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Reproductive justice and childbirth reform: doulas as agents of social change

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REPRODUCTIVE JUSTICE AND CHILDBIRTH REFORM:

DOULAS AS AGENTS OF SOCIAL CHANGE

by

Monica Reese Basile

An Abstract

Of a thesis submitted in partial fulfillment
of the requirements for the Doctor of
Philosophy degree in Women's Studies
in the Graduate College of
The University of Iowa

May 2012

Thesis Supervisor: Professor Ellen Lewin

ABSTRACT

This dissertation is an investigation of doulas as agents of social change through the lens of feminist theory. Doulas are nonmedical health care workers who provide physical, emotional, and informational support during pregnancy, childbirth, and/or the postpartum period. Because of doulas' willingness to work within the structures of the hospital setting, some have questioned the effectiveness of doulas as change-makers. While much feminist scholarship on the politics of birth centralizes the issue of medicalization, I demonstrate that expanding this line of analysis aids in better understanding the cultural impact of doula care as part of a larger picture of reproductive health advocacy.

Through discourse analysis, participant observation, face-to-face ethnographic interviews, and online surveys, I track the goals and effects doulas ascribe to their work, both activist and professional, and on both an individual and group level. Rather than asking whether doulas can successfully challenge the medicalization of birth, I seek to understand how the doula movement contributes to social justice through challenging various overlapping axes of inequality, related to race, class, gender, and sexuality. This analysis highlights the work of doulas in marginalized communities that is, as yet, under-researched and under-appreciated, while also illuminating the multifaceted effects of the dominant medical model of birth.

I observe that doulas are increasingly working to empower people in multiple facets of their lives, beyond the birthing room. Rather than being incapable of, or uninterested in, creating social change, doulas are increasingly bringing a new political consciousness into birth work, as evidenced by the emerging designations of "radical doula" and "full spectrum doula." I argue that this movement among doulas represents a new paradigm in birthing rights activism, which connects childbirth choices to a larger reproductive justice agenda and

forges connections between birthworkers and activists for causes such as LGBT rights, abortion rights, prisoners' rights, and economic and racial justice. By reimagining the reach of their work, many doulas are drawing necessary connections to social justice issues that are often overlooked in the childbirth reform movement, which tends to focus on medicalization as the primary issue.

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PH.D. THESIS

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Dedicated to the memory of Paula Mandell

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ABSTRACT

This dissertation is an investigation of doulas as agents of social change through the lens of feminist theory. Doulas are nonmedical health care workers who provide physical, emotional, and informational support during pregnancy, childbirth, and/or the postpartum period. Because of doulas' willingness to work within the structures of the hospital setting, some have questioned the effectiveness of doulas as change-makers. While much feminist scholarship on the politics of birth centralizes the issue of medicalization, I demonstrate that expanding this line of analysis aids in better understanding the cultural impact of doula care as part of a larger picture of reproductive health advocacy.

Through discourse analysis, participant observation, face-to-face ethnographic interviews, and online surveys, I track the goals and effects doulas ascribe to their work, both activist and professional, and on both an individual and group level. Rather than asking whether doulas can successfully challenge the medicalization of birth, I seek to understand how the doula movement contributes to social justice through challenging various overlapping axes of inequality, related to race, class, gender, and sexuality. This analysis highlights the work of doulas in marginalized communities that is, as yet, under-researched and under-appreciated, while also illuminating the multifaceted effects of the dominant medical model of birth.

I observe that doulas are increasingly working to empower people in multiple facets of their lives, beyond the birthing room. Rather than being incapable of, or uninterested in, creating social change, doulas are increasingly bringing a new political consciousness into birth work, as evidenced by the emerging designations of "radical doula" and "full spectrum doula." I argue that this movement among doulas represents a new paradigm in birthing rights activism, which connects childbirth choices to a larger reproductive justice agenda and

forges connections between birthworkers and activists for causes such as LGBT rights, abortion rights, prisoners' rights, and economic and racial justice. By reimagining the reach of their work, many doulas are drawing necessary connections to social justice issues that are often overlooked in the childbirth reform movement, which tends to focus on medicalization as the primary issue.

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INTRODUCTION

In January of 2007, I attended the national summit of the group National Advocates for Pregnant Women (NAPW), an organization which, according to its mission statement, "works to secure the human and civil rights, health and welfare of all women, focusing particularly on pregnant and parenting women, and those who are most vulnerable – low income women, women of color, and drug-using women" (NAPW 2012). The summit brought together, and underscored connections between, advocacy agendas that are often considered unrelated and even contradictory: abortion rights; midwifery advocacy; drug policy reform; anti-domestic violence advocacy; universal health care; and prison reform. Lynn Paltrow, executive director of NAPW, explains the ways in which these seemingly distinct agendas connect:

> While abortion issues are used to divide the U.S. electorate, women -- whether pro or anti-choice -- living in red or blue states -- are united by health, economic, criminal justice, environmental and drug policies that are undermining the ability of mothers and fathers to provide, protect, and care for their families. NAPW believes that by acknowledging these commonalities, recognizing the intersections, and focusing on more than just the right to choose abortion, we can advance a positive, effective, and successful long-term reproductive and social justice agenda. [Paltrow 2007]

At this conference, I spoke on a panel with 8 other doulas entitled "Providing Support for Pregnant Women: Real Life Stories and Lessons Learned." We all discussed challenges we have faced providing support for pregnant and birthing women when race, class, or cultural difference has complicated the notion of woman-to-woman support so popular in the doula consciousness, and when issues such as addiction, welfare status, language barriers, or immigration status introduced hurdles that affected our abilities to

effectively advocate for women during childbirth.[1] In the question-and-answer session after our panel presentations, a debate arose concerning words doulas use to refer to the women they serve. After a lengthy discussion about the virtue of using the term "client" as opposed to the more medically-oriented "patient," one attendee spoke up with a suggestion I had never heard before: "Why not call them fellow activists?"

This conceptualization of the doula's relationship to those she serves struck me immediately as refreshingly radical and pointedly political. It also struck me as highly unusual, and even taboo, within the doula movement. Indeed, it sparked a heated response from a number of doulas in the room, who elaborated the drawbacks of being "too militant" or "too political" in how we describe our work. When I talked to the woman who made this suggestion after the panel, I found that she was a community-based doula in New York who worked with young Latina women and was involved in community organizing to fight police brutality against women of color. During the weekend of this conference, I met many women like this one: doulas whose work arises out of explicitly feminist, class conscious, and antiracist politics, and who situate their practice in terms of larger community organizing and activist projects. Although I had been a doula for close to a decade, I felt, for one of the first times, like I had found my place in the community of birthworkers.[2]

In the summer of 1994, in Omaha, NE, as part of a national gathering of young feminist activists called riot grrrls, I stood outside a women's health clinic with a few dozen other feminists, mostly in their teens, escorting women past anti-abortion protesters. I was pregnant, and, in the confrontational style of the riot grrrl movement, I had written "Mother for Choice" on my exposed belly in black marker. People on both sides stared, not knowing

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[1] This panel was organized by Christine Morton, who wrote the first sociological study of doulas (2002). I am indebted to her for her foundational research, and for inviting me to be a part of this life-changing conference.

[2] I use this term to encompass doulas, midwives, and childbirth educators, in recognition that these roles often overlap.

what to make of me. I felt as though the protesters saw me as a desecration of motherhood, and at the same time, pregnancy did not really seem to fit with my identity as a young radical feminist. I knew I was embodying a powerful, politically potent contradiction, and I felt both deliciously deviant and profoundly alone.

In 1995, I began my certification as a childbirth educator with the only organization at the time that was training independent educators: The American Academy of Husband Coached Childbirth, otherwise known as the Bradley Method. I had taken a Bradley Method class during my pregnancy, and I made some dear friends in that class, including the instructor, who went out of her way to welcome me. I felt, in many ways, empowered by the knowledge about the birth process I gained from that class, but nonetheless, as a bisexual, 19-year-old single mother, I felt constantly that I was an exception, an outlier. My life experiences and values did not match up with the married, heterosexual, middle-class lifestyle assumed by the course curriculum and displayed by the other students.

I taught Bradley classes and tried my best to modify the curriculum to make it more my own. Soon, people began asking me to attend their births, and I found that I loved being with laboring women. In 1999, I trained and became certified as a doula and left the Bradley Method for BirthWorks, an organization with a more woman-centered philosophy. My training gave me many useful skills and insights, but no one talked about how to work with lesbian or single moms, and no one could relate to my problems getting childcare for overnight births. Every time I would tell the story of my son's birth at home, which was a powerfully positive and transformative experience, I was aware of the narrative erasures I felt I had to make to keep my story palatable (like the fact that I was in the process of fleeing an abusive relationship when I had my home birth). I managed to make my unique position a strength, and became known in my community as someone who knew how to work with "nontraditional" families. Still, my identity as a birthworker has always felt messy and leaky.

On the first day of the NAPW conference, Lynn Paltrow explained that the conference was organized around dispelling the myth that "some women have children and

some women have abortions." Remembering how I felt standing outside the clinic in Omaha so many years before, I suddenly began to feel enlivened, as though somehow my existence was legitimate. As the conference unfolded, my identity as a birthworker and activist also began to feel validated, as another pervasive myth began to crumble: the myth that some reproductive rights advocates (abortion providers, clinic workers) are only concerned about the avoidance of pregnancy and motherhood, while others (midwives, doulas, and childbirth advocates) are solely concerned about achieving it.

At this conference, I met others who were engaging with these connections, and over the course of the weekend, I learned to appreciate relationships I had not previously seen between my own commitments to both empowered childbirth and social justice: There were pregnant women in prison, and doulas who helped them? Advocates for victims of domestic violence were creating programs specific to understanding battering in the childbearing year? I returned from this conference full of inspiration, hope, and an entirely new appreciation of how doulas can conceptualize, and contribute to, social change.

This dissertation is directly inspired by the connections, both theoretical and interpersonal, that conference facilitated. It is an investigation of doulas as change-makers through the lens of feminist theory. Rather than attempting to objectively assess whether or not doula care is feminist, my work seeks to understand how doulas' specific strategies contribute to, and are influenced by, different types of feminist activism. At work here are several important issues, including the tension between liberal, radical, and cultural feminism, and debates about the use and value of reformist, revolutionary, and essentialist strategies for effective activism. Also at play are questions surrounding the value of women's caring work, feminist uses of science, gendered knowledge and cultural authority, and the ability of feminist analysis to simultaneously theorize race, class, sexuality, and gender. The doula movement is rich ground upon which to locate an analysis of the relationships between feminisms, medicine, and reproductive politics in the U.S.

While much feminist scholarship on the politics of birth centralizes the issue of medicalization, I demonstrate that expanding this line of analysis aids in better understanding the cultural impact of doula care as part of a larger picture of reproductive health advocacy. By focusing on whether doulas are able to successfully demedicalize birth, we risk losing sight of other critical issues. What other outcomes of doula care might be relevant to the lives of pregnant and childbearing families? Rather than asking whether doulas can successfully challenge the medicalization of birth, I seek to understand how the doula movement contributes to human rights and social justice through challenging various overlapping axes of inequality, including race, class, gender, and sexuality. By reconfiguring the terms of inquiry and placing the priorities and experiences of marginalized communities at the forefront of my research, I highlight the work of doulas that is, as yet, under-researched and under-appreciated. At the same time, this consideration of issues crucial to marginalized communities illuminates much about dominant cultures of childbirth, exposing multifaceted effects of the dominance of the medical model.

I observe that doulas are increasingly claiming identities as activists and working to expand the traditional model of one-on-one birth care through innovative projects that seek to empower women in multiple facets of their lives, even beyond the birthing room. Rather than being incapable of, or uninterested in, creating social change, as some researchers have suggested, doulas are increasingly bringing a new political consciousness into birth work, as evidenced by the emerging designations of "radical doula" and "full spectrum doula," which I examine in depth in Chapter Six. I argue that this movement among doulas represents a new paradigm in birthing rights activism, which connects childbirth choices to a larger reproductive justice agenda. Doulas working in the reproductive justice model are shaping new directions in the priorities of birthworkers, and forging connections between birthworkers and activists for causes such as LGBT rights, abortion rights, prisoners' rights, and economic and racial justice. I argue that by reimagining the reach of doula work, these doulas are drawing necessary connections to social justice issues that are often left

overlooked in the childbirth reform movement, which often tends to focus on medicalization as the primary issue.

Background

Doulas are people[3] – usually, but not always, mothers – who are trained and often certified to provide non-medical physical, emotional, and informational support during pregnancy, childbirth, and/or the postpartum period. The popularity of doula care has been growing steadily since the 1980s, when researchers first began to document the benefits of labor support,[4] and there are now thousands of people worldwide who have embraced this profession. DONA International, the oldest and largest doula certifying organization, founded in 1992 and based in Denver, CO, boasts over 7,000 members – a significant expansion from 750 members in 1994.[5] While DONA is by far the most widely recognized doula organization, there are many other national and local organizations that train and certify doulas.[6]

Not all doula work is the same; birth doulas provide assistance during labor and birth, and postpartum doulas provide care in the period after birth. Some doulas offer support for abortion, adoption, pregnancy loss, and other reproductive experiences. Some doulas practice privately and are paid by individuals for their services, and others work on a

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[3] Although the doula profession is overwhelmingly female-dominated, I use the term "people" instead of "women" here to recognize the presence of male, transgendered, genderqueer, and non-gender-conforming doulas, several of whom have contributed in important ways to this research. Because my project engages with doulas' critiques of gendered ways of understanding birth and birth work, I strive to use gender-specific and gender-neutral language interchangeably.

[4] I describe these studies in more depth in Chapter 2.

[5] Most of these members are in the U.S. and Canada. DONA has around 200 members outside North America. Statistics available at http://www.dona.org/aboutus/statistics.php.

[6] At the time of this writing (2012), I have been able to locate 23 such organizations, many of which are also large and well-established, such as PALS (the Pacific Association of Labor Support), CAPPA (Childbirth and Postpartum Professional Association), CBI (Childbirth International), BirthWorks International, ToLabor, and Birthing From Within.

volunteer basis, sometimes in formalized hospital-sponsored programs designed to provide doula care to anyone who may want labor support. Still others offer community-based care in programs that are affiliated with clinics, prisons, neighborhood centers, and other agencies and institutions. Doulas, as individuals, represent a wide variety of personal backgrounds, political and religious convictions, experiences with birth, and philosophies of care.

Doulas are part of a larger childbirth reform movement, which includes professionals in related fields, such as childbirth educators and lactation counselors; health care providers; midwifery advocates; and other parents and concerned citizens. Childbirth reformers are concerned with issues such as the steadily rising cesarean rate in the U.S., which reached an all-time high of 32.9% in 2009 (Martin et al 2011:9). Despite spending more money per capita on health care than any other nation, the U.S. has comparatively poor outcomes in terms of perinatal, neonatal, and maternal mortality and low birth weight (Sakala and Corry 2008:3). Black mothers and babies experience even more concerning maternal and perinatal health outcomes, with far higher rates of preterm birth, low birth weight, and fetal, perinatal, and maternal mortality (Hamilton et al 2011:10-13; Mathews et al 2011). The Milbank Memorial Fund's 2008 report on Evidence-Based Maternity Care describes this as a "perinatal paradox: doing more and accomplishing less," and concludes that "contemporary maternity care in the United States involves considerable overuse of harmful or ineffective practices…and underuse of beneficial practices" (Sakala and Corry 2008:3). Childbirth reformers advocate for a reversal of this state of affairs, calling for increased use of midwives, doulas, and other alternatives to the mainstream medical model of birth.

The emergence of the doula movement[7] is an outgrowth of the women's health movement of the 1970s, which criticized the medicalization of birth in the hospital setting as

[7] I use the term "doula movement" to refer to the general presence and activities of doulas, doulas' organizations, doula communities, and doula supporters. While doulas themselves do not always explicitly define themselves as being part of a "movement," the activities of doulas do meet the criteria of social reform

patriarchal and disempowering to women. As such, many of the goals of doula care run parallel to feminist principles: expanding the range of reproductive choices for women, centralizing embodied knowledge, and promoting self-help and solidarity among mothers. At the same time, many feminists regard the rhetoric doulas often employ in service of women's empowerment as problematic. It often rests on conventional gender prescriptions, figuring motherhood as the central defining experience in a woman's life, naturalizing heterosexual relationships, and celebrating a feminine identity that is fundamentally connected to nature and the body.

In contrast to some of the more radical critiques of American childbirth practice advanced by the midwifery and homebirth movements, doula care often represents a more accommodating variety of childbirth reform, most often seeking to improve women's birth experiences within the hospital setting, where 99% of births take place. In order to gain entry into American birthing rooms, doulas must fit neatly into existing hospital structures, dealing with the occasionally conflicting needs of birthing women and doctors through complex combinations of resistance and acquiescence. The doula's job is focused on assisting families on an individual level. Although many doulas see their work as having a long-term transformative effect on hospital protocols and on larger cultural attitudes about birth, they view this change as occurring one birth at a time.

Because of the willingness of most doulas to work within the structures of the hospital, some have questioned the effectiveness of doulas as change-makers. In her ethnography of doulas, sociologist Bari Meltzer Norman concludes that they are largely "apolitical" and "passive," and that "In trying to make quiet waves, doulas ultimately help along the current medicalized system of birth" (2007:280). Similarly, journalist Jennifer Block wrestles with the idea that, "By supplementing the handholding and informed consent

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movements in that doulas, as ordinary citizens, make collective claims in order to enact social change (Tilly 2004). I also use the term "childbirth reform movement" in the same way and for the same reasons.

conversations that nurses and doctors should be doing, and by buffering the level of intervention, [doulas] are perpetuating the very system they are in the business of changing" (2007:160). A bit more optimistically, Christine Morton explains that "doulas' ability to redefine the reality of childbirth in the U.S. is…strengthened but also potentially weakened by their ongoing, continuous presence within the hospital setting" (2002:300). These assessments raise an important question: to what extent are doulas capable of creating institutional change in order to improve birth experiences and outcomes?

Context and Significance

The first cross-cultural examination of childbirth, Brigitte Jordan's *Birth in Four Cultures* (1978), paved the way for critical examinations of how social forces shape birth practices. Since the early 1990s, with the publication of such works as Robbie Davis-Floyd's *Birth as an American Rite of Passage* (1992), there has been a proliferation of scholarship on childbirth in the U.S., and the anthropology of birth has since branched out in several directions and converged with a number of disciplines[8]. Key texts in the anthropology of reproduction have offered powerful critiques of the patholigization of women's bodies and capitalist reliance on women's productive and reproductive labor. For example, Faye Ginsburg and Rayna Rapp, in their 1995 anthology, present a wide ranging exploration of ways in which reproduction (and research on reproduction) are inherently political. New work in this area continues to inform and be informed by the goals and strategies of the childbirth reform movement. However, a survey of the recent body of childbirth literature, both popular and scholarly, shows a relative paucity of attention to the birthing experiences and concerns of women in the margins. Poor women, immigrants, women of color, teens and single mothers, homeless women, drug-addicted women, and incarcerated women are,

8 See Becker 2000; Bobel 2001; Borst 1996; Caton 1999; Davis-Floyd and Dumit 1998; Ginsburg and Rapp 1995; Klassen 2001; Layne 2002; Kahn 1995; Macdonald 2006; Maroroddian 2003; Pollack 1999; Treichler 1990.

with a few important exceptions, virtually absent from the literature.[9] My analysis of the strategies employed by doulas who serve populations that are both underserved and underrepresented contributes to filling this gap and also, I hope, will invite further work in this area.

My research is guided by scholarship on women's health activism that incorporates a sustained analysis of how race, class, sexuality, and gender shape women's priorities and actions as they work for reproductive rights (Morgen 2002; Nelson 2003; Silliman et al 2004; Solinger 2005). Jennifer Nelson explains,

> There is a tendency among feminists, both contemporary and historical, to suggest that by defending the rights of white middle-class women to bodily integrity and sovereignty, women of color and poor women's rights will also be defended … this logic is problematic … both the state and reproductive providers treat poor women of color and white middle class women differently. [2003:186]

Nelson demonstrates that struggles by poor women and women of color against forced sterilization and coercive contraceptive policies tied to welfare were integral to the formation of the reproductive rights movement. She argues that these efforts have not been adequately acknowledged in feminist discourse, both among activists and in publication. Women of color in the U.S. have long proposed that a "reproductive justice" model replace the "reproductive rights" paradigm. This shift recognizes that reproductive rights include not only abortion rights, but also freedom from coercive welfare policies and forced sterilization, the right to bear children, and equal access to the economic resources that are needed to do so (Morgen 2002; Nelson 2003; Silliman et al 2004; Smith 2005). Informed by these insights, I draw attention to an emerging group of doulas, whom I refer to as reproductive justice doulas. I show that their work is integral to the childbirth reform movement, and is forging

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[9] Notable exceptions include: Kaufert and O'Neil 1990; Merrick 2001; Murphy and Rosenbaum 1999; Nestel 2006; and Solinger 2010. Notable works attending to the history of childbirth in communities of color include: Berg 2002; Mathews 1992; McGregor 1998; Morgan 2004; Schwartz 2006.

critical connections between the childbirth reform agenda and the reproductive justice movement.

My research is also informed by intersectional analyses of reproductive politics, such as work by Angela Davis (1983), Gertrude Fraser (1995; 1998), Deborah Kuhn McGregor (1998), and Dorothy Roberts (1997). These scholars, with their careful attention to how racism, sexism, and sexual and economic exploitation affect childbirth and other reproductive experiences, have guided me in considering how intersecting systems of oppression and privilege affect the priorities and practices of doulas, and the lives of those whom they serve. I centralize the issue of disparity in maternity care, and return to the question Rickie Solinger articulates: Who gets to be a legitimate mother in the US, and what do race and class have to do with it? (2005:2).

In the field of anthropology, I draw on feminist and critical medical anthropological approaches, which are concerned with the social production of bodies and the ways in which (often bio-)medical discourse constructs certain bodies as inherently pure or polluted, modern or primitive, and deserving or undeserving of rights and resources.[10] I am also inspired by critical medical anthropological work that focuses on structural critiques and activist intervention. As Merrill Singer describes, critical medical anthropology is concerned with understanding health and illness

> …in terms of the *interaction* between the macrolevel of political economy, the national level of political and class structure, the institutional level of the health care system, the community level of popular and folk beliefs and actions, the microlevel of illness experience, behavior, and meaning, human physiology, and environmental factors." [1998:225]

In arguing for a "critical praxis in medical anthropology" Singer encourages anthropologists to lend their skills to community-based organizations and political struggles, and I hope this work will make such contributions.

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[10] Becker 2000; Briggs 2003; Kelm 1998; Rapp 1999.

I am also influenced by ethnographic studies of motherhood and mothers' movements and activism. Much of this work analyzes women's narratives of how their race, class, and status as mothers influence their political engagement (Berg 2002; Ginsburg 1998; Higginbotham 1993; Lewin 1993; Naples 1998; Ragone et al 2000). Motherhood is often reflexively thought of in oversimplified terms, either as a relatively static identity or an indicator of female oppression. Feminist scholarship on motherhood has crucially reminded feminists and broader audiences that motherhood is also a powerful site for mobilization, politics, and community building.

