Role of Lay Midwifery in Maternity Care in a Large Metropolitan Area

FLORENCE ELLEN LEE, RN, MPH, and JAY H. GLASSER, PHD

MATERNAL AND CHILD HEALTH has traditionally occupied a central role in the delivery of medical care. It is not surprising therefore that it has also been in the vortex of our societal concern for the adequacy and availability of medical services. A basic ingredient of maternal and child health is, of course, adequate maternity care. The proliferation of social programs—Medicaid and neighborhood health centers, to cite but two examples—illustrates the cumbersome public fiscal insurance and piecemeal delivery programs that have appeared on the medical care horizon and which directly affect maternal services. Problem areas in these services have been defined both by the providers and consumers (*1–3*). The unmet needs in U.S. maternity care are documented by the unattended home deliveries reported in recent newspaper articles, the lack of prenatal care of an estimated 20 percent of expectant mothers, and the fact that the United States does not have an enviable infant mortality rate (*4–7*).

The debate about the future of medical care delivery has grown louder and more pervasive. The issues of the cost, quality, and continuity of care—including maternity care—are being described in terms of access, manpower, consumer attitudes, and the reorganization of systems (*8–15*).

Ms. Lee is assistant professor, Scott and White Department of Nursing, Mary Hardin-Baylor College, Belton, Tex., and Dr. Glasser is associate professor of biometry and computer sciences, School of Public Health, University of Texas, Houston. Tearsheet requests to Florence Ellen Lee, RN, FEL, Mary Hardin-Baylor College, Belton, Tex. 76513.

Our purpose is to view one aspect of medical care delivery, the use of midwife services. In many developed countries both the midwife and home delivery are formally built into the care system (*16*). In the United States, the practice of midwifery is usually regarded as a curious anachronism, although the nurse midwife has been accepted on a limited basis as a junior member of the maternity team (*17–18*). The lay midwife, on the other hand, is largely unrecognized by, and has little contact with, members of the medical community (*19*). Few articles or studies document the characteristics, or even the existence, of lay midwifery and its clientele despite the possible influence such practice may have on maternal and child health.

We have collected data on the characteristics of the lay midwife, her practice, and her clientele in a multicultural setting, Houston and Harris County, Tex. We specifically sought to discover why expectant mothers in this setting had midwife home delivery — whether out of ignorance or choice. The extent of midwife practice in this urban area, its needs, rationale, and content, led us to question some widely held assumptions about maternity care services and midwives. Specifically it raised questions about (*a*) the necessity of routine hospital delivery, (*b*) the autonomy of the U.S. physician in the provision of maternity care, and (*c*) the concept that lay midwives and home delivery are used only by the underprivileged, women lacking adequate finances, sufficient knowledge, or conventional maternity care resources.

Background

A 1956 court decision (*State* v. *Banti*) ruled that the midwife (Banti), who had been charged with the practice of medicine, was not guilty under Texas laws, and therefore she might legally practice midwifery. A provision of the Texas public health laws requires midwives to register, and in 1970, 1,500 were registered in the State; they were credited as being attendant at 2.3 percent of the total live births reported in the State that year, according to a U.S. Public Health Service report (*20*), "Vital Statistics for Texas, 1970" (*21*), and raw data for 1970 from the State health department. (We assume that most of the birth attendants who were classified as "midwife and others" were midwives.) The percentage of recorded deliveries by lay midwives in Texas in 1970 ranged from none in some counties to more than 20 percent of total live births in others (table 1).

Table 1. Deliveries by lay midwives in Texas counties in 1970 in relation to total live births

Percentage of midwives deliveries	Total counties	Total live births	Total midwife deliveries
Less than 1 ...	120	143,959	405
1–9	114	72,608	2,221
10–19	15	8,642	1,121
20 or more	5	5,415	1,562
Total	254	230,624	5,309

SOURCE: Reference 21.

In the Houston-Harris County area, where maternity care services are offered by both the public and private sector of medicine, the 9 lay midwives registered at the local health department during 1970 were reported as having attended 122, or less than 1 percent, of the 34,543 reported live births that year (*21*). These nine midwives apparently did not solicit business; nor were their names available to expectant mothers through the health departments of Houston or of Harris County.

The only formal contact between the area's lay midwives and the medical community was apparently an annual visit scheduled—but not necessarily completed—by public health nurses to the homes of the midwives. Some members of the medical community were apparently unaware of the existence of the local lay midwife practice, while the lack of contact of other members of the medical community with the lay midwives was apparently strategically planned "with an eye to elimination [of the practice of midwifery] in the future" (*22*).

