to avoid the experience of labor and birth by opting for a caesarean section (Ryding, 1993). What medical professionals may consider a successful birth (healthy baby) does not necessarily meet the same criteria of success for the woman who delivered (Lavender et al., 1999).

Childbirth experience, embodied knowledge, support, agency and control are all conceptual definitions used in this thesis to understand the stories of the women interviewed. Understanding these definitions sets a framework from which to view the narratives presented in this research.

2.8 The Socio-Economics of Maternal Health

In this section I will discuss the role of socio-economic status in pregnancy and birth. Socio-economic status (SES) varies between social and economic classes in the United States. This creates health disparities for people of color who predominately experience lower SES in the United States. High socio-economic status translates into better overall quality of life, better health, and better birth outcomes (American Psychological Association, 2015). “Health damaging exposures or health enhancing opportunities are socially patterned and because an individual’s response, which may modify their impact or alter the risk of future exposures will be

powerfully affected by their social and economic experience” (World Health Organization, 2000). In this section I will discuss barriers to adequate maternal health care and the different aspects of health disparities associated with low SES and maternal health.

2.8.1 Barriers

Much of the research on Hispanics and reproductive health care focuses on how barriers affect outcomes for Hispanics. There are several factors that create barriers for women/women of color that seek maternity care services along the United States – Mexico border. Barriers such as language, citizenship status (within the United States), low socio-economic status, and inadequate insurance access can create difficulty for women trying to seek the best maternity care available (Byrd et al., 1996; Braveman et al., 2001; Roth & Henley, 2012; Miller & Shriver, 2012; Marquis & Long, 2012; Escarce & Kapur, 2006). Hispanic women generally have low socio-economic status (SES) and that affects access to different choices in birthing, and it can affect overall birthing experience (Roth & Henley, 2012; Teijlingen et al., 2009).

Socioeconomic status is described as absolute and relative levels of wealth and the power and prestige closely associated with wealth, reflected in income, economic assets, occupational status, and education level (Braveman et al., 2001). Higher socioeconomic class and power is attributed to better maternity care outcomes (Lazarus, 1994; Bridges, 2011). Women may want a medical birth, yet their barrier(s) prevents them from being able to get that preference and, instead, as Miller and Shriver (2012) argue, “as active negotiations of their social world people act *from* their habitus but *in response to* the reality of the world around them.” Women who deliver at Maternidad La Luz may prefer a different way of birthing, yet for them, perhaps Maternidad La Luz is the best solution. This does not mean that Maternidad La Luz does not

provide quality maternity care, but rather, women may not be able to make the choice that they prefer.

Bergman and Connaughton (2013) used interviews with Hispanic prenatal patients to understand what type of care they considered to be patient centered care (PCC). In this research, Mexican-American and Hispanic referred to any woman of Mexican heritage residing in the United States regardless of nativity or citizenship status (Bergman & Connaughton, 2013). The qualitative study found 5 themes that patients identified as important aspects of patient centered care and they are a friendly relationship, effective medical care, use of the Spanish language, understanding of the information given to them by the doctors, and an elimination of racism (Bergman & Connaughton 2013). There is a link between these 5 themes and barriers that Hispanic patients face. Bergman and Connaughton (2013) identify general Hispanic cultural aspects that link the 5 themes and barriers that Hispanic patients face and a need for a culturally sensitive PCC approach. Hispanic women perceive health care provider visits as social rather than business like, and serious facial expressions and mannerisms, hurried movements, giving improper goodbyes, and lack of eye contact is perceived as anger by the patient of the doctor (Bergman & Connaughton, 2013). Patients felt better understood, and also understood the information imparted during the visit when the doctor was friendly, attentive, and respectful in a culturally sensitive manner (Bergman & Connaughton, 2013).

2.8.2 Maternal Mortality and Morbidity

Maternal mortality is still an issue for women in the 21st century despite advancements in medicine and technology. In 1987, the Centers for Disease Control began to collect data from all 50 states as well as NYC and Washington D.C. on maternal mortality rates (Center for Disease Control [CDC], 2014). Despite being a global north nation, The United States has seen a steady increase of maternal mortality rates since 1987, and is one of the only global north nations that continues to see an increase in maternal mortality (CDC, 2014). The CDC and other medical and

educational outlets provide advice for women who want to become pregnant

"It is important for all women of reproductive age to adopt healthy lifestyles (e.g., maintain a healthy diet and weight, be physically active, quit all substance use for good, prevent injuries) and address any health problems before getting pregnant. Visit your health care provider at recommended scheduled time periods to discuss if or when you are thinking about getting pregnant. This is important to make sure you receive appropriate medical advice and care, and have healthy pregnancies" (CDC, 2104).

This advice provided by the CDC is well-intentioned, however someone with low SES may not have access to components that make-up a healthy lifestyle. In the United States, white women in general have 12.5 deaths per 100,000 live births, while black women have a staggering 42.8 deaths per 100,000 live births, and the remaining 17.3 deaths per 100,000 live births are of other women of color (CDC, 2014). The three leading reasons for maternal mortality are hypertension, diabetes, and chronic heart disease, health issues that are linked to quality of life (CDC, 2014). While the CDC offers very good advice, it also seems to ignore the socio-economic factors that also contribute to maternal mortality.

In a recently published article titled *Is Racism a Fundamental Cause of Inequalities in Health*, authors Jo C. Phelan and Bruce G. Link posit that racism causes inequalities of SES in The United States which then causes inequalities in health (Phelan & Link, 2015). Connecting this to maternal mortality, hypertension, diabetes, and chronic heart disease are health problems that predominately affect black women and women of color (Department of Health and Human Services, 2012). The better the socio economic status, the better overall quality of life that person will have. Issues of racism in The United States contribute to inequalities in health. The issues of racism may not be overt as they are usually systemic and institutional meaning that they are not easily detected, and are shrouded in bureaucracy and tradition. In the United States, "all other race, ethnicity, and nativity groups are at a higher risk of dying from

pregnancy related causes than U.S.-born white women, after adjusting for age differences (Creanga, Berg, Ko, Farr, Tong, Bruce, Callaghan, 2014, p.5). For decades, social scientists have been working on issues of racism, discrimination, and sexism, trying to understand/reveal underlying reasons and exposing the systemic and institutional reasons contributions to these issues.

Another cause of concern that is usually discussed along maternal mortality is maternal morbidity. Maternal morbidity “encompasses physical and psychological conditions that result from or are aggravated by pregnancy and have an adverse effect on a woman’s health (Creanga, Berg, Ko, Farr, Tong, Bruce, Callaghan, 2014, p.5). Like maternal mortality, maternal morbidity rates in the United States have risen steadily over the last sixteen years (Creanga, et al., 2014). Severe maternal morbidity affects over 60,000 women every year and the rise is linked to factors such as increase in maternal age, pre-pregnancy obesity, preexisting chronic medical conditions, and cesarean delivery (Creanga, et al., 2014, p. 6). Cesarean delivery is a factor that is linked to maternal morbidity. Some of the health risks for future pregnancies and deliveries associated with a cesarean are risk of placenta previa, placenta accrete, placental abruption, ectopic pregnancies, rupture of the uterine scar (from a previous cesarean), injury to organs, hemorrhage, extended hospital stay, extended recovery time, negative emotional feelings, incontinences, death, and the need for future gynecological surgeries (Sakala, 2012). Women who have more than one cesarean are often encouraged to have another cesarean for future births. However, cesarean delivery is major surgery, and the adverse health risks grow with each delivery, placing a limit on how many babies a woman can safely carry to full term. The baby’s health can also be impacted by the way they are birthed. Asthma, upper respiratory issues, and no exposure to the beneficial vaginal microbes, are just some of the health problems that can arise for babies born

via cesarean (HMHB, 2012). In general, the United States has a high maternal mortality rate among global north nations, and it also has a high cesarean rate as well. The cesarean rate in Texas is 34.9% (Cesarean Rates, 2015). In El Paso Texas there is a vast difference of cesarean rates between hospitals. For example, private hospital Sierra Medical Center 32.6% of low-risk births are via cesarean, Las Palmas Medical Center has a 30% cesarean rate, Providence Memorial Hospital has a 31.2% cesarean rate, while at the county hospital University Medical Center had a 12.2% cesarean rate (Cesarean Rates, 2015). Nationally, Cesarean delivery rates dropped in 2014 from 32.9% to 32.2%, a decline seen mostly among Hispanic women (Martin, Hamilton, Osterman, 2015).

Having low SES can create barriers to accessing systems of health equity. Barriers such as poverty where an individual lacks constant financial and economical stability can create a domino affect of negative health outcomes.

2.9 Medicalization of Childbirth

Western medicine is a term used to describe the current system of medical practice in the United States and other parts of the world, whose knowledge base is modern science, where practitioners receive a license by their respective government. These medical licenses, used to establish positions of power and knowledge, are issued to a candidate who learns standardized curriculum and passes the standardized tests. “The curriculum, teaching, and testing are under the control of the current holders of the license; in other words, professional qualifications are controlled by the respective profession” (Lorber, 1997, p. 35).

In “Has the Medicalization of Childbirth Gone Too Far” authors Johnson, Newburn, MacFarlane, (2002) discuss how medicalization has changed what is considered to be a normal birth process. Obstetricians are vital in the preservation of life and the use of medical technology

during medical complications in childbirth, however involvement and medical intervention has become the norm during low risk pregnancies, with no full proof of effectiveness. Johnson, Newburn, MacFarlane, (2002) state that factors that contribute to increased intervention by obstetricians are private practice, medico-legal pressures, and no patient involvement in the decision making process. Furthermore, the authors argue that emerging evidence shows that higher rates of normal births are connected to beliefs/ideas about birth, implementation of evidence based practice and team working (Johnson et al., 2002). Women experience increased rates of drug and instrument intervention, which have also lead to an increase in caesarean sections (Johnson et al., 2002). This article discusses unnecessary non-medical interventions that are performed in some countries such as shaving and enemas. This study also reports that in Brazil where the caesarean rate is 36%, doctors were active in the decision making process and used their expertise and authority to “help” women choose a caesarean (Johnson et al., 2002). Johnson et al., (2002) state that in the UK, midwives deal with a lot of guilt and blame and thus, this continued blame culture works to disempower professionals. Finally, Johnson et al., (2002) offer some solutions for de-medicalizing birth by implementing maternal and newborn programs, with factors such as the right attitude, focus, leadership, teamwork and personal and financial support, for quality improvement.

2.10 Safety of Birthing Centers and Midwifery-Led Birth

There are a few studies that have been published in the past few years that show how safe it can be to birth at a birthing center with a midwife. I will briefly discuss a few studies that have shown the safety of midwifery led birth. It is important to understand that midwifery led births are safe to counter the narrative that hospitals are the safest place to birth a child while all other places are considered unsafe.