Also essential to the development of this project has been scholarship concerning third wave feminist strategies,[11] many of which doulas are employing to transform the doula movement, as well as broader ideas about gendered bodies and motherhood. Although some feminist scholars have rejected the "wave" metaphor for understanding feminism (Guy-Sheftall 2002; Springer 2002), I see this conceptualization not as a means of designating altogether separate strategies, but, as Amber Kinser puts it, as a way of describing "yet more motion in a long history of feminist movement… an ongoing process, ebbing and flowing, slowing and quickening its pace in succession" (2004:131). Kinser argues that "what is most influential in defining a 'third wave' is its position relative to, and therefore how it is poised to respond to, the current socio-cultural, technological, and political climate." I am interested in how the doulas in my study are negotiating this current cultural climate through their work, and I observe that many of them are approaching their work in a way that Kinser describes as characteristic of third wave feminists: "They embrace pluralistic thinking within feminism and work to undermine narrow visions of feminism and their consequent confinements, through in large part the significantly more prominent voice of women of color and global feminism" (133).

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[11] Findlen, ed. 2001; Heywood and Drake, eds 1997; Labaton and Martin, eds 2004.

As a study of third wave feminist activism, Chris Bobel's *New Blood: Third Wave Feminism and the Politics of Menstruation* (2010), in particular, has inspired me to observe parallels between radical doulas and the radical menstrual activists she writes about. Like "radical menstruationists," radical doulas are "inspired by third wave values of multiplicity, contradiction, inclusion, and everyday feminism" (100). They are working to reclaim a gendered bodily process from institutional control while, at the same time, rejecting a romanticized view of that process. By using gender neutral language to describe birth, they are also working to "uncouple the gendered body" from that process, as menstruation activists do by using the term "menstruators" (100).

I am also inspired by the wealth of scholarly attention that has been paid to midwives and midwifery movements.[12] While there are many parallels between midwives and doulas, they are distinct professions that demand attention to overlapping, yet still separate, issues. To date, doulas have not been studied to the extent that midwives have. Although many studies have been carried out evaluating the clinical outcomes of doula care,[13] doulas have been the topic of comparatively minimal qualitative research. In 2002, sociologist Christine Morton published the first dissertation on doulas, and her work has been integral to the development of my research. Bari Meltzer Norman's chapter, "The New Arrival," in the book *Laboring On*, co-authored by Barbara Katz Rothman and Wendy Simonds (2007), also presents the results of ethnographic research with doulas, focused on feminism and the medicalization of birth. Other publications have considered the perspectives and experiences of doulas, usually as case studies of doula programs, or of the perceptions of health care providers toward doulas.[14]

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[12] Borst 1996; Davis-Floyd and Johnson, eds. 1996; Craven 2007, 2010.

[13] See: Hodnett et al 2003; Hofmeyer et al 1991; Kennell et al 1991; Klaus et al 1986; Schroeder and Bell 2005; Sosa et al 1980.

[14] See: Abramson et al. 2006; Bowers 2002; Gentry et al. 2011; Kane Low et al. 2006; Papagni and Buckner 2006; Wen et al 2010.

Like many ethnographers,[15] I see myself as embodied in my research, rather than detached from it. Much of my knowledge about doulas and childbirth activism comes from my own experiences over the past seventeen years as a birth doula, childbirth educator, midwifery advocate, and more recently, a Certified Professional Midwife. My first-hand knowledge of labor assisting allows me access to the lived realities of birth work, which involves specific educational, emotional, and physical commitments, as well as substantial lifestyle adjustments. It has also given me the opportunity to participate in extensive relevant interactions and communications with the general public, families I have served, policy makers, and other activists and childbirth professionals. This research is also informed by my experiences as a teen and single mother, and a participant in the third wave feminist riot grrrl movement. In many important ways, my involvement in the childbirth community has been strengthened, hampered, and otherwise informed by the realities of my own shifting social position and activist commitments.

This research is not an autoethnographic exercise, and my personal experience is not central to its arguments. At the same time, as a longtime birthworker and mother, I do draw upon my various ongoing intimacies with birth work to investigate the childbirth movement as a reflexive insider. I come to this project with a specific investment in redefining and expanding the goals of the childbirth reform movement, and in thinking about the terms and vectors through which many are doing that work, so that a more diverse group of people can have access to a wider array of positive outcomes in childbirth.

Methods

This dissertation is a feminist interdisciplinary project, which relies on several methodological approaches, including discourse analysis, participant observation, face-to-

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[15] See: Behar and Gordon 1995; Lal 1996; Lewin and Leap 1996; McClaurin 2001; Smith 1999, Trinh 1989; Visweswaran 1994; Wolf 1992.

face ethnographic interviews, and online surveys, as well as feminist theories of the body, reproduction, science, technology, and intersectionality.

First, I am interested in how doulas and other birth workers interact rhetorically with representational practices that shape the meaning of childbirth. Through close readings of key popular texts in the alternative birth genre, as well as professional publications by and for birth workers, I analyze the imagery and discourse of natural childbirth in order to understand the rhetorical atmosphere that permeates the doula movement. I am particularly interested in how the meanings of natural childbirth are constructed in the context of race, class, and gender politics. Describing the importance of discourse analysis for studies of social movements, sociologist Nancy Naples explains that:

> Discourse has material consequences for social movement actors. In order for movement frames to gain wide acceptance, they need to resonate with prevailing cultural constructions. Because master frames frequently draw on recognizable symbols and values to mobilize and effect social change, …they have the potential of incorporation into the wider political environment in ways that originators might not have intended. [2003:106]

Following Naples, I explore the questions: What prevailing cultural constructions of race, class, gender, and sexuality has the childbirth reform movement needed to resonate with in order to gain acceptance? Have these constructions had unintended consequences for the movement? And in the face of a certain level of cooptation, how might childbirth reformers be creating new ways of structuring their political identities?

Second, I am interested in how birth workers take action to bring about changes in the culture and experience of pregnancy and birth. I investigate this on both an individual and group level, and I track what goals and effects birthworkers ascribe to their work, both activist and professional. To explore these questions, I have utilized face-to-face interviews and online surveys, gathered after approval from the Institutional Review Board (IRB# 200903769). I also participated in two major conferences for birthworkers and activists: National Advocates for Pregnant Women in 2007, and the Midwives Alliance of North America regional conference in 2009.

When I began my research, I expected to conduct a small-scale study of the local doula community in Iowa City, Iowa of which I am currently a part. I designed an open-ended interview schedule that asked questions about doulas' experiences, training, and thoughts about advocacy, feminism, and social change (See appendix A). I recruited doulas to participate in interviews through word of mouth, and conducted face-to-face interviews with nine local doulas. These interviews ranged in length from one hour to three hours each. As I began to realize that my observations and arguments required that I attend to the voices of doulas on a national level, I decided to broaden my sample. In addition to these eight local doulas, I conducted face-to-face interviews with five doulas and one midwife from out of state, and I also designed an online survey that asked questions similar to my interview schedule (See Appendix B).

I recruited survey participants through emails I sent to doula listservs, and through a link to my survey I posted to both Facebook and the Full Spectrum Doula Network, both social networking websites. The recruitment script for my survey specified, " All doulas are invited to participate. I am particularly interested in the work of those who identify as radical or full spectrum doulas, and those doing community-based or volunteer work."[16] The International Center for Traditional Childbearing granted me permission to post a link to their organization's Facebook page for the purpose of recruiting doulas of color, and Miriam Perez, blogger at Radical Doula, provided a link to my survey on her blog in a post entitled, "Help a Radical Doula with her Dissertation Research."

220 doulas started my online survey, and 156 completed it, resulting in a response rate of 70.9%. In analyzing my responses, I disqualified those who began but did not complete the survey. While my survey reflects the ideas and experiences of those eager to talk about them, and thus is not a random sample of doulas, it does provide the views of a

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[16] Because of my recruitment strategies and the goals of my research, the perspectives of more socially conservative doulas are not as fully represented as those of the social justice-oriented doulas I am interested in representing.

diverse sample of doulas. It includes doulas from 40 states and five Canadian provinces. The average age of survey respondents was 32, with the oldest respondent 68 years old, and the youngest 20 years old. The vast majority of survey respondents identified as female, four identified as male, and one as genderqueer. I asked respondents to identify their race/ethnicity as an open-ended question. 84% of respondents identified as white; 11% black; 3% Native American/American Indian; 2% Hispanic/Latina; 1% each as Jewish, White/Hispanic; Asian/Pacific Islander; Afro-Latina, and biracial/mixed-race. The vast majority of survey respondents, 94%, had some college education, and 68% had college degrees. I also asked about relationship status in an open-ended question. 73% indicated that they were married, engaged, partnered, or in a committed relationship. 22% were divorced, separated, or single. Two survey respondents indicated that they were in poly- or multi-partner relationships.

I assigned pseudonyms to all of my interviewees and survey respondents, except for three already public figures: Miriam Zoila Perez, Shafia Monroe, and Jennie Joseph. To analyze my data from both surveys and interviews, I collected responses to each of my questions and developed codes from recurring responses. From these codes, significant themes and issues emerged, and these themes and issues structure my arguments. For my analysis of the doula movement, I also read multiple blogs and websites written by and about doulas. In particular, the Full Spectrum Doula Network, Radical Doula blog, and the website of the International Center for Traditional Childbearing have been key sources for understanding the priorities and discourse of radical doulas, full spectrum doulas, and doulas of color – groups which are sometimes distinct, and sometimes overlapping, but which share in a commitment to the intersectional approach of reproductive justice.

Chapter Overviews

Chapter 1: "At The Foot Of A Woman": Scope, Practice, And Feminist Implications of Doula Care

To begin, I draw on my data, as well as my own experiences, to describe the lived realities of doula practice. I examine doulas' perspectives on the hardships, rewards, and motivations of their profession; the economics and emotional labor of doula work; and issues of access to doula care and to the doula community itself. I explore doulas' relationships to feminism and outline the meaning and practice of doula care in the context of several relevant feminist issues: the debate over reformist vs. revolutionary strategies for social change; the holistic, medical, and humanistic models of birth; feminist ethics of care; feminist epistemology and authoritative knowledge; and issues of cooptation and consumerism.

Chapter 2: Constructing the Natural

Here, I analyze the history, imagery, and discourse of *natural childbirth*, one of the central organizing ideologies of the childbirth reform movement in which doula care is embedded. I investigate the often-problematic assumptions about gender, race, sexuality, and class that have informed the social construction of natural childbirth, both historically and in the present. I outline a brief social history of the gendered, raced, and classed meanings of natural childbirth since the mid-19th century, and examine the diverse ways that feminisms have approached childbirth activism since this time. Extending this analysis into the 20th century, I survey canonical literature of the natural childbirth movement since the 1970s and into the present, and also consider feminist theoretical perspectives on nature, culture, and technology. I argue that the discourse of natural childbirth contributes to the conceptual positioning of doula care and other alternative birthing practices as a white, middle class phenomenon, and that it is important for doulas and other childbirth reformers to question the utility of this term as the foundation for an ostensibly feminist movement.

Chapter 3: Contested Epistemologies: Evidence Based Medicine and the Doula

When calling for change in the maternity care system, doulas often rely on the rhetoric of science and evidence-based medicine as they interact with clients and the public. However, they equally make use of non-scientific arguments, and continue to centralize the embodied knowledge of birth-givers. In this chapter, I analyze the prevalence and efficacy of doulas' calls for evidence-based medicine through the lens of feminist science studies. I show that, rather than employing the rhetoric of science in opposition to situated, bodily knowledge, doulas work instead to highlight the connections between scientific and embodied epistemologies, and approach ways of knowing about the practice and experience of childbirth in a way that is much like the "strong objectivity" approach Sandra Harding proposes (1991a). They do so while also contextualizing epistemological claims about birth within the larger complex of medical, legal, and cultural forces that shape birth experiences.

Chapter 4: "A Tricky Business:" Doulas as Advocates for Childbearing Women

Turning to the everyday work of doulas, I investigate the extent to which doulas see themselves as advocates for their clients, and how this advocacy is enacted both within and outside the birthing room. Drawing on my interview data and participant observations, I discuss the difficulties that arise from the fact that the acceptance of doulas is predicated on their assumed docility within hospital settings. Looking at doula work as an amalgamation of both resistance and accommodation, I argue that doulas' advocacy takes radically different forms depending on who the doula is interacting with, and the context in which those interactions are taking place. I introduce the idea that doula work forces doulas to engage with larger political tensions usually not considered specific to childbirth. Through doulas' stories, I discuss the rewards and challenges of providing care when doulas are working with people who don't fit into dominant ideals of motherhood (i.e., lesbians, poor women,

addicts, immigrants) and various strategies doulas are developing for dealing with those challenges. These strategies are part of the larger project of childbirth reform, and though they emerge in relation to individuals, they also inform and are informed by broader beliefs about childbirth, women, medicine, and social privilege.

Chapter 5: Birthworkers of Color and the Political Dimensions of Tradition

In this chapter, I discuss the historical and contemporary landscape of African American midwifery in particular and the work of midwives and doulas of color in general. I analyze the discourse of groups such as the International Center for Traditional Childbearing, in which "tradition" refers not only to the historical practices of birthworkers of color, but also to a distinct tradition of grassroots activism in historically marginalized communities in America. I argue that by making social justice work central to their definition of tradition, birthworkers of color offer an intersectional critique of how race, class, and gender influence maternal and child health in the U.S.

Chapter 6: "Call Them Fellow Activists:" Reproductive Justice and New Directions in Doula Care

Here, I examine several emerging paradigms of doula care, and how they differ from the traditional model of private doula care, in philosophy, form, and function. I present case studies of organizations and publications that represent these new trends, as well as data from interviews and online surveys. I look specifically at community-based and prison doula programs and "full spectrum" doula projects, which apply the doula model of care to reproductive experiences such as pregnancy loss, abortion, and adoption. I examine the emerging identity category "radical doula," and outline the ways in which this category's meaning is currently still solidifying. I argue that these new directions in doula care are driving productive and vital connections between birthing rights advocacy and a broad-based reproductive justice approach linking reproductive health care and social justice.

CHAPTER 1

"AT THE FOOT OF A WOMAN": SCOPE, PRACTICE, AND FEMINIST IMPLICATIONS OF DOULA CARE

In this chapter I draw on my data as well as my own experiences to describe the lived realities of doula practice. I examine doulas' perspectives on the hardships, rewards, and motivations of their profession; the economics and emotional labor of doula work; and issues of access to doula care and to the doula community itself. I explore doulas' relationships to feminism and outline the meaning and practice of doula care in the context of several relevant feminist issues: the debate over reformist vs. revolutionary strategies for social change; the holistic, medical, and humanistic models of birth; feminist ethics of care; feminist epistemology and authoritative knowledge; and issues of cooptation and consumerism.

What is a Doula?

DONA International, the oldest and most prominent doula training organization, defines a doula as "a trained and experienced professional who provides continuous physical, emotional and informational support to the mother before, during and just after birth; or who provides emotional and practical support during the postpartum period" (DONA, "What is a Doula?" 2012). Although the term "doula," a Greek word,[1] is now associated with assistance during childbirth as well as the postpartum period, it originated in reference to the postpartum care of mothers and babies, specifically in the area of breastfeeding and maternal-infant bonding. Dana Raphael coined the term in *Breastfeeding: The Tender Gift* (1973). Raphael's definition of a doula is "one or more individuals, often

[1] "Doula" is commonly understood by Americans as meaning "a woman who serves" in Greek, although the term also carries negative connotations in its original translation, which can also mean "slave."

female, who give psychological encouragement and physical assistance to the newly delivered mother" (1973:172). In the 1980s, pediatricians Marshall Klaus and John Kennell began publishing research on the effects of such woman-to-woman assistance, and found, seemingly by accident (Gilliland 2002:548), that the presence of a doula throughout labor and birth not only improved mother-infant bonding, but reduced the length of labor and the use of various obstetric interventions (Klaus and Kennell 1983; Klaus et al 1986; Sosa et al 1980).

As Kennell and Klaus continued to publish research on birth doulas, those who had been attending births informally as mothers' helpers and childbirth educators found a new definition for their work. In 1988, the Pacific Association for Labor Support (PALS) was formed by Penny Simkin, who trained doulas and published *The Birth Partner* in 1989, a manual that is still widely used in its current form as a 398-page book, currently in its third edition, in doula training programs. In 1992, Doulas of North America (DONA), the first international organization to train and certify doulas was founded. The widespread recognition of the term "doula" is thus a relatively recent development; along with other seasoned doulas, I myself can remember doing doula work before it was designated as such.[2]

Currently, there are multiple certifying organizations for doulas, and though certain elements of ideology and scope of practice differ slightly between certification organizations, the skill sets of doulas are relatively uniform. The training and certification process usually involves reading several books about childbirth; attending a workshop to learn techniques for labor support; assisting at a specified number of births (anywhere from three to ten) and submitting evaluations from parents and health care providers from these births; participating in a childbirth education class series; and a research or writing component. The costs for completing doula training range from $300-$400 up to upwards of $1000. Although

[2] Christine Morton's 2002 doctoral dissertation, "Doula care: The (re-)emergence of woman-supported childbirth in the United States," explores the history and origin story of doula care in depth.

workshops are offered in most states, travel expenses may be added to this fee, should a prospective doula not have access to a required workshop in her area. Internet-based distance learning programs have become more popular over the past five years. Certification may take anywhere from nine months to three years. There are no state licensing requirements for doulas. Some doulas choose to practice without becoming certified, but credentials have become increasingly important in the past five years as doulas are becoming more visible, and as more women conduct their doula work as a business. In many communities, there is a certain degree of competition between local doulas, and it is not unusual for expectant women to interview several doulas before choosing one to work with.

Depending on the certifying organization and the individual trainer, as well as the doula, experiences of doula training can vary widely, even though certification requirements are fairly uniform. I asked the doulas in my study about the strengths and weaknesses of their training, and the strengths they most commonly identified had to do with the experience and passion of their trainers, the specific comfort measures they learned, the and the community they gained access to as a result of their training. The biggest weakness doulas identified was the lack of formalized mentoring or for beginners. Many doulas suggested that certifying organizations incorporate guidelines for apprenticeship or shadowing experiences. Claire Peterson, an Iowa City doula, said,

> I think it would have been helpful to do more shadowing, where you have to do a certain amount of births [with another doula] before you even go into a birth situation [alone], just so you could learn a variety of different doulas' techniques, and just so you could feel more comfortable and the pressure's off.

Doula trainings do incorporate hands-on practice and role-playing with the other trainees. But while the doulas in my study generally regarded this as one of the most helpful components of the training experience, they also found it to be insufficient once they actually began attending births. As Casey Amato, a doula and massage therapist in Washington, said, "You can't be taught about birth in a class. You have to be taught at the foot of a woman."

Once she has agreed to work with a woman or couple, a doula usually meets with expectant parents several times prenatally to discuss the family's concerns and desires for the upcoming birth, and to determine how they will best work together. At this time, the doula will help the mother to create a birth plan, or list of preferences for the upcoming birth, and become familiar with it, as she will be responsible to "help the woman have a safe and satisfying childbirth as the woman defines it" (Simkin 1998:1). The doula typically sets aside one month of on-call time for each birth – two weeks before and two weeks after the estimated due date. When she is called to the birth, she will perform a variety of tasks, such as helping with comfort measures such as relaxation, movement, and positioning; assisting families in gathering information about the course of their labor and their options for best facilitating it, whether physiological or pharmaceutical; and providing emotional reassurance and comfort to the woman and her family. After the birth, the doula will help with initial breastfeeding if necessary, and remain at the place of birth until mother and infant are stable and ready to sleep or spend time with their family. The doula will also usually make one or two additional visits in following weeks to review the birth and answer any questions about postpartum recovery or infant care. Doulas attend births in hospital, birth center, and home settings, but practice most frequently in hospitals, and they typically charge between $400-$1000 for services.[3]

In contrast to midwives, physicians, and nurses, a doula's presence during labor and birth is continuous and uninterrupted.[4] Since she does not perform tasks of primary health care provision, the doula is able to focus her attention completely on the mother's emotional, mental, and spiritual needs, as well as her physical comfort. There are no

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[3] There is a great deal of difference, geographically, in the average fee for doula services. DONA encourages doulas to consider what is locally typical in setting fees. In the community in which I practice, the average fee is around $600.

[4] Some midwives, especially those attending home births, do provide a continuous presence, though they may not arrive at a birth until the mother is in active labor, whereas doulas often begin providing hands-on support in early labor.

restrictions on a doula's clientele: doulas attend births for those with high and low risk pregnancies. They attend births involving medical induction, epidural anesthesia, and cesarean surgery, as well as those incorporating few to no medical procedures. The significance of the doula's role as a non-medical support provider is underlined by the latest literature review on labor support by researchers at the Cochrane Institute. This study concludes that "continuous support from a caregiver during labour appears to confer the greatest benefits when the provider is not an employee of the institution." The researchers attribute this to the "divided loyalties, additional duties, self-selection, and the constraints of institutional policies and routine practices" that influence care providers like nurses (Hodnett et. al. 2003:20).[5] Since the first studies on labor support were published, clinical research on doula care has been extensive, and has repeatedly been shown to be associated with lower rates not only of cesarean deliveries, but also of pain medications, induction of labor, forceps and vacuum deliveries, and postpartum depression (Hodnett and Osborn 1989; Hodnett et al 2003; Hofmeyer et al 1991; Klaus 1986; Kennell 1991; Sosa 1980). There have been no documented drawbacks to doula care.

Scope of Practice

A doula's scope of practice is important; what a doula does *not* do in the birthplace is often as important as what she does do. Because doulas are not licensed medical providers, they must be careful to not do anything that could be considered the practice of medicine. DONA has outlined the scope of practice for doulas, which has become both formally and informally standard. Doulas do not perform any clinical assessments of either mother or baby before, during, or after the birth. Any type of medical diagnosis or treatment, such as vaginal examination, assessment of fetal heart tones or maternal blood pressure, or

[5] Trials included were conducted in Australia, Belgium, Botswana, Canada, Finland, France, Greece, Guatemala, Mexico, South Africa, and the United States, and were all conducted in hospitals. The review describes "remarkable consistency in the descriptions of continuous labor support across all trials" (2003:13).

administration of medication is considered outside the scope of a doula's practice.[6] Areas of individual expertise, such as massage, herbalism, aromatherapy, or other complementary and alternative medical techniques, are considered gray areas, and although doulas may recommend or utilize such therapies with their clients, they are encouraged to do so outside their capacity as a doula. Many doulas do have a working knowledge, for example, of acupressure points or herbs to stimulate contractions, and in my experience, will usually not hesitate to share this information with clients, if they have asked for it. However, they are also usually careful to specify that they are not prescribing or recommending an alternative therapy, just sharing information that the client may want to talk with a health care provider about. There is some debate among doulas as to the propriety of using or recommending alternative therapies, but since individual doulas, their clients, and their health care providers vary so considerably, the consensus usually comes back to reliance on best judgment.