Methods

Our methods consisted of casefinding and intensive interviewing of lay midwives and of mothers who had used their services. Health department personnel aided in the compilation of a list of 12 such midwives, which was finally expanded to 13. With the help of these 13 midwives and the mothers interviewed, a list of 52 mothers in the area who had used midwife services was also compiled. We believe that all the area's lay midwives were thus identified. Through pretested questionnaires and informal discussion, information was obtained from 46 mothers and 11 lay midwives. One interview with a midwife was incomplete. When needed, an interpreter assisted with the interviewing.

The majority of the residences of the 13 lay midwives and the 46 mothers studied were in Houston, the largest city in the area. Otherwise, there did not appear to be a particular pattern in the distribution of the women by census tract. Although the lay midwives and the mothers using midwife services in some instances lived in close proximity, the nearby midwife was not necessarily the one used. Possible explanations for this were volunteered by the mothers when they were interviewed. Some stated that they contacted several lay midwives one by one as they learned of them before selecting their own midwife. Other mothers apparently used the services of the first lay midwife they found.

Midwives Studied

Social and personal. All the lay midwives we identified were either Mexican-American or Negro women. Those interviewed, however, served all the major racial groups of Houston and Harris County—blacks, Caucasians, and Mexican-Americans. Table 2 summarizes the social and personal characteristics of the 11 lay midwives in the study area. All the midwives interviewed either were or had been married, and all except two had children of their own. The median number of children was four. The majority of these midwives were housewives who had owned and lived in their present homes for a median period of 16 years. These homes ranged from small unpainted houses in need of repair to apparently well-maintained two- to three-bedroom frame houses. A physician was the midwife's usual source of medical care. All the midwives interviewed were considered to be literate, as evidenced by copies of their birth certificates which they themselves had completed and signed.

Table 2. Social and personal characteristics of the 11 midwives and 46 mothers interviewed

Characteristic	Midwives	Mothers
Median age range	56–65 years	30–34 years
Median educational attainment	9th grade	10th grade
Median monthly gross income	Less than $300	$300–$450
Median period in present residence	16 years	5–9 years
Own their home	11 midwives	28 mothers
Married or has been	11 midwives	38 mothers
Race		
Negro	4 midwives	20 mothers
Mexican American	7 midwives	18 mothers
Caucasian	0 midwives	8 mothers

Training. The 10 lay midwives with whom interviews were completed reported that they had been trained informally: 4 had been trained by a physician, 4 had been trained by another lay midwife, and 2 had "learned by doing." After practicing midwifery, three of the women had attended classes for lay midwives. All said, however, that they had not attended refresher classes and that classes had not been available to them within the preceding 5 years. The majority reported that no one in the medical community had discussed pregnancy, labor, or delivery with them within the past 12 months. Exceptions included two practicing lay midwives who stated they had consulted with a physician. Awareness on the part of the lay midwives of their limitations is demonstrated by the fact that a majority said they would be interested in attending refresher classes.

Current practice. The median period of practice of the lay midwives interviewed was 34 years. Seven women actively practiced in 1970, the study year; six were actively practicing in mid-1971. The small number of lay midwives practicing, coupled with the difficulty the mothers reported in finding a lay midwife apparently resulted in delayed prenatal care. All the lay midwives reported that they routinely referred clients to a physician. Several Negro and Mexican-American mothers not included in this study reportedly had had deliveries at home "unattended." The median number of deliveries during 1970 attended by the midwives interviewed who were actively practicing that year was seven. The lay midwives, as well as assisting with delivery, had prenatal and postnatal contact with a majority of the mothers using their services. We learned from the mothers and the midwives that the extent and scope of that contact was tailored to meet the mother's individual needs.

Mothers Using Midwifery

Social and personal characteristics. The social and personal characteristics of the 46 mothers interviewed are summarized in table 2. These mothers were Negro, Mexican-American, or Caucasian. The majority were housewives who owned their own homes, in which they had lived for a median of 5 to 9 years. These homes ranged from small unpainted houses in need of repair located in crowded, noisy, unkempt neighborhoods to ones apparently worth 15 to 20 thousand dollars located in newer housing developments. From the

appearance of the mothers and the responses elicited by the questionnaire, we judged that they were of average intelligence and comprised a conventional study population. Their regular median gross family income per month was $300 to $450; the majority of their husbands had been employed at their jobs for more than 5 years. Four mothers said that their monthly income was much above $450; only five reported that they received welfare or social security checks. The mothers' educational levels ranged from second grade to college graduation; the median educational attainment was completion of the 10th grade. Their usual source of medical care was a particular physician.

