LIVING INCUBATORS: ARGUING FOR PREGNANT WOMEN'S AUTONOMY AND BODILY INTEGRITY IN AN AGE OF EVER-INCREASING REPRODUCTIVE TECHNOLOGIES

by

MELANIE JO DeMAEYER

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ABSTRACT

In this thesis I evaluate the medicalization of birthing bodies through the use of reproductive technologies. This thesis argues that the best solution for ensuring the bodily integrity and autonomy of pregnant and birthing people is through midwife-assisted births. Midwifery provides a compelling opportunity to subvert and challenge the medical-industrial complex and its invasive reproductive technologies, which extend beyond the hospital to promote socio-political and cultural ideologies surrounding the bodies of pregnant women and other pregnant subjects. I argue that elements of a do-it-yourself (DIY) feminist consciousness present in the practice of midwifery makes midwives uniquely positioned to encourage and sustain ethical embodied communities. Within these communities pregnant and birthing people are provided opportunities for autonomy, and, thus, midwives and the choice to employ them play a vital role in the establishment of reproductive justice for all.

DEDICATION

To my mother, Beverly Dianne Burdette DeMaeyer, my grandmother, Blanche Josephine Mylius Burdette, and my sister, Kristyn Dianne DeMaeyer. Each of these women have supported and sustained me through their love, strength, laughter, and wit. They are with me in all that I do. Thank you for instilling in me a belief in the extraordinary power of relationships among women. Each of you are my guiding force, my northern star.

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Chapter One

Introduction

I came to this project in a serendipitous way. To say that this thesis grew out of a singular place of interest for me would be untrue. I have been fascinated by the birth stories of the women in my family for as long as I can remember. As this project evolved into what it is now, I wanted to do my best to honor those stories. As a third wave feminist who often feels equally connected to the second wave, and thus understands that these waves are not distinct entities, I am deeply committed to the work of reproductive justice activism, as well as the value of the midwifery model of care. Therefore, it was particularly resonant for me to build connections between these forces. For me, this project certainly is not just an academic endeavor; it is a personal one as well.

This project is a transgenerational one, both in feminist terms and literally, as well. In feminist terms, it employs texts from feminists associated with both the second and third wave, and traces a trajectory of thought which has been carried throughout each wave of feminism. In predominant thought the use of the waves metaphor limits feminist thought through the employment of oftentimes ageist and reprocentric categories, a matter I explore further in Chapter Four (Creating Embodied Communities: Midwives, Zinesters, and Reproductive Justice). It begins with the radical idea that women have a right to determine what happens to their bodies, and follows the feminist debates, ideologies, and movements around that determination through the lens of reproductive control to reproductive rights and, finally, to

reproductive justice. This thesis recognizes that there was something gained from the work of each wave and that there is also something to be learned, and sometimes reassessed. This project is also transgenerational, in the sense that it traces the histories of the stories of women giving birth from the late nineteenth century to the present, pointing out the ways in which the language and the struggles that women faced 100 years ago may not be very different than what they currently face.

In a literal familial sense, I have found a way to acknowledge the birth stories of two of the women in my family. Their stories informed this project as much as any, and continue to help inform my own feminist and activist politics, particularly in relation to reproductive justice. My maternal grandmother gave birth in the era of scopolamine. Her encounter with it did not include the "spotty, nightmarish" memories that women of the 1950s and 1960s wrote to women's magazines about, but it did include its own degrading caveat. The night my grandmother went into labor with her second child, her first child, Patricia's, appendix had burst. Twelve-year-old Patricia had complained of cramps early in the day. My grandmother, unaware that Patricia had appendicitis, thought her cramps were caused by menstruation. She had given her a heating pad in an attempt to minimize her pain. However, Patricia's pain increased severely and she lost consciousness before my grandparents could get her to the hospital. It was while waiting to see a doctor that my grandmother went into labor. Being in a panic about Patricia, and feeling guilty after being berated by the doctor for giving her a heating pad, my grandmother tried to hide her labor pains from the hospital staff for some time. When she had a particularly painful contraction while the nurses were talking with her about Patricia's condition she realized she had lost all choice in the matter. The nurses informed a doctor, who then ordered her to admit herself to the hospital. My grandmother was put on a stretcher and was literally carried away from her

daughter whose prognosis was still unknown. Taken to another floor and assigned to a doctor and nurses who were unaware of the situation unfolding with Patricia, my grandmother frantically tried to inform them that she could not be "put under" until she knew if her daughter would survive her surgery. The nurses and the doctor thought that she was "out of her mind," and, even though my grandmother insisted that she would not and could not give birth until she knew about Patricia, she was ignored. The last thing my grandmother remembers about the birth of Patricia's younger brother, and my uncle, is being given scopolamine, a drug commonly used at the time as an amnesiac for birthing women. When the drug finally wore off, she did not ask to see the baby she had given birth to, but instead asked for Patricia–not knowing whether or not her daughter had made it through surgery. Fortunately, she had.

Thirty years later my mother struggled with infertility brought on by endometriosis. After several miscarriages, she sought out some of the fertility treatments I allude to in Chapter Four of this project. For her, technological intervention in pregnancy and birth was a welcome medical advancement and resource. Having suffered miscarriages and an almost full-term stillbirth, she relied on the reproductive technologies of the 1980s to get pregnant, and later to reassure her that her pregnancy was "normal and healthy." She remembers very little of her first birth, to the stillborn baby she named Darryl, but she has deep regrets that she was not given the opportunity to decide what would happen with his body. Instead of waiting until my mother woke up from a drug-induced sleep, the doctors at the hospital asked my father what to do with baby Darryl's body. My father decided to donate his body to science in an effort to contribute to research. His thought was that other people should not have to experience the grief of losing a child to massive, pharmaceutical drug-induced birth defects. When my mother woke up, she was devastated. She never saw Darryl and was told by her doctor that it was better that she had not

seen him as, he felt, it would have upset her more. Years later, my mother says she probably would have made the same decision, but, all the same, she feels she should have had the opportunity to consider all of her options. Part of her consolation comes from the knowledge that through the donation of Darryl's body to research, and through other donations of stillborn infants with similar birth defects to Darryl's, researchers found that thalidomide, a medication given to pregnant women for morning sickness and nausea, was causing widespread miscarriages and stillbirths. After learning about the devastating side effects of this drug, my mother refused any kind medications throughout her other three pregnancies, and she delivered me, my brother, and sister without the use of any pain relieving drug. Her intent was to remain fully conscious in order to make decisions about her own body and the babies she was delivering. For my mother, and other pregnant subjects, who lost a child to the effects of thalidomide, or other drugs given during pregnancy, the judgment was already passed. If only *they* had known, if only *they* had been strong enough not to take the medicines offered to them, then perhaps everything would have been okay. The judgment is placed on the pregnant and birthing subject, not on the doctors who prescribed the drug, or the medical-industrial complex that developed it.

While the birth stories of my mother and grandmother are different and took place three decades apart, they intersect and resemble each other in important and significant ways. In their birthing experiences, the interventions of varying levels of medical knowledge and technology play key roles in their autonomy and bodily integrity, just as those interventions, on a broader scale, continue to either supplant or interfere with and diminish the subjectivity of pregnant people who give birth in hospitals today, depending on how such technologies are used. While there are positive technological interventions, like those involved in treating infertility, there are reproductive technologies that compromise the bodily integrity of pregnant and birthing people,

like the ultrasound, the cesarean, or even the fetal heart monitor. These sometimes compromising and unnecessary interventions into birth and pregnancy are what I focus on within this thesis.

It does not require much investigation to see the connections between the forced drugging in my grandmother's birth story to the forced cesareans of those trying to give birth naturally in hospitals in 2010. What has changed is that pregnant people do have the right to refuse an epidural or the administration of a drug like pitocin, and they certainly are not given scopolamine anymore. It is important to note that the use of pitocin, a drug that is given in hospitals to induce labor and speed contractions, often results in emergency cesareans and uterine ruptures and can only be refused for a very short period of time. The right to refuse drugs like scopolamine and pitocin has been hard won and, as is the case with pitocin, it is often not acknowledged or respected.

In this thesis, I argue that the midwifery model of care and the midwives who practice it offer the best solution for the protection of a pregnant person's bodily integrity and autonomy of all of the options available today. This model strongly values the subjectivity of the birthing person and actively involves them in the process of their birth. Additionally, the midwifery model and the movement to legalize direct-entry midwives in the United States have vital connections to the framework of reproductive justice and the sociocultural change that such a framework endeavors to make.[1]

The resurgence of a do-it-yourself (DIY) spirit in third wave feminism coincides with the growing resurgent interest in midwifery. DIY consciousness within third wave feminism stems from the era of Riot Grrl and handmade zines, but can be traced throughout much of feminist history in some form or another. It is also operates within a decade in which there has been a

[1] This project is analyzing pregnancy and birth from a Western perspective, with a focus on the United States. In other regions, the pregnant person is highly valued, a situation which is different from many of the experiences of women in the U.S., where the most value is placed on the fetus.

renaissance of craftwork and a call for a return to, or reclamation of, “traditional” pathways of creativity. It is my contention that these revivals are not happening in a void, separate from each other, but that those who are drawn to and are responsible for fostering their return, or open acceptance, are responding to and rebelling against “individualism,” or the idea that each person is only responsible for themselves, and the hegemonic technologies and modes of (re)production which are the calling cards of late-capitalism and dominant medico-discursive power.

In order to create and ensure the pregnant subject’s bodily integrity and autonomy we must critically analyze the disciplinary effects of the phallocentric medical gaze, and move towards approaches which rely on what is commonly known as a more woman-centered approach to birthing and pregnancy. By focusing on pregnant women and other pregnant subjects and their psychological, emotional, and bodily needs, desires, and experiences, we will be able to create a space for pregnant subjects to be viewed as beings with the rights and privileges of full citizens and not merely fetal containers, a situation that fits most broadly to the view of women as “less than” in a gendered economy of subjectivity.

Of course there should be a space for some technological and medical interventions in pregnancy and birth. The reproductive technology that is available to women today provides for methods of conception that would not otherwise be available, including those which helped my own mother. Due to technological and medical interventions, such as in vitro fertilization, women and others desiring pregnancy who have been diagnosed with fertility issues, or deemed as infertile, might have the opportunity to conceive and carry to term. Additionally, reproductive technologies offer same-sex couples, transgender people, intersex people, queer people, disabled people, poor people, people of color, and single women access to more reproductive options. I discuss briefly how using these technologies benefit these populations, but do so in the context of

my broader argument, while noting that in choosing to use these technologies these bodies are constituted in a manner which makes them more vulnerable to disciplinary use of the medical gaze than they would be otherwise. It is also important to note that some pregnant people do experience high-risk pregnancies and may choose or need to be monitored more closely by their obstetricians.

To be clear, this is not an anti-technology or techno-phobic project by any means, and I recognize that the use of technological and medical interventions in birth have saved the lives of many. Reproductive technologies, like fetal heart monitors and other monitoring devices, as well as cesarean sections, are sometimes useful in situations like these. Moreover, as I am arguing for the bodily integrity and autonomy of pregnant people, I believe it is important to note that some pregnant people prefer and feel safer having access to all possible reproductive technologies for themselves and their unborn fetuses. While this project will touch on why some pregnant subjects might favor this birth choice (in light of the prevailing medical knowledge and propaganda), it will not get into the debate which surrounds, for instance, scheduled cesareans at the request of the mother.[2] That said, I support medical advances in reproductive technology that will provide for the needs and desires of all pregnant people, whether they choose to have or require technological intervention or not. Pregnant and birthing people ought to have access to the full range of reproductive technologies, but these technologies ought not to be forced upon them without total informed consent. My study focuses on the ways in which those who birth are compromised in culture and society and the ways in which reproductive technologies

[2] There is a need for feminist analysis of the issues raised by these instances, and for analysis of the similar and related designer celebrity births which also rely on reproductive technology. For instance, there are celebrities who have requested removal of their gestating beings in the 8th month, for the sake of having a cuter "preemie" and to curtail the problem of stretch marks, which surface more in the final month of pregnancy. Additionally, the catch phrase "too posh to push" (used for those seeking scheduled, and unnecessary cesareans) owes its origins to Victoria "Posh Spice" Beckham after she scheduled the births of her three children around her husband's soccer schedule.

reinforce and facilitate the medicalization of birthing bodies and the implications of these interventions.

I am aware that not all people who give birth identify as women. Many, including those who identify as queer or trans and others, might use or prefer different terminology, in order to resist the dominant ideology connected with use of the label and category of woman for their own reasons. While there is a need for an analysis regarding the impact of reproductive technologies on birthing subjects who do not identify as women, the length and scope of this project does not afford the possibility for the much-needed in-depth critical study of this particular relationship, though much of this analysis can be broadly applied to these subjects. With the exception of the phrase "woman-centered" when discussing a midwifery model or approaches to birth, I have made every effort to use inclusive language. I consider the implications of my arguments for these subjects, in order to provide a more complete analysis and to allude to the need for further work in this area, some of which may be in my own future as a feminist scholar. Because of the complicated and often necessary relationship these subjects have with reproductive technology, and for that matter, the greater medical industrial complex, the focus of this thesis has been on those outside of the primary group affected by this situation, but instead on the primary group (women) this situation affects. My understanding of the importance of building a critical framework and analysis for these subjects contributes to the delicate complexity of this work and the inclusion, through broadly applied schemes, adds richness to this analysis.

In the second chapter of this thesis, following this introduction, "'Womb with Legs': What Happens When the Pregnant Woman Falls Out of the Picture," I introduce the socio-political and socio-cultural ideologies surrounding pregnancy and birth. I explore Supreme Court

cases, images of celebrity pregnancy, and discuss the public/private split that affects the citizenship of pregnant people. I investigate the ways in which reproductive technologies inform and contribute to these overarching ideologies. In addition, I argue that it is not only the disciplinary use of reproductive technologies which have affected pregnant person's subjectivity, but also the ways we view pregnancy and birth in the media. I will draw parallels to medical technology and media-generated photography of pregnant women, beginning with Lennart Nielson's now iconic *Life Magazine* photos of a fetus in utero. I argue that these images paired with advancing medical reproductive technology have influenced social thought about pregnant bodies and have structured the bodily integrity and autonomy of pregnant subjects as much as or more so than restrictive laws dictating the limits of pregnant embodiment. This chapter also offers a discussion of Irigaray's concept of a placental economy, whereby the pregnant subject and the fetus are joined by a mutually shared organ (the placenta). The placental economy complicates the concept of feminist autonomy, as it demonstrates in a biological sense, that in pregnancy and birth it is always already about *both* the pregnant subject *and* the fetus. In this chapter I begin my discussion of pregnant subjects as prisoners. I discuss the ways in which the disciplinary gaze, aided by reproductive technologies and those technologies employed in mass media, is used to control pregnant subjects, sometimes criminalizing them for no other reason than that they demand their right to bodily integrity. I cite the relationship between Foucault's panopticon and the ways in which pregnant and birthing subjects are watched in society and in hospitals. I expand this analogy in the third chapter of this project, using actual cases of imprisoned women and pointing to the similarities between the restraining of pregnant and birthing bodies in both prisons and hospitals, to Foucault's discussion of the treatment of the mid-eighteenth century prisoner, Damiens.

In Chapter Three, “Prisoners of Policy: Midwifery, Reproductive Justice, and Birthing Practices in the United States,” I offer a brief historical sketch which leads into the current issues and debates surrounding the relationship of pregnant subjects to technology in the arena of childbirth. I briefly trace the history of pregnancy and birth in the United States, moving from homebirths to medically managed pregnancies, in order to examine the shifting medical and social ideologies which have allowed for women and other pregnant people to be erased or diminished from pregnancy and birth. Within this chapter I frame the current status of hospital birth as an issue of reproductive justice and explore the ways in which the movement for reproductive justice intersects with the movement for midwifery. I include statements from the American Congress of Obstetricians and Gynecologists against midwives and their model of care; and I provide analysis of the current legal status of direct-entry midwifery in the United States in order to argue that midwifery is a vital component of reproductive justice.

Finally, in Chapter Four, “Creating Embodied Pregnancies: Midwives, Zinesters, and Reproductive Justice,” I discuss how a move away from public pregnancies afforded by the technological gaze–when used as a tool to discipline pregnant subjects–and hospital births can lead to restoring bodily integrity during pregnancy and birth. Through the use of midwives and a reliance on the pregnant subject’s own unique role in pregnancy we can reclaim pregnant bodies from the disciplinary gaze and move towards an autonomy for pregnant people which will not only benefit them, but all those affected by and in need of reproductive justice. I argue that the resurgent interest in midwifery care is part of the DIY consciousness present in third wave feminism and that observations made of DIY politics can be extended to midwifery. A DIY ethic creates space for those who are often excluded from mainstream culture and discourse by giving those people the opportunity and the power to share their knowledge and experience in

alternative forms of their own making. I conclude with a discussion of the revolutionary potential of seeing the relationships built by midwives as embodied communities, which allow for the reclamation of space and autonomy for the birthing person.

This project makes use of the DIY ethic, reproductive justice, and the rich history of midwifery in this country. I believe that there is great potential in these strands of feminism for the empowerment of pregnant and birthing subjects. By seeing and employing each of these seemingly separate histories as interconnected and mutually beneficial, a framework that will support and protect the autonomy and bodily integrity of pregnant and birthing subjects can be created and sustained.

Chapter Two

"Womb with Legs[3]":
What Happens When the Pregnant Woman Falls Out of the Picture

"The library card catalogue contains dozens of entries under the heading 'pregnancy': clinical treatises detailing signs of morbidity; volumes cataloguing studies of foetal development, with elaborate drawings; or popular manuals in which physicians and others give advice on diet and exercise for the pregnant woman…No card appears listing a work which is concerned with the subject, the mother as the site of her proceedings."

Iris Marion Young, *Throwing Like a Girl and Other Essays in Feminist Philosophy and Social Theory*

"The moment when all eyes turn away from my belly, and toward the monitor, even I become a passive observer of an 'Other,' an 'Other' which cannot be seen with the eye. For the fetus to be seen as an independent entity, the woman must drop out of the image."

Sharon Lehner, "My Womb, the Mosh Pit"

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As reproductive technology has advanced, so too has our collective societal fascination with pregnant women, particularly on seeing inside of them or on focusing on their pregnant bellies. Simone de Beauvoir writes in *The Second Sex*, "All agree in recognizing the fact that females exist in the human species; today as always they make up about one half of humanity. And yet we are told that femininity is in danger; we are exhorted to be women, remain women, become women," (xiii). But what does it mean to *be* woman, to *remain* woman, *become* woman? What must one do to be seen and interpreted as woman? "Woman? Very simple, say the fanciers of simple formulas: she is a womb, an ovary; she is a female–this word is sufficient to define her," writes Beauvoir (3). In her assessment, society declares that in order for a person to be a

[3] This phraseology belongs to Anne Balsamo as referenced in the Works Cited list for this document.

woman, she must first and always be a womb; anything less and she is inconsequential, and a danger to femininity.

This may be a conceptualization of woman that dates back to antiquity, as Beauvoir illustrates, but what happens when, as we see today, a pregnant person's sole purpose for existence is to be a womb, an existence in which she is reduced to, and remains, a vessel for the fetus? Contemporary theorist, Lauren Berlant writes, "At this time in America the reproducing woman is no longer cast as a potentially productive citizen, except insofar as she procreates: her capacity for other kinds of creative agency has become an obstacle to national reproduction" (153). As a woman's pregnancy begins to become public–that is, as she shares the information willingly, or because her body with its morning sickness or protruding abdomen tells others for her–she becomes a site of concern, often not for herself, but for that of her unborn fetus.