Doulas vs. Midwives

One of the most frequent questions doulas answer about their scope of practice is how their work is different from that of midwives. This question reflects common misconceptions about midwives as much as it reflects the relative newness of the doula role. Because of the marginalization of midwifery in the U.S., many people believe that midwives are basically doulas – that they provide hands-on care and reassurance, and little else. While some newer representations of midwifery in the media, such as *The Business of Being Born,* are beginning to remedy these misperceptions, most people do not realize that midwives are primary health care providers whose scope of practice includes clinical skills and responsibilities that far exceed those of the doula. While doulas' training involves a weekend

[6] There is an exception to this: Birth Arts International offers monitrice training and certification. A monitrice offers non-medical labor support in addition to a limited set of clinical evaluations, such as vaginal exams, blood pressure monitoring, and fetal heart monitoring, often in the early stages of labor before the parent(s) go to the hospital for the delivery. Relatively few doulas offer monitrice services; because these tasks can be considered the practice of midwifery or the practice of medicine, a monitrice may be open to prosecution for practicing medicine or midwifery without a license, depending on the state's laws.

training workshop and an educational process that typically takes less than a year, midwifery training typically takes 3-5 years and involves extensive hands-on clinical training and rigorous educational preparation.[7]

Midwives, like physicians, are responsible for providing comprehensive prenatal care, assessing maternal and fetal health through monthly checkups and screening for pre-eclampsia, gestational diabetes and other health conditions that could affect pregnancy and birth. Although they may collaborate with, or refer clients to obstetricians, if warranted, they attend births as primary and independent care providers. They assess maternal and fetal well-being throughout labor by monitoring the fetal heart rate and maternal vital signs; they are responsible for delivering, or "catching" the baby, which may involve managing complications such as shoulder dystocia; and they are trained and equipped to manage postpartum and newborn care, which may include controlling hemorrhage, suturing perineal tears, and neonatal resuscitation. They attend births in homes, hospitals, and birth centers. Midwives attending home births usually carry a comprehensive assortment of medical equipment to births, such as oxygen, anti-hemorrhagic drugs, local anesthetic and suturing equipment, and handheld fetal monitoring devices. [8]

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[7] Because there are two types of midwifery certifications in the United States: the Certified Nurse Midwife (CNM) and the Certified Professional Midwife (CPM), and because some midwives, especially those in states that don't recognize the CPM credential, choose not to certify, the training processes for midwifery vary. I have described elements of midwifery training that are typical and common for both CNMs and CPMs.

[8] Some state statutes place restrictions on the types of drugs and medical equipment midwives can carry. Whereas obstetricians have specialized training in the care of high-risk pregnancies and births, and in surgical delivery, midwives care for clients who are in good health, without potentially complicating health conditions. Because they only care for low-risk, healthy people, it is rare that midwives encounter birth emergencies, but this does not mean that they are unequipped to handle them. A significant portion of midwifery training involves emergency management and risk assessment, including differentiating situations that fall within the midwife's scope of practice from those that require the transfer care to a physician. National statistics on planned home births with Certified Professional Midwives indicate that the rate of transfer from a planned home birth setting to a hospital is about 14%, with about 4% of those transfers requiring cesarean delivery (Johnson and Daviss 2005).

In contrast to midwives, doulas have none of these clinical responsibilities. While some doulas undertake their work as a step toward a career in midwifery, many doulas have no interest at all in becoming midwives. Leah Summers in Iowa exemplifies this position:

> There's such a full responsibility in the care of women and children. I so much admire the strength of midwives, and I'm so enchanted by the profession, and I would absolutely love to be a midwife, but I ultimately don't want that level of responsibility. I'm just the doula. I'm not in charge. The midwife is in charge. I'm part of the team and part of a connection to helping a woman achieve her goal, but holding that ultimate responsibility in place is other women's work.

Being a doula allows those who are drawn to being with women during childbirth a way to do so without the "full responsibility" of safeguarding the lives of two people. Doula work is similar to midwifery in that it involves many of the same extreme occupational commitments, such as living an on-call lifestyle. In order to be a doula, one must be willing and able to be called away to a birth at any moment of any day or night. Many doulas explain the rigors of the on-call lifestyle on their websites and contracts, in order to convey to clients the sacrifices doulas make to attend births, and to justify their fees. This example, from the Big Belly Doula Services website, is representative:

> Although I am dedicated to this work, being on-call all the time requires a very high level of personal sacrifice, including a willingness to be awoken after half an hour of sleep to go attend a labor for the next 40 hours. About 25% of my clients have some kind of early labor which starts and stops, resulting in multiple phone calls – often in the middle of the night. In past years, I have spent my birthday at a labor, my family spent Christmas day without me, I've had to cancel (and then reschedule) numerous classes and appointments, and find middle-of-the-night childcare when my husband was away on business…. I cannot take weekend trips away from the area, and even day trips have to be judiciously chosen. I never know what I'm going to encounter at a particular labor - I may end up wearing out my body supporting the woman in different birth positions; I may take catnaps sitting in a chair; I may eat nothing but crackers and dried fruit; I may end up holding a vomit bowl for someone vomiting with every contraction during transition; I may end up with blood, meconium or worse on my clothes. Thank goodness I LOVE my work! [Big Belly Doula Services 2012]

Although this description may seem exaggerated, I can attest that it paints a perfectly accurate picture of the unpredictability of a doula's life. The doulas in my study cited these

challenges as the hardest part of their work, but like the description above, they also tended to say that the rewards of doula work make up for the hardships. Allison Gray from Virginia compared her work to that of her friends who have more typical office jobs:

> A doula's work is difficult because being on call limits your lifestyle. However, the rewards are greater than any other profession. When my friends come home from work, they've written emails and held meetings; when I come home from work, I've watched a woman push a baby out of her body and held a new life in my arms.

Similarly, Emily Carothers in Vermont describes the feeling of personal fulfillment she derives from attending births:

> The difficulties surrounding being a doula involve long hours, and low or no pay. But it is an amazing feeling to witness the newest human being on the planet. It brings about a peace in my soul that is certainly not seen in other professions.

Doulas tend to see these hardships of "long hours and little or no pay" as a necessary tradeoff to the privilege of witnessing an event of such power and significance. As another doula said, "I am as filled as I am depleted after a birth."

The Economics of Doula Care

The stated vision of DONA International is "a doula for every woman who wants one." This vision is echoed by many of my study participants, like Anna Johnson from Michigan, in sentiments like, "I would like to see it grow more and become accessible to anyone and everyone who wants/needs doula care." Despite these goals and intentions, the concern that not enough people are able to access doulas is an issue that came up again and again in my surveys and interviews. Doulas link limited access to doula care to two major causes. The first is lack of widespread awareness about what doulas do. Many doulas expressed frustration about this. As Maggie Harper, a doula I interviewed, put it:

> A lot of people don't understand what a doula does or why it might be nice for them to have a doula. The number one reason I hear that people don't want a doula is that they want privacy. And they think the doula is going to be this 5th wheel, and be in the way, and ruin intimacy. I think there's a lot more public education, awareness, and outreach that could be done. The DONA motto is "a doula for every woman that wants one." Well, the problem is not that many women

> want one right now. And I feel like if women and their partners better understood the value of having a doula, a lot more people would be wanting them. Doulas are really great – not just for the laboring woman but also for her partner.

The second major reason doulas identified for why people lack broad access to doula care has to do with a certain insularity characterizing the doula community itself. Doulas perceive this as an unfortunate and unintentional circumstance, caused by the fact that often, both being a doula and using a doula are tied to economic and social privilege.

To illustrate, when I asked about the weaknesses of the doula profession, many doulas in my study responded with complaints like, "the assumption that doulas are only for the wealthy," and "I feel that doulas in our society are considered a luxury item," and "it has become more of a status symbol for white women with money than it has become a support available to every woman birthing." While many doulas are actively working to remedy this, they often find it difficult to make their services accessible in terms of cost. Even when doulas are paid in full, they find that is difficult or impossible to make a living working as a doula. When I asked Gloria Rose, one of my interviewees in Iowa, whether she felt doulas were paid enough, she laughed and said, "Sometimes I lose money in [paying for] childcare. It's getting better now that my kids are older, but by the time we do all the prenatals and postpartum visits, if it's a really long birth, I'm losing money."

Similarly, Beth Curtis, an Iowa doula in training, described her difficulty with attending births for low- to no cost, which is typical for new doulas, or those attending the births that will count toward their certification:

> I've been encouraged to start charging, but I haven't, because the majority of people who are contacting me are doing so because I'm new and in training, and because they can't pay the full fee. And I'm in that boat, too. I understand. And I want to be able to do that, but at the same time it's becoming more of an issue because I've had some really long births, and – looking at what I was compensated hourly, and missing work without [compensation]– it's just hard.

Beth's own position as someone with a lower income puts her in a bind. She is especially attuned to the financial strain of her clients, which makes her hesitant to begin charging for her services, but she also recognizes that doing doula work is potentially putting her, like

Gloria, in a position of hardship. Edith Dunston in Maryland echoed these material concerns related to doula work:

> My work outside of doula work is completely unrelated. I really like it and it pays the bills. More importantly, it pays my health care bills. Without my day job, I couldn't afford to be a doula, because I couldn't afford my medical insurance. Isn't that ironic?

This concern about being able to "afford to be a doula" reveals one of the reasons that doula care is not available to more people. Not only is being able to afford doula services an issue, but being able to afford *to be* a doula is a problem. Doulas are right to observe that it is often a marker of privilege both to have a doula and to be a doula.

One solution to the problem of client access to care is for doulas to attend a certain number of births per year at no cost. Many doulas see this as a matter of course, and as part of their obligation to give to their communities. However, some doulas see this strategy as exacerbating the problem. Hazel Davis in Oregon, said:

> Doula organizations could do a lot more, in my opinion, to help community doulas from constituency populations, like myself, to access training and stay in business. We need to make money to make this work. Affluent volunteerism is hurting our profession and making it into a privilege. We should ALL expect a fair wage from all clients who can afford it. This is how we lift up the dignity and legitimacy of traditional women's work. Additionally, organizations such as public health agencies, Planned Parenthood, and social service agencies should be hiring doulas, and doula organizations should advocate for this. We have to leverage resources for low-income, single, and women of color doulas. Having doula associations is not enough. The lifespan of a doula is way too short and we have the most inexperienced doulas doing the free births for the most needy clients because those with experience can't make a decent living to stay in the business or take on volunteer births. Can doula associations fix this?

Hazel sees the solution as resting in the hands of doula organizations and other social service agencies, rather than individual doulas undertaking "affluent volunteerism." She recognizes that women's work is being devalued in the private, fee-for-service model of doula care, and that funding for doula services must be institutionally valued as a social good in order to be accessible to both doulas and those seeking their care.

Even though private doulas tend to work within privileged communities, their position as caregivers still places them in a class of women whose work is marginally paid and often undervalued. The use of the word "doula" and the association of labor support with servant work is not insignificant. Doulas work for hours, and sometimes days on end, often without sleep, food, or relief, performing tasks that are menial and sometimes difficult. Because of the maternal overtones of doula work,[9] there is some tension around whether women become doulas as a career, or as a calling. This question reflects central concerns and assumptions about gendered economic determination and the nature of women's work, paid and unpaid.

The Emotional Labor of Doulas

The vast majority of doulas in my study have other jobs in addition to doula work. Out of 156 survey respondents, only 2 said they are full-time doulas, and 9 identified themselves as full-time doulas and stay-at-home mothers. The vast majority are employed in other caring professions, such as: child care; work with victims of sexual assault, child abuse, and domestic violence; care for the elderly and those with disabilities; hospice care; and education. Many were students, and many work for non-profit organizations. It is also common for doulas to do other forms of birth-related work such as lactation counseling, childbirth education, and placenta encapsulation,[10] as well as other forms of bodywork, such as massage therapy and yoga instruction.

Whatever other profession they have, the vast majority of doulas in my study see their work as connected to a larger goal or calling that structures everything they do. Many

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[9] "Mothering the mother" is a common catch-phrase and the title of an early book on doulas (Klaus 1993).

[10] Placenta encapsulation is a process by which the placenta is dried, powdered, and put into capsules to be ingested by the mother in the postpartum period. A practice rooted in Traditional Chinese Medicine, human placentophagy is becoming more common in the U.S. Proponents claim that placenta capsules improve postpartum health by replacing nutrients and hormones present in the placenta.

identified that larger goal as related to the education and empowerment of women and girls, as Anna Johnson's response exemplifies: "I teach sexuality education at a local alternative high school where I also mentor students. Many of them are teen and young parents. It is not related to my doula work but is part of my broad social justice and education goals." Even when doulas have another job in an unrelated field, they tend to make connections. For instance, Gladys Ingham in Virginia said she works as an Internet technologies business analyst, but that these occupations are connected because "they both require me to listen to what people are saying and find the true underlying need." The most common connection doulas made between their doula work and their other work was that of helping. As one doula, who is also a nurse at a county jail said, "I am a helper and healer by nature."

Considering the fact that doulas experience their work as of a kind with other forms of emotionally-based "helping" work, it is important to attend to issues of women's work -- in particular, affective labor, which is naturalized as essentially feminine. In theorizing emotional labor, Arlie Hochschild observes that of all women working, roughly one half have jobs that require emotional labor, and that "Emotional labor does not observe conventional distinctions between types of jobs" (2003:11). Hochschild argues that emotional labor involves displays of "seeming to love the job" which requires both "surface acting" and "deep acting" – practices which actually transform the personalities of the actor (2003). In the case of doula work, a substantial emotional investment is involved, and doulas certainly play affective roles that require acting the part. However, doulas speak less of learning to love their work, and more of ways in which the power of witnessing birth is genuinely and deeply emotionally affecting and transformative, often surprisingly so. As we have seen, this is often what draws and keeps doulas in this profession. For example, Cray Gardiner, an Iowa doula I interviewed, told me about the first birth she attended, before she had any children of her own:

> I was just blown away by how powerful the experience itself was. I just didn't realize how magical it was going to feel, and what kind of an impact it was going to have on my own life. I'm certain in my own

> world that that experience was probably what planted the seed for me to keep being involved in the birth world and to have home births myself.

Similarly, for Iowa doula Leah Summers, the first birth she attended was an intense emotional experience, and a turning point in her life:

> It was a home birth and it was great. I cried, you know? I walked into the door at 2 in the morning, and I could hear her moaning, and I just started crying, because, you know, it had only been 2 years since I'd given birth but it was just that overwhelming familiarity, and I think part gratitude that I wasn't experiencing it! [laughs] And holding the space for her – it was just so moving.

Like Leah, many doulas spoke about feeling the emotional intensity of birth as a bodily experience. For instance, Wave Azul, also in Iowa, describes:

> My favorite thing is when that baby is born and lying on that mama. I just want to cry. I feel like my whole body gets warm. And I like holding babies. I always get a pang in my breasts, like I think I'm going to leak milk, even though I don't have milk. I love it. It reminds me that we're animals, we're human beings, that we need this. Because we walk around every day pretending that we don't have bodies.

For Wave, the reality of our bodies and our bodily experiences are an essential part of what makes doula work meaningful. This is not to say that there are not aspects of this work that are difficult to manage, both emotionally and physically. Wave went on to describe the physical labor of doula work:

> It's hard! Sometimes you're just exhausted. And sometimes, you know, that mama has figured out that you rubbing her back is the best thing in the world. And about 3 hours in, you feel like you're going to die. And those are actually the moments where I'm thinking to myself, "I'm forty [years old] now. I don't know if I can do this anymore. Maybe I shouldn't do this anymore." I have thoughts like a woman in transition, like "I think I need an epidural!" [laughs] Physically it's more difficult than people say.

The combination of physical and emotional energy required to attend births as a doula, along with the interpersonal challenges that often arise in hospital settings, combine to make doula work intensely challenging. This fact can be easy to overlook, and is downplayed in popular representations of doulas as hand-holders.

The difficulty of what a doula does is often not appreciated by clients until after the birth itself. For instance, in postpartum contact with clients, it is common for doulas to hear, especially from male partners, that they didn't have any concept before the birth of how the seemingly small and simple things a doula does would add up to be so "life saving." Despite the fact that parents often describe the assistance of their doulas in hyperbolic terms, doulas themselves are taught to downplay their own work. In doula trainings and publications, experienced doulas often model the idea that receiving thanks after a birth is a sign that the doula did not do enough to help the birthing woman feel her own strength. As an example, doula Angela Horn wrote in the *International Doula*:

> At the end of our journey, I don't want [my clients] to feel that they couldn't have done it without me. I want them to say "We did it!" meaning that I held the space and assisted them in discovering the tools they needed to step out into this uncertain journey in confidence together, discovering their own power and that of their partner. [Horn 2010:7]

The doulas in my study also reflected this idea. Claire Peterson in Iowa told me, "I don't want her to think of me later on. She can say, yeah, I had a doula, but when my client forgets to call me, I take that as a compliment." While Claire seems to have fully embraced the idea that her presence as an individual beyond being simply "a doula" is unimportant, the disavowal of the importance of one's work can be difficult. Wave describes an instance of talking herself out of wanting credit for the work she did, and her own conflicted feelings about this:

> Recently, [a client] was saying something about her birth, and she was describing this thing that her husband did that I clearly remember that *I* did; he did *not* do it. And there was this moment where I felt pouty, like I want credit! And then [I told myself], "Okay, just forget it. Let the dad have the credit." Those [situations] are tough sometimes in terms of ego. This idea that it's a good birth if someone doesn't remember you … We don't need flowers and chocolates and streamers in the sky, but I think it's another way to discount women's work.

Wave brings up an important tension doulas contend with: how does one simultaneously claim the value of women's work in birth, while devaluing one's own work as a doula? Jamie

McCall in Wisconsin offers an explicit critique of doulas' devaluation of women's caring labor:

> It is an undervalued profession in almost every aspect. Doulas themselves undervalue their work. Because the word doula means "woman servant," like many service professions, women are providing services that many just expect them to do because they are women (help a friend have her baby, stay up all night, be "on-call," assist with breastfeeding, provide suggestions and resources, care for infants and children, nurture, etc. And accepting a fee for these services (regardless of education, training, experience, expense, time, and energy) is often questioned.

Another survey respondent from Wisconsin, Sonya Carpenter, spoke to this issue. She said that doulas "poor themselves out" to serve the birthing family. While this response was likely an error of typing or spelling, I found it an apt one.

The extent, and the ending, of doulas' relationships with clients is also often a challenge. Cray pondered these questions:

> When you're someone's doula how long does that mean? Are you their doula for life? What kind of relationship is that? What are the bounds of that? I know that all doulas say "this is when I'm on call for you," but what is the policy around that, and where does that relationship end? *Does* that relationship end? *How* does it end?

The ending of a doula relationship is often difficult, because intense bonds have been created. Many doulas experience the final postpartum visit, at which payment is often collected, as especially awkward. Not only is the relationship ending; both parties are also acknowledging, through payment, the fact that doula care is paid labor, which diminishes its perception as a "pure" expression of love or care.

The Face of the Doula Community

Many of the doulas in my study who expressed concerns about the accessibility of doula care cited the homogeneity of the doula community as a barrier. As Merrie Whitley in Michigan said,

> We're a bunch of white women subsidized by partners (myself included). If we're not or we opt to ensure we're making a living wage, we may be cutting ourselves off from those who need us most. And honestly, there will be people who NEED the more experienced

> members of our community that simply will not EVER have access to them.

Merrie points out a vicious cycle related to success as a doula: those who are the most experienced tend to charge the most for their services, which leads to the best doulas only being available to those with the most resources, who arguably are the ones least in need of the assistance of a doula. While many doulas described their work as having feminist motivations and outcomes, others pointed out problematic elements of the doula community. For example, Jason Epstein, a male doula from Washington, observes:

> The birth community seems diverse, community-based, and tends to fight sexist oppression. On the other hand it feels very heterosexist, transphobic, and always refers to birthers, doulas, and others as 'mommas', 'ladies' or 'sisters'.

Jason points out that the "birthing community" as a whole is well aware of problems relating to sexism, but has not yet gone beyond essentialist ways of thinking about birth, or extended that political awareness to incorporate language that is inclusive of the LGBT community. As a male doula, his perspectives are undoubtedly informed by his unique position in the doula community.[11]

Hazel Davis in Oregon critiqued the standard of professionalism for doulas:

> Internalized sexism shapes our professional standards: wear pearls, smile, don't drink or dance or swear, don't date, don't be sexy or opinionated, don't be butch, don't look or be too young, don't be "cultural," don't look or act too common, don't act too smart, be the Pious Heterosexual Archetype of Feminine Purity and Submissiveness. Very limiting.

Indeed, this is how many doulas are represented in mainstream publications such as *The International Doula.* What this doula describes is a particular performance of middle-class, white, heterosexual femininity that pervades ideals of professionalism in many spheres of American society. Hazel's analysis, however, raises an important question: does this professional standard represent a disconnect, if doulas are in the business of female

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[11] I take up issues of gender identification more extensively in chapter 6.

empowerment? And does it put limitations on who feels they can be a doula or have a doula?

The heteronormativity of the doula community is a limitation that several doulas in my study specifically cited as personally difficult. Ginger Rossi, a doula from Colorado who responded to my survey, said, "I cried the first night of doula training, convinced that there was no place for me as a lesbian in the birth world." Although there are now more opportunities for lesbian, bisexual, and queer-identified doulas to connect with each other, such as the Full Spectrum Doula Network social networking website, it can be isolating, especially in some communities, to be surrounded by representations of birth and that ignore lesbian existence and experience.

Although the doula profession is made up mostly of women, there are several male, transgendered, and genderqueer doulas practicing today. Jason Epstein in Washington described his training as "Very open to me as a male doula and a queer/trans ally," but at the same time, as "somewhat heterosexist." He decided to become a doula because, as he said, "a transgendered friend was thinking of becoming pregnant and needed someone who could refer to someone giving birth with male pronouns." The notion of childbirth as separate from femaleness represents a new challenge to the doula profession, but more than one doula in my study indicated that there is a need for doulas who are capable of making this leap.

The whiteness of the doula movement is also noted by many doulas. Wave, who has worked as a doula in several states, said:

> There are not enough doulas of color. And that was true in California, where it was much more diverse than Iowa, and in North Carolina where it was much more diverse than Iowa. There's just something missing there. And I think, in part, that could be related to the whiteness of DONA and the privileges you must have in order to attend training.

As I detail in chapter 5, there are more doulas of color now than ever before, and some doula organizations, particularly DONA, are actively working to increase racial diversity

among their members and trainers. However, there are distinctions made within the field of doula practice that reflect veiled raced and classed divisions: "private" vs. "public" doulas, and "professional" vs. "community" doulas. Sandra Morgen observes the same veiled language of class in her study of the women's health movement, and cautions that:

> As long as class (and race, ethnicity, and other power relations) structure the resources, opportunities, and textures of relationships among women, work organizations that aim to subvert or transform dominant power relations need sustained forums in which workers learn from each other and communicate directly about their different perspectives… Social movement organizations will have to go beyond promotion of diversity to respect the multiple perspectives of those who occupy different social locations and to change organizational practices that obstruct the development of truly diverse and democratic organizations. [2002:217]

The need for these conversations is acknowledged by some doulas and not at all by others. In fact, many doulas in my study told me that the diversity of the doula community is its biggest strength. These types of "sustained forums" are only just beginning to take shape within the childbirth reform movement, and where they are occurring, I argue that they are largely the result of the attunement to intersectional politics brought by reproductive justice doulas.

Feminist Implications of Doula Care

Doulas are a diverse group of people, with widely divergent political and social beliefs and backgrounds. In this way, doulas mirror other groups within the childbirth reform movement, like midwifery activists and home birthers, who represent the entire span of the political spectrum. In her 2001 ethnography *Blessed Events,* Pamela Klassen demonstrates that the small percentage of American women who give birth at home represent a wide range of ideological perspectives. Not all of them had feminist motivations for their decision to bypass hospitals and biomedical approaches to birth; on the contrary, many of the women in her study came from what she terms "traditionalist" backgrounds and beliefs, some of which include decidedly nonfeminist ideas about the subordinate place of women in society. Rather than separating her interviewees into two distinct sets of

homebirthing women, Klassen's analysis shows that "feminist and traditionalist approaches to childbirth collide and conjoin" (2001:xii).

In my research, I have observed that the same dynamic occurs among doulas. Sometimes this conjoining is expressed in individual perspectives, such as this response from Nancy Rich in New York:

> While I don't identify with the part of the modern feminist movement that supports abortion, I do consider myself a pro-life feminist. The doula work I do is definitely feminist. I support woman being in charge of their bodies and their births and don't think that the medical establishment, and men in particular, should be making decisions for them.