Table 3. Use and planned use of maternity care by 46 mothers who had used midwife services for home deliveries

Use of services	Number of mothers
Prenatal services used	
Public health clinic	10
Saw physician for any reason	31
Received referral to physician by midwife	20
Time midwife was contacted:[1]	
1st trimester	20
2d trimester	11
3d trimester	10
While mother was in labor	5
Postnatal services used	
Visited by public health nurse	29
Found visit helpful	16
Visited by midwife	37
Visit was on day of delivery or day after	31
Visited physician within 1 week of delivery	4
Visit was related to delivery	2
Delivery services used	
For all children born:	
Only midwife	12
Hospital and midwife	32
Other[2]	2
For first born:[3]	
Midwife	25
Hospital	21
For last born:[3]	
Midwife	36
Hospital	10
Future or ideal use of services	
Delivery of next baby:	
At home by midwife	26
Not at home by midwife	4
Would decide site and attendant at the time	6
Question not applicable[4]	10
Delivery of babies in general:	
Should be at home with midwife	17
Should be at hospital with physician	6
Either site and either attendant suitable if certain criteria met[5]	23
Family planning:[6]	
Would use	28
Would not use	8
Question not applicable[4]	10

[1] Median number of midwife visits in prenatal period was 4.
[2] 1 had experienced only home deliveries, attended by either a physician or midwife; the other had experienced both home and hospital deliveries. The home deliveries were attended by either a physician or a midwife.
[3] Each of the 2 categories includes 5 mothers who each had only 1 delivery.
[4] These women stated that they were sterile.
[5] Provided that the woman was healthy and physician did not say hospital delivery was advisable.
[6] 12 reported that their last pregnancy had been planned.

Maternity history. The median number of pregnancies of the 46 mothers interviewed was 6. We learned from the maternity history of the mothers that 56 percent of the total 273 deliveries to the mothers to date had been home deliveries by midwives. Twenty-five mothers had used lay midwife home delivery for their first baby, while 36 had used such services for their latest delivery (table 3). In each of these groups, there were five mothers who had experienced only one pregnancy. Twelve mothers had used only midwife home delivery; one mother had experienced only home deliveries, attended either by a physician or a midwife. The majority, 33 mothers, had had both a hospital delivery and a midwife-attended home delivery. Twelve reported that they had planned their last pregnancy; 28 said they would use family planning in the future (table 3).

Prenatal and Postnatal Care

Historically, the function of the lay midwife has been to serve as a birth attendant. In the area studied, however, the practice of lay midwifery also included prenatal and postnatal visits with mothers. The median number of prenatal visits with midwives, based on reports by the mothers interviewed, was four. The midwives, however, said the actual number ranged from none to eight depending on the individual needs of the client and the availability of transportation. The usual number of prenatal and postnatal visits, with the number of midwives reporting each number, was as follows:

Number of visits	*Number of midwives*
Prenatal:	
0–1	4
2–3	3
6–8	2
"As necessary"	1
Postnatal:	
2–3	8
4–5	2

As table 3 shows, 20 mothers contacted the lay midwives early in pregnancy. The 46 mothers reported, however, that they contacted the midwives at all stages of pregnancy up to and including the onset of labor. Of the five mothers who got in touch with midwives after the onset of labor, four said they had planned to have a hospital delivery. Three of these mothers called a midwife when delivery at home seemed imminent; one who had left the hospital to check on her children decided at that time to have her baby delivered at home by a midwife. The one mother who said that she had planned in advance to use the services of a midwife in home delivery stated that she could not contact a midwife earlier since she "didn't have any money." The prenatal care of approximately 15 of the mothers interviewed must be considered inadequate if the criterion is that prenatal care must be provided by a physician, since these 15 used the prenatal services of a midwife but did not see a physician. Despite statements of midwives that they referred mothers to physicians, only 20 mothers reported such a referral (table 3). Some mothers, however, volunteered the information that the midwife knew that they were already seeing a physician.