Evidence based maternity care research shows that the best care for women does not always happen in the hospital under the care of an obstetrician gynecologist (Stapleton et al., 2013, Declercq et al., 2013, Johnson et al., 2002). In a longitudinal study conducted by Stapleton

et al., (2013), the findings were consistent with previous findings in other studies that focused on midwife led care and midwifery led birth centers in comparison to obstetric care (Stapleton et al., 2013). Furthermore, the mortality findings were also consistent with previous research in other countries (Stapleton et al., 2013). In addition, the strengths of this study were the large sample size of 15,5740 women initially participating, also geographically diverse birthing centers, a data collection over a period of 4 years, and data collected were entered by care providers (Stapleton et al., 2013). The cesarean rate was 6% for women who delivered at birthing centers versus the national rate of 25% in hospitals (Stapleton et al., 2013). In total, 83.7% of women gave birth at a birthing center, 79.4% were discharged with their newborns and sent home, and 1.9% needed emergency transfer to a hospital for either the mother or the newborn's health (Stapleton et al., 2013). The authors of this study (Stapleton, et al., 2013) contend that the data from this study show the safety of midwifery-led birth center model care in addition to low obstetric intervention rates.

Another study set out to evaluate the safety of home births in North America (United States and Canada) that involved direct entry certified midwives in places where the practice of midwifery was not a part of the health care system (Johnson & Daviss, 2005). The cohort started out with 5418 women who planned to labor and deliver at home; 655 were medically transferred to a hospital (Johnson and Daviss, 2005). Among all women in the cohort, the medical intervention rates were 4.7% epidural, 2.1% episiotomy, 1.0% forceps, 0.6% vacuum extraction, and 3.7% caesarean section (Johnson & Daviss, 2005). No maternal deaths were reported. The cohort was made up of women who were older, had lower SES, higher education achievement and non African-American and non-Hispanic. Medical intervention for home births was lower than those in the hospital. Overall women who had home births with a certified professional

midwife had low rates of intrapartum and neonatal mortality, similar to low risk hospital births (Johnson & Daviss, 2005).

In another study, MacDorman and Singh (1998) studied the differences in birth outcomes for infants delivered by certified nurse midwives (CNM) in hospitals compared to infants delivered by physicians within hospitals in the United States. MacDorman and Singh (1998) used logistic regression models to examine differences, neonatal and post-neonatal mortality and risk of low birth weight. MacDorman and Singh (1998) used data from the national linked birth/infant death data set for 1991 birth cohort. CNMs experienced 19% lower infant deaths than physician births, a 33% lower risk of neonatal mortality and a 31% lower risk of low infant birth weight compared to physician attended births (MacDorman & Singh, 1998). MacDorman and Singh (1998) concluded that the labor and delivery practices of the midwife and doctor might play an important role in the birth outcomes they observed.

Recent data on birthing with a midwife, however, these studies focus on homebirths. Longitudinal studies of midwives in a birthing center is are few because of the time, money and resources needed for this type of research. Homebirth data and research exist, but because this thesis and research focuses on birthing centers, the homebirth data is not relative to this thesis. Contemporary data shows that much of the research is conducted outside of the United States in countries like Canada, or the United Kingdom where healthcare models and systems differ greatly from those in the United States. Research tends to focus outside of the United States. While the research conducted in the United Kingdom or Canada are somewhat relative to the United States, I argue that outcomes could be significantly different in the United States because of the different health care system, different issues of racism and discrimination, different types of populations and needs.

2.11 Theoretical Framework

The life course approach concept and feminist standpoint theory were used as theoretical

guides to understanding the data collected from the interviews with each participant. Feminist standpoint theory provides a lens from which to view how the women in this research made decisions, and life course approach offers a lens in which to view how biological and social factors affects health care outcomes, and life course approach offers an avenue for creating future policy. As defined by Anderson (2000),

“Feminist epistemology and philosophy of science studies the ways in which gender does and ought to influence our conceptions of knowledge, the knowing subject, and practices of inquiry and justification. It identifies ways in which dominant conceptions and practices of knowledge attribution, acquisition, and justification systematically disadvantage women and other subordinated groups, and strives to reform these conceptions and practices so that they serve the interests of these groups” (Anderson, 2000)

As a conceptual framework, life course perspective helps to explain health and disease patterns and health disparities, like those in maternal health. Glen Elder, one of the developing theorists of the life course approach, describes life course theory as “a common field of inquiry, providing a framework that guides research on matters of problem identification and conceptual development” (Elder, 1998, p.4). Furthermore, Elder (1998) argues that “historical forces shape the social trajectories of family, education, and work, and they in turn influence behavior and particular lines of development” (Elder, 1998, p. 2). Elder (1998) explains that while some people may be able to choose a path to follow via human agency, their choices are not done in a “social vacuum” (Elder, 1998, p.2).

Life course perspective covers four basic principles as discussed by McDaniel and Bernard (2011) “our daily experiences form a trajectory that begins at birth and stretches to death; life-course patterns unfold in a multiplicity of interconnected realms; that social bonds form throughout our lives that affect our own life course and that of others; that a variety of local and national contexts shape life courses, and are shaped by them” (McDaniel & Bernard, 2011,

p.2). Additionally, the life course approach in sociological terms “aims to understand the evolution of life courses primarily as the outcome of institutional regulation and social structural forces” (Alwin, 2012, p.2). Life course approach compliments feminist standpoint theory because it adds dimension to understanding the decision making process that people (in this case women) undergo. The choices and reproductive decisions women make are socially, culturally, and politically shaped (Jordan, 1997; Rich, 1986; Lorber 1997; Ehrenreich & English, 2010; Begley, et al., 2007). Women have individual choices, however, many decisions are influenced by societal patterns and expectation. “Standpoint epistemologies are most convincing to thinkers who are used to investigating the relationship between patterns of thought and the historical conditions that make such patterns reasonable.” (Harding, 1991, p 134). Life course approach is applicable concept that demonstrates how societal patters, historical conditions, and cultural expectations play a role in the decision making process and outcomes.

Feminist standpoint theory offers a way for women’s lived experiences to become part of the dialogue. Through this framework we can examine women’s experiences of prenatal and postnatal care and how their perceived care was compatible with their own desires. Feminist standpoint theory (FST) makes three claims: 1). Knowledge is socially situated; 2). Marginalized groups are socially situated in ways that make it more possible for them to be aware of things and ask questions than it is for those who are non-marginalized; 3). Research, particularly that focused on power relations, should begin with the lives of the marginalized (Bowell, 2011). Therefore, 1) women in pregnancy, who have experienced pregnancy and giving birth, 2) as a marginalized group (women), have a perspective, and they may understand and see things differently than someone who identifies as male, and 3) research that focuses on power relations (such as the research presented in this thesis) should begin with the lives of women (the

marginalized). “Standpoint as the design of a subject position in institutional ethnography creates a point of entry into discovering the social that does not subordinate the knowing subject to objectified forms of knowledge of society or political economy.” (Applerouth & Edles, 2012, pp 568; Smith, 2005)

Dorothy Smith (1987) argues that no one can have complete, objective knowledge; no two people have exactly the same standpoint; we must not take the standpoint from which we speak for granted. In order to do this Smith states that we must recognize it (our standpoint), be reflexive about it, and problematize it (Applerouth & Edles, 2012). While women as a group experience systemic marginalization, women of different socio-economic backgrounds, and most significantly race and ethnicity, experience systemic marginalization differently. Therefore, generalizations such as “all women want natural births” cannot be made, because it erases the very ways in which women from different race or class may desire a certain choice that cannot be generalized. What can be said is, women as a historically marginalized group want access to knowledge and choices, so that as autonomous individuals, they can make the right decisions for themselves. Kimberle Crenshaw (1989) originated the concept of intersectionality, a way to describe how race, class, gender/sex and other attributes create an individual’s social standpoint. It is intersectionality theory that helps bring together feminist standpoint theory and matrix of domination. Matrix of domination is the concept that social position is made up of multiple contiguous standpoints rather than one fixated standpoint. Patricia Hill Collins (1990) further expands on standpoint theory by intersecting race with gender and class. Collins standpoint epistemology is an extension of standpoint theory, interjected with race. Collins argues, “groups who share common placement in hierarchical power relations also share common experiences in

such power relations. Shared angles of vision lead those in similar locations to be predisposed to interpret in comparable fashion” (Applerouth & Edles, 2012).

Often systems of power generally do not recognize a birthing woman’s standpoint, and Feminist Standpoint Theory provides women a space in which their knowledge and standpoint are essential to making the best decision for the best outcome in maternity care. Using Feminist Standpoint Theory in this thesis is important because it adds another dimension of perspective. It provides a more in-depth understanding of how and why some actions are preferred over others. Lorber (1997) argues that critical medical sociologists have shown evidence of race and class biases in Western medicine, and feminists add gender to those biases, creating an intersectionality of social position (Lorber, 1997). Furthermore, feminists argue that in Western medicine, the bodies of white, middle-class men represent the medical norm; thus, “women who menstruated, got pregnant, and went through menopause were sick” (Lorber, 1997, p. 2). Female health is seen as pathology, rather than a natural process of health. “Gender is a social institution that patterns interaction in everyday life and in major social organizations (Lorber, 1997, p. 5). Gender impacts one’s interactions and perceptions. Feminist standpoint theory instructs how the research and interviews were conducted. Feminist standpoint theory also guides how the birth stories shared by the participants should be received.

Chapter 3: Methodology and Research Data Analysis

3.1 Methodology

This thesis employed a semi-structured interviewing process to uncover testimonies of birthing choices and experiences to explore how women who have previously given birth at Maternidad La Luz feel about the kind of care they received there, and how they feel about their birth experience and the meaning they make of this experience. The goal is to allow women to speak about their experience freely. Harding (1987) argues, “one distinctive feature of feminist research is that it generates its problematics from the perspective of women’s experiences” (Harding, 1987, p. 7). Ground up level inductive theory is used in this thesis because the theorizing comes from the interviews. Feminist standpoint theory argues that the voices of the marginalized (in this case, women) should be forefront and essential to create a starting point to analyze their lived experiences. To chose a theory then to go out and conduct research could have the potential to overlook important information. Story telling has been a power tool in feminist action because as Gonzales (2012) explains, sharing stories/story telling is medicinal practice and a form of traditional knowledge and healing (Gonzales, 2012, p. 39). The ability to speak one’s own story prevents one from being the object of a story.

The research for this thesis took a feminist approach in regards to design of interview questions, the approach during the interview, thematic coding and analyzing of the interview. Through visual sociology, I used a documentary titled *Catching Babies* as a secondary source of information for this thesis. Duffy (1999) contends that documentaries are useful sources of information that can be used in research projects as either primary or secondary sources, depending on the format of the documentary. Harper (1988) describes visual sociology as the “use of photographs, film, and video to study society and the study of visual artifacts of a society” (Harper, 1988, 54). Further, Harper (1988) argues that visual sociology is a “collection

of approaches” utilized by the researcher to use different forms of media to understand, examine, and analyze social phenomena (Harper, 1988, 55). Using the documentary as a secondary source allows me to introduce another form of published media and documentation about Maternidad La Luz to be discussed and reviewed within this thesis.