Some of the doulas in my study explicitly disavowed feminism, for several reasons. Martha Masterson in Iowa said "I am not a militant person and when I think of the term 'feminist,' I think of someone who is very rigid in their beliefs." Oyauset Owens in California said she did not consider herself a feminist because "feminist movement was created for white women to have a place among men." Some said that they identified themselves, but not their work, as feminist because, as Alison Gray in Virginia put it, "personal beliefs should be checked at the door when helping a client." For others, feminism and birth work is intrinsically tied. Megan Tate, a survey respondent from Oregon, said:

> With absolute certainty I consider myself a feminist, and yes, my work as a birth attendant is my greatest feminist act. When women have empowering birth experiences I see them change. I see them get bigger and stronger in their bodies. They heal from old wounds. They live the rest of their lives with the knowledge that they are powerful. It is a gift and an honor to be a witness to this.

Anna Johnson from Michigan said, "I identify as an Indigenous feminist. My doula work is part of a broader feminist goal to make life safer and more equitable for my people." Most of the doulas in my study, whether or not they identified themselves or their work as feminist, saw their work as good for women's rights in that they support women's "autonomy," "empowerment," and "informed choices," and because they help women feel strong in their bodies.

A few doulas asserted that birth is "not just about women" – that it is also about men, and about babies who may be male or female. Interestingly, for some doulas, this sentiment was the basis for rejecting the idea that doula work is feminist, while for others, it was linked to feminist principles. For instance, Jason Epstein said,

> While I certainly think of myself and my work as feminist I also think of it as support for all genders. I recognize that women have been oppressed and experience trauma around birth. While there are people who are not women who give birth, most people who give birth identify as women and I hope to use my role and privilege to support their choices and safety.

The diversity of doulas' perspectives on feminism, gender, race, and doula care is emblematic of the fact that the meaning of feminism is, of course, not monolithic. It is important to attend to feminist implications of doula care as a facet of women's health care, which has never ceased to be political.

Reform vs. Revolution

In 1982, Barbara Katz Rothman, reflecting on the childbirth education movement and the embrace of Lamaze "prepared childbirth" by hospitals in the U.S., offered this assessment:

> It is widely held that the childbirth practices developed in the 1920s, including heavy medication, make up "traditional" childbirth, and that childbirth preparation is a revolution against that tradition. That is not what happened. The childbirth preparation movement, far from being a revolution, is at most a reformation movement, working within the medical model. [1982:79]

The distinction Rothman makes between reform and revolution echoes a persistent and often divisive issue for feminists, one that was particularly contentious around the time she was writing. As feminists began to apply Marxist analysis to theories of gender oppression, they not only made connections between patriarchy, capitalism, and the sexual division of labor, but they also identified two contrasting strategies for feminist action. Put simply, liberal feminism is understood to be concerned primarily with individual rights, freedom, and choice within extant political structures (such as capitalism), whereas radical feminism is

interested in dismantling those structures altogether. Furthermore, as Catherine MacKinnon explains, "for radical feminism, although the person is kept in view, the touchstone for analysis and outrage is the collective 'group called women'" (1989:40). The approach of liberal feminism is considered reformist, whereas the radical feminism represents the goal of revolution.

The radical critique of liberal feminist approaches contends that "they do not challenge the existence of the state, but only challenge its ideology" (Eisenstein 1981:349). MacKinnon explains that liberal feminist reform "tends to focus on the individual as if social life were constructed of an amalgam of independent and solitary individuals, so that social change is a matter of moving their lives one by one" (1989:52). According to this model, because doulas focus on helping women individually within the medical system, rather than dismantling the system itself, they are reformists, not revolutionaries. The doula's job is to make the hospital birth experience more palatable for women by adding an element of encouragement and support. The fact that such comfort and assistance is usually experienced positively by birthing women is a mixed blessing, from a revolutionary perspective. While the birthing conditions of individuals are undeniably important, it could be argued that adding to their improvement in the hospital only works to keep women a compliant part of that system, and does little to question whether healthy women should continue to be routinely hospitalized, medicated, and operated on during birth.

A division of loyalty between reformist and revolutionary strategy can certainly be seen among some feminists. Others, however, have argued that it is more useful to view reform and revolution as complementary approaches, rather than as mutually exclusive. For example, Sandra Harding argues against such a dichotomy: "…The kinds of actions thought of as only reforms can and frequently do play a crucial role in bringing about large-scale social changes; the supposedly revolutionary kinds of actions sometimes do not threaten the prevailing system at all" (1976:273). Harding contends that the role of reform has gone undervalued, and that reforms are often a precursor to more monumental changes. In the

end, she encourages feminists to evaluate their actions only as they contribute to the ultimate "feminist goal of a non-oppressive society" (282).

Doulas, similarly, relate their work to a single overarching goal: that of helping women have the births they desire. This kind of stance problematizes revolution, at least as it is usually understood, as a single, fundamental, and sweeping change. Just as feminists have found that there is no one vision of a "non-oppressive society," doulas understand that birthing women's needs and preferences are extremely diverse. As doulas work to accommodate such a proliferation of desires in birth, they mobilize multiple strategies, both ideological and material. The tension between reform and revolution, and between individual and institutional change, can be observed in several elements of doula care, all of which have important implications for feminist theory and action.

Humanizing Birth

In 1982, Barbara Katz Rothman's *In Labor: Women and Power in the Birthplace* examined American childbirth practice from a feminist perspective, and conceptualized a fundamental difference between two approaches to birth: the medical model and the holistic model. In this schema, the former approach is characterized by its treatment of birth as pathological and need of control and the latter by its belief that birth is a normal process in need of support. This distinction gave legitimacy to the homebirth and midwifery movements, tied them to feminism, and provided a new and useful set of terms within which to advocate for women-centered birth practices.

Informed by both Rothman's analysis and the cross-cultural approach of previous works such as Brigitte Jordan's *Birth in Four Cultures* (1978), Robbie Davis Floyd published her groundbreaking *Birth as an American Rite of Passage* in 1992. Davis-Floyd performed an exhaustive analysis of the standard procedures of American hospital birth, demonstrating the ways in which they, like any set of ritual practices marking passage into a new social status, reinforce core societal values. In exploring these values, Davis-Floyd coined the term

"technocracy" and further expanded Rothman's classification of the medical vs. holistic models of childbirth, linking the holistic model clearly to women's best interests and exposing the medical model's service to institutions, and technology, and general male dominance. *Birth as an American Rite of Passage* was an explicitly feminist text. Through ethnographic interviews, Davis-Floyd explored how women interpret the cultural messages that are sent through different ways of managing birth, with the conclusion that midwife-assisted and out-of-hospital birth practices allow women to cross into the state of motherhood with an intact and renewed sense of selfhood and agency.

More recently, Davis-Floyd has expanded on the oppositional framework of technocratic vs. holistic birth and has conceptualized a third, mediating model: the humanistic approach (2001). Characteristics of this model include mind-body connection (as opposed to the strict separation of the technocratic model or the radical oneness of the holistic paradigm); mutual decision-making and connection between practitioner and patient; focus on disease prevention; openness to alternative healing modalities; and balance between the needs of the institution and the individual (2001:S10-S14). Humanism, Davis-Floyd explains, originated "as an effort driven by nurses and physicians working within the medical system to reform it from the inside" (2001:S10). As doulas have become a more mainstream element of maternity care in the U.S., the "inside" is precisely where they have found themselves.

Rather than calling technobirth into question, humanists wish to "make it relational, partnership-oriented, individually responsive, and compassionate" (Davis-Floyd 2001:S10). Unlike the direct-entry midwife, who functions as a sort of hero of the holistic model, the contemporary doula is not a radical challenger of the conventions, or even the very premise of hospital birth. She is a distinctly non-oppositional force, humanizing but not openly criticizing mainstream obstetrics. This position is logical, considering that doulas must constantly serve as a bridge between the desires of birthing women and the protocols of the medical system in which they practice.

Christine Morton argues that "doulas represent a middle ground between the currently polarized perspectives of medical and midwifery models of care, with the potential to expand public awareness of midwifery but also to be absorbed into, and thus, uncritically accepting of, medicalized childbirth" (2002:9). I am also interested in the ways in which doulas humanize birth care, and bridge the medical and midwifery models of care, and I seek to expand this argument by attending to the means by which doulas may be able to humanize the birth experiences of those most marginalized in maternity care.

Care and Feminist Ethics

The dynamics that underlie doulas' interactions with hospital staff are wrapped up in the gendered politics of care, and for this reason, it is useful to analyze them through the lens of feminist ethics. In distinguishing a feminist ethics of care, Rosemarie Tong stipulates:

> Any ethics of care that can safely and accurately be termed "feminist" must distribute the weight of moral responsibility equally between the genders, not only by requiring women to be just as fair-minded as virtuous men supposedly are, but also by requiring men to be just as attentive to other people's needs as virtuous women supposedly are. [1999:34]

Tong's claim is applicable to the ethics of doula-physician relationships, even though not all physicians are necessarily men. Doulas occupy a subordinate and feminized position in relation to physicians, whose authority may be interpreted as an effect of patriarchy regardless of their sex. Doulas are repeatedly asked to extend themselves to build connections with physicians – an action necessary if they are to care for their clients. The rationale is that if the doula attains a good reputation among medical care providers, those providers will be more willing to work with her and her clients in a positive way, leading to better birth experiences.

In doula trainings and in publications such as DONA's *International Doula* (*ID*), communication with health care providers is a substantial topic. The doula's mediation and negotiation skills are considered essential for avoiding any conflict that might arise in the birthing room. "Doulas never interfere with the relationship between client and care

provider. It can be a challenging task at times – requiring tact, patience, and good reflective listening skills," writes a contributor to the *ID* (Worzer, quoted in Young 2002:16). The doula is sometimes encouraged to rationalize the disrespectful behavior of hospital staff to herself and her client, as in this article titled "Working With Difficult Caregivers": "Sometimes it helps to remind the client privately of possible reasons for the caregiver to act or speak thoughtlessly, e.g., he has several patients in labor, she is tired, he may have personal issues going on, etc." (Lane 2000:13).

Doulas are also encouraged to send thank-you notes to hospital personnel "for working with you [the doula] as part of the team" (Keon 2001:11). While courteousness, diplomacy, and thank-you notes are indeed useful tools in building positive professional relationships, the doula is often expected to bear an uneven share of responsibility for the development of these relationships. According to Tong's assertion, a feminist ethics of care would structure this relationship a bit differently: the physician would be equally responsible for reaching out to establish and maintain contact with the doula. Thank-you notes would circulate both ways.

Feminist perspectives on the ethics of care express caution about demands of endless caring, "lest female caregivers fall prey to the notion that caring is their duty whether anyone gives them anything in return" (Tong 1999:40). Tong argues that "what makes an ethics of care feminist is not only that it celebrates values like caring, but also that it refuses to permit a value like caring to 'trap' women by requiring them, but not men, to tend to others" (34). Guided by these premises, I explore doulas' interactions with various care providers in chapter two.

Feminist Epistemology and Authoritative Knowledge

In her essay "Feminism, Medicine, and the Meaning of Childbirth" (1990), Paula Treichler argues that "the problem of traditional childbirth for women is not rooted in medicalization *per se*, but in monopoly: monopoly of professional authority, of material

resources, and of what may be called linguistic capital – the power to establish and enforce a particular definition of childbirth" (116). Brigitte Jordan explains that it is not the content of such definitions, but the cultural legitimacy of their producers, that determines the dismissal of certain forms of knowledge as unreliable and the sanctioning of other forms as authoritative. Authoritative knowledge, according to Jordan, is that which "within a community is considered legitimate, consequential, official, worthy of discussion, and appropriate for justifying particular actions by people engaged in accomplishing the tasks at hand" (1997:58). Because of the centrality of technology in American childbirth, and the position of obstetricians as keepers of this technology, authoritative knowledge is granted to physicians in the hospital setting, and denied to laboring women. Jordan demonstrates the ways in which the bodily knowledge of birthing women is "overridden, is ignored, is denied, or most frequently, is sidetracked, deflected, and replaced with some other definition of reality," that which is produced by doctors and machines (1997:67).

Regardless of the fact that obstetrics is a profession that men do not dominate as completely as they used to, the dynamics that deny laboring women authoritative knowledge as they give birth have everything to do with gender. Critiques of hospital birth that rely on the biological sex of patient and doctor may be becoming outmoded, but a more sophisticated analysis of different types of knowledge as gendered independently of sexed bodies is both needed and applicable. Bodily knowledge, especially that which is generated during childbirth, is figured as feminine and devalued as such, whereas scientific, quantifiable data is masculinized as it is produced, whether by men or women (Bordo 1987).

The childbirth movement's validation of non-medical forms of knowledge about birth invokes feminist epistemologies centered on revaluing the everyday, bodily knowledge and experiences of women. The apprenticeship model of midwifery education exemplifies the value placed on the experiential and the embodied:

> Apprenticeship learning involves the whole human being--body, emotions, mind, spirit – and therefore is the most powerful form of learning there is. We all learn to be full members of our cultures

> through this kind of experiential learning. Pure apprenticeship learning is connection-based, as opposed to didactic learning which can seem to take place in a vacuum, with no apparent connection to anything. [Davis-Floyd 1988:120]

Doulas also seek to provide an important intervention into the uneven distribution of authoritative knowledge by placing value and priority on women's embodied understanding of their needs during childbirth.

One of the clearest examples of this is the common scene in hospital birthing rooms in which a good deal of attention is fixed on the electronic fetal monitor, which is routinely strapped to women during labor. This device consists of two sensors, one picking up the baby's heartbeat through ultrasound, and the other registering contractions. Both are plugged in to a machine that displays these readings on a computer monitor and prints them out on a strip of paper. It is typical for nurses, doctors, family members, and others to watch this monitor so intently that all attention is diverted away from the laboring mother, who now has any number of people looking at the screen and telling her she's getting a contraction. Unless the woman has an epidural and cannot feel her contractions, this is of little advantage. No one knows better than the woman herself when she's getting a contraction, or how strong it is. One of the most valuable skills a doula can develop is the ability to assess how a woman's labor is progressing with no clinical measurements. This is done simply by paying keen attention to the mother's bodily signals, such as her vocalizations, movements, and emotions, by responding to her requests, and by asking her about the sensations of her labor. By focusing on the mother (and ignoring devices like the fetal monitor), the doula seeks to shift the attention in the room away from the instruments and machines, and toward the birthing woman as primary actor, thus privileging her knowledge as authoritative.

Launching epistemological challenges to biomedicine's monopoly on the meanings and methods of birth is an important facet of the subtle but powerful challenge doulas pose to the hegemony of standard obstetric management of birth. There is a clear belief within doula culture that a woman's experiences of her body need not be observable or quantifiable

in order to be true or valid. However, doulas are also aware of the radical disconnect between this perspective and that of the medical model. In response to this, doulas and other childbirth reformers have also attempted to secure the efficacy of alternative birthing methods, as well as their legitimacy as care providers, *within* the discursive realms of science. These attempts have focused largely on invoking the scientific rigor of evidence-based medicine, and also rely on feminist revisionings of the meaning of science and objectivity. I take up this topic in depth in chapter three.

Cooptation and Consumerism

Sandra Morgen describes the danger of cooptation as "one of the perennial paradoxes of the women's health movement" (2002:88). This is certainly also a paradox for childbirth reform efforts, including doula care. Although the childbirth reform movement has significantly expanded the options available to many women giving birth in the U.S. and beyond, the idea of natural childbirth has been arguably transformed from an oppositional discourse to one of accommodation. Whereas proponents and practitioners of natural childbirth were considered medical heretics only twenty years ago, hospitals have more recently come to embrace the idea of birth as natural, at least rhetorically. The reasons for this are undeniably complex, and are a part of a centuries-old struggle over the power to define birth in the midst of intense social changes involving medical professionalization (Leavitt 1986; Wertz 1989).

Considering the increasingly profit-driven system of American health care, the cooptation of the concept of natural childbirth seems to have more to do with the response of hospitals to an increasingly competitive health care marketplace and the demands of women as consumers than to an interest in equalizing power in the labor room or affirming the wisdom of women's birthing bodies. Mardorossian observes the effects of the cooptation of alternative childbirth methods, claiming that "by incorporating alternative models of childbirth into their delivery practices, hospitals ensure that the responsibility for

the failure of 'natural' childbirth gets shifted onto the couple's shoulders" (2003:120) and arguing that ultimately, this appropriation has the ideological effect of "the production and reproduction of patriarchal and capitalist power" (120). These issues are important for doulas as they struggle with the effects, both positive and negative, of their own incorporation into hospital systems.

Cooptation is closely related to consumerism. In speaking about "birth options," doulas rely heavily on the rhetoric of choice, which is familiar to the feminist ear, but which also reflects the values of consumer culture. There is questionable value to relying on consumerist vindications of reproductive rights. The feminist health movement of the 1970s encouraged women to approach their health care as consumers, in order to exercise their agency and transcend their subordinate positions as patients, relative to male physicians and institutions. The phrase "a woman's right to choose" is emblematic of this strategy. However, as childbirth and motherhood have been increasingly commodified[12] and neoliberal ideology has become a more powerful social force, consumerist notions of personhood and citizenship are increasingly recognized by feminist activists and scholars as having less than democratizing effects.

Examining the effects of the consumer framework for midwifery activism, Christa Craven observes that "midwifery advocates' adoption of consumer-focused advocacy strategies, in the context of the neoliberal promotion of market-based approaches to social and economic justice, has had harmful effects on the emergence of cross-class organizing efforts toward attaining reproductive rights" (2007:709). Craven argues that because economic inequality leads to uneven access to reproductive decisions, a reliance on the rhetoric of "choice" and health care "consumption" reinforces divisions among those in need of reproductive services, and inhibits effective advocacy. I bring this analysis to bear on the investigation of doula care that follows, and seek to identify ways in which the doula

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[12] See Taylor et al (2004).

movement can become more inclusive so as to effectively advocate for the needs of all birthing families.

CHAPTER 2

THE SOCIAL CONSTRUCTION OF NATURAL CHILDBIRTH

In order to fully understand the culture and practice of the doula movement, it is necessary to analyze the history, imagery, and discourse of *natural childbirth*, one of the central organizing ideologies of the childbirth reform movement in which doula care is embedded. In this chapter, I investigate the often-problematic assumptions about gender, race, sexuality, and class that have informed the social construction of natural childbirth, both historically and in the present. I outline a brief social history of the gendered, raced, and classed meanings of natural childbirth since the mid-19th century, and examine the diverse ways that feminisms have approached childbirth activism since this time. Extending this analysis into the 20th century, I survey canonical literature of the natural childbirth movement since the 1970s and into the present, and also consider feminist theoretical perspectives on nature, culture, and technology. I argue that the discourse of natural childbirth contributes to the conceptual positioning of doula care and other alternative birthing practices as a white, middle class phenomenon, and that it is important for doulas and other childbirth reformers to question the utility of this term as the foundation for an ostensibly feminist movement.

Feminism, Pain, and the Natural

> There is no doubt that the history of childbirth can be viewed as a gradual attempt by man to extricate the process of birth from woman and call it his own.
>
> Suzanne Arms, *Immaculate Deception* (1975:25)

The childbirth reform efforts that grew out of the women's health movement of the 1970s relied heavily on a popularized history of childbirth that imagined women as essentially and timelessly linked to contemporary ideals of natural birth. As the above quote from Suzanne Arms illustrates, much of the popular critical evaluation of the medical

management of birth has assumed a monolithic, unified center of command from which the systematic domination of women through the manipulation of childbirth descended.[1] However, the natural childbirth movement is not historically aligned, in a clear trajectory, with feminist motives. Indeed, there has never been any ideologically homogeneous alliance among those who call for natural birth or those who champion its medical management, and the historical relationship of feminism to ideas about natural childbirth has been inconsistent, and often contradictory. In her article "Feminism, Medicine, and the Meaning of Childbirth," Paula Treichler reminds us that "physicians did not uniformly declare a war on nature, nor did they decide that they should adopt an ideology of intervention and subordination of women" (1990:122). Indeed, the movement of birth into the medical arena could not have happened without the consent of childbearing women. Historians of childbirth such as Judith Walzer Leavitt (1980; 1986) have pointed out that women were willing participants in this shift for various reasons, some of which were informed by feminist concerns of the early 20th century. Additionally, the medicalization of childbirth did not have the same effect on all women. Instead, the movement of birth into the medical arena was an uneven process, one that involved the consent, resistance, exclusion, and exploitation of various groups of women.[2]

In the early decades of the 20th century, giving birth in hospitals and with drugs was, for some women, a means of liberation. As Robbie Davis-Floyd explains, "To give birth outside the home was to conceptually redraw the boundaries of women's appropriate spheres and hence to achieve a greater possibility of earlier escape from the enforced 'confinement' of motherhood" (1992:165). In direct contrast to the efforts of late 20th century feminist childbirth reformers, women rallying for choices in the birthing rooms of

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[1] An example of this kind of text is Barbara Ehrenreich and Dierdre English (1970) *Witches, Midwives, and Nurses: A History of Women Healers.* New York: Feminist Press.

[2] For histories of the medicalization of childbirth, See Borst 1996, Caton 1999, Fraser 1998, Leavitt 1986, McGregor 1998, Sandelowski 1984, and Wertz & Wertz 1989.

the early 20th century were demanding access to anesthesia. In fact, the first real grassroots, woman-led, mass consumer movement to make appeals for childbirth reform in the U.S. was made up of these wealthy, urban women (Sandelowski 1984). The avoidance of pain drove these women's demands. However, historians have also noted that the use of anesthesia was a marker of social class, not only because it indicated that a woman's family could afford the expense, but also because excessive pain and difficulty in childbirth, the kind that demanded medical attention, was an indicator that a woman was fragile, and therefore, both civilized and feminine (Briggs 2000; Leavitt 1986; Wertz & Wertz 1989).

In the 19th century, hysteria, or "nervous exhaustion," was considered a significant medical condition, worthy of entire treatises dedicated to its symptoms and treatments. Hysteria was intimately tied to ideas about race, femininity, civilization, and motherhood. Constructed as a disease of the uterus, hysteria's symptoms were often said to manifest in birthing rooms as long, difficult, painful labors (Briggs 2000:247). George M. Beard, a 19th century American neurologist and specialist in "nervous disorders," noted in 1880 that "for the last half century, among the upper classes of this country, [gestation and childbearing] have become pathological; they have become signs of disease" (1880:78). Hysteria was tied to both gender and social class: to be strong in body indicated one's status as working class, which was considered decidedly unfeminine. For Beard and other scholars of hysteria, the nervous weakness that characterized difficulty in childbirth was directly related to one's level of civilization: "The process of parturition is everywhere the measure of nerve-strength. Had we no other barometer than this, we should know that civilization was paid for by nervousness" (1881:76). Hence, the reputably more robust women of lower class and darker skin were said to give birth more easily and more often.

In actuality, women of socioeconomic disadvantage did not have shorter or easier labors; on the contrary, malnourishment and poor living conditions contributed to birth outcomes that were less than optimal for these women. Immediate resumption of work after the birth of a child was a fact of life for poor women that reflected their lack of choice

regarding forms of labor such as agricultural production, child care, and household duties. The lack of any interval of rest in the postpartum period was a major contributing factor to maternal morbidity and mortality, leading to complications like postpartum hemorrhage (Leavitt 1986). And although physicians widely circulated stories about the ease with which nonwhite and working immigrant women gave birth, they rarely attended these women outside of their training in hospitals. It was upper-class American-born women that actually comprised the bulk of the patients that physicians had contact with; the medical discourse concerning so-called robust birthers persisted because of its rhetorical power, not because of its empirical accuracy.