The mothers commented that their prenatal and postnatal care had been tailored to their specific personal needs. They used a mix of services. Some mothers visited a physician before seeing a lay midwife; some visited a physician only after being referred by a midwife. Ten mothers used the services of a public clinic, but the majority who used physician services saw a private physician. Some used the prenatal and postnatal services of both a physician and a midwife; others used the prenatal services of both but saw only the physician postnatally. Some mothers used a physician's prenatal and postnatal services while keeping in touch with a midwife.

During the postnatal period, 29 of the 46 mothers were visited by another member of the health care team, the public health nurse (table 3). Only 16 of those visited, however, said that the visit was helpful; in contrast, all the midwives said that the nurse's visit was good.

Maternity and Postnatal Care

Deliveries to the 46 mothers studied routinely took place in the home. All the lay midwives interviewed stated that they assisted with the birth only by supporting the baby as it was being delivered. On occasion, they reported, they had successfully manipulated the cord from around the neck of the baby during delivery. The midwives' descriptions of the delivery and of the care given the mother during the immediate postnatal period suggest the need for further instruction in midwifery. Nevertheless, anyone who without ever having observed a delivery by a lay midwife uses the norm—hospital delivery—as a basis for comparison (rather than the perfect delivery) cannot evaluate adequately the quality of the procedures midwives use (*23,24*).

After the delivery, most of the midwives stayed with their clients from 1 to 2 hours. It was during this period that all the midwives and most of the mothers said that the midwife's fee was paid, usually in full. This fee ranged from nothing to $125. Six midwives said that the amount depended on the client's ability to pay. The median range of fees paid was $51 to $75; the median fee charged by the midwife was $60.

To assess the adequacy of services, we asked the mothers if either they or their newborn infants had seen a physican or gone to a hospital in the first 7 days after delivery. Four mothers answered affirmatively, but the two visits that were made for causes related to delivery were for minor conditions, which were treated on an outpatient basis. One mother whose baby was dead at birth said the lay midwife was not at fault. Nevertheless, this mother also commented that since the midwife could "only do so much," there "ought to be a doctor she can call if she needs him." We therefore assumed that the death might have been related to the birth process. Whether or not the death would have occurred had the delivery taken place in a hospital cannot of course be determined (*24*).

Hospital Versus Home Delivery

The 33 mothers who had experienced both a midwife home delivery and a hospital delivery were asked to compare the experiences. Three mothers found the experiences comparable, 3 found hospital delivery preferable, and 27 found home delivery preferable. One mother expressed negative feelings about home delivery, stating that it was dangerous if a problem arose during delivery.

Twenty-one mothers had negative feelings about hospital delivery, stating, for example:

It was cold and indifferent.

Crying of the woman in the next bed was not pleasant.

I didn't have the same doctor I had for prenatal care. You're not treated like a person.

The doctor usually got there at the last minute—had to hold the baby back until he came.

I did not get the personal attention I got at home.

I was afraid my baby was crying and nobody was paying attention.

When I went to the hospital, they tried to send me away, but my husband and I stayed around the hospital. In about 30 minutes we went back to the doctor, and they had to rush me to the delivery room because I was about to have my baby.

It was hurried and impersonal and you could hear women groaning and carrying on.

I had terrible headaches and nausea and vomiting from the anesthesia and shots.

I was knocked out with drugs and didn't get to see my baby for several hours, and then just for a minute.

I got so lonesome—couldn't speak English—husband couldn't visit—nobody to stay with the kids. It was scary in the hospital.

Husband is sent away just at the time you need him.

They tried to hold me to make me have a spinal anesthesia.

The nurses sometimes were nasty, and when I rang the bell didn't come for quite some time.

They didn't believe me when I told them I was ready, and when they came back, my baby was already born.

The apparently negative feelings and experiences of these mothers about hospital delivery were not, however, the primary reasons they cited for choosing midwife home delivery.

Reasons for Using Lay Midwives

Why did an expectant mother have a home delivery attended by a lay midwife when custom dictated hospital delivery? The reasons could be significant since other expectant mothers both now and in the future might choose home delivery for similar reasons. Following are the principal reasons the mothers in our study gave for having their last child delivered by a lay midwife, with the number citing each reason:

Reason	*Number of mothers*
Just preferred midwife home delivery	14
Had negative feelings about the hospital (and drugs used in it)	8
Was following example of her mother	6
Finances	5
Baby-sitter problems	3
Only because delivery at home seemed imminent	3
Language difficulties	2
Wanted to be with her family	2
Had always had midwife home deliveries	2
Preferred a woman attendant	1