3.2 Sampling

The participants for this research are women who live in El Paso Texas and have birthed or attempted to birth at Maternidad La Luz. Semi-structured interviews were conducted with 6 women who have received care from Maternidad La Luz. A mix of convenience sampling and snowball sampling to find women who were interested in being interviewed was used. I asked Maternidad La Luz if the birthing center would like to participate in this research and Maternidad La Luz declined citing limitations with time and resources as reasons for being unable to participate. Instead, I found participants by asking people within my surrounding community if they knew anyone who had birthed at Maternidad La Luz and two women were identified who would be interested in being interviewed. Through those two participants I was put in touch with three women who they thought might be interested. As the interview process began, more women would hear of this research and pass along their contact information. In the end, six out of ten women contacted made the concrete decision to participate. I went through The University of Texas at El Paso’s Internal Review Board (IRB) for approval for my research and my research was given exempt status. At the beginning of the interview, each participant received a confidentiality form and an informed consent form that they signed.

3.3 Interview Phase

Five of the interviews occurred face to face, and one took place over an email exchange. For the face-to-face interviews, I met with each participant at a place that they chose, at their

home, at a coffee shop, and at a community center. Each interview was conducted in English and they were recorded with permission, with my iPhone using the Audio Memos app that allowed me to upload each interview to my computer. The first interview took place April 2014 and the last interview took place April 2015. As a feminist interviewer it was important for me that participants felt free to speak in-depth about their birthing experience. Birthing is an experience that is unique to women alone. The participants were made to feel free to talk openly about their birthing process, so the structure for the interview was less rigid. For the face-to-face interviews the range was between one hour and two and a half hours, with the average length of the interviews at 97.6 minutes. Each interview was analyzed to examine key themes highlighted in the women's experiences. Attention was paid to how the women described how she felt in relation to her maternity care at a birthing center with a midwife, and how she perceives her overall birth story in retrospect.

The questions asked were posed so that participants were able to discuss their birth process and feelings associated with their birth experience in as much detail as possible. Not every question was asked in every interview since some women spoke so freely that they answered an interview question in another answer without being asked or prompted.

3.4 Data Analysis

During data analysis of the interviews, I identified participants' perceptions of their birthing experiences, care received during the participants' pregnancies, expressions of meaningfulness in their experiences, and their social network support. Though I knew these categories existed from the interview process, these categories emerged mostly after coding the data. The process of analysis began by first transcribing the audio recorded interviews. It was through this process that I became more familiar with the data in the interviews. I looked for analogies, repetition of words or phrases, and metaphors in the interviews. It was also important

to note differences between experiences. After transcribing each interview, I created a document for each participant with a table where I had a column for their quote of importance, a column for themes present in the literature, and then a column for my analysis. Then after I did this for each participant interviewed, I then created a document for each theme, then I added to the analysis on each document. I keyed in on the participant's ways of knowing, thinking and observing in their prenatal and postnatal care. Pseudonyms were assigned to each participant to respect their privacy

Although I wanted to answer specific questions, I welcomed women to describe whatever aspect of their birthing experience they wanted to elaborate on. I found that when women spoke of their birthing experience, they would speak about the thing that was so important to them. So one participant might describe in great detail how her family treated her decision, while another participant might not have provided a detailed response for that same question, but gave a rather long drawn out story in response to another question. This gave space for the participants to speak freely, from the heart, and without interruption. These testimonies are oral *her-stories*-part of a feminist epistemology of co-generating knowledge.

Chapter 4: Results

In this section I will introduce the women who participated in this research and then I will go through the results of the interviews conducted.

4.1 The Participants

Erin

Erin is a 24 year-old Mexican American woman living in El Paso Texas. Erin has only one child and had only one pregnancy and is recently married. Erin attended two years of college and is currently a stay at home mom. I met Erin through another contact and she agreed to participate in this research. Erin, like other participants, became interested in Maternidad La Luz because her aunt gave birth there. Erin was very close to her aunt, lived with her aunt, and explained that her biological mother was no longer in the picture and considered her aunt to be her mother. Erin was single when she found out she was pregnant, and her aunt assisted Erin in paying for half of the total cost of birthing at Maternidad La Luz,

Robin

Robin is 34 years old and a Caucasian white woman from El Paso Texas. Robin has only one child and one pregnancy and is currently single. Erin has a bachelor's degree and works as an artist and writer. Robin was influenced to go to Maternidad La Luz because her sister had given birth there and had a positive birthing experience. Robin also has an aversion to hospitals, so for her, birthing out of the hospital was most important.

Nina

Nina is 33 years old and a Colombian American woman who currently resides in Northern California, but lived in El Paso during the time that she attempted to birth at Maternidad La Luz. Nina has two children and is married. Nina wanted a midwife for the birth

of her first child, however, due to laws and regulations in California, she was unable to use a midwife. Nina was living in El Paso attending The University of Texas at El Paso when she became pregnant with her second child and sought care from Maternidad La Luz. Nina states that though she tried to have her baby at Maternidad La Luz, she was unable to deliver at the birthing center within the legally allowed time and was transferred to University Medical Center and was able to deliver vaginally the next day.

Carla

Carla is 34 years old and a Native American-Mexica Chicana who is from El Paso Texas. Carla has two children and is currently single. Carla has a master's degree and works in the non-profit sector. Though Carla initially wanted to study at Maternidad La Luz, she ended up using their services during the birth of her second child. Carla states that she wanted to use a midwife during her first pregnancy when she was 15 years old, however, she was legally kept from doing so. Carla recounts an incredible birthing experience at Maternidad La Luz and credits her midwife who was also her cousin by ceremony (within their Native American-Mexica tradition) as guiding her through her birthing journey and creating a beautiful experience.

Jennifer

Jennifer is 36 years old and a Mexican American woman who currently lives in El Paso Texas. Jennifer has two children and is married. Jennifer attended a few years of college and currently works in the retail sector. Jennifer had just moved to El Paso from out of state when she found out she was pregnant. Having had a friend who used a midwife and had a home birth for which Jennifer was present, Jennifer in turn was inspired and encouraged to find a midwife in El Paso. Jennifer chose Maternidad La Luz because it was affordable.

Kali

Kali is 35 years old and a Mexican American woman who currently lives in El Paso Texas. Kali has two children and is married. Kali has a master's degree and works for a for-profit college. Kali was the most gregarious of the participants, who had so much to say about

her birthing experience saying at one point in the interview, “I’ve really thought about this a lot.” Kali chose Maternidad La Luz because it presented to her an opportunity to birth in an atmosphere that celebrated birth and honored the birthing woman.

Table 1.1 Participants

Name	Age	Ethnicity	Number of Children	Level of Education	Marital Status
Erin	24	Mexican American	1 Child	Some college	Single
Robin	34	Caucasian	1 Child	4-year degree	Single
Nina	33	Colombian American	2 Children	4-year degree + graduate degree	Married
Carla	34	Native American Mexica Chicana	2 Children	4-year degree +graduate degree	Single
Jennifer	36	Mexican American	2 Children	Some College	Married
Kali	35	Mexican American	2 Children	4-year degree + graduate degree	Married

4.2 Themes of Interviews

This section of the results will cover the three objectives and the findings associated with each objective as was found during the interview process.

4.2.1 The Decision to Birth at Maternidad La Luz

O1: What factors influenced women’s decisions to birth at Maternidad La Luz

Objective one sought to understand why women would choose to birth at Maternidad La Luz even though other options such as a private midwife, or hospital birth are available in the city of El Paso. Through the interview process it became clear with all six participants that community and family influences, affordability and past experiences played a role choosing Maternidad La Luz.

Community and Family Influences

Family members/their community influenced almost all of the participants when it came to deciding to birth at Maternidad La Luz. Attitudes and expectations of childbirth are shaped and conditioned by family, community and religion and is also defined by socioeconomic status of the women (Bogdan, 1990). Participants knew friends or family members who had either used a midwife as their primary health care provider during a pregnancy and/or birthed at Maternidad La Luz. The positive experiences of the friends and family encouraged the participants to seek services at Maternidad La Luz.

Friends (community) can influence decisions. For example, for participant Nina, attending a home birth for a dear friend inspired her to use a midwife for her own births. Nina said, "It was then that I knew I wanted to have a midwife." Being able to participate in her friend's home birth, seeing how well her friend's birth went shaped Nina's outlook on midwifery led births.

Jennifer also knew a friend who had a home birth, and although she was not in attendance for her friend's birth, her friend's positive experience made an impression on Jennifer. Jennifer stated, "I knew about midwives and natural birthing because I knew someone back home who had a midwife and she really liked the experience, but she had the baby at home. She would talk about how she enjoyed birthing that way. I found out I was pregnant, and I remembered how she talked about her experience in a good way."

Erin knew several people who had a midwife led birth and each of those experiences influenced her decision to birth at Maternidad La Luz. "My aunt had my cousin there." Erin had an aunt who had a baby at Maternidad La Luz, and Erin has a sister who lives in out of town and she used midwife for her pregnancy. "I had a friend who had a private midwife" Erin knew another person who had a midwife. Erin discussed that she knew people who had birthed with a

midwife and of how happy they were with their outcome. For Erin, having an aunt who had a birthing experience at a hospital with an obstetrician and a birthing experience with a midwife at Maternidad La Luz and having that perspective really helped in Erin's decision making.

In the case for Robin, remembering that her sister had birthed there influenced her decision as well. Robin paused to consider what care she would go after when "then I realized my sister had her baby at La Luz." For Robin, her close relationship with her sister, and her sister's positive experience with birthing at Maternidad La Luz with a midwife helped shape her decision.

Carla had first learned of Maternidad La Luz while pregnant with her first child. The midwife she wanted to use with her first child was studying at Maternidad La Luz during that time. "You know when I had first learned about MLL, from my midwife with my son, she was studying there." Though Carla was unable to legally birth with a midwife because at the time of her first pregnancy Carla was 15 years old and a ward of the state in foster care. She was determined to have a midwife with her second child, which she did.

Although Kali birthed with an obstetrician with her first child, she birthed with a midwife for her second child. After the birth of her first child, Kali befriended student midwives who worked at Maternidad La Luz and as these friendships deepened she began to learn more about midwifery birth, thus leading her to birth there with her second child.

Strong familial and community ties play an important role. Generally, women do not make decisions of the where/how/with whom to birth, alone. Rather, the decision is made after inquiries. Women will choose a place/person/medical professional based off of recommendations. While it is not the only reason why women choose a birthing place, it is a part of that final decision. A few participants expressed the desire to have a homebirth with a

private midwife, but were unable to afford the cost of a private midwife, so the best alternative for them was Maternidad La Luz. Also the time frame for some of these participants choosing to birth at Maternidad La Luz was prior to the Texas Tech and UMC re-introduction of the Certified Nurse Midwives. One participant had a child after the re-start of the CNM program at Texas Tech and UMC, yet she had no idea that midwives were available in a hospital setting in her own city.