In her essay, "America, 'Fat,' the Fetus," Berlant discusses a video her sister gives to her of her nephew's first two years of life. The "document of family-making," as Berlant describes it, begins with a sonogram. Recounting the opening scenes of the video, Berlant observes:

> [It begins] in the sonogram room, where my sister (Valerie), my mother, the technician, and my brother-in-law (Richard) are commenting on the sonogram screen. Valerie and my mother are briefly visible in this scene; otherwise the commentary is *disembodied* and the sonogram *dominates* the frame. Richard's voice carries a great deal of authority – he's a doctor and he knows how to interpret the images Valerie generates. (192, *emphasis mine*)

Valerie, the person who is "generating" images is not seen; her voice, while present, is not associated visually with a person, and the focus is instead the fetal image on the sonogram screen. In many ways this is a parallel for the way we see, or rather fail to see, the pregnant person. They are not their own subjects, or their own beings, but instead play "other" to the fetus, the "subject," they are carrying.

Where does this fixation on the fetus originate? One might begin with the technology that allows us to see pregnancy publicly, that is, not just among those we know, or the strangers we pass on the street, but how we see and understand the people on our television screens and on magazine covers. Berlant discusses the real-life pregnancy of Lucille Ball on the long running, vastly popular, 1950s sitcom, *I Love Lucy*. Ball's pregnancy was the first real-time celebrity pregnancy that Americans could watch, and it broke boundaries as it brought a formerly taboo, private subject into the homes of Americans. Feminist theorist Lauren Berlant writes of Lucy's comedic attempts to inform her husband, and, thus, the audience, of her pregnancy:

> This surplus of failed performances reveals the frantic improvisation around the new, often unpredicted knowledge that pregnancy heralds: how do you tell, what do you tell, who do you tell, what are you telling, when should you tell? The technological reconfiguration of privacy through the sign of Lucy's pregnancy does not eliminate the difficulty of these questions but intensifies it. (188)

As Ball's pregnancy progressed so did the comfort level of Americans in seeing a real-time public pregnancy; a phenomenon made possible through the technology of cameras and television screens. Her pregnancy marks the beginning of our obsession with celebrity pregnancy, an obsession which extends beyond the bellies of celebrity women and into the lives of "private" citizens. Suddenly it is acceptable to watch women's abdomens with anticipation and speculation that there will be news of a baby on the way.

What does it mean to be publicly pregnant? Robyn Longhurst found, while doing research for her essay, "Breaking Corporeal Boundaries: Pregnant Bodies in Public Places," that the 31 pregnant women she interviewed "experienced a shrinking of their lifeworlds" (Longhurst 82). Her findings stand in stark contrast to the images of pregnant celebrities we see photographed in great detail on the covers of magazines in our local grocery store checkout. Their bodies, it seems, are not held to the same standards of the pregnant bodies that Longhurst

writes about. She notes, “Pregnant bodies are not to be trusted, rather, they are to be dreaded, when occupying a public space” (82). By contrast, this dread of “everyday” pregnant bodies is caused by the fear that they will not appropriately maintain borders, positions, and rules in the manner of the contained corporeality of the “rational man” in a public space (Longhurst 84). In a paragraph which links Kristeva’s concept of the abject[4] and Grosz’s thoughts on women’s bodies as “modes of seepage,” Longhurst writes:

> Their bodies are often considered to constantly threaten to expel matter from inside –they may vomit, cry, need to urinate more frequently, produce colostrum which may leak from their breasts, have a “show” appear, have their waters break…even more than these leakages, they constantly “threaten” to split their one self into two or more. (84)

Posing a challenge to the fear of seeing “ordinary” pregnant women in public spaces, Sandra Matthews and Laura Wexler edited *Pregnant Pictures* (2000) a compilation of theoretical writing and photographs of pregnant people. Wexler and Matthews sought to address popular notions of the pregnant body as “carnal,” “sentimental,” and “grotesque,” as well as to photograph “ the pregnant woman as an individual” (1). Of the joining of their artistic medium and the pregnant person, they write, “The physical productions of the pregnant body are indiscreet–a subject for the doctor’s office, the bedroom, and the private talk of women. Camera work, on the other hand, is tasteful, an appropriate topic for the dinner table conversation, the museum symposium, the chic magazine” (1). They catalog a wide range of images of pregnant bodies, most interestingly, those whose bodies which might be considered a form of the abject, therefore improper for public viewing.

[4] For Kristeva, the abject is not what is dirty or impure about the body, but rather, “[It] is that which is not in its proper place, that which upsets or befuddles order…Dirt signals a site of possible danger to social and individual systems, a site of vulnerability insofar as the status of dirt as marginal and unincorporable always locates sites of potential threat to the system and to the order it both makes possible and problematizes” (Grosz 192). For further analysis of the Kristevan abject see the citation for Elizabeth Grosz in this document.

Wexler and Matthews dedicate an entire chapter to the phenomenon of public celebrity pregnancy. They discuss in great detail the now iconic image of actress Demi Moore on the front cover of *Vanity Fair* and attribute its publication to the beginning of the proliferation of the public pregnant icon (201). The image of Moore, who posed nude for the photograph, is far removed from what most women in the late stages of pregnancy probably feel is accessible, that is, the image is not widely representative of the many pregnant subjects who struggle to attain a proper body for the public sphere during pregnancy. In this image taken by famed photographer, Annie Leibowitz, Moore is perfectly coiffed, glamorous, and even a bit incandescent. She shows no signs of the stretch marks, swollen ankles, or fatigue from sleepless nights or the strain of carrying additional weight. All signs of "ordinary" and "everyday" pregnancy are vanished from view through skillful use of airbrushing. Wexler and Matthews assert that Moore represents a consumable, albeit scandalous version of a pregnant person, achieving pregnant icon status through the sheer glamour she exudes. Within in capitalist countries, especially the United States, pregnancy, and therefore the pregnant subject, is not seen as valuable because it is not profitable. It is not productive, but pre-productive, and then, with the birth of the fetus it becomes reproductive. We support celebrity pregnancy because they provide for the option of economic productivity. The money and industry created around celebrity pregnancies represents an extremely lucrative option to the capitalist regime, and is therefore supported not only by mass media but by those who consume it.

Even Moore, whose image spawned numerous copycat photographs, was not allowed to be entirely visible; the issue of *Vanity Fair* was sold with a plastic wrapper and a white sheet of paper covering much of her nude form (Wexler and Matthews 201). Pregnant icons, while still censored to some degree, are certainly growing in number since the 1991 photograph of Moore

first appeared, but the women in these images still do not represent the women Longhurst spoke to who felt their "lifeworlds" becoming smaller. Carol Stabile attempts to explain this misrepresentation in her essay, "Shooting the Mother: Fetal Photography and the Politics of Disappearance":

> In a culture which places such a premium on thinness, the pregnant body is anathema. Not only is it perhaps the most visible and physical mark of sexual difference, it is also the sign for deeply embedded fears about femininity and the female reproductive system. (191)

Therefore, a woman's and other bodies which bear the physical markings of pregnancy cannot achieve the status of icon. Their bodies will never be interpreted as glamorous, their stretching skin and leaky orifices so threatening to propriety are not safe for public viewing or discourse.

It is in the public realm, a realm where pregnant people can never truly exist as citizens, where reproductive technology intersects with the doctor's gaze and the photographer's lens that we must continue to interrogate. Together, these two technologies–the medical and the artistic, move our focus from the mother and onto her fetus. They help to define the boundaries of the public and private subjectivities of pregnant women. This fear of pregnant women in public spaces is incongruous; in order to be considered a subject women must first be a womb, and when they are wombs women no longer occupy proper bodies for public spaces. If women cannot occupy public spaces, then they cannot be seen as full citizens with the rights and privileges that designation entails. In their article, " Citizen Bodies: Embodying Citizens –A Feminist Analysis," Chris Beasley and Carol Bacchi note that traditionally, "[The] notion of citizenship as active *public* participation privileges 'hegemonic masculinity' as well as marginalizing women, amongst others, given their association with the private sphere. To the extent that citizenship is equated with the public sphere, women are not and cannot be 'full

citizens'" (340). Not having access to full citizenship, and, as a result, lacking full autonomy and bodily integrity, leaves women with little power in public discourse and decisions.

As I discuss in Chapter Three of this project, the Supreme Court based their ruling, which legalized abortion, in *Roe v. Wade* on the right to privacy; however, they intentionally created space in their decision for state intervention into the private lives of women. Their argument states that there comes a point at which a "woman's right is no longer sole" and that her right to privacy while pregnant is subject to being "measured accordingly" by outside bodies (*Roe v. Wade* 1973 410 U.S. at 158). This dismisses the bodily integrity of the pregnant or birthing subject in favor of interpretations and decisions made by outside forces whether they are medical, personal, or governmental. Additionally, the ruling is not congruent with other Supreme Court rulings dealing with bodily integrity and privacy, particularly when the rulings involve the bodies of men. Contemporary feminist philosopher, Susan Bordo, discusses another Supreme Court ruling, *McFall v. Shimp*, which hinged on the right to privacy and bodily integrity. Bordo writes, "Shimp's bodily integrity was legally protected to the extent that he was permitted to refuse a procedure (a bone-marrow extraction and donation) that could have prevented his cousin's otherwise certain death from aplastic anemia" (73). She notes that similar cases in which a Seattle woman sought to have the father of her child with leukemia donate his bone marrow and one in which a father sued the mother of his son's half-siblings to have tests done for bone marrow matches for his son also maintained the precedent (73).

The legal precedent confirmed in these cases, and as in the case of Shimp, does not extend to the bodies of pregnant women; not in the *Roe* decision and not in the actions which have followed it has women's total bodily integrity and autonomy been protected or respected. Bordo writes:

> The doctrine of informed consent is a protection of the *subjectivity* of the person involved –that is, it is an acknowledgement that the body can never be regarded merely as a site of quantitative processes that can be assessed objectively, but must be treated as invested with personal meaning, history, and value that are determinable only by the subject who lives "within" it. (74)

If informed consent is not protected for pregnant people then in the eyes of the law they are neither full citizens nor subjects. Bordo's statement refers directly to how informed consent is a double-standard for women and men in judicial decisions, pointing to cases of forced obstetrical interventions, sterilizations, and the Supreme Court case *Rust vs. Sullivan*.[5] However, her statement could be directly applied to the arguments midwives are making about less technological interventions in birth, the right to choose how and where to give birth, and the right to refuse unnecessary cesareans. In fact these claims made by midwives are directly in line with the doctrine of informed consent and are discussed further in the next chapter of this project. Bordo establishes, "According to the doctrine of informed consent, even when it is 'for the good' of the patient, no one else–neither relative nor expert–may determine for the embodied subject what medical risks are worth taking, what procedures are minimally or excessively invasive, what pain is minor" (Bordo 74). Midwives argue for informed consent in their model of care, and, ironically, the Wisconsin delegation of the American Congress of Obstetricians and Gynecologists (ACOG) unwittingly point out this commitment when they note, "[Midwives] adhere to a principle where the midwife and the patient determine individual practice guidelines for an individual patient on the standards, values and ethics held by the midwife and the patient" (American Congress of Obstetricians and Gynecologists). This standard set forth by midwives is obviously in direct opposition to the standard set by those in hospital settings and by the medical disciplinary gaze.

[5] The decision in *Rust vs. Sullivan,* also known as the "gag rule," made it illegal for doctors in federally funded clinics to offer or provide information regarding access to abortion, even in cases where women have no other access to medical advice. For more information see, *Rust vs. Sullivan,* 59 USLW 4451 (1991).

In July 2009, a New Jersey appellate court made a decision which caused outrage among reproductive justice and midwifery activists alike:

> In the case, *New Jersey Division of Youth and Family Services v. V.M. and B.G.*, the New Jersey appellate court found that V.M. and B.G. had abused and neglected their child, based on the fact that the mother, V.M., refused to consent to a cesarean section and behaved erratically while in labor. The mother gave birth vaginally without incident, and the baby was "in good medical condition." Then she was never returned to her parents, and the judge in the case approved a plan to terminate their parental rights and give custody of the child to foster parents. (L. M. Roth)

In yet another egregious example of disregard for the informed consent of a pregnant woman, George Washington University Hospital won a court order to perform a cesarean section on a terminally ill woman; an order which went against the decisions made by the woman, her husband, and her doctors. The woman and her baby died after the forced operation. Bordo writes, "A woman who *no court in the country would force to undergo a blood transfusion for a dying relative* had come to be legally regarded, when pregnant, as a mere life-support system for a fetus" (77). Other women have been placed in similar positions by the courts and by the Catholic church, namely in situations where families and hospitals have been ordered to keep pregnant women who are brain-dead on life support until the fetus is viable (Bordo 81). This represents a set of conditions which Berlant identifie as "fetality," or the valuing of the fetus over the welfare and rights of the pregnant subject. Berlant writes:

> The emergence of fetality has retraumatized a set of already vulnerable bodies: the body of the woman unsettled by pregnancy and already exposed to misogyny and the state; the impoverished, the young, the often African American or Native American women who have had little access to reproductive health support apart from a scandalous history of state chicanery with regard to contraception; the fetus vulnerable to law and to abortion; pregnant women and fetuses alike, forced to register ideological contestations over what comprises "the good life" in America. (Berlant 149)

In a country where there has been forced sterilization, cesareans, and a whole host of other court-ordered obstetrical interventions/invasions, we see that women's bodies are often considered property of the state as objects for manipulation or experimentation and are subject to its whims and rulings. The fetuses that are "protected" by the state are the ones that are most valuable–those that are healthy and that will be born to white, middle- to upper-class women–whereas the fetuses that are seen as less valuable–those that will be born disabled, poor, and of color–are protected to a far lesser extent. In cases where a fetus could be born with a disability, pregnant people are often encouraged, or at the very least, given support if they choose, to abort. Additionally pregnant subjects who are poor, of color, or disabled are often villainized for being pregnant, a stark contrast to the way that those who are middle- to upper-class and white are treated, because it is falsely presumed those who are of color, poor, and disabled will need to rely on government money to support their child once it is born. A fetus is only as valuable as its assumed ability to be productive, and therefore, those fetuses that are seen as being reliant on government funding are less protected than those who are assumed to not be reliant on said money. This concept of value and productivity can be seen throughout the histories of reproductive politics surrounding pregnant subjects who are poor, disabled, and of color; these subjects are the ones whose bodies have been forcibly sterilized, experimented on, and eliminated.

Pregnant subject's bodies are regarded not only as state property but also as the property of the men who are the fathers of their future children. When interviewed for the television series *Nightline* about "father's rights" during pregnancy one man responded:

> […] I feel like by her having the right to abort that child is her having the right to destroy a part of me without me having any say-so. And –she –you know, she wants control of her body. *But what about me? Am I not allowed to have control of my body?* That baby is a part of my body also. (Bordo 91, *emphasis mine*)

One must wonder what this would-be father is really interested in: "protecting" the fetus from the woman carrying it, or ensuring, as Susan Bordo so aptly assesses, "that his desires not merely *equal* but *supersede* those of the mother" (89). It seems apparent that he is more interested in the property of his body, the baby, to which he claims to be intrinsically linked, helps this man and others with arguments like his, to exert control not over their own bodies but the bodies of pregnant women. Moreover, by appropriating the language of bodily control this man and other men, who, like him, are members of the National Right to Life Committee, twist feminist rhetoric which argues for the bodily rights of pregnant women and use it to reaffirm their own power. Bordo writes, "[The description] of himself as so intertwined and interconnected with the fetus that not only is *he* 'part of that child'–which is true–but *the child* is a 'part of [his body] as well–which is not true" (92). In this father's words it is possible to see how fetality can be used as a mask for patriarchy. He is claiming control over women's bodies, through the construct of fetal rights and thus *his perceived rights* to dictate what happens to *his property*. He makes little distinction between his assertion of control over what happens to the fetus and his desire to have control over what the pregnant person does or does not do.

While this man is not physically linked to the fetus while in utero, as the pregnant woman is, the actions he takes before and during the woman's pregnancy have been shown to impact the fetus, implications of which I will discuss later in this chapter.

Women's bodies, in contrast to those of men's, are inherently linked to the fetus they are carrying. Feminist theorist, Luce Irigaray, interviewed Hélène Rouch about the relationship between the mother and child in utero, focusing their discussion on placental economy. Rouch describes the placenta as:

> A tissue, formed by the embryo, which while being closely imbricated with the uterine mucosa remains separate from it. There is a commonly held

> [misconception] that the placenta is a mixed formation, half maternal, half fetal. However, although the placenta is a formation of the embryo, it behaves like an organ that is practically independent of it. It plays a mediating role… as the mediating space between the mother and the fetus… and a system regulating exchanges between the two organisms. (Irigaray 38)

The placenta is therefore a mutually beneficial organ, which facilitates the life of the pregnant woman and the growth of her fetus. Rouch states that the pregnant body immediately recognizes the embryo as a foreign body and tries to reject it in the manner it would with a transplanted organ, but because of the mediating role of the placenta, her body, and therefore she, does not reject the embryo. Rouch tells Irigaray:

> There has to be a recognition of the other, of the non-self, in order for placental factors to be produced. It's as if the mother always knew that the embryo (and thus the placenta) was other, and that she lets the placenta know this, which then produces the factors enabling the maternal organism to accept it *as other*. (Irigaray 41, *emphasis mine*)

In this way, the pregnant person's body determines whether or not it will accept the other, the placenta and, thus, the embryo. In a placental economy the pregnant person has symbolic autonomy, a right that does not exist in the public sector where pregnant people have been forced from view.

Irigaray writes about the placental economy and the implications for its absence in science and technology:

> The placental economy is an organized economy, one *not in a state of fusion*, which respects the one and the other. Unfortunately our cultures, split off from the natural order–and the scientific methods used to get back to it more often than not accentuate that distance–neglect or fail to recognize the almost ethical character of the fetal relation. (41, *emphasis mine*)

Irigaray's analysis allows for a symbolic autonomy and peaceful coexistence occurring within the pregnant person's body that is absent in a culture where the fetus is seen as separate from the pregnant person's body. The neglect and failure to recognize this coexistence can be seen most

clearly in the ways we are able to view the fetus through photography and other view enhancing technologies.[6]

In 1965, ten years after Lucille Ball appeared pregnant on *I Love Lucy*, *Life* magazine ran Lennart Nilsson's famous series of fetal photographs in an article entitled, "Drama of Life Before Birth" (Berlant 166). This was the first time that Americans were able to see a fetus separate from a woman's womb, a feat which relied upon technology to reach the desired effect. The series featured one image of a living fetus, while the others photographed had been miscarried or aborted. In order to capture the image of the fetus, in color and in utero, Nilsson had to use a specially developed wide angle lens and a flash attached to a surgical scope (Berlant 166). Imogen Tyler, also discusses and expands upon Berlant's analysis of Nilsson's pictorial. She writes in her 2001 essay, "Skin Tight: Celebrity, Pregnancy, and Subjectivity" about the stages of gestational pictures we begin to see following Nilsson's pictorial:

> Early gestational pictures often show the fetus floating within the embryonic sac: a spherical container that stands in for the skin and marks the fetus as separate and self-contained. Later photographs, more clearly depict it as a being with skin; with carefully lit close-ups often of the face, hands, and feet. What is disavowed within these images is not only the *pia mater*, the mother's skin, but also, and as a consequence the pregnant woman who is the structuring absence of these photographs. (80)

Nilsson's pictorial contributed to a discourse which began to separate the body of the pregnant woman from the fetus, depicting the fetus as an entity apart from and not a part of the pregnant woman's body. Separation of the maternal body from that of the fetus gives the still developing fetus personhood, and is an opportunity which allows fetal activists to argue for the protection of fetus from the potentially harmful pregnant woman.

[6] For more on the benefit of placental economy, or the benefit of privileging the placental relationship between pregnant subject and fetus see Maher, JaneMaree. "Visibly Pregnant: Toward a Placental Body." *Feminist Review*, 72 (2002): 95-107.

This leads us to ponder: Who is the subject of pregnancy? Who are we watching, is it the pregnant woman or the fetus? Can women ever be their own subject, or must they always exist in relation to someone, whether it is to man or fetus, or both? If one must be a womb in order to be a woman, a participant in society and reproduction, what happens once this is accomplished? Must her bodily integrity be relinquished; was it ever really hers to begin with? Beauvoir writes, "The close bond between mother and child will be for her a source of dignity or indignity according to the value placed upon the child–which is highly variable–and this very bond, as we have seen will be recognized or not according to the presumptions of the society concerned" (36). We see this very value in who we choose to see as a full subject, whether it be to the pregnant person or to the fetus.