The 20 women who reported that their choice of midwife home delivery was based on just preferring it (14 women) or on the example of their mothers (6 women) were questioned further about their more underlying reasons. The main reasons they then gave for their choice were as follows, listed with the number of women citing each reason:

Reason	*Number of mothers*
Was more relaxed and more comfortable at home with family	5
Had previously been forced to use midwife home delivery and now preferred it	4
Had experienced natural childbirth in the hospital previously and thought it would be better and easier at home	3
Preferred natural childbirth in her home and used midwife because she could not find physician whose fee she could afford or because she knew friends who had uncomplicated midwife deliveries	3
Had considered both hospital delivery and home delivery and decided midwife home delivery was preferable	3
Finances	1
No need to go to the hospital since she was not sick	1

In other studies various reasons have been given for using the lay midwife. Dodge (*25*) said that "Many women are forced by . . . economics or ignorance to accept services of the 'granny women,' " and Osgood said that "they are utliized wherever a community lacks or is deficient in health personnel and faciliites—or even when physicians and nurse midwives are available—due to a variety of economic, social, or cultural factors." Lay midwives in the study area were apparently used for the same reasons as those cited by Dodge and Osgood. The mothers studied were apparently conventional women of average intelligence who, having previously experienced both hospital delivery and midwife home delivery, believed that their individual needs in normal labor and delivery were better met in midwife home delivery. The medical community needs to acknowledge the existence of lay midwifery and to examine the reasons for its utilization, as well as the effects of that utilization.

To assess the true feelings of the 46 mothers about midwife home delivery, we asked them if their next delivery would be a home delivery with a midwife attendant. Twenty-six replied affirmatively (table 3). When, however, the women were

asked where in general they thought the delivery of babies should occur (not just as applied to themselves), only 17 said that delivery should be at home; 6 said delivery should be in a hospital; and 23 said that either hospital delivery or midwife home delivery was all right if certain criteria were met. In spelling out these criteria, 5 said the choice of delivery site should be the expectant mother's; 1 said that a first baby should be born in the hospital, but that thereafter the site of birth should be the mother's choice; the other 17 stated that if a mother was healthy, then home delivery was preferable, but if there were complications or the physician thought it advisable, delivery should take place in a hospital. These results appear to demonstrate critical thinking by the study population on the question of hospital delivery versus midwife home delivery.

Conclusions

We have drawn the following conclusions from our study of lay midwifery in Houston and Harris County, Texas:

1. The innovative utilization of lay midwife services, or of a unique mix of midwife and conventional services—a utilization based on the conscious choice by mothers who were of seemingly average intelligence—raises questions about some of our common assumptions and approaches to maternity care services.

2. The dearth of studies of midwifery or comparisons of midwife deliveries with hospital deliveries or with physician home deliveries means that policy and planning related to lay midwifery cannot be adequately or intelligently formulated.

3. More study is needed to establish what the role of the lay midwife should be, both in terms of delivery of services and in terms of the human needs of the consumers of such services. These studies should include a comparison of the practices of the midwife with those of the medical care system in respect to efficacy, efficiency, costs, and comfort of the patient.

4. Referral services need to be established at local health departments to encourage mothers who are going to use lay midwife services to get in touch with the midwives early in pregnancy. Also, records should be kept on the mothers and babies attended by lay midwives so that the results of midwife practice will be available for assessment and comparison with other practices.

5. Should lay midwifery be allowed to atrophy and possibly die because of lack of recognition and lack of referrals, or should the total medical system take a team approach to maternity services and find a place for lay midwives? We believe that this is a question that needs to be reexamined.

REFERENCES

(1) Willson, J. R.: Health care for women: Present deficiencies and future needs. Obstet Gynecol 36: 180 (1970).

(2) Montgomery, T. A.: A case for nurse midwives. Am J Obstet Gynecol 105: 309 (1969).

(3) Edward, J.: Needed: patient-oriented nursing in the maternity unit. Hosp Top 48: 83, March 1970.

(4) Chase, Helen C.: The position of the United States in international comparisons of health status. Am J Public Health 62: 581 (1972).

(5) Report of a Macy Conference: The training and responsibilities of the midwife. Josiah Macy, Jr., Foundation, New York, 1967.

(6) Vital and Health Statistics: Report of the International Conference on the Perinatal and Infant Mortality Problem in the United States. Department of Health, Education, and Welfare, Washington, D.C., 1967.