Familial and/or community support or lack thereof may alter preferences, however, even though some of these participants did not fully receive support they still held on to their ideas and plans for their birth. Participants engaged with family and community when it came to making decisions. Erin engaged with her community, “I talked to those friends, I talked to my sister, I talked to my aunt so I could understand why a midwife was better.” She asked questions asked for and received opinion about what was a better experience for her friends, the experiences with an obstetrician or the experiences with a midwife, “I asked around for friend’s and family’s opinion of a good O.B. or good midwife.” Although Erin’s boyfriend was uncomfortable with Erin giving birth at a birthing center with a midwife, he generally did not know what a midwife actually did, “he had no idea what that [having a baby with a midwife] was even about so he thought it was like having a woman come and help you give birth...he had no idea they receive a lot of schooling on pregnancy and birth.” Erin’s boyfriend misconceptions are the common misconceptions people have about midwifery led births.

In addition to having a boyfriend/partner who held misconceptions about midwifery that also shaped his opinions about their knowledge in birth, Erin also dealt with family who were not fully supportive. Erin explained that there were people in her extended family who were not very open to the idea of a midwifery led birth because they also thought that it wasn’t safe,

though her family wasn't too opinionated, she stated. Eric explained, "I had a few family members say something or make a joke." Even though the Erin recalled some family members having opinions and making jokes about her decision, she states that the "the people who I care the most about were very supportive." When inquiring about what kind of jokes were made said Erin replied that it was so dumb she really couldn't recall it now. Erin discussed how a great-aunt of hers told her a story about a baby who died during birth with a midwife. "Aunt...[told] me a horror story of a midwife...caused the death of her baby cousin at birth and made her aunt sterile...I don't want to hear that." This made Erin upset not because of content, but because it was not respectful of her birthing decision. Erin explained that when she retold what her aunt did to her, the person she was retelling the story to simply replied, "well it is a cautionary tale." Erin said, "I don't even know what that means. Doctors still do the majority of deliveries in America (United States) and mothers and babies still die." Erin was upset even when retelling the story. She said to her it didn't matter. "It also didn't change my mind." The story her aunt relayed to her did not change her mind.

In Robin's case, Robin stated that everyone in her family and circle were supportive about her decision to birth at MLL, "everyone in my family, in my circle were supportive about it." Though her sister had birthed there back in the late 80's mother and sister were happy that it was still in operation, "everybody was happy and grateful that La Luz was still there." Robin says that her partner's family was very supportive during the labor and after the labor "my partner's dad- his step dad, was very supportive." The family helped by holding the baby and simply helping with whatever while the Robin did paper work "was there and held the baby while I did paperwork and all that stuff they have to do and get the placenta."

Nina had family that were initially skeptical about her decision but they eventually came around to embracing her decision to birth at Maternidad La Luz with a midwife. Nina states, “My family was unsure about the whole thing.” Though her family was unsure of her decision to use a midwife, “they did trust that my spouse and I had done our "homework" and knew this would be safe for me and the baby.” Even though her mother did comment “*esta con la partera*¹⁰,” she (her mother) too realized that “it was the best choice for me.”

Carla on the other hand did not experience a lack of support, rather, she had the support of her ceremonial cousin who was also her midwife at Maternidad La Luz, and she had the support of her mother who would attend appointments with her. Carla said, “yes people who I respected were very supportive...of course you always get naysayers but those aren’t people who are close to me.”

Though Jennifer and her partner lived in different city from their parents, they still kept in close contact with their families. Jennifer recalls that their parents didn’t understand why they didn’t want to give birth at the hospital. “My parents and my partner’s parents didn’t understand why we didn’t want to use a hospital...both our mothers gave birth in hospitals and they enjoyed their experience.” While their parents were never rude, they also weren’t encouraging “they were polite I mean they didn’t, you know, say anything rude...but they weren’t encouraging. My mother asked me a few weeks later if I was worried about something going wrong with a midwife, but you know I wasn’t.” Jennifer’s mother voice her concern about something going wrong during pregnancy with a midwife, but Jennifer didn’t feel worried, in fact, “the more I heard people questioning me, the more I wanted to do it. My mother, our mothers were worried about something happening but I wasn’t. My partner was a little worried because his mother kept telling him things like, ‘what if she has to go to the hospital, what happens then?’ you know, “what if she starts hemorrhaging then what?” Jennifer states that months after she had her son,

¹⁰ Translation: “This one (her) with the midwife.” Term coined by Maria Cristina Murillo.

her partner told her that his mother had voiced concerns. Jennifer recalls that she was glad her partner did not want to tell her what his mother was saying. “He didn’t tell me any of this until after I had the baby, like I’m talking months later, we were talking and he said, “hey I didn’t want to tell you, but my mom was really worried there.” Both families were worried about something happening, to which Jennifer remarked, “I was glad he didn’t tell me.” Jennifer’s family’s misconceptions about the risk of childbirth with a midwife came perhaps from the fact that Jennifer was the first person in her family who birthed with a midwife. “Nobody in my family had ever given birth with a midwife before, I was the first one, and so they had no idea what it was about.” “Nobody said much else to me, mostly I think because we weren’t living in the same city at that time so I didn’t have to see them...But our parents you know, we talk to them on the phone so much, so, of course we would hear them question the process.”

Previous/Past Experience

Another theme that emerged from the interviews was that some participants had a birthing experience with an obstetrician to compare to with a midwife, either through a family member or they themselves had the experience to make comparisons. This emerged when participants discussed why they were encouraged to birth with a midwife instead of an obstetrician, or when they were questioned about their choice to birth with a midwife. This was something that emerged that five participants mentioned. Having this comparable experience further solidified their feeling that the choice to birth with a midwife was better. For instance, Carla had an obstetrician with her first birth but a midwife with her second birth, Carla liked that Maternidad La Luz took their time to inquire about her nutrition and diet, “even going over a diet plan, what I should be eating, talking about how I’m feeling, you know doctors never did that...they never told me to you know eat more beans and less jalapeno.” In her first birth, Carla stated that though she wanted to use a midwife, she was very young and was not allowed, so she gave birth with an obstetrician and she stated “It felt emotionally sterile with a doctor.” In

contrast, her experience delivering her second child at Maternidad La Luz was empowering and she felt that Maternidad La Luz and birthing with a midwife “was more in-depth, more loving caring, all those great emotional attributes to midwifery care.”

Similar to Carla, Jennifer also had an obstetric experience she could compare to the experience she had with a midwife. Jennifer said that she would say that having had an obstetric experience, she realized how great her first birth (with Maternidad La Luz) was because her second birth (with an obstetrician) was really out of her hands. “My doctor with the second baby didn’t really know me the way the midwives did here.” “My second birth was the exact opposite” (of the positive experience she had at Maternidad La Luz). “We weren’t living here (in El Paso) when I had my son (second child) so my choices were very limited...so I know what it’s like to have an experience where your concerns matter versus having an experience where [your] concerns come 2nd or 3rd to everything else.” When asked to go further into detail about her second birth, Jennifer replied that it was a long story and not something she really wanted to discuss and out of respect for her privacy her second birth was not questioned further.

Erin was a participant that didn’t have a personal obstetric experience to compare with her midwifery experience, though her aunt and her boyfriend had experiences with obstetricians that influenced Erin’s decision to use a midwife for her pregnancy. Erin states, “My aunt talked about how it [Maternidad La Luz] was a better experience than being in a hospital.” Erin’s aunt had an experience giving birth at Maternidad La Luz, and hearing her aunt express how positive her birthing experience was for Erin played into her decision making process. “Having known a few people who had given birth with a midwife instead of a doctor I had a good idea of how happy they were with their decisions to have a baby with a midwife.” Erin explains that her boyfriend had experienced an obstetric hospital birth secondhand when he supported his sister

during one of her births. Erin's boyfriend was present for a portion of his sister's labor and was witness to how his sister was not guided in her pain after she was given Pitocin to induce labor, and his sister had to wait until she was four centimeters before she could be given an Epidural for the pain. Erin recalls that her boyfriend told her after the birth that he realized that she made the right choice because his sister was let alone to deal with her pain before the Epidural, and was mostly alone after the Epidural was administered. Erin states that he was able to see how she was guided throughout the whole labor process.

Kali recalls her first birth in which she chose a well-known obstetrician in El Paso. She began to describe her first prenatal visit. "My first baby, my first doctors visit, first time mama, really young I want know know *everything* and I'm pregnant, tell me what is going to happen!!!" To which she realized, the medical professionals at her obstetrician's office weren't too concerned with what she did and did not know, and their response to her enthusiasm to learn about her pregnancy through them was, "don't worry about it you're fine, doctor's super busy." Kali's first visit did not go as she had thought.

"I waited there 2 hours for the doctor to see me for 10 minutes to make sure, check my weight and check my vitals check out to make sure everything is perfect, but really no time for questions. I remember feeling silly because I was so young, right. I remember feeling like there was nothing special about what was happening to me. It kind of devalued this process for me at 21. The doctor wasn't going to help provide me with any information, I was just going every month."

Kali at a young age faced her pregnancy decision and made the best of her situation with the resources she had. Kali describes going to a tarot card reader and being told by the tarot card reader that she was going to have her baby at night and that it would be complicated so she should be ready.

"So sure enough that day I go to the doctor after dancing all weekend...and I go to the doctor that week and I am 3 centimeters dilated. When I went to the doctor

he was like ‘ok your 3 centimeters dilated I want you to go to the hospital tonight you’re going to have your baby tonight.’ I remember telling the doctor that I don’t have any contractions, my water hadn’t broken and I was like can’t I wait until my water breaks I really want natural birth. And he was like, ‘well if you want to risk infection, that’s up to you.’ At nighttime I got together with all my girl friends. Then, because I remember what the lady told me about the nighttime, I waited ‘til the day-time. In the morning I went to the hospital, they gave me Pitocin, they induced my labor, they broke my water I had absolutely no complications. I gave birth in 4 hours, like boom boom boom no problem what so ever. Within an hour I was walking. Perfect. I did not suffer. The minute I started suffering, they kept increasing the Pitocin and they would ask, ‘are you ok are you ready for your epidural?’ As soon as they got more intense I had to get the epidural, after a few hours I had to. I had to. I went from 3 centimeters to you know, in 4 hours! I got the epidural there is no way I would have done it without the epidural and that was it.”

Kali’s experience of her obstetrician pushing her to go to the hospital at 3 centimeters without contractions or without broken water is typical in the United States. Without contractions, her labor was not going to start, and so the administration of Pitocin helps to artificially start the labor process, but it ultimately leads to epidural use because the contractions from Pitocin come on fast, and are extremely painful. Normal labor contractions start small and build over hours, but with Pitocin, the contractions start big and every contraction after grows bigger in a shorter amount of time. Kali ends her retelling of her first birth by stating, “That wasn’t in my plan at 21 years old and you’re uniquely influential at 21 years-old especially when you don’t know, and at that age I did not know. Even then I look back at myself at that time and I’m very grateful that knowing now what I know, things could have been really intense. I was able to breastfeed my son for a year and a half, at an age where girls aren’t doing that. I was very fortunate and I got by.” After this first birth experience, Kali began to look at other options and she describes how she began befriending midwives by chance. She credits meeting and befriending midwives as part of the reason why she chose Maternidad La Luz.