In her 1983 essay, "Pregnant Embodiment: Subjectivity and Alienation," Iris Marion Young discusses the pregnant woman's relationship to the fetus, "She feels the movements of the fetus, the contractions of her uterus, with an immediacy and certainty that no one can share" (59). At the time of the essay's original publication, sonograms, fetal heart monitors, and the fetal monitor during labor were just beginning to be used to monitor the bodies of pregnant women. Young states:

> Recently invented machines tend to devalue [the knowledge of the mother]. The fetal-heart sensor projects the heartbeat of a six-week-old fetus into the room so that all can hear it in the same way. The fetal monitor attached during labor records the duration and intensity of each contraction; the woman's reports are no longer necessary. (59)

First, Nilsson's photographs let us see the separation of the fetus from the body of the pregnant woman in print, and now, it is here, at this time in the world of reproductive medicine, that we can see the separation of the pregnant body from the fetus, even during labor. If a woman is no longer needed to tell the story of her pregnancy or her labor or to describe what she feels

happening within and to her body, then she is reduced to a holding cell, or as Anne Balsamo phrases it, "a womb with legs" (87).

The meaning of the ultrasound imaging of fetuses functions on three levels, the level of "evidence (diagnosis)," the level of "surveillance (intervention)," and also the level of "fantasy or myth" (Pollack Petchesky 70). Feminist political theorist, Rosalind Pollack Petchesky writes:

> Evidence shades into fantasy when the fetus is visualized as though removed from the pregnant woman's body. This is a form of fetishization, and it occurs repeatedly whenever ultrasound images construct the fetus through indications which sever its functions and parts from their organic connection to pregnant women. (70)

Removing the woman's body and her voice, denying her the experience of her corporeal and phenomenological experiences, privileges the male gaze. The gaze of technology, the one that eliminates a woman's full subjecthood, *is not of the woman*. Pollack Petchesky writes, "Visualization and objectification as privileged ways of knowing are *specifically masculine*" (68). Due to the culturally constructed relationship between gender and technology, those with masculinist privilege are often the developers and operators of technology.[7] Thus the historical links to industrial capitalism of both modern technology and hegemonic masculinity symbolically links their relationship to the themes of domination and control present in the reproductive technologies which interfere with the autonomy of pregnant bodies.

Furthermore, those who seek reproductive technology and medical intervention in attempts to become pregnant open their bodies to a disciplinary gaze, "… literally penetrating the female body to scrutinize the biological functioning of its reproductive organs. In the process the female 'potentially maternal' body is objectified as a medium to look through" (Balsamo 93).

[7] Curiously, the majority of those operating ultrasound technology are women and they are "trusted" with this task as long as pregnancy is diagnosed as "normal." For "high risk pregnancies" obstetricians almost always conduct ultrasounds on pregnant patients.

The potentially maternal body, to use Balsamo's phraseology, becomes nothing more than a shell which holds the pieces–the eggs and the uterus–necessary in order to create and sustain a fetus.

This literal penetration of the pregnant person's body, alluded to by Balsamo, occurs throughout pregnancy. For instance during an ultrasound, "As part of the coupling of human and machine, a transducer is pressed onto and rolled over the woman's belly. If the ultrasound is done during the first twelve weeks of pregnancy, the transducer, phallic-shaped and sheathed with a condom, may be inserted into her vagina" (Mitchell and Georges 375). The pregnant person is literally penetrated by a phallic shaped instrument in order to see the highly prized fetus. The phallus-shaped object then becomes secondary in bringing forth its visual gift of phallic replacement, the fetus. Anthropologist Melissa J. Cheyney suggests, "When women choose to birth at home with midwives they see themselves as effectively evading unnecessary and even harmful medical surveillance and manipulation–what Foucault calls the panopticon of disciplinary power" (261). Foucault uses the panopticon, literally the central observation tower found in circular or podular design prisons, as a metaphor to demonstrate how the "gaze" is central to the operation of power. Cheyney notes, "Once individuals internalize the notion that they might be observed at any time and, in the case of pregnant women, that their bodies have become 'public property' and are continuously subject to the gaze of 'natal panopticonism' individuals often become their own observers and enforcers, thereby turning themselves into 'docile subjects'" (261). As we can see in Cheyney's analysis, pregnant people and the use of monitoring devices masquerading as reproductive technology and through engagement with the medical industrial complex can often become docile prisoners of the phallocentric medical gaze.

In the 2003 postscript to her aforementioned landmark essay, Iris Marion Young confirms the power dynamics created by the use of sonogram technology to visualize the fetus.

She discusses the pregnant person's privileged relationship to the fetus, noting that the pregnant person is the only person who can *feel* the weight, position, and motion of the fetus, "…as a part of herself yet not of herself. Others have access to feeling this developing life only by contact with and through her" (61). She goes on to discuss how the subjective experiences felt by the pregnant person are converted into "objectified observables" through the use of "proper instruments" by anyone with access to these technologies. These objectified observables are then defined as the authoritative knowledge of pregnancy and the state of the fetus, leading to the devaluation of the pregnant person's once privileged insider knowledge. She points directly to the accelerated use of sonogram technology as the catalyst for making it possible "…for anyone to experience fetal movement by looking at the same projected image" (61). She continues, "This shared and shareable experience of the fetus tends to have more status as 'reality' than the feelings only [the pregnant person] can report. It is no accident, that this authoritative reality comes to those who witness it by way of *vision*…Sonogram technology [has put] a visual representation of the fetus at center" (61). Many feminist critics of science have analyzed the effect of privileging visual knowledge, and Western culture's general tendency toward scopophilia, over other tactile, oral, or intuitive knowledge.

Pregnant people quite acutely, have struggled with this scopic privileging, and, perhaps, those who are incarcerated and pregnant provide the most extreme cases of this. One woman reported, "It was like it [the fetus] moved for her [the sonographer] but not for me" and yet another reported, "It was neat and all that, you know, to see the baby moving. But, I don't know, I guess I thought the mother was supposed to feel it. Like that's when you know it's there" (Mitchell and Georges 379). Feminist anthropologists Lisa M. Mitchell and Eugenia Georges explain, "So convincing is the cognitive and sensual apprehension of the fetus via the electronic

mediation of ultrasound technology that women may routinely experience a 'technological quickening' several weeks before they sense fetal movement in their own bodies" (373). This technologically constructed visual representation of movement within the pregnant person's body demonstrates the privileging of visual and objective knowledge over the tactile and oral subjective knowledge reported by the pregnant person. In this age of ever-increasing reproductive technologies, the quickening *felt* by the pregnant person becomes a quaint rite of passage and the technologically mediated quickening created and facilitated by sonogram technology becomes the definitive and authoritative experience of pregnancy.

Women, who conceive through reproductive technology using in vitro fertilization, artificial insemination, or similar techniques, are rarely outside of the medical gaze during their pregnancy. They are scheduled for a myriad of tests on themselves and on the fetus, closely monitored office visits, and they are screened throughout their pregnancy for complications, such as diabetes. Balsamo writes:

> Some experts unabashedly agree that part of the new concern for the fetus is due to advances in visualization technologies and the promise of fetal medicine as a new medical specialty…The same technological advances that foster objectification of the female body through the visualization of internal functioning also encourages the "personification" of the fetus. (93)

This personification of the fetus only takes place if the fetus is deemed healthy first by the sonographer and then by the doctor. Once a fetus is determined to be healthy and a pregnancy is seen as "normal," both the sonographer and doctor begin to refer to the fetus as "your baby." The sonographer plays a large role in the personification and creation of subjectivity for the fetus. The ultrasound image described *for* the pregnant patient includes diagnostic information (usually an estimation of age and weight) as well as statements about the "physical body, appearance, and activity, subjectivity, potentiality, and social connections to kin and to the sonographer"

(Mitchell and Georges 376). Later in pregnancy, particularly while attempting to determine the sex of the fetus, sonographers discuss specific "personality traits" of the fetus in accordance with whether or not they are able to capture a clear image of its genitals, using phrases such as shy, modest, and cooperative (Mitchell and Georges 377).

The personification in medical reproductive technologies has even extended so far as to include frozen, fertilized embryos. There are laws which protect frozen embryos, and if a couple decides to break up or get a divorce they must go through court proceedings to determine who will get custody of the embryos. Frozen embryos cannot be donated to medical science due to a national ban which prohibits them being used for stem cell research (Gettelman 45).[8] Balsamo asserts:

> New reproductive technologies do not, in a singularly deterministic sense, construct these new social tensions. But they are implicated in the production of a new set of possibilities, wherein the rights of the pregnant woman are set against the 'rights' of other people to intervene in her pregnancy or to act on behalf of the unborn fetus. (98)

It is the ways of "seeing" that reproductive technologies provide which help to form the social and legal tensions present around the bodies of pregnant women.

Of course, there are some benefits to having access to reproductive technology. In many ways it allows for women and men to conceive outside of the bounds of heterosexual relationships. Women can choose, if they have the financial resources available, to use a surrogate mother,[9] in vitro fertilization, or artificial insemination, based on the specifics of their circumstances. Reproductive technology also gives hope to the many women who were once thought to be infertile because of difficulty conceiving outside of the laboratory. Although, in

[8] There is hope that the ban on embryos used for stem cell research will be lifted during the Obama administration.
[9] There are many ethical issues surrounding the debates of surrogacy which I do not have the space to explore in this project. For more see Markens, Susan. *Surrogate Motherhood and the Politics of Reproduction.* Berkeley: University of California Press, 2007.

these technologically influenced discourses a woman is rendered separate from the fetus, and the fetus is thus granted personhood, she is still responsible for the well-being of the fetus and can be held accountable for it.

In granting the fetus personhood, anti-abortion activists find support in their argument that the fetus must be protected as an entity separate and as important as the pregnant woman. If a pregnant woman chooses to abort a fetus, she is met with laws and restrictions which impede her right to do so and which hinge on the personhood of the fetus. For instance, the relationship between ultrasound technology and controlling the bodies of pregnant people becomes clear when one considers that in some states it is mandated by law that a woman who is seeking an abortion also be shown an ultrasound image of her fetus.

Additionally, women who do not abort are still held accountable for their actions in regard to the fetus they are carrying. In particular, women with limited or no access to prenatal care or women who have a history of substance abuse are implicated in their responsibility to the fetus. Anne Balsamo discusses some of the surrounding debates about what appear to be benign public health services. She interrogates:

> Medical research that establishes a broader list of substances and behaviors that endanger a fetus, an expanded argument about the relationship between maternal behavior and fetal development, new public health programs that seek to increase minority patient/client participation and institutional/clinic surveillance, and the criminalization of certain forms of drug consumption. (Balsamo 103)

Fetal advocates use medical surveillance in public health as way of protecting the fetus and regulating the behaviors of pregnant or potentially pregnant women. In one instance fetal advocates proposed that state officials use a monitoring system to enforce laws on pregnant women. In this case, and in others similar to it, “Women would be forced to attend their prenatal visits and obey doctor’s orders; and women could be prosecuted and punished for smoking or

using drugs during pregnancy" (Balsamo 109). These are issues which directly impede women's access to public health services and punish women who do not abide by regulations put in place to control their bodies. Additionally, women who do not have to seek public health resources for prenatal care are not subjected to these regulations as closely as those who do.

These regulations and laws are heavily embedded in race and class issues. Take for example the campaign to raise awareness about "crack babies" which was targeted primarily at poor women of color. The campaign was based on studies which argued for the connection between crack use and birth defects, but failed to take into account the serious implications of alcohol use, poor nutrition, and inadequate prenatal care, all of which have been implicated in causal relationships with birth defects (Shivas and Charles 186). In 1997, for example, CRACK (Children Requiring a Caring Kommunity) was formed in Anaheim, California with the mission "to save our welfare system and the world from the exorbitant cost to the taxpayer for each drug-addicted birth by offering effective preventative measures to reduce the tragedy of numerous drug-affected pregnancies" (KigvamasudVashi). What the members of CRACK–which later became Project Prevention in an attempt to be less inflammatory–are referring to when they use the terminology 'preventative measures" is not of course education or access to affordable and safe reproductive health services, but instead payment to low-income, substance abusing women for sterilization. Andrea Smith correctly points out that CRACK/Project Prevention's message is clear, "Poor women who are substance users are the cause of social ills, and that the conditions that give rise to poor women becoming substance users do not need to be addressed" (86). Smith continues to analyze the message of CRACK, "It further trades on a racist image of women of color in particular being the cause of social ills, as CRACK/Project Prevention primarily advertises in communities of color" (Smith 86). The racist and classist policies of

CRACK/Project Prevention are not much different than the policies of public health agencies in the United States, as research has shown that while black women are more likely to be criminalized for drug use during pregnancy (due in part to their higher rate of interaction with public health services), pregnant white women are more likely to engage in substance use. Additionally, public health facilities as well as private doctors are more likely to report black women than white women for substance use during pregnancy (Roberts 9). Furthermore, this is an issue of whose fetus is more valued; not in the sense that CRACK/Project Prevention, public health officials, or private doctors are more concerned about the health of women of color or the health of their babies, but instead that these officials and organizations are concerned with how much money it will cost to care for these babies of color if they are born with special medical needs. Implicit in this "concern" are racist, classist, and ableist values which further complicate the issues of citizenship and bodily integrity.

Regardless of whether pregnant people are seeking public services they are still mandated by laws and judicial rulings which question the validity of their citizenship and bodily integrity. There have been many women who have been prosecuted for endangering the life of their unborn fetus. Notably, in the last decade pregnant women have been charged with manslaughter because the vehicle they were driving was involved in an accident and the fetus died; they have also been charged with providing alcohol to a minor when consuming alcohol while pregnant (Daniels 83).

But what about fathers; are they prosecuted in the same way? Evidence suggests that they are not, and for all the posturing of The National Right to Life Committee and its male members about "babies" in utero being a part of their bodies, I suspect that if they were subject to the types of discrimination, invasion, and intervention that pregnant women are, they would not be as apt

to align themselves with the fetus. Many feminists are hesitant to point to the connections between the behavior of a pregnant person's male partner and the health of the fetus for fear that establishing connectivity will only give power to the patriarchal regime (Daniels 85). This fear stems from the possibility that the male external factors that endanger a fetus will be underplayed and that the external factors performed by the pregnant subject that might contribute to fetal harm would be emphasized, resulting in cases similar to those cited in the above paragraph. I believe, however, that it is important to point to the (exterior) connections the father, or male partner, has to the fetus in order to begin to alleviate the sole prosecution or persecution of pregnant women for fetal harm.

Scientists have documented, and continue to research, the connections between the toxins that are passed through the father's sperm to the gamete, and which later develop as, or contribute to birth defects (Daniels 88). [10] However, of utmost importance to me, is how the social behaviors of the father or the pregnant person's partner are attributed to fetal harm. For instance, if the partner of pregnant person is addicted to drugs or is physically abusive they may create environments where the pregnant person is subjected to undue stress (Daniels 89). These men are not prosecuted or for that matter persecuted in the same ways that pregnant women are. In fact, in the case of abuse, it is often the woman who is blamed for any harm to the fetus because she has "chosen" to stay in an abusive relationship. In addition to the responsibility of women as carriers of life to the fetus/future citizen, what should be considered in cases like those mentioned above, is the social behavior of the sperm-providing male and how they may contribute to fetal harm.

The balance here is a tricky one, and I will not pretend to have a formula or even a discourse which would protect or ensure the pregnant woman's rights and autonomy. Cynthia

[10] While this is important research, due to space limitations I have chosen not to explore it at length here.

Daniels, in her essay, “Fathers, Mothers, and Fetal Harm: Rethinking Gender Difference and Reproductive Responsibility” writes of a need to incorporate the dialogue of paternal responsibility while maintaining the pregnant woman’s right to corporeality. As a beginning to a discourse of collective responsibility she states:

> First, [we must] include men in thinking about prevention of and culpability for fetal harm. Second, while we recognize the contributions both men and collective institutions make to fetal harm, the nature of both biology and social structure requires that we address what is unique about women’s particular relation to reproductive responsibilities. Third, any talk about reproductive responsibility must begin and end with talk about corporate and social responsibility for fetal harm. Lastly, as a collectivity, we have failed to address basic requirements of health care and reproductive choice, we must do this in order to move forward. (96)

This is not a simple agenda, nor should it be, but in beginning to address what Daniels has articulated and by continuing the work of further articulation we might find ourselves with a more nuanced approach to both social practices and legal issues surrounding reproduction. It is crucial that we begin and continue to incorporate the advocacy, activist, and praxis work of those engaged with midwifery and reproductive justice into feminist critiques and analysis of the bodily integrity and autonomy of pregnant and birthing subjects.

This work can begin through analyzing the intersections of women and other pregnant subjects, fetality, the public/private spilt, and technology. Sharon Lehner writes in her essay, “My Womb, the Mosh Pit,” of the connection between technology and her own experiences of pregnancy and abortion:

> The relationship between technology and biology becomes the relationship between mother and child. I bonded with an image, I aborted an image, and I deeply mourn an image. The image does not supersede the material presence of a pregnancy, it *mediates, interprets, and supports* the physical presence of an unborn child. (Lehner 548, *emphasis mine*)

Lehner's words are reminiscent of the role of the placenta in a placental economy, that of a mediator and support system providing both separation and connection to woman and fetus.

Today we see the ways technology intersects with pregnancy in many venues. In science, for example, we see how cloning is eliminating the need for an embodied pregnancy. Take for example, yet another issue of *Life* magazine, which printed a photograph of a researcher in Japan, described in the article as a proud father, "…in his lab with a plastic box serving the function of a uterus in which a goat is gestating," (Wexler and Matthews 216). This researcher and the subsequent picture raise the possibility of a completely disembodied reproductive process.[11]

On the other hand, some women, such as those engaged in the Quiverfull movement, for instance (of whom Michelle Duggar is probably the most famous), and those with other religious beliefs regarding pregnancy and birth, who advocate publicly against birth control and believe that each new child is a "gift," are choosing not to control reproduction with medical or technological intervention.[12] In fact, many Americans watched attentively as Michelle Duggar gave birth to her 19th child on her family's reality television show, *18 Kids and Counting*. By most feminist's standards, the case of the Quiverfull movement and the decision not to control reproduction is not an empowering one. The Quiverfull movement traces its beginnings to the book, *The Way Home: Beyond Feminism, Back to Reality* (1985) written by a former activist in the feminist movement turned antifeminist and homeschool advocate, Mary Pride. The movement is based on the idea that the Bible mandates married women to be bearers of children and homemakers, and, thus, it is their duty to reproduce children until their bodies can no longer support pregnancy.

[11] This has long been a fear and/or point of contention among feminists who study the intersections of birth, pregnancy and technology. For more see Rosalind Pollack Petcheskey in the works cited.
[12] For more see Joyce, Kathryn. *Quiverfull: Inside the Christian Quiverfull Movement*. Boston: Beacon Press, 2009.

Nadya “Octomom” Suleman, who used in vitro fertilization to conceive octuplets, is the case of a woman who became a celebrity, in part, because of the amount of children she was carrying, but also because she is a single mother who relies on welfare to support herself and her children. The discourse which surrounds her is very different than the discourse surrounding the Duggars, because she is relying on public funding. Additionally, she is portrayed as crazy and irresponsible for having that many children, with many critics asserting that there is no way she will be able to provide for, give attention to, or adequately raise her children. The ethics of the doctor who performed Suleman’s in vitro fertilization has been called into question, not just because he implanted far more fertilized eggs than is considered medically sound, but because he performed the procedure on a woman utilizing the welfare system. Suleman’s case is reflective of the class politics which surround the use of reproductive technology for conception. If she was married and could support her children without the aid of welfare, then her story would be far less politicizing, and would probably be interpreted as a medical miracle.