While some feminist scholars like Barbara Ehrenreich have argued that hysteria can be read as a social response to changing gender roles in a rapidly industrializing society, others, like Laura Briggs, offer a reading of hysteria that also analyzes its important racial implications, pointing out that hysteria was considered a disease of "overcivilization" at a time when strict ideas of race and cultural difference were supported by the separation of human groups into the categories "savage," "barbarian," and "civilized." While barbarians and savages were considered more robust, and some argued, healthier as a result of hard physical labor, hysterical women suffered from the effects of too much civilization – lack of exercise, use of corsets, and excess of thought. This kind of disease could only have applied to white Anglo-American, upper class women, and indeed, this was the consensus of physicians at the time (Leavitt 1986:80; Briggs 2000:247). Thus, hysteria not only defined proper roles for women; it also functioned within the rubric of social Darwinism as a way of reinforcing essentialized racial hierarchies.

Nineteenth century medicine in the U.S. placed a high value on pain as an essential component of general health and healing, both physical and emotional. Belief in the curative power of pain is evidenced by the popularity of strong medications, such as emetics, that produced immediate bodily effects, and the use of techniques such as blistering the skin in order to counteract other forms of bodily trauma. Many physicians believed that pain

sensations in childbirth were not the effect, but the trigger of uterine contractions, and that the screams of women in labor eased pressure on the perineum, reducing the chance of tearing. In addition, popular cultural and medical opinion often linked suffering with love, especially in women. Maternal affection and the pain of childbirth were connected thus by Howard Haggard in 1929: "The very suffering which a woman undergoes in labor is one of the strongest elements in the love she bears for her offspring" (quoted in Pernick 1985:47). Physicians also raised concerns about the safety of drugs like Twilight Sleep, which was often administered inconsistently from one medical practice to another (Leavitt 1980). Judith Walzer Leavitt points out that American doctors also

> …lashed out against the "pseudo-scientific rubbish" and the "quackish hocus-pocus" published in McClure's [magazine] and simply refused to be "stampeded by these misguided ladies." These physicians did not believe that nonmedical people should determine therapeutic methods; it was a "question of medical ethics." [1980:157]

Clearly, issues of control and scientific authority played a role in these debates.

Sectarian physicians (naturopaths, herbalists, homeopaths, hydropaths) as well as "regular" doctors (those who would eventually embody mainstream medical practice as allopathic physicians) opposed anesthesia, but for slightly different reasons. Naturopathic physicians tended to see pain as a necessary part of life, sometimes carrying therapeutic value, but also indicating the judgments of nature. For these practitioners, the closer one was to "natural law," the less pain one suffered. This theory depended on very specific interpretations of nature, which included physical, moral, cultural, and spiritual dimensions, and depended on the actions of individuals. In contrast to the biblical literalists, for whom pain in labor was a universal law, for hydropaths and other "natural" healers, pain was "an individual punishment, totally unnatural, nonnormal, hence pathological" (Pernick 1985:53). They contended that pain in childbirth could, and should, be eliminated, not through anesthesia, but by living in accordance with nature.

As some women demanded anesthetic relief from the sensations of labor, others were more attracted to the theories of the nonregular physicians. In opposition to the use of

the corset and other constraints of nineteenth century femininity, these women sought to free themselves of hysteria, often looking to more "primitive" women, especially Native Americans, as representatives of a more "natural" state of being. In 1889, suffragist Elizabeth Cady Stanton gave a lecture urging the women in her audience to follow the example of indigenous American women: "We know that among Indians the squaws do not suffer in childbirth. They will step aside from the ranks, even on the march, and return in a short time bearing with them the newborn child" (quoted in Wertz & Wertz 1989:115). Stanton went on to explain that with nonrestrictive clothing and exercise, anyone could give birth "without a particle of pain" as she and scores of Native women did. Although Stanton presents her "squaw" in an idealized manner, her allusion to native women as "uncivilized" is an integral part of the logic of her argument.

Feminists like Stanton were correct in blaming certain practices of the upper class, such as the use of corsets, for a host of health problems for women. Women who regularly wore tightly-laced corsets developed rib deformations and atrophied abdominal muscles, as well as decreased lung capacity and predisposition to fainting--all conditions which limited the body's ability to respond well to the demands of pregnancy and birth. Feminists were not the only ones to lament the effects of fashionable feminine behavior. Wertz and Wertz note that physicians such as Frederick Hollick asserted:

> Unfortunately, custom and false notions have given this melancholy state the stamp of propriety, and thrown around it the charm of fashion. The suffering invalid is called interesting, and the pale-faced debilitated creature, scarcely able to crawl about, is styled, genteel, while robust health and physical capability is termed coarseness and vulgarity. [1989:112]

But although the interests of feminists and physicians sometimes converged, they also conflicted, and women were the recipients of many mixed messages concerning proper feminine behavior. At the same time medical professionals were discouraging the model of frail femininity, women who sought greater mobility in the public sphere were demonized for abandoning their sacred duties as keepers of the home, and any suffering they

experienced in labor was seen as a result of their transgression of the rules governing the correct behavior of their sex.

While the poorest urban women, frequently homeless and/or unmarried, sought maternity care in charity hospitals as their only option, a significant number of working-class, lower middle-class, immigrant, black, native and rural women never had any contact with physicians until well into the 20th century. A combination of factors, such as poverty, geography, and cultural beliefs about the impropriety of men as birth attendants meant that until childbirth in hospitals became standard between the 1930s and 1950s, these women used midwives and other informal networks of women to assist them in childbirth, not physicians (Leavitt 1986:78). The transition from home to hospital birth was dependent on the increasing privatization of hospitals, and the growing number of upper class women subsequently choosing to give birth in institutions that physicians promoted as modern, safe, and comfortable. It was not apparent, however, even in the midst of this transition, that hospital birth or the use of anesthesia was actually better for women or babies. In a popular manual for women written in 1935, Claude Edwin Heaton acknowledges the tensions between competing philosophies at the time:

> If childbirth is woman's greatest risk, she has a right to know it. If it is true that home delivery is safer than delivery in the hospital, expectant parents have a right to know why. Do American women demand too much relief from pain? Are too many operative deliveries being done? Is the maternal mortality higher in the United States than in any other country of like standards? [1935:xvii]

These questions mirror those of the contemporary natural birth movement almost uncannily, and indicate that women were not passive victims of increasing male medical control, but, like contemporary childbirth reformers, were actively questioning it.

While the midwifery movement today, informed by feminism, is focused on helping the mother direct her own birth experience, it was male physicians, some outwardly misogynistic, who orchestrated the first wave of the natural childbirth movement in America. Dr. Robert Bradley, who instigated the incorporation of fathers as coaches into the

birth room, wrote the still popular *Husband-Coached Childbirth* as an instructional text for men, teaching them how to properly direct their wives' actions and decisions during pregnancy and birth. In its first edition, the text sported opinions like this one from the chapter entitled "The Coach's Training Rules":

> Buster, you have to live with this baby factory. If your act of love results in the changing of your wife from a pretty, stimulating companion, a warm, affectionate, passionate lover, and a charmer who 'likes being a girl' –to a sway-backed, varicose-veined, round-shouldered slob; to a cold, frigid ('Get away from me') rejecter of affection, to a hostile resenter of a woman's role ('Men have it easy'), you have no one to blame but yourself. [1965:122]

Dr. Bradley's book is now in its only slightly less offensive fifth edition (2008), and the American Academy of Husband-Coached Childbirth boasts thousands of certified childbirth instructors who teach prenatal classes based on his work. English physician Grantley Dick-Read's 1953 *Childbirth Without Fear*, in a quintessentially postwar style, elevated the status of motherhood to mythic proportions, asserting that birth should be made more joyful for women so that they would find their natural and proper roles as mothers more appealing. Although Read and Bradley may well have had women's best interests at heart, their work does uphold traditional, even regressive, gender roles and embodies a distinctly pronatalist politics.

Race, Representation, and the Primitive Birthing Body

More recent popular literature on the virtues of natural childbirth exoticizes birth in "other cultures" in much the same way as Elizabeth Cady Stanton did, encouraging "modern" women to emulate these outsiders' "natural" ways. "Primitive" birthing women, squatting alone in the bush to give birth, are used to paint an idealized portrait of strong womanhood. Ignoring the devastating effects of encroaching "civilization" on indigenous peoples of North America, Stanton's rhetoric naturalized "the march" of forced relocation as a benign and routine aspect of the Native American experience. Stanton's description of the "squaw" portrayed her as a timeless being in some pristine forest, covering up the fact

that so many Native American women "on the march" were in the midst of a painful displacement from their homes, and that they and their newborn children were quite likely to suffer from infectious disease, starvation, or other devastating effects of forced relocation.

The way in which Stanton idealized the native woman, untouched by civilization, reflects a pervasive noble/barbaric savage dichotomy, one that is still present in many contemporary representations of natural childbirth. In the last decades, the discursive trend has shifted its focus away from Native American women, perhaps reflecting the marginalization of Native American struggles and identities in U.S. political discourse. Instead, currently prevailing depictions commonly feature women in "exotic" locations like Africa and South America. However, the effects of colonialism, and indeed any indication of the political situations or health concerns of mothers in the global south is absent from descriptions of their "primal" birthing practices.

The now classic *Immaculate Deception*, written by Suzanne Arms in 1975, was one of the first influential books to criticize hospital birth, and to call for a return to midwifery care in the United States. Named a Best Book of the Year by the *New York Times*, it undoubtedly spoke to many women and midwives. Although it articulated an important critique of the gendered power dynamics at work in the politics of obstetrical practice, *Immaculate Deception* offered a somewhat simplified history of childbirth that revolved around an age-old struggle between women and men for control of the birth process. Arms begins her second chapter with a discussion of "the primitive woman," speaking as if somehow able to get inside her psyche:

> What, then, separates primitive woman from the American woman today? Basically it is attitude: primitive woman was accustomed to seeing all of life's processes – birth, death, reproduction – take place immediately around her. Childbirth was part of the natural order of things, a commonplace occurrence, and she dealt with it matter-of-factly, instinctively, and without fear. She did not expect what we call 'pain in childbirth,' as pain to her was associated with unnatural occurrences such as sickness or injury...Woman's built-in knowledge of childbirth was something she could not articulate or explain; it was unquestioning, unselfconscious, and uncomplicated. [1975:11]

In a strikingly similar fashion, Pam England, author of the more recent *Birthing From Within* (1998), describes her encounter with Lucy, a three million year old hominid fossil, on display at the Maxwell Museum of Anthropology at the University of New Mexico in Albuquerque. Like Arms, England seeks to articulate the thoughts of a distant other:

> When Lucy was pregnant, she did not know how or when she conceived. She was not preoccupied with how many centimeters her uterus was, how many grams of protein she ate, or when her due date was. She lived moment-to-moment, unconsciously responding to her gradually changing patterns in sleep, diet, and movement as her belly grew full. The day Lucy went into labor, she didn't know how many centimeters she was dilated, whether she was one day early or two weeks late. There was no one who could communicate what she needed to do. She automatically responded to her body's messages...I became absorbed in my fantasy of how Lucy gave birth, and tried to imagine what it would be like to give birth primally, without self-consciousness. For the first time, I understood that if I tried to force, control, or give birth in any particular way, to fit a preconceived notion, it would not be "natural." [1998:13-14]

England's description, by her own admission a "fantasy," is not substantially different from Arms' musings about "primitive woman." The juxtaposition of these texts illustrates the historical tendency of some popular anthropological thought to conflate the primitive with the past, envisioning white, Western society at the top of an imagined evolutionary timeline. In England's musings, the absence of a scientific or medical discourse around childbirth is what separates "modern" women of today from Lucy. It is by virtue of her inability to measure time, cervical dilation, or protein intake that Lucy comes to signify the natural. England's vision of Lucy's "natural" relationship with her body and the process of childbirth bears no correlation to whatever Lucy's life was like in reality. There is no way we can be sure that Lucy was not frightened, ill, or suffering. Similarly, Arms' primitive woman, void of cultural specificity, seems to function solely on a precognitive level. She does not learn about birth from her relatives or her community; that knowledge is somehow perfectly encoded in her body. To further reinforce the stereotype of the intellectually lacking, yet bodily powerful woman of color, this representative of the primitive has no ability to "articulate or explain" her experience. Here, these texts seems to echo so many European explorers, who, upon

encountering peoples whose languages they did not understand, were unable to conceive of the presence of any form of communication at all (Morgan 2004:27).

This mirrors the silencing of voices of the poor and enslaved women whose bodies were used for medical experimentation in the 19th century. Schwartz (2006), Briggs (2000), and McGregor (1998) detail how slavery helped further the medicalization of childbirth and the professionalization of medicine. Schwartz (2006) argues that the development and professionalization of biomedical obstetrics and the functioning of slavery existed in a symbiotic relationship, as doctors relied on access to slaves for clinical experimentation, and slaveholders relied on doctors to ensure the successful reproduction of their labor force. McGregor looks specifically at the career of J. Marion Sims, known as the father of gynecology. Sims built his medical career on the treatment of vesico-vaginal fistulas, perfecting his surgical technique on unanesthetized slave women and poor Irish immigrants, who, according to the medical belief of the day, had a greater tolerance for pain than did middle- and upper-class whites. In his writings about the development of his surgical technique, the voices of his experimental subjects are conspicuously absent, eclipsed by Sims' claims that the enslaved women "begged him to proceed with further surgery" (McGregor 1998:51). McGregor explains, "[Sims] expressed his admiration of his African American women patients…for their ability to endure pain. They 'implored me to repeat operations so tedious and at that time often so painful that none but a woman could have borne them'" (1998:61). Sims had material investment in the idea that poor women and women of color did not experience pain, and even lauded them for that supposed ability.

Natural childbirth discourse also applies romanticized fantasies about hypernatural birthing bodies to more contemporary indigenous women. A popular video made in 1979, entitled "Birth in the Squatting Position," features five Brazilian women who took part in a study documenting the benefits of the squatting position for birth. The video begins with images of pre-Columbian pottery and sculpture depicting laboring and birthing women, a device that conceptually links Brazilians in the late 20th century to their ancient counterparts

and suggests both their timelessness and their existence partially in the past. The voiceover describes the work of the researchers: "Whilst working in the south of Brazil with Indian women, we noticed that their gynecological condition is better than that of more sedentary, civilized women. They walk a lot, and have many children. To rest, they squat, and in this position they give birth." Here, the categories of "Indian" and "civilized" are clearly set in opposition to one another, implying that to be Indian is to be void of civilization. Apart from the numerous and significant merits of the squatting position, this film, like the texts by England and Arms, represents the decision to squat as "automatic" or "built in," and the degree to which squatting might be of benefit is only rendered intelligible through the scientific discourse of the researchers.

As in 19th century discourse, these women are represented as healthier because of their more physically demanding lifestyle. One shot in the film depicts a Brazilian woman birthing her placenta, then standing up matter-of-factly and closing her robe, echoing the tale of the "tribal" woman pushing her baby out and returning immediately to work. Gendered and racialized constructions of work here reproduce the historical association of reproductive labor with productive labor. This kind of depiction of native women is parallel to the way in which European explorers understood the "deceptive beauty and ultimate savagery of blackness" in colonial encounters with African women (Morgan 2004:14). Ultimately, as historian Jennifer Morgan demonstrates, the willingness to exploit African women's labor became intimately tied to ideas about production and reproduction. She explains the material consequences of the idea that African women gave birth painlessly and with ease. These women's "pain-free reproduction (at least to European men) indicated that they did not descend from Eve and…illustrated their proclivity for hard work through their ability to simultaneously till the soil and birth a child" (2004:8). The denial of the full humanity of colonized women through the denial of their pain in childbirth, then, was essential in forming the basis of racialized enslavement in the colonial era.

In contrast to the use of natural birthing ability as a justification for racialized oppression, the discourse of natural childbirth tends to encourage cultural unity through colorblindness. The multiculturalist rhetoric that declares, "we are all one" is pervasive in natural childbirth literature, and while it is well-meaning, its excessive focus on the notion of the natural erases an essential component of childbirth: transnational politics and power. In Michel Odent's *Birth Reborn* (1986), a text that has been highly influential in the United States, Odent, a French obstetrician, details the development of the *salle sauvage*, or primitive room, at his famous clinic in Pithiviers. He describes the implications of this room, "built for privacy, comfort, and freedom of motion" in terms of cultural connection:

> After seeing how much tribal births filmed in New Guinea and South Africa resembled births in our own *salle sauvage*, I became even more convinced that there was some universal component in the behavior of mother and newborn, and that – given the right kind of environment, where she could feel free and uninhibited – a woman could naturally reach a level of response deeper within her than individuality, upbringing, or culture. [1986:13]

While certain biological elements of childbirth may indeed transcend culture, biology can never exist in a cultureless vacuum. The assumption that all women marked as "tribal," "indigenous," "natural," or "primitive" give birth in idealized "free and uninhibited" environments overlooks the considerable constraints placed on women in the developing world. The freedom from intensive medicalization and technological management of birth is arguably a trivial matter in the face of women's disproportionate suffering from the injustices of global capitalism, which often culminate in high maternal mortality. Lack of access to living wages, adequate food and water, basic health care, and decent housing are often the realities that structures the birth experiences of women in the locations Odent and others romanticize.

Childbirth in neocolonial settings bears the legacy of controlling discourse and policy regarding population, poverty, and resources. The World Bank and other international lending organizations have incorporated population control programs as a requirement for economic aid in many parts of the developing world (Hartmann 1995:125). The underlying

assumption here is a familiar one: that impoverished "third world" women of color are to blame for their poverty because of their uncontrollable fertility. The dynamics of international lending and structural adjustment programs also limit the amount of money national governments can spend on health care, which further strains the well-being of childbearing women (Van Hollen 2003). In her ethnographic study of childbirth among poor women in the Tamil Nadu region of southern India, Cecilia Van Hollen clearly demonstrates how such policies can affect the childbearing experience. The routine insertion of IUDs immediately following births and abortions in Tamil Nadu is undertaken "often without informing women beforehand and sometimes explicitly against women's wishes" (2003:142). This is a far cry from the freedom that Odent imagined "primal" women having as he attempted to create a "natural" environment for his French clients.

The tendency to homogenize women's experience on the basis of a shared, universal motherhood is also present in the book *Mamatoto*, published in 1991 by the cosmetics chain The Body Shop. *Mamatoto*, self-described as a "delightful look at birthing lore and rituals," is comprised of 170 pages of colorful photographs and pseudo-ethnographic descriptions of rituals and beliefs surrounding pregnancy and birth in a variety of "nonwestern" cultures. At times, specific groups are mentioned, such as the Tapirape Indians of Brazil, or the Dogon people of Western Africa, but there are no accompanying citations of any ethnographic studies. At other times, the writing is more vague, referring to "people in some parts of Africa" or simply "women in many cultures" (Roddick 1991:12). As the introduction informs us, the research for this book was conducted by Anita Roddick, founder of The Body Shop, in "frequent travels south of the equator" which led her to wonder, "what do we share with women in other lands? And what can our ancestors teach us?" (4). Contributing author Carroll Dunham is credited with anthropological research described in a note at the end of the text as "essential…to the development of The Body Shop's mother and baby range of products" (176). Without this note, a reader might not realize that concurrently with the publication of this book, The Body Shop introduced a specialty line of skin care

products under the name *Mamatoto*, and although no Body Shop products are mentioned in the body of the text itself, the book is clearly another product bearing the *Mamatoto* brand name. It is as though the magical herbs that The Body Shop transports straight from the jungle to their belly salve are made more potent by the image of the primitives who have used them since the beginning of time.

This dynamic is comparable to what Anne McClintock terms "commodity racism," a shift away from scientific racism at the end of the 19th century through which "the narrative of imperial Progress" was converted "into mass-produced consumer spectacles" (1995:33). McClintock describes how soap marketing strategies of this era relied on civilizing and whitening discourses and images. As she explains, "Victorian cleaning rituals were peddled globally as the God-given sign of Britain's evolutionary superiority, and soap was invested with magical, fetish powers" (1995:207). One advertisement McClintock analyzes features a black child whose skin is made white after bathing with Pear's brand soap (1995:213). This same dynamic is reproduced in The Body Shop's *Mamatoto* line of lotions and bath products, marketed to new and expectant mothers for themselves and their babies. However, in this case, images of exotic birthing mothers are used to communicate the naturalness of the ingredients and the women who purportedly use them – a naturalness with the power to redeem the Western consumer. Just as "the Victorian middle-class home became a space for the display of imperial spectacle and the reinvention of race" (McClintock 1995:34), the contemporary middle-class American bathroom, may also now display similar racialized relationships, under the guise of multiculturalism.

The Body Shop is known for its opposition to animal testing and its use of fair trade policies, but the representational politics of *Mamatoto* obscures the uneven distribution of global wealth that has very real consequences for childbearing women and babies. For instance, *Mamatoto*'s side-by-side comparison of risk factors for mothers and babies in "industrialized and non-industrialized countries" juxtaposes a list of chemicals, "Carbon Monoxide, Inorganic lead, Aluminum, Benzen" to a list of quaint-sounding precautions:

"Lying too long in the sun will cause the fetus to melt away; Sleeping in the fields at night, a jealous ghost might steal your baby" (1991:41). As Sheryl Nestel points out, according to *Mamatoto*, "the only threats which exist in the forest, village, and hilltop dwellings of Primitive women are largely imaginary, existing because of Primitive superstition" (1995:12). This comparison conceals the realities of environmental racism, and the very real dangers posed to pregnant women and fetuses by toxins from electronic waste regularly shipped from North America and Europe to Africa and Southeast Asia.

Immaculate Deception, Birthing From Within, *Birth Reborn,* "Birth in the Squatting Position" and *Mamatoto* all represent "primitive" childbirth as something to be emulated by "modern" (i.e., white, Western) women. These types of representations of birth are fueled, at least in part, by the idea that contemporary white Americans are cultureless, and that the appropriation of certain cultural practices has redemptive power (Di Leonardo 1998). Here, we see the reversal of earlier colonial tropes of redemption, whereby European imperial powers presented themselves as the saviors of natives, and thus naturalized their dominance – a reversal that nonetheless continues to preserve the primitive/civilized dichotomy.

Anti-imperialist feminist considerations of the worldwide distribution of resources contend that it is overconsumption in the First World, not overpopulation in the Third World, which is the cause for the persistence of extreme gaps in wealth and poverty. Exploitative trade policies and the use of sweatshop and child labor are also identified as major contributors to global economic inequities. In this context, it is important to note that the exoticization of childbirth is not just an ideology; it is also an industry. Although *Mamatoto* is out of print, and the *Mamatoto* line of products is no longer on the market, various other products and services are consumed by privileged mothers-to-be who are searching for a more natural pregnancy and birth experience. Such trends include the popularity of Maya Wrap baby slings, Mayan abdominal massage, the Guatemalan rebozo, Navajo Blessingway ceremonies, and Indian practices of lotus birth and infant massage. Prenatal yoga classes are often advertised to women as an ancient method of connecting

with their bodies in preparation for birth. These products and practices can indeed contribute to the well-being of mothers and babies, and facilitate bonding between them. However, the trend toward consumerism and consumer activism sets a less community-oriented tone for the natural childbirth movement. American women interested in "natural" birth and mothering may be more likely to purchase a New Native brand baby sling than to join a local political organization advocating for increased access to midwifery care. Thus, even as global flows of power and capital tie women ever more intimately together in relations of economic dependence and exploitation, mothers-to-be are becoming alienated from their immediate community through the atomizing effect of the capitalist marketplace. As Christa Craven has shown, this works to the detriment of reproductive rights advocacy (2007; 2010).

The primitive-exotic trope in natural childbirth discourse is at times problematic because it erases cultural specificity in its insistence on a cultureless "nature." Conversely, at other times, it is equally problematic in its attempts to delineate difference through its depictions of "culture." In all instances, what is missing is a consideration of political economies of power and the way they operate in a global context.