Affordability

When asked why the participants chose Maternidad La Luz, the cost and affordability was one of the main answers given. Robin mentioned the affordable cost and a way to save

money by birthing there. For Robin, the fear of hospitals was the leading drive to birth at a birthing center, not necessarily the cost. The cost was secondary. Erin talked with her friend and was told how expensive a private midwife was. Erin explained that the price for everything at Maternidad La Luz was affordable and she thought it was worth it for what she wanted – a home birth styled birth, “the price was really affordable for what I wanted.” The cost of Maternidad La Luz was paid for by both Erin and her aunt. Erin’s aunt gave her half of the money for the cost of Maternidad La Luz as a gift for the new baby. “So when I found out Maternidad La Luz was still operating and it was affordable I went with that. Affordability kept Erin from choosing a home birth with a private midwife. Erin explained that she was sure she would have qualified for Medicaid because she wasn’t working and she was unmarried, but she didn’t apply for it because, “I didn’t need it. My aunt was helping me pay [to birth at Maternidad La Luz].”

Jennifer spoke of not having insurance so affordability of having a midwife was the point, “I didn’t have insurance, my partner’s job covered him, but not me.” Affordability of Maternidad La Luz was a draw for Jennifer because as she states, “If it had been expensive, I wouldn’t have done it I think.” When asked what she would have done if Maternidad La Luz had been out of her price range, Jennifer explained, “Well, I guess I would have just given birth at the hospital or something. I don’t know. I didn’t have to think that far ahead, it was like ‘I’d rather have a midwife, let’s just see about this place. I didn’t have to consider a hospital or O.B. at all.”

Although none of the participants had access to private insurance, they had access to state coverage through Medicaid. However, lack of access to private insurance did not play a big role in the decision factor of choosing Maternidad La Luz. The participants wanted a specific type of birth that they felt they could not have in a hospital setting. When the participants spoke of

why they chose Maternidad La Luz, they spoke of wanting a pregnancy and birth that reflected their own ideas of autonomy and choice – even if they did not use those words specifically. Two participants spoke of wanting a homebirth but they were unable to afford a private midwife and so for them, Maternidad La Luz was the right alternative. As Erin explained, “I could hire a private midwife but it was really out of my price reality.” Jennifer also explained “I had considered a homebirth but it was too expensive.” Even though Maternidad La Luz does offer homebirth services for a higher fee, when Jennifer and Erin were asked if they had considered that route both explained that it price for that was still a little more than they could afford. Erin stated, “it wasn’t that much more, but I was already strapped and getting help from my mom so a homebirth through Maternidad La Luz was not an option.” In addition, Jennifer stated, “Birthing at the clinic was within my price range, not their homebirth option. I didn’t inquire much about it because we needed to buy things for the baby so we had to spread money out.”

This data sample shows that finances, more than insurance played a role in the decision making process. If these two participants had enough money, they would have hired a private midwife to birth in their own home. While some private insurance does cover a private midwife, it is not accessible by all. While state Medicaid for pregnant women does cover a Certified Nurse Midwife for low risk births in hospitals, that may not be an option available for all. Texas is one of a handful of states that chose to not to participate in the Medicaid expansion program leaving millions of people without health insurance, so low income women may not qualify for Medicaid their household makes more than the maximum monthly income limit allowed by the state of Texas. A woman with a family of three, with a maximum monthly income limit of \$3400 can still qualify for Medicaid for pregnant women (TDHHS, 2015). However, households over that limit, even by twenty-five dollars, do not qualify. In 2012, Texas changed Medicaid

rules and allowed Medicaid for pregnant women to cover Licensed Midwives in birthing centers, while Certified Nurse Midwives (who practice in hospitals) have been covered by Medicaid since 2009 (TDHHS, 2015). Maternidad La Luz does not currently accept Texas Medicaid for their services, or any private insurance.

Texas Medicaid does cover birthing centers that are lead by Certified Nurse Midwives or physician. Maternidad La Luz does not qualify because the midwives at the clinic are CPMs or LPMs. Previously, the Affordable Care Act did not allow women who became pregnant to enroll after the end of the enrollment period, however this changed in February 2015 (HealthCare.gov, 2015). Now a Special Enrollment Period exists for the following life events: getting married, having a baby, adopting a child or placing a child for adoption or foster care, losing other health coverage, moving to a new residence, gaining citizenship or lawful presence in the U.S., leaving incarceration, and people who had a change in income (HealthCare.gov, 2015). Currently, coverage for pregnant women in the Healthcare Marketplace does not include midwives as birth providers, nor does it cover birth at birthing centers (HealthCare.gov, 2015).

4.2.2 Experiences and Feelings During Labor and Birth

O2: What were the women's experiences during labor and delivery at Maternidad La Luz

The second objective sought to understand what shaped the labor and birthing experience for the participants. Support, control and agency, as well as embodied knowledge shaped their birthing experience at Maternidad La Luz.

Support

Relationship building is essential to laying a foundation for trust between a midwife and the client. Some midwives had a strong sense of spiritual and ritual process which can ease fear and worry for the pregnant woman. For instance, participant Carla interviewed for this research discussed how her midwife at Maternidad La Luz was also her ceremonial cousin and therefore tended to her spiritual needs while also tending to her physical needs as a pregnant woman.

“I think one of the most beautiful variables and circumstances is that my cousin Sam, and she’s my cousin through ceremony, decided to study there that year, before I got pregnant. So by the time I was registering taking my pregnancy test and seeking their services, she had been studying there 3 months so, she was automatically assigned as my midwife. I think that all together she knew my spiritual path and she knew the ceremonies attached to it, so she was able to do pregnancy sweat lodges with me among other things. My mom had said she wish she could get pregnant because she said the way she saw Sam as a midwife she was so wanting to do it over again. She said she wished she could have another baby thanks to Sam.”

While not all women may want to receive the same type of in-depth care that Carla received, her narrative is an example of the kind of care that women can receive with a midwife. In the documentary clients and midwives are seen together in community, sharing knowledge, educating one another, and building relationships that are intimate. In the documentary is a clip of a midwife sitting on the bed of her client in the birthing center, and they are sitting very close. There is an air of familiarity between the two, a testament to the care provided. This type of care differs from the type of care offered by obstetricians in their place of practice and at the hospital.

Within the institutional system of medicine, one form of knowledge exists that generally informs the decision making process; this type of knowledge is referred to as authoritative knowledge. In this hierarchy of knowledge, at the top is the physician who has the knowledge, and below is the patient who is recipient of the skills of physician.

A visual representation of physician led care would look like this, where the physician is at the top, nursing staff second, and then the patient at the bottom, who is a recipient of the knowledge and care of the physician and nursing staff, for example:

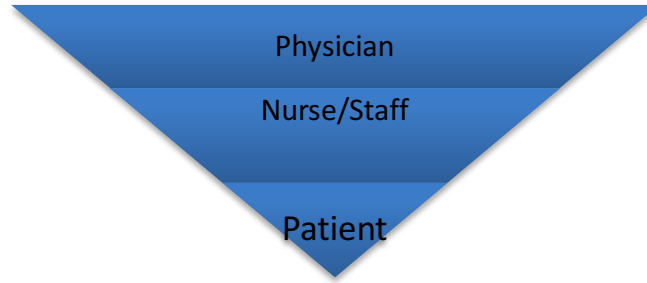


Figure 1.1: Hierarchy of Knowledge Between Physician and Patient

For the midwifery model of care, a visual representation would look like this where the patient is at the center of the care, for example:

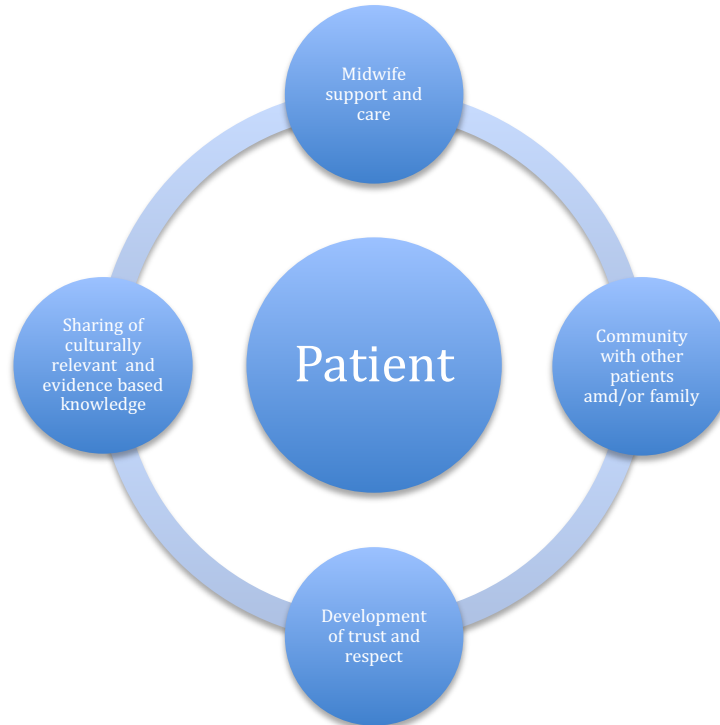


Figure 2.1: Midwifery Model of Care: Sharing of Knowledge.

In the documentary *Catching Babies*, client Rosalba Juarez offers her narrative of why she chose to come back to Maternidad La Luz for another pregnancy.

“My initial pregnancy care was in Juarez and it was very different. The hospital is very different because the questions were really...no one was really worried about how the mother is feeling. They do examinations but they’re very rushed. They don’t spend the time necessary to care for you. They don’t worry about how

you are doing emotionally. They don't ask you if you feel ok, or ask if you are being abused, or make you feel like they really care about you. That's why I decided to return here" (Lucero & Qaasim, 2011).

Within the Midwifery Model of Care, the midwife acts as a guide, and educator, there to empower and encourage their patients. Every participant interviewed discussed how obstetricians generally don't develop close relationships with their patients. However, developing a respectful relationship with a midwife that builds towards trust helps the laboring woman to open up and be vulnerable. For many first time moms, the unknown in labor and birth can lead to fears, mounting fears can cause a woman to close up and be unable to feel safe enough to birth vaginally without the use of pain meds. Groups are essential to a strong community network. As we can see with Figure 2.1 Midwifery Model of Care: Sharing of Knowledge, the sharing of knowledge is circular, dependent on a group community, everyone participating together. The Midwifery Model of Care is inclusive, building trust and community between the midwife and the patient, and within the context of this birthing center, the Midwifery Model of Care creates a community between all patients and midwives. Building community among other pregnant women at Maternidad La Luz also helps establish a trusting atmosphere in the birthing center. Thus, spaces such as Maternidad La Luz allow for the transfer of knowledge, skills, experiences, and stories that women share amongst their familial and social networks about an alternative world that exists for women in the U.S. - Mexico borderlands.

Mardorossian (2003) states that the difference between midwives and obstetricians, is that midwives respond to labor pain by assisting the woman and providing the reassurance that what was happening during her labor and delivery was supposed to happen, and an obstetrician assists the woman by intervening, stopping the pain and doing the process for her (Mardorossian, 2003). Furthermore, effective and often professional support during labor has been shown to

lower cesarean rates, requests for epidurals, and have been shown to lower overall maternity care costs (Mardorossian, 2003). Establishing a comfortable, respectable relationship with the caregiver that will address the specific needs of the woman, whether those needs be to address nutrition and diet, discussing any question or concern at length, respecting 'normal' birth processes, and even simply knowing the patient's name and face makes a difference in the way care is perceived.