In short, the public fixation on the pregnancy does not stop in the exam room; it has extended into the broader social culture. Take for example, celebrity pregnancies: The famous *Vanity Fair* cover photo of a nude and hugely pregnant Demi Moore, to cite one instance, would certainly not be as iconic if it were not for her pregnant belly. The viewer’s eye is drawn to it, imagining the happenings within. In fact, the photo is not about Moore at all, but instead about what her body is containing. Of course, there are also celebrity “bump watches,” where long before a famous woman announces a pregnancy—that is, if she is even pregnant—the American public monitors with rapt attention the state of her abdomen. Again, the focus on these women is not about their careers or their accomplishments, but their potentially pregnant bodies and the fetus they will or might produce.

Another kind of a celebrity pregnancy is the monstrous birth. Certainly, it has become difficult to turn on the television, pick up a magazine, or read a newspaper without encountering a monstrous birth[13]–a birth where everything has gone wrong, a story of a woman writhing in pain, a baby suffocated to death by its umbilical cord. These stories are not about informing women, they are about scaring them. They are about control. We are certainly in a pregnant moment, and the time for feminist inquiry into the relationship between reproductive technology, mass media coverage, and public pregnancies is now!

Feminist theorist Rosi Braidotti poignantly wrote of the intersections of technology and pregnant bodies thusly, "In the new Reproductive Technology, the uterus of one woman is worth that of the other, of any other. A uterus is a uterus is a uterus is… Female mother-machines" (53). Is it still true as one theorist wrote in 1997 that, "We are in danger of losing sight of the fact that pregnancies when they occur, occur in women's bodies" (Hartouni 67)? Or are we so fixated on fetal health and well-being that we have begun to obsess over these bodies, not as their own entities, but as the parcel in which the fetus will be brought to us, and thus only see them in a fragmented state? Perhaps it is, as Berlant so eloquently states, that "The pregnant woman and the fetus register changes in the social meanings of gender and maternity; as they meet up in national culture, they also raise questions about intimacies, identities, politics, pictures, and public spheres" (150). We can measure women's subjectivity by the status of fetal personhood, a measurement which acts as a barometer for what and whom our culture, our society, is willing to tolerate, support, and protect. As Rosalind Pollack Petchesky wrote in 1987, just as the rise of fetal ultrasounds began to occur, "We must create new images that recontextualize the fetus: that

[13] For instance Discovery Health, which is also affiliated with The Learning Channel (TLC), is responsible for such reality/ "documentary" television shows as "Deliver Me," "I Didn't Know I was Pregnant," "Then Came Six"which is about a woman pregnant with multiples, "18 Kids and Counting" which follows the lives of the Quiverfull engaged Duggars, "Obese and Pregnant," "Bringing Home Baby," and "Beyond Ordinary: Conjoined Twins, Amazing Separation" to name only *some* of their programming centered around pregnancy, birth, and mothering.

place it back into the uterus, and the uterus back into the woman's body and her body back into social space" (78). We are still working on her vision, and whether we have made progress is often difficult to tell. However, feminist interventions, in the form of intersectional analysis and their concomitant activist approaches, are much needed and represent positive future directions for maternal subjectivities in an age of advancing reproductive technologies and ever-more-public pregnancies.

Chapter Three

Prisoners of Policy: Midwifery, Reproductive Justice, and Birthing Practices in the United States

"*Perhaps the most symbolic act of rebellion perpetrated by midwives and mothers was bringing birth out of the hospital and back into women's lives and homes.*"

Betty-Anne Daviss, CNM and midwifery researcher and activist

"*To be a midwife in the US is to be an activist. Period. To be a midwife should also include being a reproductive justice activist.*"

Blogger and midwifery student, K. Emvee of *Bloody Show*

Jill, known to her readers through her blog The Unnecesarean, is furious. Like many others–mothers, midwives, and reproductive justice activists–she is angry and deeply concerned about the medicalization of birth and the rising rate of cesarean sections in the United States.[14] Jill is one of the many women in the U.S. who are advocating for birth to move out of hospitals and the hands of doctors and into homes and the hands of midwives. She is not a midwife herself, but a mother who had what she believes was an unnecessary cesarean section while giving birth in a hospital. In a recent blog entry she wrote:

> OBs, do you still think women are choosing not to birth at your hospitals because Ricki Lake said homebirths are cool? Do you still think we are only out for a "good experience?" [15]

[14] For more on the rising rate of cesarean sections in the U.S. see Plante, Lauren A. "Mommy, What Did You Do in the Industrial Revolution: Meditations on the Rising Cesarean Rate." *The International Journal of Feminist Approaches to Bioethics* 2.1 (2009), 140-147.

[15] A reference to the documentary film *The Business of Being Born* which was produced by the actress and alternative birth activist, Ricki Lake. The film as described by its marketing materials, "interlaces intimate birth stories with surprising historical, political and scientific insights and shocking statistics about the current maternity care system."

> I imagine that all of us who have openly questioned the practices of obstetricians in the U.S. have been hit with the same backlash. We must be selfish, irrational and motivated by our own personal satisfaction. We've been indoctrinated into a subculture of natural birth zealots and want to force pain on other women or just feel mighty and superior. We fetishize vaginal birth and attach magical powers to a so-called natural entrance to the world.
>
> Nah. It's stuff like "pit to distress" that made me run for the nearest freestanding birth center. If I had to do it all over again, I'd stay home.[16] (Jill)

Jill's words echo the sentiments of many of those involved in working to make midwifery more accessible, as well as demonstrate why the practice and regulation of midwifery has become an issue of reproductive justice.[17]

In the United States the prohibition of direct-entry midwives, those who are trained through apprenticeships and schooling not associated with the medical-industrial complex, is used as a way to control women's bodies and prevent them from making informed decisions about their health. The prohibition of midwifery parallels other debates that impact women's reproductive autonomy and intersects with the larger feminist issue of reproductive justice. The connections between reproductive justice and midwifery reside in the ideologies of reproductive justice and midwifery activists and advocates in regard to women's bodies, their reproductive health, and the political persecution both face. Midwifery and its surrounding ideologies, legislation, and demand for socio-cultural change can be interpreted as an integral part of the struggle for reproductive justice in the United States.

The struggle for women's control over their own reproductive health and the ability to have access to knowledge and resources regarding that health has been going on for centuries. This struggle has taken shape in a series of bodily violations against women in the form of witch

[16] "Pit to distress" is a term used to describe the maximum dosage of pitocin that can be presribed to a birthing woman in order to expedite labor and induce contractions. Pitocin has been linked to birth traumas, such as uterine tearing and fetal distress. For more information see Laura Landro in the works cited for this thesis.
[17] The use of blogs has become common practice among many women. Those engaged in the reproductive justice and midwifery communities have used them to share information, an act which I will discuss further in Chapter 4 of this project.

hunts (for women healers), forced sterilization, selective breeding through the rape of enslaved Black women, denial of medical assistance for women seeking abortions, and forced cesareans to name only a few examples. In order to lead into the broader discussion of reproductive justice in this chapter, I will begin my discussion of these sexist, racist, ableist, and classist policies and ideologies surrounding the pregnant or potentially pregnant woman's body beginning with the early twentieth century, but will bring in additional historical moments throughout the chapter.

The eugenics movement of the early twentieth century targeted marginalized communities, particularly the poor, the disabled, and people of color, using birth control policies as a way to enforce population control of these already oppressed groups.[18] In spite of these issues, or perhaps because of them, women of color who made the connections between race, class, and gender joined the movement for birth control in the 1920s, which was one of the first movements in the United States focused specifically on a woman's right to control her body's reproductive process.[19] In particular for Black women, the gender empowerment offered by the movement and the historical role of enslaved Black women as "breeders" contributed to the attractiveness of the movement (Asian Communities for Reproductive Justice 54). Reproductive justice activist Loretta Ross points out, "Reproductive politics are about who decides whether, when, and which women can reproduce legitimately and also the struggles over which women have the right to be mothers of the children they bear" ("White Supremacy and Reproductive Justice" 61). Throughout American history, entire communities–most pointedly those

[18] Population control policies can be traced back as far as the Roman Empire, where the emperor was concerned with the declining birthrate among married, upper-class couples. Emperor Augustus enacted a policy which specifically encouraged these couples to have multiple children and discouraged childlessness (Ross "White Supremacy and Reproductive Justice" 55).

[19] The Thompsonian health movement, named after the New Hampshire farmer Samuel Thompson who pieced together the healing system that became the basis for feminist alternatives to mainstream medicine, predated the movement for birth control by 100 years. Women were attracted to the movement because "… [They found] a dignified and neighborly system of care for themselves, plus public validation for their traditional role as healers for their families and friends" (Ehrenreich and English 60).

communities made up of people of color, poor people, and disabled people–have been controlled through state and federally mandated regulations which monitor when, how, and how many children a woman is allowed to have or to keep. These population control policies, which have taken a variety of forms ranging from denying access to safe birth control to forced sterilization to welfare caps, demonstrate the pervasiveness of the racist, sexist, classist, and ableist social ideologies surrounding women's control of their reproductive health.

By the 1960s, the federal government began funding birth control and other family planning options as part of its racist population control policy.[20] The Asian Communities for Reproductive Justice collective writes, "Population control has been defined as externally imposed efforts by governments, corporations, or private agencies to control (by limiting or increasing) population growth, usually by controlling women's reproduction and fertility" (54).[21] These policies were a distinct move away from the earlier claims of the 1920s birth control campaign and demonstrates how a tool for reproductive empowerment, supported by women of color, was harmfully appropriated by the federal government to be used against the very communities which supported it.[22]

As a response to population control policies, and as a product of both the feminist and civil rights movements, the women's health movement of the 1970s began establishing women's health clinics in an attempt to provide access to woman-centered family planning services (Asian

[20] Additionally, these policies were the beginning of the United States' plan to distribute and fund birth control, and other family planning options, as international population control.
[21] Andrea Smith discusses at length the racist population control policies of the United States particularly as they pertain to Native women. For more see Smith, Andrea. *Conquest: Sexual Violence and American Indian Genocide*. Cambridge: South End Press, 2005.
[22] The claims of the birth control movement were often different from the actual practices it supported. Margaret Sanger, the well known birth control activist of the early 20th century and the organization she founded, Planned Parenthood, have long been criticized for their racist policies during this time.

Communities for Reproductive Justice 55).[23] Although I will discuss this matter further later in this chapter it is worth mentioning that in concurrence with, and perhaps as an outgrowth of the women's health movement, midwives were establishing birth centers at this time. Due to the work of the women's health movement and feminist attention to oppressive reproductive policies there was a strong political and social focus on women's reproductive rights during the late 1960s and early 1970s.[24] The work of these movements culminated in the landmark 1973 Supreme Court case, *Roe v. Wade*.

The decision in *Roe v. Wade* did more than simply strike down state laws banning abortion; it also gave women the right, albeit limited, to make decisions about their bodies while pregnant. The Supreme Court based their ruling in *Roe v. Wade* on the right to privacy, yet in their decision they left room for state intervention into the private lives of women. [25] Feminist reproductive rights activists claimed the decision as a victory but noted that the decision, while granting bodily integrity to women in one breath, takes it away in another. The legal loophole in the *Roe v. Wade* decision has left it vulnerable and has contributed to it being one of the most frequently challenged Supreme Court cases in history. Due in part to the loophole, and in part to the contentious nature of "the abortion question," reproductive justice advocates and activists must continuously monitor laws and court cases to ensure that the precedent set forth in *Roe v. Wade* is not overturned or violated.

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[23] When used as an umbrella term the women's health movement, which was part of what is commonly called the "second-wave of feminism" and is responsible for the founding of the Boston Women's Health Collective, includes among other smaller movements, the Alternative Birth Movement (ABM).

[24] Women of color and poor women have long criticized this era of organizing, while it was seemingly about *all* women, it allowed for the oppression of those women who were not white or middle-class because of its focus and concern on maintaining the legality of abortion and privacy rights and thus failed to address the use of dangerous contraceptives and coercive sterilizations.

[25] The decision states, "The pregnant woman cannot be isolated in her privacy. She carries an embryo and, later, a fetus, if one accepts the medical definitions of the developing young in the human uterus…it is reasonable and appropriate for the state to decide that at some point in time another interest, that of the health of the mother or that of the potential for human life, becomes significantly involved. The woman's right is no longer sole and any right of privacy she possesses must be measured accordingly" (*Roe v. Wade* 1973 410 U.S. at 158).

To some extent, because of the work that must be done to protect the *Roe v. Wade* decision, but also due to the initial framing of women's reproductive rights by the (mostly white) leaders within the movement politics during the 1960s and 1970s, the movement for reproductive rights has long been framed by those within and outside of the movement as *an issue of choice* regarding abortion. The framework of choice, while inherently flawed, became particularly problematic with the passage of the Hyde Amendment (1977) which prohibited the use of taxpayer funds to pay for abortions for women whose healthcare is funded by the federal government–those on Medicaid, in the Peace Corps, indigenous women who rely on the Indian Health Service, and those in the military or government– creating yet another barrier to the access of abortion, and reproductive healthcare in general.

While most white activists remained faithful to the "choice" paradigm, the movement was never solely about access to abortion. Those within the reproductive rights movement, particularly people of color, also fought for women's access to birth control and family planning services, and against forced sterilization (Ross, "The Movement for Reproductive Justice" 9). However, even though there was increased attention towards women's reproductive rights during this time there were still egregiously racist population control policies which allowed for the involuntary sterilization of large groups of women of color. Feminist and reproductive justice activist Andrea Smith has written about these policies extensively, citing that in the 1970s Indian Health Services was responsible for involuntarily sterilizing up to 50 percent of Native women (82). Furthermore, in 1970 the U.S. Department of Health, Education, and Welfare accelerated programs that paid for costs to sterilize Medicaid recipients. By 1979, 7 in 10 hospitals were

violating federal guidelines through their disregard of consent procedures and were using "elective hysterectomies" to sterilize women (Smith 81).[26]

By the early 1990s, some activists within the reproductive rights movement began to express their aversion to the "choice" paradigm. These activists felt that "choice" was a construct that applied to privileged mostly white, middle-class and upper-class women–because of its assumption that all women had equal opportunity and access to reproductive health services. They believed that there were many factors which affected the access women had to reproductive health services long before an individual woman had an opportunity to even consider "choice" as an option.

Another Supreme Court decision, this one almost twenty years after the *Roe v. Wade* decision, helped these activists explain the links between socioeconomic status and reproductive rights. In their 1992 decision regarding *Planned Parenthood of Southeastern Pennsylvania vs. Casey* the Supreme Court ruled "the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives" (*Planned Parenthood of Southeastern Pennsylvania v. Casey,* 1992 No. 505 Supreme Court of the US). According to the *Planned Parenthood vs. Casey* decision women who have privilege and access in order to control their reproductive lives have the ability to participate equally in the socio-cultural and socio-economic realms of the United States. However, proponents for reproductive justice wondered about what this decision meant for access to reproductive services for all women (Asian Communities for Reproductive Justice 55). Moreover, while "the reproductive rights framework came to champion women's entitlement to a full range of rights related to reproduction, reproductive freedom, and reproductive health…there was wide

[26] Of course sterilization abuses did not stop in the 1970s. In 1997 Barbara Harris founded CRACK (Children Requiring A Caring Kommunity), now known as Project Prevention. CRACK targets communities of color and pays women with a history of substance abuse to be sterilized. This is discussed further in Chapter 2 of this project.

recognition that an approach combining resistance to population control and advocacy for abortion rights was too narrow," (Asian Communities for Reproductive Justice 55) and consequently, a new framework was developed.

"The use of the 'choice' framework," notes longtime reproductive justice activist Loretta Ross, "underwrites the conservative idea that the personal is separate from the political, and that the larger social structure has no impact on or responsibility for private, individual choice" (Ross, "The Color of Choice" 61). Reproductive justice is comprised of three main concepts for analysis: reproductive oppression, reproduction, and social reproduction; the term reproductive justice forces activists and advocates to engage in an intersectional analysis of reproduction which broadens and strengthens the scope of the movement.[27] Ross describes reproductive justice "…as reproductive rights embedded in a human rights and social justice framework used to counter all forms of population control that deny women's human rights" ("The Color of Choice" 53). Most importantly reproductive justice requires that advocates for reproductive rights put the bodies and experiences of women of color at the center of their analysis.

By the mid-1980s, the Black Women's Health Collective began framing their work as reproductive justice, instead of using the paradigm of "choice" and "reproductive rights." By 1997, they had been joined by several other key organizations fighting for reproductive justice, including Asian Communities for Reproductive Justice and the National Latina Health Organization. Together, these three groups along with 13 other women of color organizations and longtime reproductive justice organizer, Loretta Ross, founded SisterSong Women of Color Reproductive Health Collective (Asian Communities for Reproductive Justice 61). In 2009,

[27] For more information on the feminist analytical tool of intersectionality see Crenshaw, Kimberle. "Mapping the Margins: Intersectionality, Identity Politics, and Violence Against Women of Color." *Applications of Feminist Legal Theory to Women's Lives: Sex, Violence, Work, and Reproduction*. Ed.
D. Kelly Weisberg. Philadelphia: Temple UP, 1996. 363-387.

SisterSong is now a national umbrella organization with approximately 76 allied organizations and is considered to be at the forefront of feminist thinking about women's reproductive autonomy (Ross, "The Color of Choice" 53).

Activists for reproductive justice work to ensure all women's access to a full range of reproductive rights. The Black Women's Health Collective has summarized what they believe comprise women's reproductive rights:

> The right to comprehensive, age appropriate information about sexuality and reproduction, the right to choose to have a child, the right to good, affordable health care to assure safe pregnancy and delivery, the right to health services to help the infertile achieve pregnancy, the right to choose not to have a child, the right to the full range of contraceptive services and appropriate information about reproduction, the right to choose to end an unwanted pregnancy, the right to safe, legal affordable abortion services, the right to make informed choices, the right to easily accessible health care that is proven to be safe and effective, the right to reproductive health and to make our own reproductive choices. (41)

The rights that the members of the Black Women's Health Collective are claiming as aims for reproductive justice resonate with the objectives of those arguing for the legality and legitimacy of midwives. I discuss the similarity and connections of these objectives further later in this chapter, but for reference and clarity they include: "the rights to good, affordable health care to assure safe pregnancy and delivery; to make informed choices; to easily accessible health care that is proven to be safe and effective; to reproductive health and to make our own reproductive choices" (Black Women's Health Collective 41).

I contend that midwives and the societal roles which they advocated for through the Alternative Birth Movement (ABM) and continue to advocate for in our current era contribute to ensuring the aims of reproductive justice. According to members of Asian Communities for Reproductive Justice that goal "will be achieved when women and girls have the economic, social, and political power and resources to make healthy decisions about their bodies, sexuality, and reproduction, for themselves, their families, and their communities in all areas of their lives"

(59). As reproductive justice activists continue to advocate for power and resources for women, so will advocates for midwifery who lobby for the legalization and regulation of direct-entry midwives and access to midwifery care for all those who seek it.

Midwifery was an issue of reproductive justice long before the term was coined and used as a movement shifting and shaping ideology for reproductive rights. In Europe, witch hunts for midwives and other lay healers began in the late 15th and early 16th centuries. Those who were accused and persecuted for being witches were almost exclusively peasant women and were often stripped and shaved by doctors in order to be examined for "devil's marks." It is widely estimated that the total number of people killed is in the millions, with 85 percent of those deaths being old women, young women, and children (Ehrenreich and English 39). Through the witch hunts male doctors were able to create a monopoly over the practice of medicine, even though their practices were based on less adequate knowledge than that of the centuries-old knowledge of lay healers. The monopoly created by male doctors allowed for professionalization to become an integral element in the practice of medicine. Since women did not have access to formal education, it became almost impossible for them to legally practice medicine or healing.[28] As Barbara Ehrenreich and Deidre English point out,

> A profession is defined by its *exclusiveness*. While the female lay healer operated within a network of information-sharing and mutual support, the male professional hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity…Thus the triumph of the male medical profession is of crucial significance: it involved the destruction of women's networks of mutual help–leaving women in a position of isolation and dependency–and it established a model of expertism as the prerogative of the social elite. (38)

[28] Elizabeth Blackwell, one of the first women to graduate from medical school in the United States, had to apply to over 16 medical schools before she was finally accepted. While this is not unheard of by present standards at this time in history applying to multiple medical schools was excessive.