Nature, Culture, and Technology

In Western society, "nature" forms one half of an often problematic binary: that of nature vs. culture.[3] The way in which people experience birth has always and everywhere been culturally mediated. Although some birth practices, such as the use of upright positions, are more conducive to the biological needs of the mother-baby dyad during labor than others, all are deeply connected to cultural values. Therefore, there is no one socially untouched, purely "natural" way to give birth. Nature is not an innocent category, not a description of an essential, universal reality that existed before there was a word to describe

[3] The nature/culture binary and its implications for feminism is theorized exhaustively in Ortner 1996.

it. The meanings of the natural vary over time and across cultures, and are socially constructed rather than self-evident. While physiologies and ecosystems do indeed exist, humans are universally cultural, and in all cases co-mediate nature and culture, often going to great lengths to make the cultural appear natural. Brigitte Jordan argues that "the distinction between what is biological and what is social is, in many ways, purely analytic" and that "the physiology of birth and its interactional context (or the sociology of birth and its physiological context) constantly challenge all efforts to separate them" (1993:3). Nature is never separate from culture.

Technologies are also tied inextricably to the biological and social processes of reproduction. Donna Haraway's examination of the concept of nature and its relation to human-machine partnerships is embodied in the figure of the cyborg, a "hybrid of machine and organism" (1991:149), which works to subvert the boundary between nature and culture.[4] The application of cyborg theory destabilizes the category of technology in childbirth; the simple tools used by midwives in homebirth settings, such as fetoscopes, umbilical cord clamps, backup oxygen tanks, and even methods of heating water all fall into the category of technology. Inspired by Haraway, Davis-Floyd reflects on having a cesarean birth: "I could have pondered the coevolution of human and machine that started in Europe in the 1700s and led to this moment – or did it really start hundreds of thousands, perhaps even millions of years ago, the first time a hominid female sharpened a digging stick? Was it the first hunter's spear that was piercing my belly now?" (1998:256). There are no clear criteria that can be applied universally to separate simple technology from complex technology, better technology from worse technology, helpful technology from harmful technology. Jana Sawicki explains that the dualistic logic that demands the separation of

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[4] Much has been written about what it means to identify with the cyborg, what the cyborg represents, how it is exemplified in everyday life, to what extent we are all cyborgs, and how cyborg theory affects gender (Alaimo 1994; Balsamo 1996; Downey and Dumit 1997; Gray 1995). This recent scholarship has produced its own field, "Cyborg Anthropology," and some scholars draw on Haraway's theory of the cyborg to contend with the implications of reproductive technologies (Davis-Floyd and Dumit 1988).

reproductive technologies into either repressive or liberatory categories is "limiting because it detemporalizes the process of social change by conceiving of it as a negation of the present rather than as emerging from possibilities in the present" (1999:195). In order to make meaningful changes affecting the social conditions of childbirth "in the present," a return to a romanticized ideal of the "natural," for Sawicki, is an ineffectual starting place.

This pervasive split between nature and culture has sparked intense debates, especially in terms of gender. For feminists, the equation of the natural with the female and the cultural with the male has been especially problematic, and feminist theory has wrestled with how to define the position of women within this binary.[5] The idea that women and men have inherent, distinct essences relies heavily on biological difference, and reproductive capacity has, for centuries, been invoked to explain women's nature and to restrict their access to full citizenship, political participation, social status, and personal safety. The term "natural childbirth," then, is problematic from a feminist perspective, in that it participates in the association of women, particularly childbearing women, with nature, and implicitly opposes these natural women to cultural men in an all-too-familiar dichotomy. In addition, natural childbirth may function equally problematically to construct "natural" women in opposition to "unnatural" women, naturalizing procreative heterosexuality and motherhood itself, and thus upholding patriarchal values.[6] Here, the question that ecofeminist scholar Stacy Alaimo poses is crucial: "When similar myths are used for opposing ideological ends, how does one assess the terrain and intervene?" Will using the language of the natural serve the goals of contemporary childbirth advocates, or will it ultimately be used to once again bolster the relegation of women to one side of a never-ending list of hierarchical binaries?

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[5] See Bordo 1987, 1993; Butler 1993, 1999; Haraway 1989, 1991; Merchant 1981; Ortner 1996; Plumwood 1993.

[6] See Ladd-Taylor and Umansky, eds. 1998 for analyses of the "bad mother" trope, particularly Elaine Tyler May, "Nonmothers as bad mothers: Infertility and the Maternal Instinct," pp. 198-219

In addition to envisioning a fixity of fundamental nature, essentialist perspectives tend to universalize experience in a way that "takes the patterns visible in one's own time and place to be accurate for all" (Ferguson 1993:82) and can thus have exclusionary effects. The first challenges to feminist claims about a "women's experience" came from those who did not see their lives and struggles represented in the feminist theorizing of the women's movement of the 1970s. These theorists have argued that feminist theories of gender tend to be representative of primarily white, middle class, heterosexual women's experience, and thereby marginalize all others (Hull et al 1982; Jagose 1994; Lorde 1984; Lugones and Spelman 1983).

Essentialism and its attendant problems are implicated in the construction of any value system that relies on ideas of the natural. But a consideration of childbirth activism must also attend to the politics of the body, especially to the body as necessary for political mobilization. Postmodern feminist critiques of essentialism have sparked intense debates about the utility of the category "woman" itself. Anne Balsamo gives voice to the unease with which some feminists view the postmodern deconstruction of gender categories:

> After acknowledging the impossibility of biological essentialism as a foundation for the identity of "woman," feminist thinking proceeds to an analysis of the cultural construction of the body, and is immediately confronted with a discourse that gleefully joins it in deconstructing biological essentialism. In the process, feminists encounter unsolicited assistance in doing away with "the body," which served—at one point, if not now—as the necessary foundation of women's empowerment. [1996:31]

Some, like Balsamo, argue that an anti-essentialist, postmodern perspective erases the agentic subject, thereby making political action impossible. If there are no longer any women, how can there be any feminism or feminist activism? In response, theorists like Judith Butler counter that, "The critique of the subject is not a negation or repudiation of the subject, but rather, a way of interrogating its construction as a pregiven or foundationalist premise" (1992:9), and further, that the very premise that the (unproblematized) subject is foundational to political action is itself a political move, naturalizing the conditions upon

which the subject is constructed in the first place. Butler argues that to destabilize and expose the social construction of the subject is not the same thing as obliterating the subject altogether.

Attending to these questions and their implications for feminist projects, Diana Fuss (1989) seeks to "question the stability and impermeability of the essentialist/constructionist binarism" itself (2). She argues:

> There is no compelling reason to assume that the natural is, in essence, essentialist and the social is, in essence, constructionist. If we are to intervene effectively in the impasse created by the essentialist/constructionist divide, it might be necessary to begin questioning the constructionist assumption that nature and fixity go together (naturally) just as sociality and change go together (naturally). In other words, it may be time to ask whether essences can change and whether constructions can be normative. [1989:6]

This non-binary approach to the essentialist debate is useful here. While the discourse of natural birth infuses the childbirth movement, on a day-to-day basis, doulas and childbirth reformers integrate a multifaceted praxis of social change, which includes identity politics, (sometimes strategically) essentialist, social constructionist, and epistemological interventions.

In her study of the international circulation of *Our Bodies, Ourselves (OBOS),* Kathy Davis argues that the assumptions made by postmodern feminist theory regarding *OBOS's* naturalization of the biological female body prevents a serious engagement with feminist health activism and the way in which the transnational circulation of *OBOS* functions as an epistemological project (199). Davis points out that "this [postmodern] theory gets in the way of exploring what has been the most distinctive feature of OBOS, namely, a politics of knowledge that invited individual women to use their own embodied experiences to engage critically with dominant practices of knowledge" (199). Davis shows that *OBOS* "did not assume that women would automatically have identical experiences, needs, or interests simply by virtue of having a female body." Instead, the book "recognized differences in women's embodiment" and therefore was successful at "generating a transnational feminist

politics of the body" (200). Davis's analysis shows that the centralization of bodily experience does not necessarily correlate with essentialist and universalizing ideas about femininity or womanhood.

Material feminism also offers important reconsiderations of the nature/culture problem for feminist theory. Stacey Alaimo and Susan Heckman explain,

> The more feminist theories distance themselves from "nature," the more that very "nature" is implicitly or explicitly reconfirmed as the treacherous quicksand of misogyny. Rather than perpetuate the nature/culture dualism, which imagines nature to be the inert ground for the exploits of Man, we must reconceptualize nature itself. Nature can no longer be imagined as a pliable resource for industrial production or social construction. Nature is agentic – it acts, and those actions have consequences for both the human and nonhuman world." [2008:4-5]

Along with recognizing the agency of nature, material feminism also calls for a consideration of the interactions between nature, politics, and bodies, and not just on a representational or discursive level. Alaimo and Heckman go on to state, "Political decisions are scripted onto material bodies; these scripts have consequences that demand a material response on the part of those whose bodies are scripted" (2008:8). A materialist feminist approach can help us understand the perspectives of several doulas in my study, who maintain that "all birth is natural birth." For these doulas, birth is always occurring in a body (and I would add, interacting with other bodies, institutions, and politics) and is therefore never not "natural."

Doulas' Perspectives on Natural Childbirth

Among doulas, opinion varies greatly as to what actually constitutes natural childbirth. Some define it as birth free of pain medication, some think birth is only natural when there is no clinical assessment or involvement at all; some call anything that is not a cesarean "natural childbirth." Anthropologist Margaret Macdonald, who examines natural childbirth discourse in the context of Canadian midwifery, argues that natural childbirth is a "slippery concept." She notes that the definition of natural childbirth is shifting away from essentialist understandings of nature and women's bodies, toward a more individualized view

in which the naturalness of birth is defined more loosely, and "What constitutes natural birth is being reconceived and relived in ways that are more individual, contextual, and contingent" (2006:251). This new definition, Macdonald argues, makes room for the judicious use of biomedical technology and is centered on informed choice and maternal control.

I asked the doulas in my study about their perceptions of the term natural childbirth and whether they or their clients defined this as a goal. Rather than necessarily *redefining* natural childbirth, the doulas I surveyed and interviewed were more likely to either to use the term unproblematically, or to discard it altogether, in favor of other terminology. The vast majority of my respondents stated simply that natural childbirth means birth "without drugs or medical interventions." However, many doulas also said they felt this term is too vague, and prefer to use more clearer, more specific language. Alternate descriptors doulas suggested include unmedicated birth, physiological birth, normal birth, low-intervention birth, gentle birth, freebirth, and optimal birth. Echoing Robbie Davis-Floyd's realization about her cesarean birth, Natasha Hoyle in Iowa indicated, "there is no such thing as natural childbirth. Even interventions like having someone present at your birth make it not 'natural.'"

The biggest problem doulas cited with this term was the risk of inducing guilt by virtue of an inherent implication of a value judgment about birth. As Edith Dunston in Maryland said, " I wouldn't want a woman who ended up with something other than an unmedicated vaginal birth to feel as though she somehow failed to be 'natural.'" Doulas are highly aware of the fact that the use of this term can be alienating to clients, and to the general public. Christina Rodriguez from Illinois said,

> I always have issues with the term "natural" because I do not want to isolate my mothers who have elected some intervention. I know the standard is usually a birth with no medication and no interventions. I think this term is kind of pointless because it can make mothers who opted for the epidural, narcotics or any type of intervention feel less than human or like some freak. I think it can also promote feelings of guilt, so I try to stay away from it.

Doulas like Christina, who find the term natural childbirth "pointless," make important observations about the implications for their clients as individuals. I argue that it is also necessary to interrogate this framework's larger political implications.

Conclusion

Along with the rise of contemporary natural childbirth discourse has come a set of representations of birth that often perpetuate a romanticized view of birth in more "traditional" times as being inherently closer to nature, and therefore better than "modern" biomedical birthing practices. These representations hold up as ideal the bodies and birthing abilities of women coded, both implicitly and explicitly, as primitive. While the celebration of non-biomedical models of childbirth may be, in some ways, liberatory, the idealization of the primitive birthing body functions within, and helps maintain, the pervasive and pernicious dichotomies of civilized/primitive and modern/traditional that have justified a host of oppressive attitudes, policies, and practices. In particular, gendered, classed, and racialized forms of exploitation and control have been dependent on the idea that people of color, especially women, are essentially different from, and more "primitive" than, "civilized" white women and men.

To be clear, natural childbirth advocates, particularly those who work as midwives, doulas, and childbirth educators, have made important contributions to the health of disadvantaged women in the U.S. It is the larger health care system, not the natural childbirth movement, that is failing these women in the most egregious ways. But it is important to consider the rhetoric in which alternative birth practices are embedded. The romanticization of birth in "other" cultures, though not a malicious or intentionally oppressive act, contributes to the conceptual positioning of natural childbirth as a white, middle class phenomenon. This is troubling precisely because options such as midwifery care, which have been shown to reduce adverse outcomes such as low birth weight, are of particular benefit to precisely those populations which suffer most under the U.S. biomedical

model – poor women and women of color. It is bitterly ironic that the rhetorical practices of the natural childbirth movement may alienate these women and thereby contribute to the inaccessibility of low-tech, health promoting birth options. It is for precisely this reason that I wish to draw attention to the negative consequences, however unintended, of racialized representations of birthing bodies in the popular imagination.

Childbirth functions as a site of ideological potency, at which prevailing beliefs about motherhood, gender, race, and class converge. Through exoticizing representations of the primitive birthing body, popular natural childbirth literature, in many instances, works to reinforce and to naturalize pervasive social hierarchies based on race, class, nation, and culture, while rendering the actual, varied birthing conditions and experiences of a widely diverse group of women invisible. It imagines these women as artifacts or objects frozen in time, and thereby denies them full and present humanity, failing to contextualize childbirth within the realities of contemporary and historical social inequalities and power imbalances.

As I will explain in later chapters, doulas are increasingly involved in exchanging universalizing discourses of the natural for historically and politically contextualized discussions of childbirth and maternity, and beginning the difficult work of interrogating the ways in which those involved in the natural childbirth movement are implicated in the very systems of power and oppression they work to resist.

CHAPTER 3

CONTESTED EPISTEMOLOGIES: EVIDENCE-BASED MEDICINE AND THE DOULA

Since the 1990s, proponents of natural childbirth in the U.S. have relied increasingly on science-based evaluation of obstetric practice. In particular, the results of randomized, controlled trials (RCTs) and systematic meta-analyses of such research have become central components of the critique of the medical management of labor and birth. In numerous books, articles, letters, websites, and conferences, advocates of birth alternatives (both within and outside the medical establishment) are demanding that providers of maternal health services administer more evidence-based care to the women they serve. Acknowledging that the language of science carries significant authoritative power in our culture, they submit that in order to make concrete changes in obstetric practice in the U.S., childbirth reformers must speak to biomedicine in its own language.

While other health activist groups, such as those seeking research and treatment for AIDS and breast cancer, have successfully implemented this strategy (Epstein 1996; Spanier 2001), the efficacy of this approach for childbirth reform is less evident. There is considerable disagreement within the alternative birth community over whether it is appropriate to apply standardization, randomization, and other elements of scientific study to birth practices outside the medical model, and indeed whether those studies are even relevant measures of desirable care (Johnson 1997:351). Although evidence-based care seems, at first glance, like a reasonable goal, and is widely appealing to many providers of maternity care, it is a model that is also controversial, and even looked upon with disfavor by some physicians (Straus and McAlister 2000).

When calling for change in the maternity care system, doulas often rely on the rhetoric of science and evidence-based medicine in their interactions with clients and the

public. However, they equally employ non-scientific arguments, and continue to centralize the embodied knowledge of birth-givers. In this chapter, I analyze the prevalence and efficacy of doulas' calls for evidence-based medicine through the lens of feminist science studies. Rather than employing the rhetoric of science in opposition to situated, bodily knowledge, doulas work instead to highlight the connections between scientific and embodied epistemologies. The doulas in my study approach ways of knowing about the practice and experience of childbirth in a way that is much like the "strong objectivity" approach Sandra Harding proposes as an alternative to traditional understandings of scientific objectivity (1991). They do so while also contextualizing epistemological claims about birth within the larger complex of medical, legal, and cultural forces that shape birth experiences. Drawing on a Foucauldian understanding of regimes of truth, I examine doulas' perceptions of the culture of power and authority in medicine, and the role that the rhetoric of science and evidence based medicine plays in that culture.

Feminist Science Studies and Childbirth Reform

The field of science studies has generated several central questions concerning issues such as objectivity and bias, the construction of scientific knowledge, and the intersection of social forces with scientific practice (Kuhn 1996; Harding 1991; Latour 1999). Incorporating an analysis of the gendered power relations inherent in scientific enterprise, feminist approaches constitute a particularly important set of contributions to science studies. As Sandra Harding explains, "eliminating sexist bias in biology and the social sciences might require redefining objectivity, rationality and the scientific method. Eliminating the reliance on misogynistic metaphors in science could require eliminating gender itself" (1991:19). Feminist scholars of science incorporate antiracist and postcolonial perspectives (Smith 1999), reminding us that "sciences have been part of the imperial and colonial practices of [our] cultures...Scientific and technological productions are now the foundation of the global political economy" (Harding 2001:291). Feminist science studies remind us that the

discourses and uses of science are gendered, and are vitally important to institutional functions, cultural struggles, and personal identities and experience.

A feminist science studies approach opens up fruitful possibilities for analyzing the strategies of the doula movement. It allows us to examine ways in which childbirth reformers, through their engagement with scientific research methods, seek simultaneously to establish the legitimacy of their cause, and to challenge key elements of medical practice. The complex convergences of feminist concerns about childbearing with issues of biomedical authority speak to the inextricability of science and the social forces it is embedded in. Rather than focus on the impact of American culture on obstetric science, as many scholars have done quite successfully (Martin 1997; Davis-Floyd 1992), I combine a critical feminist approach to unequal distributions of power in the birthplace with Latour's (1999) understanding of the impossibility of separating science from society. I examine the production of the discourse of evidence-based care as an effect of the struggle for authoritative knowledge about birth. I historicize the use, and examine the effectiveness, of this discourse as a tool for contesting truths, and contextualize Sandra Harding's (1991) pivotal questions: Whose science? Whose knowledge?

Feminist epistemologies have been, and continue to be, central to the production of nonmedical forms of knowledge about birth. The political drive of the women's health movement sought to put embodied experience at the center of health care. The childbirth-related literature that came out of this movement, such as the now classic *Spiritual Midwifery*, included a vast collection of homebirth stories, combined with instructions for midwives (Gaskin 1977), and the apprenticeship model of midwifery education is based on an embodied model of knowledge acquisition. Likewise, as doulas seek to help their clients prioritize their everyday, bodily knowledge and experiences, doula care has become an important arena for pushing the limits of authoritative knowledge about women's bodies, and challenging the structures that police those boundaries.

The rhetorical approach of natural childbirth advocates has undergone some significant shifts since the 1970s. Childbirth activists in the 70s and 80s frequently criticized routine hospital procedures in a distinctly politicized, feminist manner. For example, In the book *Silent Knife*, Lois Estner describes a childbirth class taught by co-author Nancy Wainer Cohen, in which she demonstrates the stress of anticipating a cesarean section for failure to progress: "In class, Nancy gets her stopwatch and a knife and says, 'Okay, the males in this room have two minutes to get an erection and ejaculate. Those who fail to do so will have the tips of their penises cut off. One, two, three – go!'" (Cohen 1983:266). As this example illustrates, natural childbirth was explicitly associated with feminist critiques of gendered power during the height of the women's health movement. But during the Reagan-era backlash of the late 1980s and 1990s, as feminism was pronounced "dead," the influence of feminist rhetoric began to be eclipsed by the rhetoric of science and scientific evidence. The movement seemed to be asking, or responding to, the question that Sandra Harding articulates: "How could women and politics be producing facts that anyone should regard as serious challenges to the impersonal, objective, dispassionate, value-free facts that the natural and social sciences have produced?" (1991:108). Although the childbirth reform movement has always depended on the authority of science and statistics to some degree, in the 1990s, epistemological claims based on the rhetoric of science moved closer to the center.

Demands for Evidence-Based Care

Evidence-based medicine (EBM) is defined as "the process of systematically finding, appraising, and using contemporaneous research findings as the basis for clinical decisions" (EBM working group 1992). Interest in EBM grew dramatically in the early 1990s (Straus 2000; Stewart 2001) and although practicing physicians have passionate views on both sides of the debate over the practicality of EBM, it is being increasingly taught in medical schools and valued as an important application of clinical research. Evidence-based medicine relies heavily on randomized, controlled trials (RCTs), studies in which the enrollment of subjects

into treatment and control groups is assigned by random allocation, rather than by the conscious decisions of clinicians or patients. In addition to RCTs, the other main source for the evidence of EBM is the systematic meta-analysis of groups of such trials, an approach promoted famously by British doctor and epidemiologist Archie Cochrane. The Cochrane Collaboration, established in 1993, is an international organization of over 28,000 researchers from over 100 countries, which produces and disseminates systematic reviews of the effects of a wide range of healthcare topics. To date, they have published over 5,000 such reviews (Cochrane Collaboration, "About Us," 2012).

The Cochrane Pregnancy and Childbirth Group (CPCG) was the first specific Cochrane review group to be formed, and over 9,315 trial reports have been submitted to the Cochrane database from this group (CPCG, "Welcome," 2012). Although the Cochrane Database of Systematic Reviews is available only by subscription, abstracts of all reviews are available free of charge online. Members of review groups consist of health care providers, researchers, and consumers alike. Another major resource for systematic reviews of pregnancy and childbirth literature is the 1,500 page, two volume *Effective Care in Pregnancy and Childbirth*, which evaluated research since 1950 on more than 275 birthing practices (Johnson 1997:51). The book was created in 1989 by three obstetricians, Marc Keirse from the Netherlands, Iain Chalmers from England, and Murray Enkin from Canada, along with a team of researchers. A paperback companion *Guide to Effective Care in Pregnancy and Childbirth* was published in 1989 and updated in 1995 and 2000.

Evidence-based medicine forms the theoretical cornerstone of several major organizations that support the holistic model of childbirth. These organizations include Citizens for Midwifery (CfM), the Midwives' Alliance of North America (MANA), the Coalition for Improving Maternity Services (CIMS), and Childbirth Connection, formerly the Maternity Center Association (MCA). Doulas, childbirth educators, midwives, physicians, and expectant parents alike utilize information and publications from these organizations to evaluate obstetric practices. Often, doulas call attention to the gap between what medical

literature seems to support as best practice and the way in which childbirth is managed in the hospital. It becomes clear from looking at the research, they argue, that many of the routine protocols of obstetric practice have been undertaken or continued based not on an empirical demonstration of their efficacy, but instead on a specific culture of practice. Researcher and activist Henci Goer writes, "Obstetric practice does not reflect the research evidence because obstetricians actually base their practices on a set of pre-determined beliefs. If you start from this premise, everything about obstetrics, including the inconsistencies between research and practice, makes sense" (1999:3).

The fact that physicians are aware of this discrepancy, and many are comfortable with it, is demonstrated in a documentary entitled "Born In The USA" (Jarmel 2000), which includes a scene depicting obstetric nurses and physicians meeting for a case review. As one nurse justifies artificially rupturing a woman's bag of waters by stating that "there is evidence that the release of fluid causes dilation to occur more quickly," she is quickly corrected by a high-ranking physician, who quips, "every obstetrician *believes* that, but there aren't a lot of good data to support it." Another obstetrician joins in, "we do a lot of things there aren't a lot of good data to support," and the room erupts in laughter. The group goes on to acknowledge that the cesarean section the mother in question underwent was most likely unnecessary and caused by the routine induction of her labor. But instead of recommending that labor not be induced routinely at 40 weeks, the physicians agree that since the woman was aware that cesarean section is a risk of induction, they were ultimately not responsible. In other words, they chose to preserve the continuance of routine practices, regardless of the fact that they may be scientifically unjustified or harmful.