Agency and Control

Agency was another theme that appeared across the interviews though none of the participants specifically used the word agency. The participants did however explain situations in which they sought to exercise control over the situation.

Feminist scholar Donna Haraway writes,

“Situated knowledge require that the object of knowledge be pictured as an actor and agent, not as a screen or a ground or a resource, never finally as slave to the master that closes off the dialectic in his unique agency and his authorship of "objective" knowledge. The point is paradigmatically clear in critical approaches to the social and human sciences, where the agency of people studied itself transforms the entire project of producing social theory” (Haraway, 1988, p. 592).

Agency is key in birthing. Birthing isn't something that happens *to* a person, it is a process of which a woman is center. Agency allows one to voice concerns and opinions, to make decisions concerning the process of their birth. Women showed agency by delaying arrival at the clinic, by insisting to stay at the clinic when they showed no signs of active labor.

There is an atmosphere of fear that surrounds birth in the United States and that it seems to dominate how people perceive the process/outcomes/situations in birth. Women tend to give in to the authority and knowledge of the physician/medical person who is assisting them in their birth. Because authority is so strong in institutions like medicine, the medical professional is persuasive. Maternidad La Luz requires that people take an active role in their birthing process.

This is necessary since the labor and delivery is completely un-medicated. An un-medicated birth takes a lot of agency and personal strength to maneuver the process even someone is there to properly guide. Take for instance Robin's urge to defecate during labor, "I needed to take a crap and I told them I needed to poop." The sensation to defecate or urinate is associated with eminent delivery –the baby is about to be born. Robin said the midwives said, "no no it's the baby it's the baby you're feeling the pressure of the baby's head we don't want you to have the baby on the toilet because it happens a lot women think they need to take a crap and they have a baby." Robin felt autonomous enough to voice her need. Robin expressed happiness at the memory of being able to use the bathroom during her labor.

Post partum, Robin experienced pain in her abdomen and she went back to Maternidad La Luz who then referred her to the hospital because it was out of their hands. Robin states that her midwife went with her to help Robin navigate the hospital system because she was concerned that the doctors at the hospital may try to give Robin medication that could harm her breast milk, and/or try to perform a procedure that was unnecessary. "That was the first thing they wanted to do, give me Valium." The student midwife was correct in her concern because the first thing the emergency room doctors wanted to give the Robin was valium, a pain med that the student midwife knew would affect the Robin's breast milk. Robin recalls that the ER docs wanted to give her a vaginal sonogram that is intra- even though the Robin just had a baby and the uterus is considered to be an open wound, "I was like I just had a baby like let's not put anything in there." Robin discussed how she was not open to the intra-vaginal sonogram after having a baby, did not want a catheter to get urine, and she showed agency by saying no to all the procedures, though her midwife was there to help her navigate, Robin made these decisions for herself. Robin was adamant about not having catheter, "I said if I give you a clean urine

sample will you take it and they said yeah,” Robin showed agency and said no and she managed to maneuver, navigate, negotiate during her visit in the ER and was finally allowed to provide a clean urine sample as long as she cleaned well enough. “I told them, if you want an ultra sound, do it on the outside, like you would have done I.V. I was still pregnant why would you want to put it in there?” Robin successfully negotiated an ultra sound instead of an intra vaginal sonogram, and she was appreciative of the support her midwife gave when she had to go to the hospital. Robin exercised her agency in a hospital against their interventions because she felt that they were unnecessary.

Carla exercised her agency, and through embodied knowledge she knew something even though her body was not showing it, “I felt like I was in labor and I said no I’m staying here [at Maternidad La Luz] I didn’t want to leave.” Carla states even though she was not fully dilated, she felt that she needed to stay at the clinic. Nina had a belief in the power of her body to birth, “I always believed in the power of my body to do what women have done for thousands of years-give birth.” For Erin, simply choosing where to birth is an example of agency. Even though there were limits to her choices, Erin felt that “it was really all my decision anyway.” Gonzales 2012 states, “A mother’s decision to assert personal sovereignty over the most intimate and meaningful experience of her life is a key element of self-determination (Gonzales, 2012, p. 234). Asserting agency and control in one’s birthing process adds to the meaningfulness of the experience because one becomes an active participant rather than a passive actor.

Embodied Knowledge

Pregnant women experience embodied knowledge because pregnancy is a form of knowledge that is felt in the body both emotionally and physically. Participants expressed that they experienced embodied knowledge before labor or during labor in ways that were sometimes challenged. For instance, Kali states, “I remember that morning when I woke up, and my belly would get hard and I was like ok, and it was happening frequently. I told my partner to stay

home. I didn't know, I was just like, 'stay' [to her partner]." As her day progressed Kali recalls not having any pain or discomfort.

"I went to the restroom and I had the mucus plug and that's when I knew 'oh shit I am in labor,' and I had kept calling my midwife and she's like 'you sound really good', and she kept telling me, 'you're gonna know when you're in labor,' and I was like ok. I went with the ladies to have dinner and I kept saying, I'm going into labor and you should come over tomorrow. I think I will have the baby by tomorrow and I think it was the hormones talking I don't know because I felt like on cloud 9, I felt happy and nobody believed me. I went to have a fabulous dinner and then around 11pm I was like we should go to sleep. Past midnight I got a contraction and I felt it like [BOOM] and I felt it, like it WOKE me up. And I was like, we *need* to go to the clinic. Because I kept calling my midwife, I called her at 10pm because it was coming every 3 minutes and then she was like 'but you sound good,' I wasn't like AAHHHH I'm in labor, she was like 'you're gonna know you're gonna know.' I knew we needed to get the to the clinic."

Kali did not experience naturally occurring contractions with her first birth, she did not know what to expect, but she felt something happening, though until her mucus plug came out, her feelings were "unconfirmed." The mucus plug coming out, the breaking of the amniotic fluid sack, labor contractions, those are signs that others can use to recognize labor, however, women feel something happening, even if they cannot articulate the feelings, and they feel these feelings before any detectable signs of labor are present.

Carla describes how when she arrived at the clinic, she was only one centimeter, but she knew she was in labor.

"So when I got there my midwife was just on her way out, she had just worked a 24 shift and she was tired and she saw me come through and she knew she had to stay but any way she checked me and said 'go home you're tired you aren't even 1 cm yet' but I felt like I was in labor and I said no I'm staying here I didn't want to leave and so they kept checking me and checking me. I was there 3 hours and I hadn't changed I was still just one centimeter and so she was urging me to go home and I said no I can feel her coming like I said it was from 1-10 [dilation occurred from 1 centimeter to 10 centimeters] in 45 minutes."

Carla knew she was in the final stages of labor even though her body had not yet shown signs that the baby was near birth. She trusted her embodied knowledge and stayed at the clinic

rather than return home to wait. Birthing with a midwife, allows space for embodied knowledge to be validated. Even though these women felt something that their midwife felt might not be the case, the feelings of the participant were respected and validated first and foremost.

4.2.3 Post Birth Reflections

O3: What post partum reflections did women in this study have about birthing at Maternidad La Luz

The goal of this objective was to understand how women felt about their overall birthing experience with Maternidad La Luz. Regardless of outcome, all participants interviewed felt positive about their experience birthing with a midwife at a birthing center. Every participant expressed deep gratitude, appreciation, and positivity with their birthing experience at Maternidad La Luz, even if they did not ultimately birth at Maternidad La Luz, as was Nina's experience.

“It was such a beautiful experience to spend time with these miraculous women doing this amazing work. I felt safe, calm, and loved. For me there was no better place to have my baby. I never went into labor naturally. When I reached my 41st week, my midwives attempted every trick in the book to help start my labor "naturally." But it never happened. On the evening of the last day that Texas law allows me to be in the care of midwives before having to go to the hospital, they broke my water but still no labor came on. At 10:30 pm the midwife on duty informed my crew of miracle workers, Heather Sinclair, Betsy, my mother and my husband that I would need to go to the hospital because they could no longer be part of my birth. Yes, they went above and beyond my expectations. They filled me with hope that I would finally be able to have the birth experience I wanted, but they are not above the law. The closest thing to having a home birth is going to MLL. What a sweet and calming space for women of all walks of life to experience birth on their terms.”

By law birthing centers in Texas can only allow a woman 18 hours to attempt birth, then they must transfer to a hospital. Though she was unable to birth at Maternidad La Luz with a midwife, Nina still feels positive about the care she received there, and she refers to her team as “miracle workers” despite having to transfer care to a hospital.

Jennifer exclaimed, “Yes! Beyond yes! It was such a good experience. I felt like my concerns mattered. My second birth was the exact opposite. We weren’t living here when I had my son so my choices were very limited. I was so happy with my first birth, really. I tell friends and family who ask of course, that they should give birth with a midwife.” Having a positive experience has led Jennifer to inform others within her community of the options available, Maternidad La Luz being one of the best options in her opinion.

Erin felt satisfied with her experience. “I was very happy. I think that I would have another baby there if that time ever comes again. I don’t know what it’s like to have a baby at the hospital with a doctor, but you know, the midwife I had was amazing. Every appointment was catered to my needs and I had a really good experience. I was very happy with everything. I wanted to birth at home, but I really think birthing at Maternidad La Luz was like the next best thing.”

Carla was able to share her prenatal care experience with her mother, which left a positive impression upon her. “My mom had said she wish she could get pregnant because she said the way she saw [my midwife] as a midwife she was so wanting to do it over again. She said she wished she could have another baby thanks to my midwife. You know, it was always loving. That is the best way to describe it. Mom said she learned so much going with me, she learned like what the hell is going on in our bodies? So loving, educational, empowering.”

Robin said “what I liked about it which might be something other women might find as a problem is that they didn’t get too involved with you, it was like you come once a month, we check on you that day, then we just kind of let you be. There was no forcing of things. If everything seemed fine and you felt good they were ok with that. I personally enjoyed meeting

all the women [other midwives] so it was nice.” Robin described her labor and birth as “it felt like some sort of village feeling” because she was surrounded by a community of people.

Kali spoke at length about her feelings concerning midwifery and birth. For Kali, the overall experience from having her friend be her midwife, to having support and love during her birth, made her experience positive. Kali said about her midwife, “she was really cool. She was my friend. She gave me a book that got me weeping, and the way she gave it to me, she put it on my bed she didn’t push it on me, she didn’t push me. She was really cool. I love her. I will always value her. She never doubted. Never. She was like, you got this. And that’s what you need, you need people like that.”