The only area which male doctors did not have a monopoly was over pregnancy and birth, which remained the sole province of midwives for centuries following the witch hunts. The European witch hunts ominously foreshadowed the conflict which arose between male medical doctors and female midwives in nineteenth century America.

Prior to the beginning of the nineteenth century, midwives were the primary attendants during birth in the United States. Historian Judy Litoff writes about the role of midwives in birth, "In most instances, she provided moral support and encouragement to the parturient woman and, otherwise, let nature take its course. Mild herbal remedies for pain were sometimes employed, but midwives did not make use of bloodletting, purging or other 'heroic' medical practices" (Litoff 6). One of the "heroic medical practices" to which Litoff is alluding is the use of obstetrical forceps. Invented in the late seventeenth century by British surgeon, Peter Chamberlen the Elder, the forceps were developed in order to allow men to deliver babies relatively "unharmed"; and because forceps are an "instrument," at that time, only men were allowed to use them. The invention of the forceps is the primary reason that men were first permitted into the birthing room. Prior to the invention of obstetrical forceps and the adoption of their use in labor, men were rarely permitted into the birthing chamber. Feminist anthropologist Emily Martin writes in her monograph, *The Woman in the Body*, "In the development of obstetrics, the metaphor of the uterus as a machine combines with the actual mechanical devices (such as forceps), which played a part in the replacement of female midwives' hands by male hands using tools" (54). As the uterus began to be seen as a machine and as technological "aids" were introduced during labor, birth became a realm into which the watchful male gaze was permitted. The Chamberlen family kept the original forceps design a secret for more than one hundred years, and in order to ensure secrecy, the birthing woman was blindfolded. "Gradually,

physicians either bought 'the secret' from the Chamberlens or developed their own version of the forceps. Midwives could not afford to buy the forceps nor could they find physicians who would instruct them in proper use" (Litoff 7).

By the mid-nineteenth century what had been a lukewarm debate about the "midwife question" earlier in the century had turned into impassioned argument, with proponents of midwifery on one side and obstetricians on the other. The debate was informed by several factors "…the development and use of anesthesia on the parturient woman, the rapidly increasing number of formally trained obstetricians and the near absence of any formally trained midwives, and the dramatic shift in the space within which women gave birth–home or hospital" (Crook 9). Throughout the nineteenth and early twentieth centuries as more technological interventions in birth became available to the trained physician, midwives began to be labeled as "uneducated," "ignorant," "dirty," and "evil" (Litoff 32).[29] The American Medical Association (AMA) launched a campaign against midwives, creating and supporting the social stigma that portrays midwives as unskilled, dirty women putting the lives of pregnant women and their unborn babies at risk.

Initially the campaign against midwives had little to do with medical doctors seeing midwives as business competition. In 1900, fifty percent of births were occurring in hospitals–these were primarily the births of middle- and upper-class women–while the remaining fifty percent of births–those of the urban immigrant working class and rural poor–were attended by midwives. As Ehrenreich and English note, "…The regular doctors were not interested in taking the midwife's place in a Mississippi sharecropper's shack or a sixth-story walk-up apartment in one of New York's slums" (103). What medical doctors were interested in was having live

[29] The image of midwives that was perpetuated by the physicians' campaign was informed, and its success benefited from, the Charles Dickens character, Sairy Gimp.

patients for their students to practice on. Ehrenreich and English continue, “Certainly no decent woman in 1900 would want her delivery witnessed by any unnecessary young males. The only choice was the people who had the least choice–the poor. And so medical schools began to attach themselves parasitically to the nearest “charity” hospital” (104). Clearly, practicing on the poor and thus enacting control over their bodies was not only the practice of politicians (as can be seen in eugenicist policies) but also of medical doctors.

In the campaign against them, midwives were painted as foreign imports and entirely “un-American.” This is of course false, as midwives had been practicing in the United States long before it was established as an independent country. Women healers and midwives played integral roles during the colonial era and learned much of their knowledge about local herbs and remedies from the indigenous women healers who had lived on the continent prior to colonization. The medical establishment’s message played on the fear some Americans (mostly middle- and upper-class white people) had of immigrants–the false accusations that immigrants were taking over America and bringing with them germs and unsanitary conditions–and linked this fear to midwives. One medical doctor went as far as to state that the number of midwives in a community was directly correlated with the number of unassimilated immigrants. He believed that once immigrants had assimilated they no longer found a need for the dirty and germ-carrying midwives, thus equating using a midwife with being uncivilized and un-American (Ehrenreich and English 106).

Even early in its monopoly over birth, the medical establishment was not willing to respect the autonomy of the birthing woman. Ehrenreich and English cite one doctor who said he was unwilling to sit around for hours, “watching a hole” (107) and many other doctors followed this man’s line of thought. If labor was taking too long, doctors would oftentimes intervene with

forceps or a knife and often, as Ehrenreich and English note, to the detriment of the mother or infant (107). Teaching hospitals, often the "charity" hospitals previously mentioned, where it was important for students to practice attending abnormal births, were particularly biased toward these types of dangerous interventions.

The medical establishment's initial exertion of control over pregnant women's bodies can further be seen in the laws that were passed to make abortion illegal. From 1867-1940 physicians had the right to deny care to a woman seeking medical attention for injury related to an illegal abortion unless she was willing to confess who had performed the abortion. Feminist historian Leslie J. Reagan cites:

> Physicians advised each other to deny medical care to a woman who had had an abortion until she made a statement. In 1902 the editors of the *Journal of the American Medical Association* endorsed this policy…quoting a physician who counseled his colleagues to 'refuse all responsibility for the patient unless a confession exonerating him from any connection with the crime is given.' (1254)

Often the women seeking medical care were dying, or were beyond help, but medical professionals still wielded their power in order to manipulate women into revealing who had helped them. While these policies at first seem to be about controlling abortion–and in part they were–they were also about taking away business from midwives. These policies and laws are examples of some of the first attempts at professionalizing the field of obstetrics and thus, medicalizing birth.

Prior to these policies, and the smear campaign the AMA enacted against midwives, women could receive a safe and legal abortion from a midwife. It was only after the campaign and policies, like the dying declarations discussed by Reagan, that abortions became illegal and women began to seek alternate means in order to have access to them. Additionally, dying declarations were less about exonerating the physicians treating women dying from abortions

and more about identifying midwives and other lay healers who might have performed them.[30] In these policies it is possible to see some of the historical links between reproductive justice and midwifery.

Eventually midwifery was either outlawed, deemed passé, or midwives could no longer be certified to practice under state guidelines due in large part to the AMA's campaign against midwives. In addition, hospital births were seen as fashionable to women. These factors, alongside the growing number of technological "advances" to "aid" in birth, also contributed to the elimination of midwifery. Longtime advocate of midwifery Robbie Davis Floyd writes:

> [Women of color] began to actively seek access to medical care in hospitals because the state touted it as the best care for their babies–but had it also denied to them for many years based on segregationist health care policies. Once these women finally gained access to hospitals, many began to perceive the use of midwives as "going backwards." The kind of culture that had supported midwives had disappeared, and along with it the midwives. In addition, from the late 1800s on in the United States, it increasingly became the fashion for middle-class women to employ male midwives and later, obstetricians, as the modern and progressive way to give birth. After all, male-developed technologies were bringing…a thousand other modern and progressive conveniences. (34)

In addition to the reasons Davis Floyd discusses, one of the male developed technologies which supported the move of birth from home to hospital in the 1930s was the automobile which allowed for easier transport and access to hospital care.

In 1934, the New York Obstetrical Society released a statement regarding its opposition to home birth:

> It maintained "that delivery in a well-organized and well-equipped hospital is safer than home-delivery." The society argued that obstetrics was no longer "a one man job" and that, consequently, "home deliveries should not be encouraged, unless they can be conducted with every safeguard of medical supervision, equipment, and assistance. (Litoff 72)

[30] For more information on how dying declarations were used against women and their abortion providers, including how physicians and the state focused primarily on "unwed mothers" see Leslie J.Reagan's article, "About to Meet Her Maker: Women, Doctors, Dying Declarations and the State's Investigation of Abortion, 1867-1940." The Journal of American History 77.4 (1991), 1240-1264.

As the AMA's campaign proceeded, birth became less about the woman's body and more about what was convenient and profitable for the physician. In this system, which still persists, midwives struggle for legitimacy, and those who become pregnant must struggle to maintain their autonomy and bodily integrity.

As a result of the AMA's war on home births, legislation began to be passed at the state level to outlaw midwifery. Some states, like Alabama, did not outlaw midwifery officially through legislation but stopped issuing licenses to practice lay midwifery (Crook 14). Concomitantly, medical schools began to offer Registered Nurses the opportunity to receive advanced education in maternity care. The certification they were issued gave them the title, Certified Nurse Midwife (CNM). These nurses were not permitted to practice midwifery without the supervision of a physician, and, thus, while midwifery existed in hospitals, it was still under the purview of the phallocentric medical gaze.

By 1955, ninety-five percent of all births in the United States were attended by physicians (Litoff 77). Notably, not long after this time period, the Alternative Birth Movement (ABM) originated, growing out of women's dissatisfaction with obstetrical care in 1950s. Those delivering were particularly dissatisfied about the use of the drug, scopolamine, and the practice of being tied to beds and walls for hours or sometimes days while in labor. The administering of scopolamine to laboring women began in the 1930s as part of the medical model of birth as *pathology*. Scopolamine was believed to be an amnesiac and was used to put laboring women into a "twilight sleep." A woman under twilight sleep can feel and respond to pain; and thus women had to be restrained because their uncontrolled thrashing (due to their semi-unconscious disoriented state) resulted in severe injuries (Katz Rothman "Laboring Then" 17). Some women thrashed so violently that they threw themselves out of bed, and nursing texts at the time warned

against insufficient restraints. Scopolamine was not meant to eliminate the pain of labor for women, but merely to erase the memory and "trauma" of birth. Cultural anthropologist and midwifery advocate Robbie Davis Floyd writes:

> From the 1930s-1970s the use of scopolamine was heavily employed. Women were strapped down with lamb's wool bands (which did not leave marks on their arms) and often left alone to scream until the baby finally came; many women were subsequently haunted by spotty nightmarish memories. Technological interventions such as forceps and episiotomies became increasingly common as humanistic care for birthing women became increasingly rare. (38)

Women began to write outraged letters to magazines like *Redbook* and *Ladies Home Journal* detailing their experiences with scopolamine while giving birth. The images which can be found of these laboring women are both shocking and painfully representative of a woman who has lost all rights and dignity merely because she is pregnant. These images bring to mind one invoked by theorist Michel Foucault in the opening chapter of his book, *Discipline and Punish*, that of the French prisoner drawn, quartered, and a spectacle for all to see (3-5). Foucault goes on to detail the regimented day of a prisoner, regiments which are used to discipline and control, the same way that the prescribed regiments of medicine and technology for pregnant women are meant to discipline their bodies into a position, a state, which can be controlled by the medical establishment and society at large. Presently, the issue of the restraint implemented during birth is a particularly prominent issue for reproductive justice activists who are concerned about the rights of incarcerated women, an issue which I will discuss further later in this chapter.

The Alternative Birth Movement continued to gain momentum as growing numbers of women began to speak out about their hospital birth experience(s) and more women began to (re)discover the alternative of birthing at home (Daviss 71). Early leader of the ABM and midwife, Ina May Gaskin remembered, "Women interested childbirth began serving as attendants in different parts of the country, unaware of one another, an illustration of how much

this new kind of midwifery was an expression of the *zeitgeist*. For all some of us knew, we were the only midwives in the country" (Daviss 72). Many of the women who became midwives during this era learned midwifery skills because friends or family members wanted to birth outside of hospitals and the midwives attending their births needed assistance.[31]

While political rumblings surrounding midwifery were beginning to happen in the 1950s, the moniker, Alternative Birth Movement (ABM), did not originate until the counter-cultural and movement-rich 1960s. Joanne Myers Ciecko founder of the oldest direct-entry training program for midwives practicing out-of-hospital notes that the resurgence of the feminist movement at this time "was the catalyst for the creation of feminist self-help clinics and various midwifery programs, including the Seattle Midwifery School" [32] (Daviss 71). It is no coincidence then that the ABM's founding and the emphasis on reproductive rights occurred within the same decade. Long-term childbirth activist and early member of the ABM, Raymond DeVries declares:

> Collectively, we were referred to as the 'Alternative Birth Movement' giving us a home among the many movements that populated the American social landscape in the sixties and seventies. The better-known movements of that era–the civil rights movement, the women's liberation movement, the antiwar movement–were in fact our inspiration. Compared with the task of overturning centuries-old discriminatory laws or taking on the military-industrial complex, our mission seemed easy. We were confident we could "de-medicalize" pregnancy and childbirth, making a place for birth at home and for midwife-assisted birth. (Daviss 71-72)

DeVries reflection makes it seem that midwives and their allies did not expect to still be fighting for legitimacy and against medicalized birth almost 40 years later.

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[31] Here it is possible to see the spirit of a feminist Do-It-Yourself (DIY) culture among midwives. While some of these women probably did not identify as feminists they certainly became a part of a DIY culture, one which I argue has always been a part of midwifery. The "each one teach one" philosophy of lay midwives of this era and the era preceding it are exemplary of the DIY philosophy present in ideologies surrounding midwifery. I expand upon this in Chapter Four of this project.

[32] The Seattle Midwifery School was founded by the midwives and doulas of the Fremont Women's Clinic in Seattle. It was one of the first midwifery schools in the nation and has provided training for over 200 midwives since its founding in the 1970s.

By drawing inspiration from the feminist movement and the civil rights movement, the ABM laid the ideological groundwork for modern midwives to easily be made part of the reproductive justice paradigm of the 1990s and early 2000s. Additionally the core beliefs of ABM members that women "should have a major role to play in decision-making and should be given enough information to make an informed choice (including a choice about where to give birth)" (Daviss 75) and that midwives are the practitioners best-qualified to assist in births, which empower women and allow them to give birth naturally, are completely in accordance with the beliefs surrounding reproductive justice as outlined earlier in this chapter. Their beliefs are specifically reflective of the Black Women's Health Collective's assertion that women have the right to make informed choices, as well as the right to make their own reproductive choices.

By the 1980s, the original organizations of the ABM were eventually replaced by organizations seeking to professionalize midwifery. Although the American College of Nurse-Midwives (ACNM) had been in existence since 1955, midwifery as a legitimate profession did not begin to garner attention until the Midwives Alliance of North America (MANA) was formed in 1982. While ACNM, only extends membership to certified nurse-midwives (CNM), MANA extends membership to all midwives, including those without formal certification and those not practicing alongside physicians or within hospitals. The difference in the membership qualifications of these two nationally recognized and leading midwifery organizations points to major tensions among midwives.

Betty-Anne Daviss explains, "Each of the organizations that form the ABM have their own particular ideology and agenda, ranging from public awareness of prenatal psychology to lowering the cesarean rate and increasing the rate of vaginal births after cesareans (VBACs). Sometimes these conflict, pitting members of the overarching movement against each other in

various ways" (76). This can be seen most clearly in the ideological tensions between some Certified Professional Midwives (CPMs) and Nurse Midwives (CNMs).

In the early 1990s the North American Registry of Midwives (NARM), which was created in 1987 by MANA to identify standards and practices for direct-entry midwives, began a certification process for direct-entry midwives which would give all those who completed it the title, Certified Professional Midwife (CPM) (Midwives Alliance of North America). The process for certification as a CPM was fully established by 1994:

> A prime motivator for key members of the NARM board had been their belief that ACNM was going to stick to nurse-midwifery and leave direct-entry certification up to MANA and NARM. Thinking they had an open field, NARM board and committee members…created a new direct-entry credential, the Certified Professional Midwife (CPM). (Davis-Floyd 30)

However, also in 1994, the ACNM decided to create its own direct-entry credential for midwives, the Certified Midwife (CM). For MANA, the decision by ACNM to accredit direct-entry midwives was an encroachment into their already established terrain.

Both organizations were now facing the struggle for legalization and regulation for their new direct-entry certifications in state legislatures across the country. Adding fuel to an already blazing fire, "ACNM sent out a letter to legislators all over the country stating ACNM's support for its own CM credential and casting doubt on the validity of other certifications –an action many in MANA and NARM interpreted as a frontal attack" (Davis Floyd 30). While still at work within the same social and political movement, the tensions between midwives practically split the practice of midwifery in half. With those believing in the superiority of one model over the other, CNMs were seen by some CPMs as sell-outs to the medical establishment for being willing to practice oftentimes in hospitals and under the supervision of doctors, while CPMs were seen by some CNMs as "unregulated wildcats" (Simonds and Katz Rothman 290) for their

refusal to follow some of the guidelines established by the American Congress of Obstetricians and Gynecologists (ACOG).

CNMs were concerned that the historical stigmas associated with midwives would face a resurgence with the creation of CPMs.[33] On the other hand CPMs felt that the willingness of CNMs to work within the androcentric medical model was not really practicing the midwives model of care for woman-centered birth and thus, to CPMs the exclusionary governance of CNMs represented the unraveling of the history and ideologies of midwifery.

ACNM and MANA leaders and midwives tried for 3 years to resolve the ideological tensions between them and to form a more cohesive movement as well as certification process.[34] In the end, however, their differences were just too vast. Feminist anthropologists and birth activists Wendy Simonds and Barbara Katz Rothman write:

> These are not just different occupational groups competing. These are different worldviews, different value systems, despite their common source. *And the difference is not necessarily between the types of midwives but between the systems in which they operate.* So while their attentions may be drawn to each other and their fears may be for the damage each can do the other, it is the medical system that creates the conditions under which these conflicts arise. (291, *emphasis mine*)

The systems in which midwives operate, whether they are in the hospital or the periphery of it, have been the same systems midwives have been fighting all along. CNMs definitely have the privilege of operating *within* a dominant system–with all of the legal and monetary support that comes with it–while still being able to call themselves midwives. CPMs do not have the same comforts afforded to CNMs because they choose to operate outside of dominant medical

[33] It is important to note here that the stigmas feared by CNMs were originally created and perpetuated by the governing body under whose rules they practice.
[34] For more information on the Carnegie Meetings of the Interorganizational Work Group see Davis-Floyd, Robbie. "ACNM and MANA: Divergent Histories and Convergent Trends" in the works cited for this project.

structure, but they feel deeply connected to the practice of midwifery and its historical roots while practicing in free-standing birth centers and the homes of individual women.

Concerns of midwives regarding their perilous social and legal statuses [35] are legitimated by the fact that the AMA, and now ACOG, have proven to be capable and persistent adversaries of midwifery since the nineteenth century. In fact, the rhetoric from physicians about midwifery has changed very little since the AMA's first campaign against midwives. They are still using words like "unskilled" to describe direct-entry midwives as practitioners. The Oregon State Section of ACOG took this stance on direct-entry midwives in 2007:

> These CPMs are generally self taught with loose apprenticeships… Legislators are responding to the "choice," "safety," and "cost" messages put out by the lay midwife lobby. The concerns of this committee is that choice, safety, and cost issues cannot be addressed in the absence of true information regarding the morbidity that may go unreported during home births by inadequately trained providers. (American Congress of Obstetricians and Gynecologists)

Of particular note in this statement are the phrases, "absence of true information" and "self taught with loose apprenticeships." The stance of the Wisconsin delegation for ACOG, after their review of NARM's training requirements for CPMs, is no better:

> Their training requirements fall short of internationally established standards… Instead, they adhere to a principle where the midwife and the patient determine individual practice guidelines for an individual patient on the standards, values and ethics held by the midwife and the patient…The midwife philosophy states, "we support each midwife to study and grow in experience until SHE [sic] knows she is a competent attendant, realizing that no amount of certification can create for someone the intuitive certain readiness for the responsibility of a midwife." *To what extent should we protect the public from unsafe medical practice or unsafe perceived medical practice?* We may want to respect the maternal autonomy and cultural and religious beliefs that make women choose to have an out of hospital birth with traditional untrained birth attendants or, by most standards,

[35] While CNMs are legal and regulated in all 50 states, the legal status of CPMs varies from state to state. In some states direct-entry midwives (CPMs and lay midwives) are explicitly illegal. While in other states direct-entry midwives are alegal and, thus, their status and the practice of midwifery is not legally secure. "When alegal, midwifery is not specifically addressed in the statutes, but the actions involved in midwifery practice are considered the practice of medicine and/or nursing; these midwives are left vulnerable for criminal prosecution whenever anyone cares to pursue such action" (Davis Floyd and Johnson 8). This is the nature of the fight which midwives still face.