There is widespread frustration on the part of childbirth advocates in the way the medical establishment seems to be largely oblivious to the results of its own studies. For example, why has electronic fetal monitoring (EFM) become the routine standard of care when no study has ever been able to show a link between EFM and improved outcomes for women or babies (Leveno 1986; Prentice 1987), and many obstetricians themselves continue

to question this practice? (Friedman 2010). Doulas are encouraged in their training to ask these kinds of questions, and as a whole, most doulas critique mainstream obstetric practice by observing that many components of U.S. obstetric practice are overwhelmingly *not* evidence-based, but the result of a complex set of concerns over litigation, obligations to drug and manufacturing companies, efforts to create standardization and efficiency, hospital formation and structure, and appeals to obstetric tradition. For doulas and other childbirth reform activists working within the model of evidence-based care, then, the effort is to create change in obstetric practice by holding it more accountable to the dictates of the results of scientific studies. When I asked doulas what they see as the biggest barriers women face in achieving the kinds of birth and reproductive experiences they desire, one of the major frustrations that emerged was a perception of the lack of evidence-based care in medical practices. This was true across all geographical areas, and all populations served by doulas. Typical responses to this question on my survey included many along the lines of this one: "The medical establishment refuses to practice evidence based medicine. Doctors are too convinced they already know it all. They do not read their own research."

In the face of criticisms such as these, physicians are quick to defend their choices, and many vehemently resist the imperative to modify their practice according to research-based standards of care. Critics of evidence-based medicine argue that EBM "denigrates clinical expertise, ignores patients' values, and promotes 'cookbook' medicine" (Straus 2000:839). These critics maintain that there are a host of factors, such as clinical experience, that should guide the provision of medical treatment, beyond the results of studies. Some MDs are overtly hostile to proponents of EBM, characterizing them as "dazzled scientists who set out to dazzle, rejoicing like acrobatic children vaulting through the statistical stratosphere, casting down meta-analyses and systematic reviews to clinicians below" (Miles 1997:84). This particular article not only implies the inferiority of EBM supporters by portraying them as children, but also insinuates that they lack compassion: "Doctors have

been right, indeed perfectly responsible, to maintain that narrow scientism and pseudoauthority have no place in the compassionate care of individual patients" (85).

At issue here is not whether standards of evidence-based care are accurate, but whether or not they are employed from a position of cultural authority. Foucault terms this process the "will to truth" and explains that "certain statements are 'in the true' not because they are objectively true or false, but, rather, because they take place within the parameters of legitimated statements" (quoted in Yadlon 1997:647). In other words, legitimate knowledge is produced by those with the power to define truth – in this case, physicians. When science is invoked – and it frequently is – by physicians to support their practice, they gain credibility through their supposed rigorous objectivity. When used by anyone else, however, science can easily be portrayed as "narrow" and the "pseudoauthority" with which those outside the medical profession speak is but a deceptive imitation. It is worth clarifying at this point that authority is not an inherent component of biomedicine; in fact, allopathic professional knowledge gained ascendancy in the U.S. at a particular historical moment as a result of complex (and contingent) political, economic, and social factors (Starr 1982), and has been working to maintain this position ever since.

The struggle over authoritative knowledge is palpable in a recent editorial in *The Lancet*, which is explicit about putting evidence-based medicine "in its place" as an illegitimate perspective. In so many words, it begs EBM supporters to quiet down and stop challenging physician authority: "Advocates of evidence-based medicine can now afford to lower their profile to ensure that their evolving ideas find a secure place in the medical practice" (Lancet 1995:785). Miles et al. are less decorous about imagining where that secure place might be, predicting that "the screaming baby of EBM is likely to be consigned over time to the nostalgic formaldehyde of medical history" and adding that "at the present time, the majority of doctors are perfectly willing to assist in such unceremonious disposal"

(1997:85). It is evident that many physicians see evidence-based medicine as a threat to their control over definitions of important categories like health, disease, safety, and risk.[1]

Doulas perceive this power dynamic sharply, and they lament its effect on the informed consent process, which is ideally built on evaluation of the best evidence regarding any given procedure or practice. Many doulas shared their frustration at what they see as doctors' exploitation of their authority. Wanda Wolf from California said,

> [The biggest barrier is] watching doctors lie to their patients on the reason for interventions and knowing that the patient/client will most likely trust the doctor's word more than a doula's wealth of knowledge from evidence based research. We can present research studies and there is still the perception that the doctor knows best.

As Wanda perceives, the doctor's position of power trumps any research-based evidence that the doula can provide. Alison Gray from Virginia sees this power dynamic as having as much to do with birthing women's fear of questioning their care providers:

> I believe it is the doctor/hospital's prerogative to make women be quiet and submissive during the birth process, and any attempt to question [the doctor] is seen as rebellious and selfish. I'm sure very few women would just take a hairdresser's idea of a good haircut and quietly go along with it, even if it wasn't what she wanted, and that is what they are expected to do when a doctor tells them they need an induction, Pitocin, or C-section. Learning that it is not only smart but necessary to question the process is vital to achieving a fulfilling birth.

Alison's observation about the perception of maternal selfishness reflects a knowledge of the ACOG's characterization of women desiring access to home birth and other non-standard birthing choices as putting their own desires before the needs of their babies – a topic which I will take up again later in this chapter. It also reflects the cultural context of the social construction of motherhood in our culture, which demands feminine passivity and selflessness.

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[1] Physician resistance to EBM can also be understood in terms of the historical tension between private practice and public health, and the debate over single-payer vs. third party payer health systems.

Objectivity, Bias, and Neutrality: Whose Evidence Counts?

Although the rhetoric of evidence-based care is being increasingly utilized by childbirth advocates, not all supporters of natural birth regard scientific research methods as authoritative. There are those who are skeptical of the reliance on quantitative studies to evaluate birth practices, especially less medically-oriented ones, because of a belief that the methods and goals of woman-centered midwifery care are inherently different from those of obstetrics. In the case of the use of RCTs, for instance, nonmedical components of care, such as certain elements of emotional support and the place of birth, do not lend themselves well to randomized allocation, standardization, or systematic evaluation. Ethical problems can arise that would make such research difficult or impossible.[2] Additionally, there is some concern among birth advocates that dependence on EBM might ultimately undermine the hard-won value, within natural birth communities, of nonscientific, embodied forms of knowledge about birth. The fear is that "when authoritative knowledge becomes based almost exclusively on RCT research, then only techniques or approaches that have been subjected to RCT may be taken as authoritative" (Johnson 1997:357). Such a shift would disrupt some of the very foundations on which the holistic model of childbirth is based, such as the value placed on traditional knowledge, bodily experience, and intuition.

Difficulty implementing evidence-based care also stems from a lack of any explicit definition of what counts as evidence. Mary Stewart's (2001) qualitative analysis of perceptions of EBM among midwives, obstetricians, and nurses demonstrates that evidence is defined differently by different health care providers. Taking a phenomenological approach, she argues that definitions are created out of experience, which both constructs and is informed by belief systems. Therefore, providers who espouse differing philosophies about birth will form different meanings of evidence that in turn reflect their own interests and biases. Stewart also highlights the fact that the Cochrane database, as a primary resource

[2] Although there have been randomized, controlled studies of doula support. See Hodnett et al. 2003.

for establishing EBM, does not review any qualitative health research. Since the qualitative sources of evidence that are more likely to be used by midwives in their practice (intuition, history, reflection, and experience) are not included in these research analyses, EBM – though its recommendations favor low-intervention forms of care – reflects a biomedical definition of evidence.[3]

It is not only the institutional force of biomedicine, but also the demands of the marketplace that dictate what counts as evidence. Funding for studies of childbirth procedures tends to be allocated to those trials that focus on familiar medical procedures, or the use of specific diagnostic techniques or pharmaceuticals. This concern mirrors the frustration felt by many breast cancer activists over the fact that environmental and social causes of the disease are not being investigated to the same extent as treatments that fit the biomedical framework and could potentially benefit drug manufacturers (Spanier 2001). In addition, when nontraditional forms of maternity care do get research funding and produce favorable results, the studies are likely to be disseminated widely among those who already adhere to the holistic model of birth, and largely ignored by those who don't. The first six RCTs to study the impact of labor support are a good example of this phenomenon (Kennell et al. 1991; Klaus 1986; Hofmeyer 1991; Sosa 1980). Doulas across the country readily quote the combined results of those studies, and supportive health care providers made declarations like the one by perinatologist John Kennell, "If a doula were a drug, it would be malpractice not to use it."[4] However, although doulas widely quoted these studies, and still do, physicians were reluctant to accept doulas during the time they were being published. Interestingly, physicians seem now to be catching up. I was attending a birth at

[3] The other kind of evidence that factors heavily into biomedical practice is legal evidence. Although I do not develop a discussion of the legal authority of obstetrics in relation to various forms of midwifery in this chapter, it is an extremely important component of the struggle for legitimacy among birth attendants.

[4] This statement by John Kennell has become so well-known and oft-quoted, I am presently not sure whether it exists in print.

the hospital recently when a resident said to me, as though I would be astonished by the news, "There's actually a lot of research evidence that doulas shorten the length of labor and reduce C-section rates, and improve a lot of other outcomes in birth!" I was glad that he was familiar with that research, but also slightly dismayed that he felt he had to educate me on this topic.

The quantitative analyses used to direct evidence-based medicine lend themselves readily to the assertion of objectivity. They masquerade easily as statements of fact, performing what Donna Haraway calls a "god trick," a "conquering gaze from nowhere" that "makes the unmarked category claim the power to see and not be seen, to represent while escaping representation" (1991:188). Since objectivity carries this supernatural power, it has proven to be a tempting strategy for doulas and other supporters of alternative birthing methods competing for cultural prestige with the seemingly inviolable medical model. Childbirth Connection's explanation of evidence-based maternity care states, "Systematic review procedures help limit the bias and error that can easily influence results of single studies and of more conventional reviews of research. They allow us to draw much more accurate and confident conclusions" (Childbirth Connection 2012). Although this description doesn't claim that meta-analysis *eliminates* bias, it implies that the influence of bias contributes to inaccuracy, and should be limited to avoid error. In claiming this kind of accuracy and confidence, groups aligned with EBM also claim a kind of authority that may be, in some ways, problematic. Nancy Tuana reminds us that claims to neutrality go hand in hand with the privilege of unmarked positionality. This can serve to strengthen power inequalities in the realm of health care that childbirth advocates have so long fought against, since "in a culture where dominant knowledge practices are conducted primarily by members of privileged groups, the impartiality ideal serves to reinforce dominance and inequality" (Tuana 2001:12).

Not all uses of EBM, however, claim the value-free neutrality of objectivism. Some proponents of evidence-based maternity care enact a relationship to objectivity and bias that

is consistent with what Sandra Harding has termed "strong objectivity" (1991). Harding explains, "We can think of strong objectivity as extending the notion of scientific research to include systematic examination of [our] powerful background beliefs" (1991:149). Nancy Tuana clarifies, "Inquiry that is truth-conducive need not be value-free" (2001:13). Henci Goer exemplifies this perspective at several points in her introduction to *The Thinking Woman's Guide to a Better Birth* (2001). After admitting that "this book will not be neutral. I don't profess to be any more objective than anyone else about what I think makes for optimal care" (6), Goer goes on to make a "full disclosure statement" detailing her beliefs about what constitutes sound practice in labor and birth. But she does not see the extensive reviews of the medical literature she presents as any less balanced or representative of truth simply because of her views:

> I had to be selective in the data I presented, but I think I have included enough to make my case. For most chapters, I read two to three times the number of papers as appear in the bibliography and appendix reference lists. One tactic for dismissing a work like mine is to say that you can find a study to support any position, but that does not apply here. The data uniformly failed to support common obstetric practice for most of the topics I researched. [2001:9]

In fact, Goer goes to great lengths to assert her authority by describing her other prestigious publications, and pointing out similar research findings that substantiate her own.

Instead of claiming a monopoly on the production of authoritative knowledge, Goer uses an anecdote that demonstrates her commitment to its accessibility. She writes:

> To those of you who would argue that you need more letters after your name in order to write a book like this one, let me respond with a story. Penny Simkin, a well-known educator, writer, speaker, and editor, was called on the carpet by an anesthesiologist, irate that she had written a handout listing the potential trade-offs of epidural anesthesia when she was not a doctor (although he did not dispute her accuracy). 'What are your credentials?' he demanded. 'I can read,' she mildly replied. So can I. [2001:10]

So, presumably, can the reader of the *Thinking Woman's Guide*. Science is used here as a democratizing force, not a controlling one. Such an attitude reflects a feminist politics of equality, and embodies the idea that "particular biases – for example, feminist biases – can

be effective guides to truth in a context of systematic gender bias" (Tuana 2001:13). The goal of strong objectivity is not to eliminate or reduce bias, as it is impossible to function outside the realm of values. Instead, bias should be accepted, evaluated, and incorporated into scientific inquiry.

The doulas in my study described the value of EBM in a similar way. Doulas are very proud of their own training in evaluating medical research, and their own understanding of EBM, as non-clinicians. When discussing the educational component of her doula training, Sora Egger in Iowa told me:

> I'm not a medical expert, but one of the basic skills that they taught us was how to access evidence based information. So that's what part of the exam [for certification as a doula] was. Some of the questions weren't even in our reading. It was testing us: would we be able to find the answer online or in textbooks? Would we be able to find that information to pass on?

All doula training and certification organizations emphasize the importance of helping clients access evidence-based information relevant to their care. DONA International sends its members links to recent research that has implications for childbirth practice, both via email and the *International Doula* newsletter. Another reason doulas are so attuned to the evidence-based medicine model is because the efficacy of doula care has been well researched, and one of the most often cited arguments for the involvement of doulas in birth is predicated on research evidence. For instance, DONA International's position paper states:

> Analysis of the numerous scientific trials of labor support led the prestigious scientific group, The Cochrane Collaboration's Pregnancy and Childbirth Group in Oxford, England to state: "Given the clear benefits and no known risks associated with intrapartum support, every effort should be made to ensure that all labouring women receive support, not only from those close to them but also from specially trained caregivers. This support should include continuous presence, the provision of hands-on comfort, and encouragement. [Simkin and Way 2008]

However, doulas tend not to isolate scientific evidence as the only, or even the primary, measure by which they evaluate procedures or help their clients to do so. When I asked Sora how she assisted clients in accessing medical information, she told me:

> What I'll tend to do is I'll read through all the major hits [from a search on PubMed] and then go back to whichever one I feel is the most reliable. And that way I can get a medical source and I can also get the layperson's source for their personal experience, and it's nice to get the different perspectives. If I only read the medical perspective, I tend to get the same answer and they don't give the patient's perspective.

As this quote exemplifies, for doulas, experiential forms of information are just as important as clinical trials.

Feminism, Consumerism, and the Rhetoric of Choice

One of the factors influencing the trend toward using scientific justification for alternatives in childbirth, rather than a specifically feminist critique, has to do with the rhetoric of choice. Whereas women's choice in the wake of Roe vs. Wade was a highly politicized notion, it has become more of a market-driven concept in the era of intense competition between hospitals (Rapp 1999). It is not only the institutional force of biomedicine, but also the demands of the marketplace that impact what counts as legitimate and truthful. Foucault explains that truth is "subject to constant economic and political incitement" (1980:131), and this can be seen by looking at the demands of childbirth activists that actually have been met by hospitals. Instead of the stark, cold labor and delivery rooms of the past, hospitals now advertise natural family birth centers, in which the entire assembly of high-tech instruments of intervention is housed in oak cabinets, or behind framed art, next to quilted double beds. Although the décor may evoke nature with its muted earth tones, the hospital's protocols (e.g., time limits, mobility restrictions) have yet to undergo such transformations. These changes have occurred due to the increasing competition among hospitals for maternity patients, who account for a large proportion of hospitals' income. Six of the ten most common hospital procedures are maternity-related, and cesarean section is the most common operating room procedure in the country (Wier et al 2010).

On the other hand, obstetricians have rejected recommendations that threaten their economic security, even when they are brought by other powerful institutions such as the U.S. government and the World Health Organization. Both of these bodies have demanded

that efforts be made to reduce the cesarean rate in the U.S., which has been rising steadily since the 1970s, and reached an all-time high of 32.9% in 2009 (Hamilton et al 2011). In 2003, the American College of Obstetricians and Gynecologists released a statement indicating that obstetricians may offer elective cesarean surgery to women in the absence of any medical indication for the operation, despite the increased risks to mothers and newborns that the elective surgery introduces. The news release states, "In the case of an elective cesarean delivery, *if the physician believes* that cesarean delivery promotes the overall health and welfare of the woman and her fetus more than does vaginal birth, then he or she is ethically justified in performing a cesarean delivery" (ACOG 2003). The opinion of the ACOG on this matter, predictably, was discouraging to birth activists, advocates of EBM, and many feminist scholars (Bergeron 2007; Simpson 2005). More recently, in 2007, ACOG updated its opinion paper on elective cesarean to indicate that the procedure should not take place before 39 weeks, and should not be recommended for women who plan to have many children, because of the increase in complications for subsequent pregnancies that can result from a primary cesarean birth (ACOG 2007). On April 1, 2011, news releases reported that ACOG had further amended these opinions, and issued a ban on elective cesareans, as well as on electronic fetal monitoring. The release read, in part:

> The nation's C-section rate has been rising steadily for the last eleven years. It's now over 31 percent," said an ACOG spokesperson. "This is a deplorable situation that harms women and their newborns." An organization that advocates for quality healthcare for women, ACOG is asking obstetricians to halt elective C-sections. "C-sections should only be a last resort. They should never be performed for the convenience of the doctor," the spokesperson said, "or for financial or liability reasons." Since the use of electronic fetal monitoring has been shown to increase unnecessary C-section rate without any proven benefit to the mother or infant, ACOG is also calling on American hospitals to stop the routine use of electronic monitoring during labor. ACOG's new guidelines encourage women to have freedom of movement during labor, labor standing up or squatting, and to eat and drink at will.

To the dismay of many, it turned out that this was an April Fool's Day hoax (Rankin 2010).

The shift in the discourse of choice – from a political tool of feminism to a marketing tool of obstetrics – is exemplified in the debate over elective cesareans. According to the medical model of birth, safety is often perceived as directly antithetical to the laboring woman's exercise of choice. The classic textbook *Williams Obstetrics* typifies the abrupt dismissal of a feminist version of women's choice in the setting of medicalized birth. This venerated text warns that there are "risks to both gravida and fetus of placing the desire for a *meaningful experience* before the needs of the fetus-infant" (Cunningham et. al. 371, emphasis in text). The "fetus-infant" is here conceptualized as separate from its mother, and may have conflicting "needs." If medical intervention is deemed necessary for the child's "safety," how can the mother make any other "choice"? Similarly, ACOG, in its 2008 statement opposing home birth, states, "Choosing to deliver a baby at home…is to place the process of giving birth over the goal of having a healthy baby." Obstetric rhetoric around elective cesarean, however, reverses these terms, reflecting the shift toward a consumerist model of choice. Suddenly, the patient's "right to choose" a cesarean section is what every obstetrician must fight for, resisting the tyranny of natural birthers and their absolutist demands for evidence of safety. Thus, discourse is mobilized according to who benefits from which choices.

Of course, consumerist choice has been a strategy that has worked well for childbirth and other health reformers. As Valerie Boyd in California said,

> It is so important to know which hospitals are supportive, and which doctors or midwives share your ideas about birth. I think homebirth is great, but the truth is the majority of babies are born in hospitals, and we can make that better for people by changing hospitals. But that will only happen if women 'vote with their vagina' and not go to doctors or hospitals that don't support birth options.

Voting with one's vagina is certainly one way to work for change. However, many women do not have the ability to pick and choose which hospitals to patronize. Christa Craven shows that this type of neoliberal construction of birth-givers as "consumers" has its drawbacks, for reasons related to class disparities (2007). Consumers have played an important role in both breast cancer and AIDS activist campaigns evaluating and guiding

research agendas, and organizations like the National Breast Cancer Coalition have been founded to provide a forum for the collaborative efforts of physicians and laypeople alike. However, the childbirth movement is different from these interest groups in many ways. Both breast cancer and AIDS activists demand access to and research for medical treatments, and therefore do not challenge the biomedical model. The childbirth movement, on the other hand, calls for a decrease in medical intervention, even a restructuring of obstetric philosophy.

Toward Solutions: Birth Models that Work and the Importance of the Body

For all the criticisms of doulas toward the abuses of power within the medical model, doulas by and large do not seek to destroy that model; they simply wish to temper it. Rather than calling for evidence-based medicine solely on the level of individual clinical procedures, doulas and other childbirth reform advocates are emerging as champions of more evidence-based systems of health care provision. In my interviews and surveys, I asked doulas to describe what changes they would like to see in order to improve birth and reproductive health care. The two most salient themes were: creating birth models that work, and improving cultural ideas about women's bodies. I will first turn to the call for better birth models.

The 2009 anthology *Birth Models that Work,* edited by Robbie Davis-Floyd et al. outlines several examples of "lighthouses" in maternity care. This work profiles regional and national systems whose existence "shows us that good birth models work – they can combine the best of obstetrical care with the best of contemporary scientific research, ancient wisdom, basic common sense, and compassion to create systems of knowledge, skills, and practice that truly serve mothers, babies, and families" (2009:1). Through statistics, anecdotes, political contextualization, and organizational analysis, this text, publicized by

Davis-Floyd's many public speaking engagements at various midwifery and doula conferences, is influencing childbirth reformers' calls for change.

One of the characteristics of the birth models profiled in this text is the allocation of resources so that midwives care for the majority of healthy, low-risk women, and obstetricians care for those with complicated pregnancies or births. In these systems, technology and surgery are not overused, but at the same time, those who need cesareans and other forms of medical treatment have ready access to them. I did not ask the doulas in my study whether they had read this book, but typical responses mirrored the "birth models that work" theory, such as that of Cathy Robin from Wisconsin, "[I would like to see] national health care with midwives as the providers of all well woman and reproductive care, with OBs as the high risk specialists that they should be." A similar response reflects another common wish doulas voiced in conjunction with a more complementary system: a different method of training physicians. Lisa Greenaway in Nebraska said,

> I would like to see all women using midwives for well-woman care and pregnancy care and only seeing OB's if a problem arises. I would like to see home birth a viable, safe and supported option in every state. I would like new doctors to be required to see a minimum number of "natural" births in their training so they know how great it can be if you just leave her alone.

This call for educating doctors in the midwifery model reflects a recognition among doulas that experience affects the kinds of evidence a practitioner considers valid, and shapes a clinician's worldview as a whole. Gloria Rose in Iowa explains this perspective in depth:

> [I'd like to see us] use more evidence-based practice! I think we're really missing research that's applied to practices. And I'd love to see hospital practitioners be required to attend some out-of-hospital natural births. They don't seem to be educated at all in touch therapies or a birth that doesn't happen on a schedule that they predict. That's one thing I love about what I do -- I often feel like I'm educating the hospital practitioners. And they're grateful. That's a nice thing when they're really fulfilled to see a woman catch her own baby or stand and deliver. People thank me! And I'm like, I didn't do it -- *she* did it! It is really cool, and you can see that even those nurses and OBs are inspired by that experience, so it would be great if that were a part of their training.