(7) Wallace, H. M., Goldstein, J., Gold, E. M., and Gabrielson, I. W.: A survey of health status and needs of urban mothers and children. HSMHA Health Rep 86: 829, September 1971.

(8) Boulding, K. E.: The concept of need for health services. Health services research. Milbank Memorial Fund, New York, 1967.

(9) High cost of being born. Med World News 11: 31, July 31, 1970.

(10) Martin, P. L., and Smith, S. H.: Public relations in our maternity wards. Am J Obstet Gynecol 81: 1079 (1961).

(11) Milio, N.: A neighborhood approach to maternal and child health in the Negro ghetto. Am J Public Health 57: 618 (1967).

(12) Nurse midwife seen easing O.B. shortage. OB Gyn News 5: 42, Dec. 1, 1970.

(13) Isler, M.: Views on midwife's role in maternity care of the future. Hosp Top 48: 86, September 1970.

(14) Saunders, J.: Cultural differences and medical care (The case for the Spanish-speaking people of the Southwest). Russell Sage Foundation, New York, 1954.

(15) Terris, M.: Crisis and change in America's health system. Am J Public Health 63: 313 (1973).

(16) Report of a Macy Conference: The Midwife in the United States. Josiah Macy, Jr., Foundation, New York, 1968.

(17) Record, J. C., and Cohen, H.: The introduction of midwifery in a prepaid group practice. Am J Public Health 62: 354 (1972).

(18) Goldsmith, S., Johnson, J., Jr., and Lerner, M.:

Obstetricians' attitudes toward nurse midwives. Am J Obstet Gynecol 3: 111, September 1971.
(19) Mongeau, B., Smith, H. L., and Maney, A. C.: The "granny" midwife: Changing roles and functions of a folk practitioner. Am J Sociol 66: 497 (1960).
(20) Health manpower and health facilities, 1970. Health resources statistics. U.S. Public Health Service, Rockville, Md. 1971.
(21) Vital statistics for Texas, 1970. Texas State Department of Health, Austin, 1971.
(22) Hanlon, J. J.: Principles of public health administration. C. V. Mosby Co., St. Louis, 1955.
(23) Eastman, N. J.: "An obstetrician says—." Hosp Top 40: 73, January 1962.
(24) Kohl, S. F.: Perinatal mortality in New York City: responsibility factors. Harvard University Press, Cambridge, Mass., 1966.
(25) Dodge, E. F., Brown, W. E., and Rothert, F.: The midwife, should she be ignored, controlled or eliminated? Southern Med J 46: 639 (1953).
(26) Osgood K., Hochstrasser, D. L., and Deuschle, K. W.: Lay midwifery in Southern Appalachia. Arch Environ Health 12: 759 (1966).

LEE, FLORENCE ELLEN (Mary Hardin-Baylor College), and GLASSER, JAY H.: *Role of midwifery in maternity care in a large metropolitan area. Public Health Reports, Vol. 89, November–December 1974, pp. 537–544.*

A recent study has delineated some of the characteristics of lay midwives and their clients in Houston and Harris County, Tex., as well as in the main features of midwifery practice there.

Eleven lay midwives and 46 mothers who had had midwife home deliveries were identified and interviewed. The midwives had contact with the mothers both in the prenatal and postnatal periods. They said that they referred mothers to a physician prenatally. The midwives were Negroes or Mexican-Americans whose median age range was 56 to 65 years. The mothers were Negro, Mexican-American, or Caucasian; their median educational level was completion of grade 10.

The mothers told about their difficulties in locating a midwife. They reported using the prenatal and postnatal services of either a physician or a midwife or of using a unique mix of the services of both. Fifteen mothers, however, did not see a physician. Of the 46 mothers interviewed, 33 had had both hospital and home deliveries: of these, 27 said that midwife home delivery was better. Some of the reasons the 46 mothers gave for having had their last deliveries at home by a midwife were negative feelings about hospitals (and the drugs), their finances, the imminence of delivery, a feeling that they would be more comfortable at home with their family, babysitter problems, a preference for midwife home delivery, a choice of midwife home delivery after conscious thought.

The mother's use of a midwife's services or of a mix of a midwife's and conventional services, a use based on reasoned decisions, raises questions about some of our common assumptions about maternity care. More studies are needed to determine what the role of lay midwifery should be. Referral services should be provided to encourage women who are going to have home delivery by lay midwives to contact them early, and records should be kept on the consumers of midwife services. The medical community will have to decide whether to continue to ignore lay midwifery or incorporate it into a team approach to maternity care.