> inadequately trained lay midwives. *Does that mean we have to create public support and licensure for homebirth practice by inadequately regulated, inadequately trained self-anointed midwives*? (American Congress of Obstetricians and Gynecologists, *emphasis mine*)

The words each of these delegations enact against midwives are scathing and reminiscent not only of their campaign against home birth one and a half centuries ago, but also of the ideologies which were behind the laws created to "protect" women and physicians from unskilled midwives during the era of dying declarations and the earlier European witch hunts of the fifteenth and sixteenth centuries. Moreover, the language used within their statement is paternalistic ("protect") and brings to mind the fury of the Unnecessarean blogger, Jill, noted at the beginning of this chapter, which seems all the more poignant in light of these statements.

What has changed for the AMA and ACOG in terms of midwifery is that they now support nurse-midwives, specifically those who belong to ACNM. Their support can be attributed to the medical training that these midwives receive. The tensions between midwives are the same reasons that ACOG and the AMA support nurse-midwives, and are in part, some of the same reasons that direct-entry midwives feel that nurse midwives have sold out to the medical establishment.

The AMA and ACOG have not been entirely successful in eliminating direct-entry midwifery. In 2002, CPMs attended approximately one percent of births in the United States, while CNMs attended 8.6 percent and obstetricians attended ninety percent of births. Even though the numbers of births attended by CPMs account for only one percent of births, their licensure status has been improving. In 2006, twenty-one states provided licensure for CPMs (Davis-Floyd and Johnson 3) and due in part to the efforts of a national grassroots rallying

campaign,[36] which I believe has reinvigorated interest in midwifery in many ways, in 2009 CPMs were licensed to practice in twenty-six states, eight states were introducing legislation, and ten states were planning legislation (The Big Push for Midwives Campaign).

Robbie Davis-Floyd describes the professional (and political) work of midwives this way:

> Midwives play with the paradigms, working to ensure that the uniquely woman-centered dimensions of midwifery are not subsumed by biomedicine. They are shape-shifters, knowing how to subvert the medical system while appearing to comply with it, bridge-builders, making alliances with biomedicine where possible, and networkers with a sense of mission around preserving and growing midwifery.

In order to remain valid, in order to continue practicing, midwives must be all of the things which Davis-Floyd alludes to, and if they are not, the AMA will be watching. One researcher put it this way, "Midwives stories can also be read as the accounts of activists. While midwives must engage the political system when seeking legalization and licensure, their political prerogatives extend far beyond lobbying representatives to further advance the cause of professionalization" (Hough 355). Thus, once professionalization is achieved, midwives must continue to be activists in socio-political and socio-cultural realms in order to maintain their licensed status and to work against dominant medical norms, which in the minds of midwives, threaten the autonomy of pregnant women.

Although the ABM is no longer an active movement and direct-entry midwives have started their own grassroots activism to secure the status of midwifery in the United States, it is important to point to some of the accomplishments of the ABM. In the 1970s and 1980s the

[36] This campaign, The Big Push for Midwives, "…represents thousands of grassroots advocates in the United States who support expanding access to Certified Professional Midwives and out-of-hospital maternity care. The mission of The Big Push includes educating the public and policymakers about the reduced costs and improved outcomes associated with out-of-hospital maternity care and Certified Professional Midwives, the maternity care providers trained to provide that service." (The Big Push for Midwives Campaign)

activists and advocates of the ABM succeeded in securing the possibility of having a partner in labor and delivery rooms, ending the era of scopolamine use in birth by insisting that women have the right to be awake and aware during birth, creating alternative birth centers in some hospitals, providing the right for women to have food and drink during labor in some hospitals, allowing the woman's children to be present for the birth of a sibling, and providing universal access to childbirth classes (Daviss 76). Regrettably, the successes of the movement occurred in tandem with an era of increased use of electronic fetal monitoring, cesarean section, and the use of pain relieving drugs during labor.

As the twentieth century continued into the twenty-first, so did reproductive technological interventions. Pregnant people are still restricted in movement during birth, as they are hooked to fetal heart monitors, IVs, among other technologies meant to monitor the fetus and their labor. While fetal monitors and other technologies placed on pregnant and birthing subjects may seem harmless, they open the body to the possibility of a disciplinary gaze, in addition to the risk of infection and fetal damage. In this opening there is an allowance for knowledge– whether it is viewed or heard– among all those participating; that is, not only the pregnant subject but all others in the room about what is happening within the body of the pregnant/birthing subject. This opening, provided by reproductive technologies, contributes to laws and overarching social ideologies which tend to compromise the bodily integrity and autonomy of pregnant/birthing subjects.

For instance, if a doctor determines that a labor is taking too long, the doctor will induce it, which often results in emergency cesarean sections.[37] If a woman refuses a c-section, once her baby is born it can be taken from her custody; should death occur, the birthing woman can be

[37] Cytotec, a drug used by doctors and some nurse midwives to induce labor was found to increase the likelihood of uterine rupture by twenty-eight fold (Gaskin 281).

prosecuted for endangering the life of her unborn fetus. And lest we forget Foucault's prisoner, a key figure in my argument, we have only to turn to presently incarcerated pregnant people,[38] those who are often forced to give birth in chains and shackles, with steeply restricted options. In a recent instance, Shauna Nelson, a woman incarcerated for charges of credit card fraud and "hot checks," was forced to go through the final stages of her labor with both of her legs shackled to her bed. Other imprisoned pregnant women report that despite having informed prison officials that they are in labor they are not taken to the hospital until after they have given birth, and many have to give birth alone in their cells with no assistance. Ignoring incarcerated pregnant women's medical requests does not just happen when they are in labor. In an instance in a Florida jail, a woman sought medical treatment for two weeks because she was near her due date and was leaking amniotic fluid. She was denied care and by the time she saw a doctor she was told that all of her amniotic fluid was gone and her fetus' skull had collapsed. Officials at the jail then delayed taking her to the hospital for a procedure to have the dead fetus removed which further put her at risk for septic shock (R. Roth). And the list of outrageous human rights violations enacted against imprisoned pregnant and laboring women goes on.

The stories of these women–those who are incarcerated and those who have been forced to have cesarean sections–beg the questions: In this age of ever-increasing reproductive technologies who is "worthy" of medical care? Who do we value? Where are the intersections of our societal perceptions about race and class most prominent, and how do those intersections impact the needs and desires of pregnant and birthing subjects?

Because of our growing reliance on and trust in reproductive technology, pregnant people, especially those who are incarcerated, do not have control of their birthing bodies. In the history of pregnancy and birth in this country one needs only to scratch the surface in order to

[38] For more on this case and others like hers see Lynn M. Paltrow in the works cited.

find the intersections of technology and overarching social ideologies about race and class in relationship with birth and pregnancy. There have been forced sterilizations and many unnecessary drugs administered and "convenient" cesareans performed, to mention only a few examples, and we see that pregnant bodies are seen as and reduced to property in a society where they are rarely seen as full citizens, especially if they are pregnant or birthing. In our current medical climate, not only are pregnant subjects the property of the state, but they are subjected to the choices made for them by their doctors. Take for instance the rising cesarean rate: 1 in 3 deliveries in the United States results in cesarean section. Although obstetricians would have us believe that the increase in these major abdominal surgeries is due to the number of high risk births which are detected using medical technology, it is unlikely that they would point to the fact that most cesarean sections happen at times which will get doctors home early and are made necessary because of medical intervention in the first place (Plante 140).

Medical technology erases the need for and compromises autonomy in pregnancy. We no longer have to listen to the pregnant person or take their desires into consideration. A person who wants a birth in a manner that is free from technology and unnecessary medical interventions is seen as foolish and can even be prosecuted; and an incarcerated woman, who does not even have the option of how or where to give birth, can be denied medical care when she needs and requests it. Especially while considering these intersections, it is possible to surmise that, in some senses, many pregnant people are prisoners.

Aimee Newman, Managing Editor of Reality Check, a web-based newspaper about reproductive health, writes, "Whether we're talking about provider choices for childbirth or access to abortion, it is *not* too much to ask that wherever women live in this nation, the options for reproductive healthcare are not effectively criminalized in some states and legal in others"

(Newman). Her articulation alludes to the legislative work that is still ahead for midwifery advocates and those engaged in the work of reproductive justice. Both are fighting for women to be seen as legitimate citizens with autonomy and bodily integrity, and both must go to war with ever-present social ideologies and legislatures at both the state and national levels. At the state level midwifery and reproductive justice activists must work for certifications and regulations they have either fought so hard for, in the case of CPMs, or against, in the case of reproductive justice advocates. At the national level, as seen in the current debates about healthcare reform, advocates must work to be acknowledged and respected as professionals and activists with women's best reproductive health in mind. SisterSong founder and leader in the reproductive justice movement, Loretta Ross, makes the connections between reproductive justice ideologies to the ideologies–particularly those associated with disdain for the broken health care system and forced cesareans–of midwives:

> Every woman has the right to have a child, not to have a child, and to parent the children she has. The structural and systemic problems women face palpably interfere with these core values. Whether it's a broken health care system, forced Cesareans, or sterilization abuses, racism, violations of sovereignty, or cultural incompetency, many women share our understanding of the multiple reproductive injustices that challenge a woman's right to control her body and to create better conditions for her family and her community. (8)

Therein is the challenge for midwifery, reproductive justice, and their supporters. The mutually beneficial relationship that exists between midwifery and reproductive justice can make the change that is necessary for Loretta Ross' vision to come true. There is strength in numbers, and this sisterhood–even with its occasional quarrels, and its paradigm-shifting, complicated, and sometimes competing ideologies–has the power to make change for the reproductive autonomy of women and other birthing subjects, one midwife, one reproductive justice activist, one pregnant subject at a time.

Chapter Four

Creating Embodied Communities: Midwives, Zinesters, and DIY Feminism

"The pleasure of producing something yourself on your own terms can also be a conscious rejection of oppressive cultural and political values."

Amy Spencer (66)

"One very remarkable aspect of watching midwives work close-up is that their hands are so apparently skilled and their gestures so subtle. These skills are like heirloom roses that are dying out because they are not being propagated."

Naomi Wolf (177)

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In the December 2009 issue of *Bust*, which touts itself as a magazine "For Women With Something to Get Off Their Chests," an article appears by Erin DeJesus, entitled, "It's Your Life: *Bust*'s Guide to Handling Some of Life's Major Milestones–Marriage, Childbirth, and Death–With a DIY Frame of Mind."[39] DeJesus writes:

> A do-it-yourself (DIY) lifestyle can be applied to many things–whether it's altering a skirt with your Singer or getting MacGyver with home repairs. But when it comes to some of life's big events–getting married, giving birth, and laying loved ones to rest–many people leave it to the professionals, simply because they are not aware of what they can do on their own….You can do it with a DIY consciousness in your chosen setting and on your own terms. (63)

DeJesus points to a key argument in this project–that it is possible to give birth *"in your chosen setting and on your own terms"* –reminding us that birth does not have to be tightly managed by the rigid conventions of the medical industrial complex or by the phallo-technocratic hand, that it is possible to give birth without the aid of doctors, machines, and a sterilized delivery room.

[39] In some historical contexts the term DIY has a masculinist connotation. I do not employ the term in this manner, but instead use it in the context of the riot grrrl movement and its recent adoption into the vernacular of third wave feminism. In these contexts DIY represents a reclamation of space and voice for those not included in and silenced by mainstream and masculinist practices. For these subjects a DIY ethic represents the opportunity to share knowledge and ideas among likeminded individuals.

While the article is short, and catered to a mainstream audience of feminists, it is reflective of the current cultural moment

surrounding the building resurgence of craft and DIY Feminism in the United States.

The argument for a DIY consciousness within the feminist movement has its origins in the third wave of feminism, arising from the consciousness-raising that occurs among the communities of zine makers and publishers. Before I go further into this line of analysis I would like to acknowledge, as I do briefly in the Introduction to this project, that I am aware that using the waves framework as a metaphor for periods of feminism is not without its problems. In Alison Piepmeier's *Girl Zines: Making Media, Doing Feminism* she writes, "The 'third wave' of feminism is a term that loosely defines a generational and political cohort born after the heyday of the second wave women's movement… with some scholars embracing it and others arguing that it should be abandoned" (8). In terms of this project, some scholars with whom I am in agreement believe that the wave metaphor creates false generational divisions among feminists, turning feminism into a fight among sects of women and flattening out the true ideological differences among feminists which are complex and nuanced. Nevertheless, I am not ready to completely abandon the term because, as Piepmeier suggests, "… it identifies and catalyzes a particular generational group that encompasses a great deal of diversity of perspectives but that shares relevant similarities… [and] because it designates certain distinctive characteristics of late-twentieth-century feminism" (8). Jennifer Purvis writes in her article, "Grrrls and Women Together in the Third Wave: Embracing the Challenges of Intergenerational Feminism(s)," about the potentiality for a rescripting of the wave metaphor within feminism. She notes that because the wave metaphor is so deeply embedded within and outside of the movement it would be almost impossible to abandon at this point in time. Purvis argues:

> By replacing the historical categories of the first, second, and third waves with strategic positionalities–first, second, and third wave *signifying spaces*–it is possible to combine the efforts to gain access to the rights and opportunities of existing society (first wave) with efforts to revalorize that which has been previously degraded or relegated to the margins (second wave) in a third space that combines all the useful and meaningful approaches of feminisms in a mutually informed moment (third wave). In doing so, we give every revolutionary thought, action, and practice weight and consideration and open up new possibilities for envisioning feminist exchange and production. (113-114) [40]

Through this rescripting it becomes possible for each political tactic and lesson learned to be carried throughout the feminist movement, not left discarded as we move forward into "new generations." So as I reference these waves and generations, I also understand them to be categories or reference points that are under investigation; and that are, in some cases, like Purvis suggests, being rescripted.

Furthermore, midwives and the patriarchal medical and political institutions they have been forced to fight against for the last century provide an ideal example of this rescripting. Midwives do not abandon the lessons learned from, for instance, the nineteenth century campaign against them, or the tactics and successes of the Alternative Birth Movement, but instead use them to continue the trajectory of their cause and their practice. The "midwife question" and its surrounding debates offer a common thread between all the waves of feminism, and particularly between second and third wave feminists, that points to the falseness of a distinct generational divide between them. Continuing in agreement with Piepmeier and her co-editor Rory Dicker in *Catching a Wave*, the distinctive characteristics and goals of late-twentieth-century feminism which she identifies as "…shaped by and [responding] to a world of global capitalism and information technology, postmodernism and postcolonialism, and environmental degradation," (10) directly parallels with the consciousness of DIY feminism and

[40] For more further information on the wave metaphor and intergenerationality see Purvis, Jennifer. "Grrrls and Women Together in the Third Wave: Embracing the Challenges of Intergenerational Feminism(s)." NWSA Journal, Fall 2004, Vol. 16 (3). 93-123.

midwifery, given the shared interests in responding to capitalism and technology, as well as, in the case of DIY feminism, environmental degradation.

Many of the characteristics and goals of DIY feminism are reflected in the reemergence of social consciousness surrounding modern midwifery in the late-twentieth and early-twenty-first-century. This can be seen most clearly through an analysis of the coinciding reemergence of craft and the creation of grrrl zines beginning in the early 1990s as a direct response to the corporate domination that third wave feminism critiques. The values of DIY feminism are made evident through the creation of zines. These creative and political endeavors lead to other forms of creative and anti-corporate expressions, including but not limited to the reclamation of traditional forms of women's crafting. I argue that the ideological values involved in these creative endeavors has caused renewed interest in having a midwife assisted homebirth. Finally, I explore the ways in which a midwife assisted birth not only matches these DIY ideologies but also contributes, through its DIY consciousness, to the concepts of embodied pregnancies and communities.

Grrrl zines were created in the wakes of third wave feminism and the feminist punk and political movement, Riot Grrrl. "Zines are quirky, individualized booklets filled with diatribes, reworkings of pop culture iconography, and all variety of personal and political narratives. They are self-produced and anti-corporate. Their production, philosophy, and aesthetic are anti-professional," says Piepmeier (2). Their subject matter ranges from food politics to thrift shopping to motherhood. They act as an example of participatory media, created by the same women and girls who will purchase them as opposed to corporations. Michelle Comstock writes in her article, "Grrrl Zine Networks: Re-Composing Spaces of Authority, Gender, and Culture," "The grrrl zine movement has constructed a space for young women to act as writers, designers,

and artists. They have challenged not only the gendered hierarchies of alternative writing cultures but also the exclusionary sites and practices of mainstream authorship" (385). Grrrl zines, and the networks they produce, give young women the opportunity and the space to express what is really happening in their lives. Their words are not interpreted by a journalist who works for a publishing corporation and are not filtered through or by anything other than the process of literally putting pen to paper. Piepmeier continues, "[Grrrl zines] are sites where girls and women construct identities, communities, and explanatory narratives from the materials that comprise their cultural moment" (2). Zines, then, are like the grrrls who create them, multi-layered, complex, and uncensored by authoritative and patriarchal forces.

The history of feminist zines is embedded in the rich tradition of the feminist alternative press movement (Steiner 125) and as zine researcher Elke Zobl acknowledges, "[They] stand in interrelation to other artistic, social, and political movements such as dadaism, surrealism, situationism, agitprop, anarchism, and punk, in addition to lesbian, queer, and transgender liberation movements" (2). If analyzing zine history within white cultures of resistance, as opposed to those cultures and practices emerging from communities of color, there are three peaks of zine publishing: the 1930s science fiction fan zines, the 1970s the punk movement fan zines, and the 1990s feminist Riot grrrl zines (Zobl 3). However, Leah Lakshmi Piepzna-Samarasinha writes, "One can draw a history of zines that sees them as coming out of riot grrrl, punk and other usual (and majorly white) suspects, or look through an alternative lens that sees them equally birthed out of the self-publication methods utilized by Chicana, Latina, Black, Indigenous and Asian Pacific American artists, poets and writers during the '60s and '70s" (as quoted in Zobl 3). This is not unlike the history of midwifery, which if analyzed only through the Alternative Birth Movement and the present state of the field, looks particularly white. However,

if one analyzes the history, emergence, and confirmed practices of the field through a wider lens, it is possible to see the strong history of African American women as midwives and recognize the racial implications which most certainly played a role in the medical campaign against midwives. Zines and midwifery have rich histories that can be seen most clearly when there is an acknowledgement of the forces which helped to and continue to shape them both.

The process for creating a zine is not dictated by guidelines or rules, but it merely emphasizes DIY, process-oriented, non-hierarchical action and expressions (Zobl 4). *Bust* magazine, the publication which was mentioned at the opening of this chapter, started as a grrrl zine in 1993 (Piepmeier 104). *Bust* founders Debbie Stoller, Laurie Henzel, and Marcelle Karp founded the zine with the hope that it would create, "an embraceable feminist culture that's positive, that gives us stuff that we can relate to, to talk about how difficult it is to be a woman and about how much culture is misogynist, but we wanna [*sic*] just try to present an alternative, just try to create an alternative that you can read and be happy and feel good about" (Piepmeier 105). Stoller, Henzel, and Karp, and the other zine makers, have much in common with midwives, in that they see the current cultures they operate outside of–corporate for zine creators and medical for midwives–as misogynist and intrinsic to both groups' attempts to provide ethically sound alternatives to people engaged with either of them. So, for example a midwife seeks to make a pregnant person feel more in control of their pregnancy and birth experience, acting as an encourager of agency and engagement with the process. The medical model, however, often acts as a disciplinarian, watching, observing, and punishing if a birthing person does not follow the medical timeline or its expectations of "normal" labor. As for zinesters,[41] one mother and zine publisher acknowledges, "The culture around me seemed as much about building our own positive alternatives as about rejecting and protesting the negative dominant

[41] I use this term throughout to denote those who publish and create their own grrrl zines.

social system…. My highest aim was to push this society to a better place for my child, to resist dominant war like exploitative capitalistic systems as a rebel mama, to create a support network" (Spencer 59). What is echoed throughout the responses to the questions of why zines are important to their publishers, and what can also be found in the reflections of many midwives and homebirthers,[42] is the assertion that these DIY feminists are each, in their own way, creating networks or communities of support working against the patriarchal regimes of the mainstream corporate and social systems.