About her birthing experience Kali said,

“I wrote this list of how I wanted my birth to be, it starts programming something, like a prayer. I remember writing I wanted a sense of humor and I remember making the midwives laugh during each break. I wanted a water birth. There was nobody at the clinic, it was night-time, they filled the water tub, they lit candles, it was like something that doesn’t happen. It was perfect. As soon as I got to the water I remember the water lifting my body helping me rest, helping me carry myself and I remember feeling getting twisted up and I remember saying one time, *ya quero que salga ya*. And really feeling, ‘get out of me.’ I remember feeling like 5 more contractions and I heard something like “when Sam comes” and when Sam got there I remember smiling and I pushed the baby out and I pushed and my water hadn’t broken and a bubble came out and the bubble burst then my daughter came out and my partner caught her and turned her over and then laid her down on me. And there was this bliss, you know you are in a euphoric bliss. I would do it again.”

Kali said she knows that her positive experience was possible because the midwives provided space for her to trust herself.

These experiences discussed in this section provide insight into the services that Maternidad La Luz provides. In the next chapter I will go into further detail about these participants’ experiences.

Chapter 5: Discussion and Conclusion

5.1 Discussion

The research of this thesis set out to explore how women make birthing choices specifically to understand why women choose to birth at a birthing center when other options are available. In addition, the research of this thesis wanted to understand how women perceived their experience and treatment birthing with a midwife at a birthing center. The lives of women, as a marginalized group, are shaped by the social, cultural and political world around. Choices offered to women in regards to their reproductive health are limited, and women make the best decisions they can with the resources best available. Over the course of centuries, the way women birth has changed to a highly technological and bio-medical procedure. The decision to birth at a birthing center is not separate from the history of obstetrics and midwifery. Birthing with a midwife was once the way all women birthed has become “alternative” and different from the social and cultural norm. Some of the participants wanted a homebirth and remarked that birthing at Maternidad La Luz was the next best available option for them. Women make these decisions in response to the limitations and circumstances in the world around them.

Applying the life course approach in sociological terms concept to the research presented in this thesis, the choices available to the participants were shaped by institutional regulations and social structural forces. As I presented in the literature review section when I discussed the history of midwifery and obstetrics in the United States, laws and perceptions were shaped over time by entities who wanted to legitimize and standardize pregnancy and birth. Over time, through periods of regulation and legitimization, midwifery became subversive as the technocratic model of birth became standard and normalized. The technocratic model of birth became normalized as laws prevented women from being able to practice midwifery, and it was normalized when hospital birth became a status marker for women of a certain economic class.

Although a shift in perception and practice is taking place regarding midwifery, it's still institutionally regulated in a way that it is not a birth option available to all women living in the United States. Institutional regulations such as private insurance or state Medicaid cover services received by only certain professional midwives instead of all professional midwives regardless of birth setting (i.e. home, birth center, hospital). Social structural forces such as misconceptions about the safety of midwifery led birthing centers play a role in how people support women choosing that type of birth. Women as a marginalized group deal with a whole host of social pressures and issues, and heavy regulation of reproductive bodies is part of that. Women at the moment of choosing to be pregnant and have a child are working to understand a new social identity as their bodies undergo a hormonal and physiological change.

As argued, life course approach offers a roadmap to improved healthcare of mothers, children and families on a national level. The two goals of life course approach are, 1) to optimize health across the lifespan for all people, and 2) to eliminate health disparities across populations and communities (Fine & Kotelchuck, 2010). This research has shown that bodily autonomy and agency is crucial for women in their birthing process. In addition, various longitudinal studies presented in this thesis have shown the safety of birthing centers in comparison to hospital births. The safety of birthing centers is also connected to not using intrusive technology such as fetal monitoring systems, epidurals, and Pitocin, rather relying on techniques that are less intrusive and less technologically based. As explained in this thesis, intrusive techniques can create complications during labor, starting a domino effect that leads to cesarean sections, which can lead to a host of future health problems for the woman and the newborn child. Women who are active agents in their pregnancy and birth can have better outcomes in terms of complications during pregnancy. The midwifery model of care, as

demonstrated in the longitudinal studies presented in this thesis, offer a way to make space for women to be active agents in their pregnancy and labor. The midwifery model of care is not present in hospital setting, making the laboring woman reliant on the authority of the medical staff. As discussed, women with low SES have a greater exposure to maternal health disparities. Thus, using the two goals of life course approach in maternal health can progress the movement of reproductive health care for all.

I used feminist standpoint theory as a way to analyze the women's narratives simply because feminist standpoint theory offers a space in which the subjective nature of "experience" is accepted as legitimate. It may be questioned whether or not the experience, the feelings, the embodied knowledge is scientific enough. The institution of science is a product of heteronormativity and patriarchy. Harding (1987) would argue that because women have been excluded in many ways from the institution of science, the woman's perspective of the embodied experience (birth), an experience that men cannot fully partake in, is a part of science. "Women are valuable 'strangers' to the social order. Another basis claimed for feminist research by standpoint thinkers is women's exclusion from the design and direction of both the social order and the production of knowledge." (Harding, 1991, p. 124).

Hesse-Biber, Leavy, and Yaiser (2014) explain feminist objectivity as

"Knowledge and truth that is partial, situated, subjective, power imbued, and relational. It combines the goal of conventional objectivity – to conduct research completely free of social influence and or personal beliefs – with the reality that no one can achieve this goal...and recognizes that objectivity can only operate within the limitations of the scientists' personal beliefs and experiences" (p.13).

The birth experience is subjective because only women can birth, men cannot, and because of this, men can only exercise objectivity in their research and understanding of the complexities in birth. "Although labour is a universal physiological process, the more tenuous

interrelated psychological and emotional elements that women experience are often ignored in favor of more tangible components such as quality of care, interventions, and mortality and morbidity measures” (Larkin et al., 2007). Numerical and statistical data provide only one part of the information. A woman’s embodied knowledge, her perceptions, her feelings- they are all a part of science, as Harding (1987) explains

“Reflection on how social phenomena get defined as problems in need of explanation in the first place quickly reveals that there is no such thing as a problem without a person (or groups) of them who have this problem. A problem is always a problem for someone or other. Recognition of this fact, and its implications for the structure of the scientific enterprise, quickly brings feminist approaches to inquiry into conflict with traditional understandings in many ways” (p. 6).

These insights allow for the institution of medicine to improve the service of patient centered care and a reduction in barriers for patients seeking medical care. Women’s perspectives offer a fuller insight into the experience of birthing just as much as knowing when a fetus’s heart starts beating, or knowing when the lungs are fully formed in utero – it is all important knowledge that is relative.

When women are given choices, when they are supported in their decision, when they are given space to feel empowered, to exercise agency and are respected in their embodied knowledge, their experience was positive. While this thesis does advocate for midwifery-led birth, it also advocates for women to have the agency to choose whatever birthing preference that is best for them. These birthing testimonies are a part of feminist epistemology of co-generating knowledge because they add the women’s perspective on something that affects the psyche and physical body of those who birth. The study of childbirth is to make sense of the biological and cultural phenomena. Any work or research that adds to the field, contributes to the every growing data. “Advancing an understanding of women’s experiences of childbirth has both

practical and political relevance in current health-care systems to guide practice, policy formulation, and research” (Larkin et al., 2007). Understanding how women feel during their prenatal care, during the labor and birth and post partum is essential in creating a better maternity care system in the United States. Exercising choice and agency in the birthing process can ensure better outcomes for the woman, even if in the end, she doesn’t necessarily have the type of birth she initially wanted.

The women who participated in this research all had a similar commonality – they either knew someone who had used a midwife for their pregnancy and birth, or they knew someone who had specifically birthed at Maternidad La Luz. In this sample of participants, all of them had some type of prior knowledge of midwifery and/or Maternidad La Luz. Most of the participants expressed some form of skepticism from family members or friends over their decision to birth with a midwife, yet they all remained steadfast in their conviction that the decision they made was the right one for them. It seemed that when prompted to describe the day they went into labor, some women chose to describe it in detail, some described the most important parts of those memories, the cherished portion, the part of the memory that stood out the most. That was what made up their memory and chosen part of their experience as most special. It was their birth story, remembered in snap shots, that created points of interest.

Four of the six participants interviewed have degrees, while one has attended some college and one has no higher education experience. Having a college degree did not necessarily transfer into economic mobility for all the participants. While these women may not have had economic capital to be able to afford private insurance, they had social and cultural capital. Their education helped them know how to access research and information, learn of different birthing possibilities, they reached out to friends and family seeking advice and

recommendations. Maternidad La Luz was not a last choice for the participants in terms of wanting a hospital birth and then choosing Maternidad La Luz out of economic necessity. However, two of the participants interviewed discussed wanting to have a home birth with a private midwife but they were unable to afford the cost of a home birth and so Maternidad La Luz was the best alternative. All the participants interviewed discussed wanting to have a certain type of birth they felt would not be accomplished in a hospital setting. To be able to have a certain degree of control in their pregnancy and birthing process, Maternidad La Luz was chosen. Participants spoke of wanting to have control because they had either already experienced a hospital birth with an obstetrician and having a negative experience or they knew someone close to them either a friend or family member who had a midwife led birth and had a positive experience and that was highly influential. The participants also chose Maternidad La Luz because they felt Maternidad La Luz would respect their wishes, their body, their space, so that they can effectively give birth. Choice is about perspective. A low-income woman, especially low-income women of color, might want to birth with an obstetrician in a hospital because it affords them the opportunity to receive health care that they otherwise would not have received. In addition, as Fraser (1998) argues, women of color who have been systemically left out of the hospital system may want a technological birth.

Returning to the conceptual definition of ‘childbirth experience’ as presented in the beginning of this research by Larkin et al., (2007), the four main attributes of individual, complex, process, and life event were present in the interviews conducted. With the ‘individual’ attribute, women discussed how they as individuals felt about their choices and experience giving birth, and they each had different approaches to the universal act of giving birth. For the ‘complex’ attribute, the participants discussed how they dealt with their feelings during different

stages in birth. For the 'process' attribute, the participants acknowledged the different processes or stages of their birthing experience, often associated with feelings and the work the women knew they had to do to mentally be able to birth. The last attribute, 'life event' was present as well, though perhaps not as distinctly. The participants discussed how birthing with a midwife helped them feel empowered, and they felt positive to enter motherhood after a positive experience.

Connecting back to the literature on support. Support from partner or family increased feeling of positive experience and overall better quality of life post partum (Nohara & Miyagi, 2009). Support during childbirth may help women feel positive about their birthing experience. Support in the literature is described as a caring presence and the giving of emotional assistance. The midwives at Maternidad La Luz give endless support to women during labor and birth which is necessary in order to be able to birth vaginally with out pain medication. As discussed, within the childbirth experience, women go between feeling like they could give birth and feeling as though birthing was not possible. To over come the feelings of impossibility the birthing woman needs to be reminded that she can do, that she is strong, that she is supported. Kinds supportive words make a difference. Indeed, also treating women with respect and dignity during labor and birth add to the dimension of support. If women's wishes during labor and birth are respected, then she is going to feel positive about her birthing experience. To be able to birth vaginally with out pain medication, pregnant women must overcome past trauma and learn to trust and open up; to be vulnerable. To do this, a trusting and respectful relationship must be established with the health care professional. This type of relationship is key to the Midwifery Model of Care, which is essential to the practice within Maternidad La Luz.