Amy Spencer, author of *DIY: The Rise of Lo-Fi Culture*, writes "As riot grrrl zines are decreasing in numbers, many of those people once involved in the zine community are moving into a new form of DIY endeavor. The act of crafting–sewing, knitting, doing crotchet and in fact any form of craft as long as you do it yourself–has recently taken over" (64). The movement toward a new form of DIY can be seen quite clearly in the documentary film *Handmade Nation: The Rise of DIY, Art, Craft, and Design* (2009). While making this film the filmmaker, Faythe Levine, traveled around the United States to interview and record the work of nine independent craftspeople, and all but one of those she interviewed were women. Many of the women she interviewed reflected on the reasons they began to craft, citing a desire to work outside of the corporate culture that surrounds much of mainstream America and to be a part of a community of people with the similar values regarding DIY consciousness. Some of the women spoke about the conscious reclamation of crafts–like sewing, embroidery, knitting, and crocheting–which have been both undervalued by dominant, mainstream and corporate culture and maligned, historically by feminists, as oppressive towards women. Jean Railla of Getcrafty.com, a website dedicated to the new wave of craft, explains that she believes the resurgence is a form of "new

[42] In an attempt to keep the language of this chapter as concise as possible I use the term homebirther to refer to those who birth in their own homes or at birth centers with the assistance and support of direct-entry midwives.

domesticity" and acts as a way for women to link feminist principles with the idea that crafting is valuable, revaluing that which has been degraded or relegated to the margins, and that it is "a movement committed to recognizing, exalting, and most of all enjoying the culture that women have built for millennia" (Spencer 66). While at one point in time these particular forms of artwork might have been tools in the oppressor's toolbox and trivialized, these DIY feminist craftspeople have created a new culture around them. Yes they are still time-consuming, yes they are still mostly done by women–although men are increasingly learning them–but the people engaged with them see it as reclamation of community and as a way to creatively subvert hegemonic roles and values. This subversion comes through enacting a skill set which requires large amounts of time to learn, practice, and use. Time, which is so valued in the capitalist regime that it cannot be wasted, that any waste of it is subsequently eliminated, is questioned as a commodity by craftspeople. They create items which can be reproduced by the dozens using machines in factories in less time than it takes a craftsperson to knit a scarf or embroider a tablecloth. "The sharing of ideas and skills is fundamental to this craft community, which promotes accessibility and community–key aspects of the DIY movement as a whole," says Spencer (65). The overarching ideologies of these craftspeople who value community, individuality, and personal relationships are much like direct-entry midwives who have found the value in creating community and practicing a skill which has been handed down from person to person, most often from one woman to another and using that skill to further build community around the homebirthers they assist. In the second epigraph of this chapter Naomi Wolf compares the loss of the subtle and skilled gestures of midwives hands to the loss of a prized heirloom rose bush that has been neglected because no one has taken the time to learn to care for

it. Much like DIY crafters, midwives continue to honor the skills which take time and subtlety to learn, and in these ways, literally embody a DIY ethic.

In 1987, Faith Gillespie wrote, "Our turning to craftwork is a refusal. We may not all see ourselves this way, but we are working from a position of dissent. And that is a political position" (178). In much of the same way that DIY crafters do not all see themselves as activists or as subverting a patriarchal regime, not all those who seek the care of midwives see themselves in opposition to a patriarchal regime or as activists. Many who seek out midwifery care are looking for the best care available and through their own research find that midwives produce outstanding results. While some seek out midwifery care because they do not have insurance and cannot afford hospital care; this is an issue of reproductive justice and demonstrates the importance of access for those who do not have the privileges–for example, the freedom to choose whether to birth at home or not–that insurance oftentimes provides. For instance, anthropologist Christa Craven found that in Virginia low-income rural women have continued, in spite of legislation against it, to seek out midwifery care because of its lower cost.[43] Some pregnant people, however, specifically choose to birth at home because of sociopolitical beliefs and a distrust of modern medicine and obstetrics. Many who birth at home because of ideological beliefs about hospital birth become activists for midwifery. In Virginia, for example, activist mothers have often had to navigate attacks on midwifery and homebirth from the state legislature. "Medical and state officials evoked the image of 'bad mothers' and their 'bad babies' to make a case against midwives" (Craven 195). These activist mothers then emphasized the connections between interventionist and corporate biomedicine and "what they perceived as ill-

[43] For more information on the tensions that sometimes arise between those who need midwifery care because of class and those who have the privilege of choosing midwifery care see Craven, Christa. "Claiming Respectable American Motherhood: Homebirth Mothers,Medical Officials, and the State." *Medical Anthropology Quarterly* 19(2), 2005. 194-215. Print.

informed state sanctions against midwives" (Craven 195). For many homebirthers respectable motherhood means something very different than it does to biomedicine and the state; it means claiming a right to self-reliance and independence in their reproductive healthcare decisions. It means not viewing medical knowledge as authoritative or as something to be left unquestioned, but rather seeing themselves as responsible and capable of making their own reproductive health decisions. In essence, they give themselves permission to reclaim their bodily integrity and autonomy from the governing bodies who restrict access to these rights through sanctions and medical control.

Additionally, midwives, homebirthers, and zinesters challenge widely accepted ideologies about what is appropriate for public consumption. A *Bust* cover model, especially prior to the magazines ascent to becoming a widespread feminist publication:

> …was not the typical woman's magazine cover model, and therefore she doesn't function as an easily assimilable model for women to aspire to become. The discomfort a *BUST* cover might produce in a reader is part of how zines work, keeping the reader from the passive consumption mindset produced by mainstream capitalist media. It functions more specifically to interrupt assumptions about femininity and force the reader to consider how femininity and pleasure interface. (Piepmeier 106)

The cover model for *Bust* theoretically functions in a similar way as a person who births at home might for many people who feel that birth should occur in hospitals, as she does not represent what mainstream society is used to seeing. On the cover of a magazine for women, much of mainstream America expects to see a supermodel, or in the case of pregnant women, as I discussed in Chapter Two of this thesis, an airbrushed, hyper-feminine actress like Demi Moore. The homebirther represents, and literally has, the freedom to move about from room to room in their own home unconstrained and unrestrained by the regulations, technologies, and boundaries of a medicalized hospital birth. One woman writes of her labor and birth:

> [My midwife] sent me walking the halls, pausing only for encouragement and thigh massages from her and my husband. [The two of them] tried to keep me sane while I howled, growled and walked…Suddenly it was time to push. What a glorious feeling! I was so glad to be doing something. I ran around like a crazy person for a while and then squatted next to the bed. After two or three good pushes I leapt up onto the bed…I watched in the mirror…as the baby's shoulders came out together, instead of one at a time, but because of my position (hands and knees), he did not get stuck. Suddenly the whole baby slipped out. (as quoted in Gaskin 86)

This woman made noise and moved throughout her entire labor. She howled and growled. She jumped, she ran, she knelt on the floor and leapt onto the bed. She chose a position that felt good for her and she watched herself give birth. In her homebirth with a midwife she defied all of the expectations associated with a hospital birth of an immobile, passive woman waiting for instructions from her doctor.

As a representation of the abject, a homebirther's leaky, fluid body and fluid movements occur on the margins of what is seen as a proper body and a proper birth. The homebirther threatens the accepted and contained notions of what a birth should look and sound like. Homebirthers not only defy corporate, patriarchal visions of birth, but what is expected of good, responsible mothers and, thus, openly challenge femininity and socially constructed ideas of what it means to be a woman, through their insistence on birthing at home. Researcher Betty Anne Daviss writes:

> Perhaps the most symbolic act of rebellion perpetrated by midwives and mothers was bringing birth out of the hospital and back into women's lives and homes. This "coming out" was accomplished in part through the publication of books about homebirth that displayed photographs of nude women birthing their babies in full view of their partners, families, friends, and shamelessly, the photographer. Such behavior represented obvious resistance to dominant social norms, which insisted that birth should be hidden from public view (73).

Much like the attitudes toward public pregnancy, that are discussed in Chapter Two ("Womb with Legs") of this project, and through their "shameless" resistance to the constraining medical gaze, homebirthers provide an opportunity for resistance to natal panopticism. If read from the

outside in, it is possible to see that homebirthers seem to be acknowledging the lack of citizenship and thus space for pregnant people in public discourse by acknowledging that they cannot be full citizens in the public, state mandated, medical realm and thus they stay at home and birth like the irresponsible, untrustworthy person dominant society believes them to be. Anthropologist Christa Craven writes:

> Medical and state officials have historically justified state regulation and biomedical management of reproductive healthcare by highlighting the 'pathological' practices of mothers–particularly mothers who challenge dominant American trends and ideologies around childbirth…By accusing mothers of bad behavior toward or in relation to their children, medical officials join the state to contend that they are better equipped to make decisions regarding childbirth and mothering practices than the mothers they deem delinquent. (195)

In some sense, homebirthers–with their uninhibited and uncontrolled leaky and wandering bodies, their yowling and howling, their creative movements–do exactly what pregnant women are told to do, they stay out of public spaces (the hospital) and stay within the confines of the private sphere (home). In another sense, in their insistence on staying home to birth they are also doing exactly what the medical establishment tells pregnant people not to do and are therefore not enacting the societal expectations of what it means to be feminine, to be polite and follow the rules set forth by the authoritative power (the medical industrial complex). Instead they choose to govern themselves; they enact their knowledge about the dangers of hospital birth, and they use that knowledge to regain power and autonomy and subvert a system that tells them that their role is to merely be living incubators for the valuable fetus they are to deliver.

I agree with Certified Professional Midwife and anthropologist, Melissa J. Cheyney's argument that, "The processes of challenging established forms of authoritative knowledge and valuing alternative ways of knowing, combined with embodied experiences of personal power and a deep desire for intimacy in the birthplace, fuel homebirth not only as a minority social

movement, but also as a form of systems-challenging praxis" (255). Cheyney's research identifies three overarching themes in the narratives of homebirthers, which she organizes in terms of what they were seeking or found through homebirth: redefinition of authoritative knowledge, embodiment of personal power and agency, and creation of connection and intimacy in the birthplace (256). Furthermore, the homebirthers in Cheyney's study mentioned multiple terms for concepts like instinct, intuition, and embodied knowledge to define ways of knowing that were not intellectual, rational, or logical but that came from experience and their own bodies. Cheyney observes, "In asserting the value of intuition or 'body knowledge,' homebirthers are claiming multiple, legitimate forms of authoritative knowledge. In doing so, they implicitly challenge the (over)reliance on technology and hypervaluation of scientific ways of knowing" (259). The spaces they found in being able to birth at home extended beyond the systems-challenging practices that their births actualize and into their own concepts of autonomy. Together, the reclamation of multiple ways of knowing and the recognition that these modes of knowledge produce power for the women in Cheyney's study, allow for a theoretical return to Foucault and his writings regarding systems of knowledge and power as intertwined and inseparable. Cheyney writes:

> In claiming the interconnections between knowledge and power, women are echoing Foucault's argument that knowledge and power are actually synonymous terms…Because society via its representatives (governments, bureaucrats, educators, etc) acknowledges the power of some groups (obstetricians) and limits that of others (direct entry midwives), social structures functionally determine who holds the knowledge, and therefore the power. (260)

In terms of birth and reproductive knowledge, our current social structure determines that all valued knowledge, and therefore socio-cultural and political power, resides in the care of obstetricians, and, thus, the knowledge of all others, midwives and those who choose to birth at

home, is devalued and discredited. These systems of power and knowledge extend to shape who is determined to be a "good mother." Cheyney writes:

> When [homebirthers] reject the disciplinary power of obstetrics by birthing at home, they are viewed (and view themselves to some extent) as susceptible to the punishments of pain, death, and disability. Herein lies the power of social sanctioning, for a mother who is seen as accepting pain, death, and disability, especially for her infant, certainly violates the social parameters of what constitutes a good mother. (260)

The irony that is constructed here is obvious. If mainstream society valued the knowledge–both the intuitive and experiential knowledge of homebirthers, and the praxis-based knowledge of midwives–and gave credence to the extraordinarily better outcomes these modes of knowledge produce, then those who are currently constructed as "reckless" and "bad" would be interpreted in an entirely different way.[44]

Because of the value placed on these alternative modes of knowledge, births attended by midwives are dramatically different than those attended by obstetricians. In video archives of the Farm–famed midwife Ina May Gaskin's still-in-existence, matriarchal commune structured around homebirth–laboring women are seen lying naked on batiked pillows, in a small house with its windows open in the Tennessee woods, surrounded by loved ones and midwives. In her book *Misconceptions*, Naomi Wolf writes of this archival footage, "The women in the photos and film clips at the Farm look present; they look proud and sensual and ready for battle; they look strong" (188). Wolf continues, "In one video, a woman laboring on flowered sheets, radiant, held and supported by three women and her partner, gave a full smile as the baby's head emerged from between her legs" (189). The people birthing at the Farm and those birthing in hospitals look very different, both literally and in our cultural imagination. Those who birth in

[44] It is not my intention to imply here that those who do not birth with midwives are "bad" or "reckless," merely that there is value in the acknowledgement of these modes of knowing as they deconstruct the current biomedical and governmental power structure and support the autonomy and bodily integrity of the birthing person.

hospitals birth in beds, often flat on their backs, legs in stirrups. Their doctors are only present if the machines monitoring the laboring person or the fetus signal for them; otherwise, they appear only for the final pushes before delivery. Hospital rooms are often stark, sterile, and heavily trafficked; many people enter and exit throughout a birth, which creates a space about as far removed from the descriptions Wolf gives of the Farm as possible. In an attempt to market their facilities to pregnant people, some hospitals have attempted to commodify what they deem to be the most attractive aspects of midwifery care: the ambiance. Advertisements show the birthing person lounging comfortably on a double-bed in birthing suites filled with oak furniture, with slogans which imply that the hospital birth experience is "just like home" (Davis Floyd, *Consuming Childbirth* 213). This commodification of what is perceived to be the most threatening element of midwifery care within the obstetrical establishment is as unequivocally incorrect as it is insulting both to pregnant people and midwives. It demonstrates a lack of regard for the skill and care with which midwives attend birth while it assumes that the pregnant person can be duped into a false homebirth experience by oak furniture and a big "comfy" bed.

Naomi Wolf describes her own hospital birth, "I was told I would have twenty-four hours to deliver before they would have to perform surgery. That sword over my head and the ticking clock, marking the moment my doctors would decide to wield it, filled me with fear" (138). Wolf was given much longer to labor before surgical intervention than most laboring persons who are sometimes given as little as two hours or as much as 10 hours, on average, before doctors decide there is a need for surgical intervention. Also of note in Wolf's statement is that her doctors will decide for her whether or not she will have a cesarean section to deliver her baby; her consent is really inconsequential. Wolf continues, "The technology, the medical staff, and the social shame that swirled around me were all pointed at me threateningly, and kept me from using my body in

a way that would support my birth. My labor 'arrested' completely" (138). Wolf's labor ended in a cesarean and the experience she describes echoes the stories of many of those who have labored in hospitals in the last 20 years. Standing in stark contrast to Wolf's experience, when asked about "arrested labor," midwife Ina May Gaskin laughed out loud:

> There is no such thing. Midwives know that labor starts and stops. You take a walk, you eat something, you take a nap, your labor will start again. But if you have the clock hanging over you and a c-section on the horizon if you don't produce the baby, and impatient doctors checking and hovering, that practically guarantees that your labor will shut down…We set up an unnatural setting for birth and then we're surprised when women don't perform well in it. (Wolf 163)

In her statement, Gaskin is acknowledging the absolute necessity that time and patience is given to the laboring person. She demonstrates that midwives understand this need, understand that fear and the inability for the laboring person to do what they need in order to feel comfortable– walk around, nap, eat–deeply affects the outcome of a birth. The time and patience for which Gaskin advocates, and for which the medical establishment clearly denies their patients, is demonstrative of one of the ways that the ideologies of midwifery and the craft movement intersect and act in opposition to dominant societal models.

Present in Gaskin's statement is a clear concern for the needs and desires of the laboring person, a concern that is not as clear in medical models and expectations of birth. Many hospitals, not taking into account the surrounding circumstances or the uniqueness of each laboring body, follow the Friedman curve. In the 1970s U.S. hospitals began to incorporate the Friedman curve into their expected birthing timelines. The curve assumes that a woman giving birth for the first time should dilate 1.2 centimeters for every hour they are in active labor. Of much importance is the fact that least 20 percent of "low-risk" women do not progress at this standard rate (as cited in Wolf 162). What this curve assumes is that all laboring people are the same, and will have the same responses to the medical environment in which they are birthing.

The curve makes it possible for hospitals to run like well-oiled machines, much like the Cartesian medical metaphors often used to describe the bodies of birthing women in obstetrical texts and training.[45]

Beyond the theoretical implications that Friedman's curve provides are the very real situations it creates for birthing women in hospitals. If women do not dilate appropriately according to the curve they are often given Pitocin to augment their contractions. The use of Pitocin not only increases the strength of contractions but also the duration of them and thus causes increased pain. Due to the increased pain, many pregnant people opt to have epidurals, which carry with them their own set of medical issues–including the possibility of paralyzing the patient if she flinches when the needle is being inserted into her spine, for example. Additionally, once a birthing person is given an epidural she can no longer feel what is actually happening to her body. So the laboring person, who is already being monitored and told what is happening within and to her body by machines, becomes almost completely separated from what is happening to her body. She has to be told to push, she can often sense pressure but because she can no longer feel she cannot sense what midwives sometimes call "the ring of fire," a sensation that tells the birthing body to take a moment to rest, which often minimizes tearing of the perineum. Because of the lack of sensation which occurs after being given an epidural many hospital birthing women have larger tears to their perineums or are given painful and dangerous episiotomies. Furthermore, Pitocin, unlike the natural hormones released by the body during birth, does not allow the uterus to relax, a reaction which is strongly linked to fetal distress–precisely what hospitals and obstetricians claim to be monitoring and preventing. Thus, the use of Pitocin to induce labor or increase the speed of labor often results in cesarean section. As of

[45] For additional insights into Cartesian metaphors of the pregnant/birthing body as machine see Emily Martin in the works cited.

2007, 31 percent of births in the United States resulted in a cesarean section, a percentage which continues to increase each year, and has increased drastically since the 1970s when the rate was six to seven percent (Plante 140).[46]

Lauren A. Plante's article, "Mommy, What Did You Do in the Industrial Revolution," discusses at length the causes of the rising cesarean rate in the United States. Plante writes, "Skilled obstetricians are vanishing from current practice" (141). She discusses one doctor who believes that the techniques for vaginal delivery–manuevers which allow for reductions in shoulder dystocia and delivering a breech baby–are subject to too many variations in skill to be standardized into reliably good outcomes. Instead, this doctor reports that the skill, or rather the operation, that every obstetrician knows how to perform is a cesarean section. Plante responds, "Although it is a fascinating perspective on the changing of obstetrical practice, for those of us who actually work on a busy obstetrical unit, industrialized childbirth conjures up images of the factory floor" (141). Interestingly, the hospitals with the highest cesarean rates are the ones with patients who are well-insured and upper-middle-class. New Jersey, for instance, has the highest cesarean rate and the highest median household income but no lower levels of maternal or perinatal mortality. Plante writes in response to this statistic, "If cesarean is a response to any perceived risk, why would women at statistically *lower* risk of a poor outcome have higher cesarean delivery rates?" (141). Further, Plante surmises that often when women are told they are "high risk," they are taught to think of this status as "high value," as if every obstetrical intervention imaginable may be used and is at their disposal. She also draws parallels between fear and a desire to be seen as high risk which no doubt occurs because of the fear tactics employed by the mass media and the medical establishment at large. She writes, "It is clear that fear is contagious. The indications for cesarean have broadened considerably: breeches, twins,

[46] In some hospitals the cesarean rate is as high as 50 percent (Plante 143).

large babies, small babies, slow labor, and even no labor. We now see the phenomenon of perfectly healthy, low-risk pregnant women requesting cesarean delivery upfront in an attempt to eliminate all potential labor-associated risk for the infant" (Plante 142). One has to wonder that if these pregnant women, who request cesarean sections out of fear, knew what was actually causing the "need" for them, if they would still choose to birth in hospitals or at home where birth is not viewed as a pathology but a natural process.

Because the medical model treats birth pathologically and not as a normal and natural process it often creates pathologies that result in unnecessary harm to the fetus and often major surgery for the birthing person. While the American Congress of Obstetricians and Gynecologists (ACOG) is busy chastising midwives and homebirthers for putting pregnant people and babies at risk, their medical model and expectations of childbirth do exactly that. In contrast, midwives have a very low rate of births resulting in cesarean section. While some argue that midwife-assisted births are self-selected because they only accept low-risk pregnant people, Ina May Gaskin, points to the early statistics at the Farm:

> My experience is when moms are treated right and they are not scared, almost everybody can give birth well herself. We had a random sample of American women, and our experience proved it. They weren't self-selected healthy. We had people who used drugs, who had taken crack –if we had them long enough and we could put some weight on the baby they did well, too. (Woolf 189)

Gaskin points to the "crack mother," a pregnant person who long before she enters the hospital is already labeled; it is already assumed that she will have a difficult, "high risk" birth. While it is true that pregnant people with a history of substance abuse have an increased likelihood for complications during birth, in the hospital setting they are not even given a chance to have a "medically normal" birth, or a birth with no or minimal interventions. Gaskin demonstrates that it is possible for even the most maligned of pregnant people to have healthy births with the

midwives model of care.[47] Gaskin continues, "We've been centering everything on the baby and ignoring the moms…without realizing that what happens to the mom is integral to the baby" (Wolf 165). The centering of "everything on the baby" makes it possible to separate the laboring person from the baby they are delivering. This literal separation within in medical models of care is reminiscent of the legal and social separation of pregnant person and fetus which allows for the egregious violations of bodily integrity that I discuss in Chapter Two of this project. The midwives model of care:

> …is based on the fact that pregnancy and birth are normal life events" and includes "monitoring the physical, psychological, and social well-being of the mother throughout the childbearing cycle, providing the mother with individualized education, counseling, and prenatal care, continuous hands-on assistance during labor and delivery, and post-partum support, minimizing technological interventions, and identifying and referring women who require obstetrical attention. (Davis Floyd, *Consuming Childbirth* 2004)

The model followed by midwives clearly values the relationship between the pregnant person and the midwife and provides for a holistic model of care, which is attuned to not only the physical aspects of the pregnant person's experience but also provides social and psychological support. Homebirthers and midwives are partners in the midwives model of care, and it is a partnership that can be traced to the very beginning of the Alternative Birth Movement of the 1970s.

In the beginning of the Alternative Birth Movement there was little distinction between mothers and midwives. Oftentimes, mothers were the ones accompanying midwives to births in order to learn midwifery skills themselves. Midwife Ina May Gaskin writes, "In no field other than midwifery could my partners and I have entered as amateurs, arranged for our own education, and still have managed to safely produce results that far out-stripped those of the

[47] Of the 2,028 births (1970-2003) that were attended by Farm midwives, only 1.4% resulted in cesarean section. Forceps and vacuum extractors have been used in less than one percent of births.

medical professionals in hospitals with the most up-to-date technology" (131). Gaskin is well-known for teaching herself and other midwives the birth assistance techniques she has learned from reading nineteenth-century texts. She demonstrates to the highest degree the reclamation of skills that would otherwise be lost if it were not for people like her willing to undertake the time-consuming endeavor of rediscovery. The phenomenon of shared experiences as learning and practice has led to the formation of organizations like the National Association for Parents and Professionals for Safe Alternatives in Childbirth (NAPSAC), which represent the interests of parents and midwives alike. In addition to NAPSAC, organizations such as Lamaze International and the International Childbirth Education Association, which developed from collaboration between those engaged in the Alternative Birth movement, continue to educate women about their bodies and rights related to prenatal and childbirth care (Daviss 73). In the collaborative training and organizing that occurred between midwives and mothers, it possible to see the presence of a strong DIY consciousness. It is this presence which I argue has remained even as the professionalization of direct-entry midwives has occurred over the last 30 years. Today the DIY consciousness is especially powerful in the interactions between pregnant people and midwives, as midwives are present throughout pregnancy to act as allies, not as authorities. They support pregnant people in creating a birth process which respects their autonomy and bodily integrity.

To get back to the recently published book, *Girl Zines: Making Media, Doing Feminism*, Alison Piepmeier uses the concept of embodied communities to discuss the value of the materiality of grrrl zines. Her concept of embodied community draws on Benedict Anderson's notion of the national imagined community. Anderson describes the national imagined community, a metaphor he uses for the newspaper reader, thusly: "It is *imagined* because the

members of even the smallest nation will never know most of their fellow members, meet them, or even hear of them, yet in the minds of each lives the image of their communion" (as quoted in Piepmeier 79). Piepmeier notes that while the imagined community written about by Anderson is extensive, the community of zine writers is intimate and linked to actual bodies as opposed to imagined ones. She writes, "In a world where more and more of us spend all day at our computers, zines reconnect us to our bodies and to other human beings" (58). This is an ethic that is present throughout DIY consciousness. The acts that are repeated over and over by DIY conscious individuals–whether through knitting, embroidery, or creating zines–are acts that reach back and forth across time to actual individuals, actual lived histories. The products of this DIY consciousness, whether they are relationships between crafters or a scarf that was knitted and sold to someone directly, represent the connections alluded to by Piepmeier.

These same DIY connections can be made in an analysis of the practice of midwifery. In a world of ever-increasing-reproductive technologies and medical interventions into birth, midwives and their model of care allow pregnant people to reconnect to their bodies and to other trusted people during birth. One zine writer interviewed by Piepmeier identified a handwritten letter between zine publisher and reader as a site of embodied community. The zinester notes the "feel of the paper and an embossed pattern in the shape of every character formed." Piepmeier notes that the zinester, "Figures paper as connecting two bodies, so that the fingers of one person respond to the traces of the other. A piece of paper bears the marks of the body that created it as well as carrying other sensory information to the reader. The paper then is a nexus that mediates the connections not just of people but bodies" (63).

Thus, some of the observations made of zine culture and DIY politics can be extended to midwifery. In keeping with a DIY culture and mindset, a homebirth has the capability of creating

an embodied community, between midwife and birthing person, bearing the marks of their months of interaction–the exchange of knowledge, the collaboration of planning–and the actual incorporation of the birthing person's needs and body into the birth. The bodies of the birthing person and midwife literally connect, the midwife using her hands to help position and encourage, using her knowledge to help support the autonomy and growing knowledge of the birthing person. Piepmeier points to the fact that many female bodies are vulnerable to scrutiny and abuse–this is certainly true of the birthing body in a hospital–and notes that embodied communities have the potential for intervention of these vulnerabilities. She writes, "The embodied community [allows] women to negotiate and leverage their own bodies and the kinds of communities to which they belong [to] provide ways for them to create safe spaces for intimate connection" (79). There is revolutionary potential in seeing midwifery as creating embodied communities between midwives and those they assist. Embodied communities allow for not only the reclamation of space, but reclamation of the birthing body and recognition that when births take place they involve an actual person with an identity and a history as well as valuable needs, desires, and concerns.

Among homebirthers and midwives there is the potential for a reclamation of technology as well. Through blog-writing, many midwives, homebirthers, and midwifery organizations raise awareness about the benefits of midwife-assisted births and use the space of their blogs as an opportunity to build community between likeminded individuals. Blogging also allows women who have had bad experiences with hospital birth to share their stories or to gain access to knowledge about alternatives to hospital birth. In the context of zinesters writing about trauma, Stephen Duncombe writes, "Sharing their stories with [each] other and pointing their fingers at the 'accused' allows these young women to express their rage, relieve their shame, and overcome

their isolation that accompanies such an experience" (67). Duncombe's words bring to mind the rage of blogger Jill, of The Unnecessarean, whom I wrote about in Chapter Three of this thesis. Jill uses her blog as a space to share with other women the experience of her own unnecessary cesarean and as an information resource about alternatives to hospital birth. Blogs are also used sharing updates and rallying support for actions. The Big Push for Midwives keeps a blog to update people across the nation about their efforts and successes regarding the legalization of direct-entry midwives. Citizens for Midwifery, an organization that is supported by midwives and their advocates, recently posted a blog entry about the attempt to outlaw direct-entry midwives in Mississippi. Because so much of the activist work that must be done to secure midwifery is time-sensitive, it is imperative that there are communities of support which can be accessed within extremely short periods of time; and blogs–with their ability to feed into followers email or to link to other information sources–are the ideal medium. While not part of an embodied community, in a literal sense–like the actual communities created between midwives and those they assist–blogs help to build a community which supports midwifery, in a time when activism and advocacy for midwives and homebirth are much needed.

Echoed throughout the accounts of midwives, homebirthers, and zinesters is a desire to build community and share information about alternatives to mainstream, technologically-controlled, corporate dominant society. There is a deep and abiding appreciation of patience, creativity, embodiment, and agency and the time it takes to create, foster, and respect each of these. Between the work, relationships, and intersections of DIY feminism and modern midwifery, there is the possibility of creating a socially and politically transformative space for pregnant and birthing people. In order to achieve this midwifery–those who practice it and those who benefit from it–must find ways to reach across class and race divides and create pathways

which allow for access to and education about midwifery. Midwives, midwifery advocates, and their governing bodies and institutions must create spaces for all birthing subjects, not just those with race and class privilege, to not only have access to and education about midwifery care but for these groups to have access to becoming midwifery practitioners. This is a daunting task but it is crucial, in part because of the risk of that midwifery may be interpreted as a fad by mainstream America as the news of celebrities and their homebirths reach the masses, but also because midwifery has real implications for being able to create healthier births for pregnant people and the babies they give birth to. Through an intersectional analysis which interrogates who is practicing midwifery, who has access to midwifery, and who could benefit from midwifery, it is my contention that it can become the truly socially transformative force it seeks to become. Midwifery is undoubtedly an important element of reproductive justice. It is imperative that midwives and the various legislative and social organizations surrounding them ask themselves the questions that the reproductive justice framework implores and begin to incorporate those questions into their outreach procedures and efforts. Pregnant people need midwives, not only because the births they attend are successful, but because through their model of care, their respect for the birthing person, and the embodied communities they create, midwives offer an opportunity for autonomy and bodily integrity that is otherwise absent and unavailable for the pregnant person.

Chapter Five

Conclusion

"I share my midwife's experience to encourage and inform you."

Ina May Gaskin

By moving away from our dependence and glorification of reproductive technologies and unnecessary medical interventions, it will become possible to see the pregnant person as the subject of their body's proceedings. We might begin to respect and value a pregnant person's needs and desires in connection with their own unique bodily experience thereby reducing the need for, or at least the blind acceptance of, reproductive technology and interventions.

In Chapter Two of this project I cite the writing of feminist theorist, Iris Marion Young, as she wrote about the connection of the pregnant subject to the fetus. She spoke of the immediacy of the pregnant person's feeling the movement of the fetus internally and the certainty that feeling fetal movement provides. In order to move forward, to regain some of the positive dimensions of the "immediacy" of which Iris Marion Young speaks, we have to put systems in place again that will value the pregnant person's relationship to the fetus and which will reinstate their status as a legitimate subject–in part by, creating a space for the needs and desires generated by their own body.

It is not realistic to expect that all reproductive technologies can or will disappear, and I am not arguing for that. What I am arguing for is the need to critically assess the overreliance on these technologies. Once they are critically understood, those committed to ensuring the reinstatement of the pregnant person's autonomy and bodily integrity will begin to question these

technologies and the medical establishment invested in them. I believe that this can be accomplished through research and social activism that demonstrates that such technological interventions are not always already necessary–except to those with profit-driven motives. I also contend that we, as feminists, must begin to focus as much on the lived bodily experiences of pregnant women and other pregnant subjects and how they interpret their experiences in both public and private arenas.

In our current climate, midwifery is the best way to restore bodily integrity and autonomy to pregnant and birthing people. It is unfortunate that there are so many barriers to receiving the care of a direct-entry midwife. One possible solution for moving away from medicalized and technologically inundated births might be to restore the legality of midwives, thereby creating access to alternative prenatal care and birth practices.[48] Thus, the most clearly identifiable barrier to midwifery care is the illegality of direct-entry midwifery in many states. As noted in the Chapter Three of this project, direct-entry midwives are only licensed to practice in 26 states. The absence of legal access to midwifery care drastically reduces the educational and birthing options for pregnant people. Midwives and the services they provide can be interpreted by the broader feminist movement as an extension of reproductive justice. Not only do they offer care for pregnant people with few(er) reproductive technological interventions, but if allowed to practice more broadly they can provide care for pregnant people living in rural areas and those of lower socioeconomic status. [49]

[48] In the state of Alabama, a place with a long history of midwifery care, direct entry and Certified Professional Midwives are banned by law from practicing. As many other states currently have restrictions on midwifery, access to midwives is limited in many cases to affluent women with the economic means to travel. Because access to midwifery is limited to those with affluence and privilege, the need for an intersectional analysis of midwifery is enhanced.

[49] "Obstetrics as a medical specialty accounts for a disproportionate share of the rising costs of health care in the United States, as a result of over reliance on costly technological interventions and frequent lawsuits. Fear of being sued and the high costs of malpractice insurance are driving many obstetricians out of the field. Those who remain tend to cluster in cities, leaving many rural areas without obstetrical services. In contrast, midwives are rarely sued,

Yet another barrier to midwifery care, which often contributes to the illegal status of direct-entry midwives, is the outspoken opposition of many obstetricians, gynecologists, and their governing bodies.[50] These individuals and organizations are responsible for many of the stereotypes which still haunt midwives, even as midwives have worked to professionalize their image and create their own standardized certification process and model of care. Because of these deeply entrenched stereotypes there is a move among many midwives to present a united professional image, which often limits the autonomy of midwives themselves; they cannot be too militantly feminist, too outwardly "hippie" or look too much like an "earth mother" if they do not want to be the stigmatized by the image the medical community continues to perpetuate.

Even as midwives try to reach more people and establish the legitimacy of their skills, they continue to be undervalued. Their skills, much like the skills of crafters, do not provide for prestige or large salaries, require long hours to perfect and even longer hours to practice for the small sums of money they are paid. Midwives do not choose their profession to get rich; they choose it because they care about the welfare of pregnant people and find value in the skills that have been practiced and handed down over generations. In order to practice midwifery, it is probable that an element of class privilege exists. Those who do not have this privilege may not be able to make the monetary or physical sacrifices or the time commitments that the practice of midwifery requires.

Perhaps the most obvious challenge of incorporating the intervention proposed in this thesis is not the legality of midwives or the corporate medical-industrial complex, but instead the

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many serve rural areas, and their expertise in facilitating normal birth results in fewer interventions and less costly care" (Davis Floyd and Johnson 3).

[50] In some instances the persecution of midwives has extended to relatively uncontroversial nurse midwives. As noted in Chapter Three because of the medical training of nurse midwives they are generally accepted by the medical community. However, recently some hospitals have been banning nurse midwives from delivering babies at their facilities. For more see Tom Kisken in the works cited.

beliefs of pregnant people. The medical model of birth as a pathology is so pervasive. As I point out in Chapter Two, the medical model comes right into our living rooms as we view television programs that document terrifying and tragic births. Therefore, the medical model and the surrounding media-generated images of it, help to construct what pregnancy and birth should look like and include in each individual's socio-cultural imagination. The idea that a medical birth is the safest birth (because of all of its technologies and life-saving surgical capabilities) is an idea that people have been taught to embrace as normal. Anthropologist Ellen Lazarus contends:

> Birth knowledge is comprised of both biological knowledge of pregnancy and birth and social knowledge. The social knowledge includes knowledge of medical procedures that occur during pregnancy and birth in addition to institutional knowledge of the hospital as a bureaucracy–who is responsible for what decisions and how a patient can exert pressure to obtain the kind of care she wants. (26)

Thus, if a person's birth knowledge is determined by a single dominant model, or a person only has access to one kind of model, their information about what is normal or what can and should be expected of pregnancy and birth becomes skewed. Regardless of class or ethnicity, all of the women that Lazarus spoke to wanted what they perceived to be quality care. To some degree each spoke about natural childbirth, but most accepted the medical model of birth. They feared that many things could go wrong and those factors needed to be closely monitored with technological intervention and medical expertise in order to ensure that they had done everything possible to deliver a healthy baby. These women, and many others in the United States, focus on the fears that they have been taught to embody about birth rather than their own ability to retain autonomy and control in birth. One obstetrician who gave birth at the Farm and who tried to incorporate many aspects of the midwifery model of care into her work with her own patients writes:

> It has been disappointing that even when women who were motivated, well-informed, and had chosen me as a caregiver because of my natural childbirth advocacy…have struggled to exercise their autonomy. The language everyone used reflected where control lay: 'We *let* her eat, walk, not have an I.V.,' and 'They *let* me keep the baby all night.' It has been frustratingly difficult to change the atmosphere of hospital birth. (quoted in Gaskin 114)

If an obstetrician, like the one quoted here, has difficulty challenging the atmosphere and overarching social ideologies informed by the medical industrial complex, then clearly the resistance faced by midwives, homebirthers, and their advocates is undoubtedly more virulent.

In Chapter Four of this project, I argue for the importance of seeing the relationship between the midwife and the homebirther as an embodied community. This community is the beginning of the revolutionary change which can come from incorporating the ideals of reproductive justice, DIY consciousness, and midwifery into the lives of pregnant and birthing people. These ideals, which in some senses have evolved alongside one another and which have occasionally connected to one another during their own distinct histories, can intersect with one another in our current time and create a revolutionary and rescripted space for pregnant people and their sense of autonomy. While establishing autonomy for the individual birthing subject, embodied communities also allow for the autonomy of the midwife. The birthing person is not laboring without support from the midwife, and the midwife could not practice without a birthing subject who is willing to trust her skills, thus, it is important to recognize that between the midwife and the birthing subject there is a collective and mutually beneficial space. In some sense, the DIY ethic is expanded by the relationship between the midwife and the birthing subject; instead of *do-it-yourself* the ethic becomes *do-it-ourselves*, two individuals working together with a common goal.

The interventions that I argue for, which I believe will enhance the autonomy of birthing subjects throughout pregnancy and labor, require the navigation of substantial political, medical,

and social obstacles. Embracing the midwifery model of care will require a process of learning and unlearning birth knowledge. It will require that pregnant people have access to truthful, unbiased, and accurate information about pregnancy and birth as it occurs in the hospital setting, as well as that of the birthing center or home. Additionally access to information about midwifery care and midwifery-assisted births must be made available to more people than just those who are interested in subverting the medical industrial complex. Finally, this informational access to midwifery must be translated into far-reaching and widely-available access to midwifery care, with a particular emphasis on reaching poor and working-class people and communities of color. The resurgent interest in midwifery provides a rich opportunity for activists and advocates to support the continuation of these information sharing and community-building processes that have already been put in place by midwives. Furthermore, the legislative and community advocacy work that is being completed by midwives, homebirthers, and those who support them is beginning to dissolve the barriers which have been established to control the bodies of pregnant and birthing people. I am hopeful that through the building of embodied communities between midwives and those they assist in birth, and through the expansion of these communities into the lives of many, that, eventually, the autonomy and bodily integrity of pregnant and birthing persons will no longer be at risk or questioned but will be regarded with value and respect.

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