It's Not Just Poor Women

There are several misconceptions and stereotypes associated with midwives and the women who birth with them. Misconceptions and stereotypes exist because women who birth with a midwife act outside of a generally socially accepted way to birth. In short, they are the subversive ones in any cohort of pregnant women. These women are the ones who choose another way to receive care during pregnancy and birthing – a way that is vastly different from receiving care from an obstetrician and birthing in a hospital. While in the past midwifery was used predominately by poor women, in present time, women of all socio-economic backgrounds in the United States birth with midwives. Maternidad La Luz states on their website (2012) that women who choose Maternidad La Luz are primarily Mexican or Mexican-American and choose to birth at Maternidad La Luz based off of recommendations from family and friends who have previously birthed at Maternidad La Luz. In addition, Maternidad La Luz provides a short list of reasons why a woman would want to birth at Maternidad La Luz: a long standing tradition of midwifery in Mexico, a desire for woman-centered and women-attended care, a belief in the normalcy and naturalness of birth and motherhood, economic considerations, a desire for US citizenship for their children (Maternidad La Luz, 2014). These questions help answer why these women in this research choose to birth at a birthing center with a midwife. Women who come over from Mexico to birth in the United States is a practice that has continued since the development of the U.S. Mexico border. There is a long history of this practice taking place along the U.S. Mexico border. Though it is not the place of this thesis to explore the vast socio-political complexities associated with this issue, I do argue that the relationship between the U.S. and Mexico is nuanced and there is a shared life experience among the peoples who occupy that geographical space. Furthermore, it must be noted that for generations people living along the

border have crossed and lived on both sides of the border either because of work or family obligations.

Women who travel to the United States to birth must meet requirements for traveling to travel to the United States. These requirements, set by the U.S. Department of State, are a part of different visas that can be used to cross the U.S. Mexico border. Although there are different types of visas, the Tourism Visit Visa or B-2 is designated to allow people to visit the United States on vacation; visit friends and family; participate in social events hosted by fraternal, social, or service organizations; participate in amateur sports, musical or similar events or contests as long as the person is not paid for participating; enrollment in a short recreational course of study that is not for credit toward a degree; and medical treatment (Department of State [DoS], 2015). For people who are residents of Mexico, Border Crossing Laser cards are used to cross, however people with these cards are still required to meet the different visa requirements set for the by U.S. Immigration law (DoS, 2015). Furthermore, as stated on the official government travel website, every visitor is an intending immigrant unless they show otherwise (DoS, 2015). To overcome this presumption by the U.S. State Department, applicants for the B-2 visa must show “that the purpose of their trip is to enter the United States temporarily for business or pleasure; that they plan to remain for a specific, limited period; evidence of funds to cover expenses in the United States; that they have a residence outside the United States as well as other binding ties that will ensure their departure from the United States at the end of the visit” (DoS, 2015). These guidelines, as well as the process and procedures surrounding visa obtainment are meant to deter people from easily entering the United States.

I had the opportunity to speak with a former midwife from Maternidad La Luz who informed me that women who come to birth from Juarez aren't necessarily poor women, but

rather, many women from different professional fields have birthed at Maternidad La Luz (H.S., personal communication, 2015). The requirements and guidelines set by the Department of State for obtaining a B-2 tourist visa show that one must have access to personal documents such as birth certificates and identification, as well as monetary resources and ties to their country such as a job, business, or property ownership. Women who come from Mexico to birth at Maternidad La Luz may very well not be poor women, but rather women with access to the means necessary for approval for a B-2 visa, the fees, and ability to travel the across the border into the United States to birth.

5.2 Conclusion

Through an intersectional feminist lens, choice is critical and essential to reproductive freedom. Choice is key in reproductive health justice. Having access to choices and being able to choose a path that best suits one's needs is an essential part of reproductive health justice. Reproductive justice in terms of pregnancy, labor and delivery means giving the woman space to practice body autonomy, providing women with enough educational evidence based resources to help them make the best decisions regarding their pregnancy labor and delivery. Women want a certain type of birth because it appeals to their set of values, or because that type of birth is how they want to bring a new life into the world. Women who birth with a midwife must learn to deal with fears about pain in childbirth in order to be able to birth with out the use of pain medication. Releasing fears about the pain in childbirth takes time and practice, something that women who birth with midwives work on during their pregnancy. Taking time during each appointment talking with each individual patient about her specific needs, and emotional and physical issues, over time helps create a bond of trust between the woman and the midwife. In turn, this bond helps patients to understand that they can trust in the midwife's abilities to help

her birth without pain medication, and that helps the patient learn to trust herself and her body's ability to birth another human being.

Midwifery crosses borders, boundaries, and cultural lives with women's bodies. Midwives like the ones described by the participants in this thesis and the midwives featured in *Catching Babies*, spend quality time with their patient, developing trusting relationships. They learn Spanish and are able to communicate with the clients in Spanish, using correct terminology for anatomical references. Importantly, they learn the regional border Spanish idioms and lingo, an important aspect of learning a foreign language. Speaking regional Spanish helps to develop a bond. In the video, the midwives conducted various classes in Spanish with the clients, and the clients are engaged and are actively a part of the discussion. A few clients discuss having a previous child and pregnancy with an obstetrician and not being taught anything about birth by their doctor. They go on to explain that, receiving care at Maternidad La Luz also meant that they were taught so many things about birth, nutrition, emotional and mental health well being. This sentiment was also one that was constant with all the participants interviewed for this thesis. The midwives being able to speak Spanish crosses barriers and borders and in turn helps women access critical care.

Some feminist literature may portray the dichotomous relationship between the physician/obstetrician and midwives as conflicting, painting the physician/obstetrician as elitist and misogynistic (Litoff, 1990), however it is not the point of this thesis to defend or condemn that dichotomous relationship. Any progressive critique of this dichotomous relationship would be wise to first recognize that it is the institution of biomedicine that creates a disharmonious relationship between physician and midwife, and it must be acknowledged that physicians and obstetricians are helpful, supportive, and vital for pregnant women and their birthing experience.

However, this thesis would be remiss to neglect recognizing that creating better maternity care in the United States will necessitate reconstructing the current bio-medical system to include midwives and even doulas¹¹ as part of the birthing atmosphere in a hospital setting.

All childbirth options are not available to all women. The availability of options corresponds to socio-economic status, meaning that women who have greater SES have access to more financial and social capital that provides more options for birthing and motherhood choices. When women have access to more money and more education, women can choose to birth however they want – they can afford a private midwife to birth at home or they can choose to birth in the best hospital available to them. The choices become endless for women with higher SES. Women with lower SES tend to have limited birthing choices that are dependent on insurance coverage, financial limitations, access to services, and affordability. Unlike a woman with high SES, a woman with low SES doesn't have as many birthing choices, a woman with low SES will have to make certain choices within her financial limitations, choice that she would otherwise not want. Within these constraints, women have to make decisions with the best available options. Birthing centers like Maternidad La Luz are important because they provide a space where women can trust their bodies to go through the process of birth without too many technological interventions. The affordability of Maternidad La Luz helps women afford the type of birth that gives them space to birth.

All women deserve full respect and dignity during their pregnancy and birthing process. Women interviewed for this thesis acknowledged that, for them respect and dignity could only be gain by receiving care with a midwife rather than with an obstetrician. This

¹¹ Doula is a “woman who attends births in order to support the mother and assist the primary birth attendant (whether a physician or midwife)” (Rooks, 1997, p. 10).

acknowledgement came from knowing people close to them who birthed with a midwife or their own personal experience having an obstetrician for one of their births.

At the cusp, women are negotiating at the intersection limitations and affordability. Women want to make the correct decision that best suits their life, but they must do so with limited choices. Real life constraints factor into the types of choices women can make. Lack of private insurance, money, job, time, citizenship, and family support can play a role in the decision making process. There is ideation with birthing with a midwife in a birthing center or at home. Reality of the situation is that birth is unpredictable, and there is risk involved. Women are trying to manage the unpredictability and risk when they manage the type of prenatal care they seek.

5.3 Limitations

There are limitations experienced with this research. To begin, the scope of this research sample is small, only six participants. Maternidad La Luz describes their clientele as being majority Mexican nationals who speak primarily Spanish. In all my attempts to find clients who meet that criteria, I was unable to find one who wanted to participate in this research. There are distinct, lived experiences of women who were not a part of this research though they should be. Without being able to interview these women, I am unable to include their experience, thus leaving out an essential part of the research. Because Maternidad La Luz was unable to be a part of this research, I feel that I have been unable to delve deeper into this research, therefore, what I have presented here is simply the tip of this research. Future research should involve Maternidad La Luz more fully if they are willing to be involved. Maternidad La Luz's inability to be involved in this research is understandable because they are very busy with teaching students and working with clientele.

5.4 Implications for Future Research

The knowledge generated from this research is important. For future research, a comparative study that interviews women who have either birthed at Maternidad La Luz, with a private home midwife, at a hospital with an obstetrician physician, at the hospital with a Certified Nurse Midwife, and perhaps even interview women who had unattended home births, would be a study that would generate more knowledge and understand the ways women in El Paso County along the U.S-Mexico border, negotiate, make decisions pertaining to their birthing process. I argue that this research is crucial to the birthing community in El Paso Texas. Very little research exists about women of color birthing in El Paso, along the border, with midwives, in birthing centers. This data is necessary.

5.5 Future Policy Implications

As presented in this thesis, data shows that midwifery model of care led births are safe, have better outcomes than obstetrician based hospital births, and contributes to better overall satisfaction and well being of the patient. This type of birth is also less expensive than obstetrician hospital based births. Private insurance and state run Medicaid should consider revising their rules and allow full coverage of all professional midwives who work in hospitals, birthing centers, and in private homes. This full coverage will guarantee women access to all the different types of prenatal care available. In addition, because the midwifery model of care follows a system of relationship building, respect, and follows evidence based care, it could lead to a decline of maternal mortality and morbidity. Asking women, asking women of color, what their experience was like, to hear from their own point of view, brings another dimension to the decision making-policy creating table, then issues that affect their communities can be recognized, addressed and policy can be created to alleviate the issue.

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Appendix

Interview Guide

How old were you when you gave birth at Maternidad La Luz?

How many children have you given birth to in total?

Why did you decide to birth at Maternidad La Luz?

How many weeks were you when you first went to MLL?

Were your friends and family supportive of your decision to give birth at a birthing center with a midwife?

Did you encounter anybody who voiced misconceptions about midwives and/or birthing centers?

Describe the kind of care you received once you started going to MLL for prenatal care.

Did you have the same student midwife every time?

How many weeks were you when you went into labor?

Describe the day you went into labor, what was the process?

Did you know any midwives personally as friends or acquaintances before you went to MLL?

Were you satisfied with the level of care you received at MLL?

If you were to have another baby, would you go back to MLL?

Have you recommended others to MLL?

Vita

Anessa Anchondo-Rivera was born in El Paso Texas. She attended The University of Texas at El Paso where she received her B.A. in Sociology and Women & Gender Studies in 2011. Her areas of interested are reproductive healthcare justice and education. Anessa works within the El Paso community through various non-profit organizations, and organizes community events through grass-roots collectives.

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