The enthusiasm that animates Gloria's account is typical of how doulas speak of the possibilities inherent in a system that allowed for more collaboration between different types of care provision. Here, Gloria observes that the experience of feeling fulfilled and inspired can potentially be the catalyst for a shift in the culture and practice of birth. Experiential and emotional evidence emerge here as important elements of the evidence-based medicine paradigm for doulas, in addition to research-based evidence.

In envisioning a better future for pregnant and childbearing people, doulas also call powerfully for women's bodily autonomy. My data reflect an acknowledgement that women's bodies are still feared and distrusted, and that the needs of institutions often take precedence over the needs of individual women. In examining what he terms the "political technologies of truth," the mechanisms by which certain claims come to function as "true" in particular times and places, Foucault explains that a truth must be "the object, under diverse forms, of immense diffusion and consumption" (1980:131). In the U.S. today, the medical model of birth is the only way of conceptualizing birth that can be said to enjoy "immense diffusion and consumption." In addition, Foucault asserts, political technologies of truth must "be able to gain access to the bodies of individuals, to their acts, attitudes, and modes of everyday behavior" (1980:126). Obstetric regimes of truth are enabled through their access to the bodies of the vast majority of birthing women in America. Doulas recognize this. They perceive the power dynamics of authority and truth as inherently interrelated with issues of how pregnant and birthing bodies are perceived, treated, and (dis)trusted. They seek to disrupt the political technologies of medically controlled birth not just through the discourse of science, but also through the level of the body. Brandi Nolan in Nebraska explains,

> [The biggest barrier is] disrespect of women and their bodies. I think this is what is causing the issues in the majority of births (hospital births mostly...but not exclusively). If we start out with the premise that women are strong, intelligent and able to make wise decisions regarding their medical care, then why do we need to force them, pressure them, control them, violate them, or inform them of what is to be done *to* them in reproduction and birth?

For Brandi, disrespectful attitudes toward women and their bodies are directly linked to the use of coercion and the abuse of power in the birthplace. Iris Chamberlain in North Carolina expresses a similar sentiment, linking these issues to larger patterns of socialization of women:

> [We need] more positive dialogue and images of childbirth; sexual education that includes pleasure instead of fear, and images, dialogue, and education that allow women to live in their bodies instead of presenting their bodies for others.

For Iris, the situation would improve if women were socialized to trust their bodies rather than give them over to others. This is how many doulas see themselves as intervening in birth, on both an individual and cultural level.

Conclusion

It is unclear whether evidence-based medicine will become the standard for obstetric practice, or whether it will even narrow the gap between evidence and protocol in mainstream maternity care. EBM has increased the legitimacy of alternative birthing choices in some ways. The face of obstetric care is far more humanistic in many ways than it was just ten years ago. Recently, the American Public Health Association put forth a resolution in support of increasing access to direct-entry midwife attended, out-of-hospital births (APHA 2001). A longitudinal study of planned home birth in North America has been published, with positive results (Johnson and Daviss 2005). Popular television shows from sitcoms to educational TV feature women attempting natural childbirth. Bookstore and library shelves are crowded with the latest books on doulas, waterbirth, hypnobirth, doulas, and homebirth. Considering the increasing mainstreaming of doula and midwifery care and alternative birth practices, it is probable that the use of scientific discourse has had a legitimating effect on the childbirth movement where public opinion is concerned.

In spite of this, however, there are many ways in which it appears that the use of scientific discourse and the rhetoric of EBM to change obstetric practice have been largely unsuccessful. A Foucauldian analysis of truth and power is useful to childbirth reformers as

they continue to refine their strategies. Perhaps their task should be "not to criticize the ideological contents supposedly linked to science, or to ensure that [their] own scientific practice is accompanied by a correct ideology, but that of ascertaining the possibility of constituting a new politics of truth" (Foucault 1980:132). "The problem," Foucault warns, "is not changing people's consciousness – or what's in their heads, but the political, economic, institutional regime of the production of truth." (133). When the mobilization of science is understood to be just one component of this production, it becomes clear that the call for Evidence Based Medicine cannot, in and of itself, change childbirth practice in America. The challenge, then, becomes locating the broad, foundational ground on which a new politics of truth about birth can emerge.

This new politics of truth about birth can perhaps be built upon the conviction, widespread among doulas, that birth is inextricable from people's lives as a whole, not reducible to a set of measurements or a singular experiential moment. The approach of strong objectivity appears to be serving doulas and their clients well. Rather than glorifying or vilifying scientific rhetoric, doulas employ it in concert with feminist epistemologies that value emotional and bodily knowledge, and also value the role of politics and community in pregnant and birthing women's lives. Rather than seeking to eradicate the medical model, doulas envision a system in which the medical model could coexist with the holistic model, and in which obstetricians, family practice physicians, nurses, and midwives could collaborate more effectively.

CHAPTER 4

"A TRICKY BUSINESS": DOULAS AS ADVOCATES IN THE BIRTHING ROOM

In 2009, the labor and delivery floor of the Aspen Women's Center in Utah displayed a sign reading:

> Because the physicians at Aspen Women's Center care about the quality of their patient's [sic] deliveries, and are very concerned about the welfare and health of your unborn child, we will not participate in: a "birth contract," a doulah [sic] assisted, or a Bradley Method delivery. For those patients who are interested in such methods, please notify the nurse so we may arrange transfer of your care.

Why did Aspen Women's Center feel that it was necessary to ban doulas from their birthing rooms, and to refuse care to patients who wanted a doula's assistance? Are doulas really such a threat to the "welfare and health" of unborn children? While most clinical environments are welcoming to doulas at this point in time, the position of the doula is, at times, precarious. Doulas must constantly serve as a bridge between the sometimes conflicting desires of birthing women and the protocols of the medical system– a situation one doula in my study, Cray Gardiner, described as "a tricky business."

Because of the intermediary position doulas occupy, the negotiations they perform are often highly loaded exchanges that almost always involve some measure of both resistance to and accommodation of mainstream obstetric practice. However, a dichotomous understanding of resistance and accommodation is not adequate for understanding the doula's role as an advocate within and in proximity to the hospital birthing room. Instead, acts of accommodation and resistance are simultaneous and interwoven as doulas perform multiple and complicated tasks in a constantly shifting terrain.[1]

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[1] This interaction of resistance and accommodation is described in many other contexts. See, for example, Lewin (1994).

In this chapter, I consider the role of doulas as advocates in, and in proximity to, the hospital birthing room.[2] I analyze doulas' narratives of how they negotiate complex matrices of power in their interactions with clients and care providers in the liminal space of labor and delivery, and also in prenatal and postpartum visits with clients – a realm outside the birthing room proper, but one to which the politics of the birthing room undoubtedly extend. These narratives reveal the ways in which the demands of doulas' everyday practice often exceed the scope and expectations their training prepares them for, especially as doulas seek to provide care to an increasingly diverse range of clients, and they also raise important concerns about the politics of the voice.

I turn my attention first to the meaning of advocacy for doulas and the contrasting self-perceptions of doulas as advocates. I then consider the scope and limitations of doulas' ability to advocate for clients, with particular attention to the birth experiences of socially marginalized women and families. Finally, I consider the extent to which doulas' training prepares them for the range of advocacy tasks they perform in practice as they contend with what Linda Alcoff (1991) has identified as the "problem of speaking for others."

Are Doulas Advocates?

The scope and limitation of a doula's advocacy role is a perennial topic of discussion among doulas. It arises frequently on doula message boards and listservs, in private discussions among doulas, and in publications like *The International Doula* (*ID*). The meaning of advocacy for doulas is deeply connected to concerns about who speaks for whom. These concerns arise from their training; DONA, CAPPA, and every doula certification program, to my knowledge, instructs doulas not to speak for clients. This contrasts slightly with the

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[2] Although doulas do attend births in homes and in birth centers, I am focusing on how doulas work in hospital settings, because this is the context in which they work most often, and in which they describe feeling most conflicted about their roles as advocates. This is the place in which they identify their advocacy as being most needed, not in home or birth center settings, where the dynamics of power are much less hierarchical, and power is more evenly distributed among all who are present: care providers, doulas, birthing women, and others.

typical legal and political understanding of the role of an advocate, as a representative or defender of another person. DONA's official document listing the doula's scope and standards of practice reads as follows:

> The doula advocates for the client's wishes as expressed in her birth plan, in prenatal conversations, and intrapartum discussion, by encouraging her client to ask questions of her caregiver and to express her preferences and concerns. The doula helps the mother incorporate changes in plans if and when the need arises, and enhances the communication between client and caregiver. Clients and doulas must recognize that the advocacy role does not include the doula speaking instead of the client or making decisions for the client. The advocacy role is best described as support, information, and mediation or negotiation. [Simkin and Way 2008:1]

When I asked the doulas in my study to share their thoughts about their roles as advocates for their clients, many of them emphatically expressed that this is the most important component of their work. Survey respondents commonly used words like "vital" "crucial" and "central" to describe the role of advocacy, and often expressed sentiments like, "that's why people hire me" and "if I'm not advocating, I'm not doing my job."

Doulas commonly expressed the concern, learned through the process of training and professionalization, that if the doula's voice comes into play in the birthing room, it could potentially take away from the empowerment that a woman experiences when speaking for herself. Natasha Phillips in Wisconsin expressed a typical sentiment: "Ideally, I help clients advocate for themselves. On the whole, I consider myself a birth advocate, but I don't want to take ownership over someone else's process of empowerment." Only a small number of doulas in my study indicated that they did not think of themselves as advocates. For them, the term advocacy elicited a negative response, implying speaking for birthing women, rather than giving them the tools with which to speak for themselves. For this reason, some doulas, like Regina Samuelson in Washington, rejected this designation:

> I do not think of myself as an advocate for my clients because that word has the connotation of speaking for, whereas my clients should speak for themselves. My role as a doula is to be a resource to my clients and provide informational, emotional and physical support. A great deal of my work with clients prenatally is helping them find their voice, preparing to navigate birth and parenting and

> understanding that they are the ones that make the decisions for themselves and their children.

In keeping with DONA's standards of practice, Regina sees speaking for clients as un-ideal, if not inappropriate. While most doulas do not go so far as to disavow advocacy, this response is typical in that doulas tend to emphasize prenatal preparation and education as an acceptable form of advocacy in that it helps women "find their voice."

At the same time doulas overwhelmingly embrace the role of advocacy, and describe it in ways consistent with DONA's definition, many doulas also identify this question as a particularly complicated one. As Laura Barber in Texas put it, this is "one of the most vexing issues facing doulas today." The thorniness of this terrain for most doulas is related to the complex negotiations they face as they work to accomplish multiple, and sometimes contradictory, goals in the hospital setting. As doulas work to champion their clients' preferences and assure their access to information and informed consent, they often find themselves in the position of having to make difficult choices about when to speak, when to be silent, and to whom to speak on whose behalf. While doulas by and large identify with the goal of not speaking for their clients, it is also common that in practice, many doulas feel that sometimes, in order to make their clients' voices heard, they must use their own voices. I seek, in this chapter, to draw out the dynamics that shape when and why they choose to do so.

Feminist theorists attentive to the politics of difference raise important concerns about the politics of speaking for others, pointing out the epistemological importance of a speaker's location in a speech act, and the discursive danger of speaking from a privileged location on behalf of the oppressed. Linda Alcoff takes up these issues in "The Problem of Speaking for Others" (1991). Following Foucault, she explores "rituals of speaking," which she defines as "discursive practices of speaking or writing that involve not only the text or utterance but their position within a social space including the persons involved in, acting upon, and/or affected by the words" (12). She points to the importance of attending to two elements within these rituals: the positionality or location of the speaker and the discursive

context in which the speech act takes place. Both of these elements play an important part in shaping the decisions that doulas make about when and how to use their voices, and the meaning, power, and reception of their speech. With these questions in mind, I analyze the meaning and effects of the doula's role as an advocate during labor and birth by looking closely at the position and location of the doula in proximity to others present, and the inherently political context of the hospital space. I consider the strategies doulas use to negotiate the politics of voice, both in training and in practice.

The Doula's Place

As Brigitte Jordan (1997) has outlined, a clear power dynamic structures relationships between "actors" in the hospital birthing room, based upon whose knowledge is considered most authoritative. Because of the centrality of technology in American childbirth, and the position of obstetricians, midwives, nurses, and other medical staff as keepers of this technology, it is these individuals whose knowledge is granted most authority. In working to legitimize the laboring woman's bodily knowledge, doulas seek to interrupt this system. However, because they are not medical providers, their position affords their voice very little power.

Doulas are quite cognizant of their place at the bottom of the hierarchy of the hospital. Sora Egger in Iowa described knowing her place in the birthing room as an integral part of the doula's role:

> Part of the job of the doula is knowing how to work with the staff and still being an advocate without being rude, without stepping out of the hierarchy. I'm very aware of what the hierarchy is, and that I need to stay at the bottom.

The doula's position "at the bottom" is interactionally experienced. Sora went on to say:

> Once I was at a birth and I suggested a hands and knees position. The nurse said, "No, it won't work." Then the midwife came in and suggested she get on hands and knees. And the nurse was like, "Really? Oh, ok." Once the midwife suggested it, they were okay with it.

Sora's story illustrates the power positions of all involved: the nurse is in a more powerful position than the doula, and is thus able to veto the doula's suggestion. However, when the midwife, with more authority than the nurse, comes in and makes the same suggestion, the nurse must agree to it. The doula's position relative to the birthing mother, in this story, is uncertain; the birthing mother does not seem to have an active say about her (literal) position at all. However, because the doula's stated role is to "serve" and "empower" the laboring woman and her family, it can be assumed that the doula is typically subordinate to the birthing mother, even though she is a lay professional. Again, this is not always clear-cut. As we will see, sometimes the professional or (perceived) objective status of the doula affords her voice a certain power not granted to the laboring woman.

The hierarchy of the hospital is not experienced in the same way in all cases. The doula's position relative to clients and hospital staff is not permanently fixed; while it is relevant, it is not ultimately determinative. Root and Browner, in their study of pregnant women and their compliance and/or resistance to regimens of prenatal care, also observe shifting axes of power and authority between medical professionals and pregnant women, explaining that "analytic distinctions between different forms of knowledge cannot be mapped onto specific social positions. Moreover, social positions are not immutable; a pregnant woman may well be a physician" (2001:198). These observations are relevant to the position of doulas, as well. A hospital, with its shift changes and large numbers of employees, is a constantly shifting terrain.

In the community in which I attend births, hospital staff tend to be very welcoming of doulas. In fact, recently, one of our hospitals published an op-ed in the newspaper to offer thanks to the city's doulas, and "commend their efforts toward improving birth experiences and outcomes" (Leslie 2011). To my knowledge, extensions of this type of public goodwill toward doulas on the part of hospitals are exceptional, rather than commonplace. At the same time, however, doulas in my community, and around the country, are consistently aware that even in an exceptionally friendly environment, their

ability to practice is dependent on actively cultivating the benevolence of the staff by acting according to the hierarchy. Maggie Harper in Iowa expressed her concerns about the potential consequences of being perceived as stepping outside her place:

> I'm also aware that the doulas here have good relationships with the [hospital] providers and I don't want to jeopardize that. I would be loath to speak out because I don't want to make things bad for me or the other doulas. We're not medical care providers. We're there because of the largesse of the hospital. They could introduce a policy that says only the mom and her partner can be in the room.

Maggie expresses a clear understanding that her presence in the birthing room is not a right but a privilege, granted to her by the hospital and its staff, and secured by her careful adherence to her place through the proper use of her voice. This is significant because it is not only through doulas' voices that their advocacy is enacted; as I discuss later in this chapter, many doulas indicated that they think of the simple fact of their continuous presence as particularly important and humanizing, and one of the most important things they bring to their work.

Regardless of whatever privileges they may or may not have when they are there, doulas agree that it is of utmost importance that they be allowed to enter and remain in the birthing room in the first place. The doulas in my study returned, time and again, to the underlying threat of their removal from the room as the ultimate consequence of stepping outside their place. Doulas understand that the stakes of their behavior, and their reception in the birthing room, are high, and that if they upset medical staff, not only might they be asked to leave, but the rights of all mothers who want to have doulas could be jeopardized.

As the Aspen Women's Center doula ban illustrates, the fear of being kicked out of the birthing room is not an irrational one. A similar ban was instituted in 2010 by Kingsdale Gynecologic Associates, a medical practice in Ohio, which stated:

> Because of concerns for increased risk to you or your baby, the doctors at KGA have made a thoughtful, unanimous decision not to allow doulas to participate in the birthing process. It has been our experience that they may serve to create a state of confusion and tension in the delivery room, which may compromise our ability to provide the safest delivery situation possible for you and your baby.

Responses to these statements from the doula community were numerous and often humorous. Kristen Oganowski, writing on the blog "Birthing Beautiful Ideas," responded with a parody:

> It has been our experience that doulas may serve to create a state of confusion and tension in the delivery room by encouraging their clients to ask pesky questions about their care and the interventions we suggest during labor. This may compromise our ability to provide the safest delivery situation possible for you and your baby. Just repeat after us: Questions are unsafe. Resistance is futile. Paternalism tastes like chocolate.

It is clear that doulas perceive such bans as efforts on the part of these institutions to exert control and sidestep informed decision-making in the labor room.

Informed Consent

It is well-documented that informed consent procedures are imperfectly followed in the provision of medical care (Akkad et al 2004; Dixon-Woods et al 2006), and studies of decision-making in maternity care "consistently raise concerns about the adequacy of informed consent processes" (Sakala and Corry 2008:66). The ideal informed consent interaction involves three steps: the medical provider suggests a procedure or course of action to the laboring woman; the mother, and her partner and doula, if applicable, discuss the benefits, risks, and alternatives to the procedure, directing questions and clarifications to the care provider, if necessary; and the mother then relates her decision to accept, forego, or amend the procedure to the physician. In order for this ideal to occur, however, the physician must be comfortable allowing mothers to participate in medical decision-making, and if a doula is present, committed, at least on a minimal level, to facilitating informed choice through a semi-collaborative relationship with the doula. In other words, the attending physician can enable or constrain the doula's ability to do her job correctly.

It is evident, however, from doulas' perspectives, that the ideal informed consent scenario does not happen in many cases. Several doulas pointed to ways in which physicians "ignored clients' needs and pushed their own agendas." Many doulas pointed out that

informed consent is less likely to happen with clients who are in a socially vulnerable position, in addition to being in the physically vulnerable state of labor. Nicole Jamie in California observed:

> Lack of information is a major barrier, particularly when we're talking about young, uneducated, under-resourced or non-English speaking individuals. Another major barrier, and perhaps a more potent one, is the fact that health care providers in most major hospitals are not well-versed in the range of reproductive health services, research and techniques, and are not providing complete information. Instead, they often seem to be pushing an agenda.

The fact that women in labor are often "pushed" into decisions by care providers is often discussed among doulas, and is even the subject of a 2007 book by Jennifer Block of the same name (*Pushed)*. In her *International Doula* article "Do Doulas Empower?" Angela Horn argues that "Our job is not to empower [our clients], but to create an environment that fosters self discovery, the ability to ask for what they need, and the support to stand up to pressure and coercion by the medical system, when and if needed" (Horn 2010:7). The words "hold the space" are often repeated in the doula world, and refer to the power of a doula's presence, as an embodiment of support and care, to enable a birthing woman or couple to birth with confidence rather than fear. However, transforming the environment is often a tall order, especially when "standing up to pressure and coercion" is not possible.

Maggie Harper recounted an experience that exemplifies the ways in which the laboring woman (or in this case, the woman whose labor is about to be induced) may be subject to coercion, regardless of the doula's presence or verbal suggestions.

> [My client] was not overdue, but in the morning she had felt like the baby wasn't moving very much and got worried and went in. And in the afternoon she did a nonstress test and she was fine and the baby was fine, but by 5:00 or 6:00 they were saying "I really think we should induce." And they totally threw down the dead baby card, and she had had a twenty-week loss prior to this, and dead baby was not a very nice card to play with her because all she wanted was a not-dead baby. She asked, "could I just stay overnight and could we start in the morning?" They said, "if you stay we have to do something with you, and if you go home you'll have to sign out AMA [against medical advice]." And so she opted to stay because she thought she'd be so worried if she went home that she wouldn't get rest anyway. They started her right out with Pitocin. But that obstetrical resident, I just

> remember her smiling and saying, "well, we just need to give you a little help to have this baby." [high, sweet voice] And I – ugh! I was so angry, but what could I do? I mean, she made the best decision for her at the time. She was just given a crummy set of options.

Stories like this raise the question of the extent to which the presence of a doula can transform the space of the hospital birthing room, considering the doula's social location within that institution. This story, and others like it, suggest that regardless of how prepared and informed a client is, and how diplomatic a doula is, it is quite easy for a doctor at the top of the hierarchy to create a scenario in which the only "set of options" is the one s/he determines.

Advocacy Strategies and the Politics of the Doula's Voice

Through their training, doulas learn a particular type of vocal self-discipline. They learn that they can speak to their clients, but never to the hospital staff on behalf of their clients. These limits are designed to ensure that the laboring woman, not the doula, is making her own decisions for her care. Doulas take the ethics of autonomous, informed decision making very seriously, and the curtailment of the doula's own voice is seen as an essential step to ensure the primacy of the mother's voice. It is important to recognize that the issue of whether or not doulas speak for clients is a separate issue from whether doulas make decisions for them. DONA's position paper emphasizes, "most importantly, doulas do not make decisions for their clients; they do not project their own goals or values onto the laboring woman." (Simkin 1998:1). Doulas are passionate about their ability to put their own values aside for the wishes of their clients. In my interviews and surveys, doulas overwhelmingly cite this as a major strength of the care doulas provide. Cray Gardiner explained,

> [A particularly valuable part of my doula training was] understanding more about how to let go of my own agenda and really support another human being's choices… Learning how to let go of your own ego, so you can really be helpful to someone else instead of just asserting your own ideas.

While some doulas cited situations in which they are willing to speak with care providers on behalf of a client, I found no such willingness among any doula I spoke with to make decisions *for* their clients. Doulas who choose to speak to staff on behalf of their clients emphasize that they are advocating for that client's wishes, not their own.

Doulas restrain their own voices not only as an ethical matter, but also a strategic and practical one. By avoiding speaking directly to hospital staff, doulas remain in their proper place in the hospital hierarchy. In practice, however, doulas frequently find themselves modifying these clear-cut discursive rituals in response to any number of variables. Thus, the shape and texture of their advocacy is a constantly shifting mix of accommodation and resistance to multiple conventions: those of hospital system and those of the doula profession.

The process by which doulas learn their advocacy role is an important component of the professionalization experience for doulas. It is common that doulas find their approach to advocacy and voice shifting as they gain experience. Newer doulas, especially, struggle actively with how best to advocate for women without speaking for them, and how best to enact the ideals of advocacy they learned in their training once they actually begin to practice. For some recently trained doulas, the imperative not to speak for their clients comes as a surprise. Leah Summers from Iowa described the process of learning this lesson:

> Part of the guidelines for being a CAPPA member is that you don't speak on behalf of your client. You don't actually verbalize to the staff on their behalf. I really kind of struggled with that at first, telling the doctor, "get your hands on her perineum, come on!" That's really not my place, but instead, encouraging the father to ask the doctor to place the hands on the perineum. So that's a touchy area. I just feel like I have to supply the family with the tools to find their voice during their birth rather than saying, no she doesn't want the epidural.

Wave Azul, also in Iowa, describes a similar struggle:

> When I was beginning at this, and probably before I knew I was a doula, I would argue with hospital staff. And I didn't realize for a long time that that was not appropriate or conducive to a good working relationship. I remember kind of being surprised at some level that as doulas we weren't expected to sometimes really go to bat

> for the mama. So it took me a little bit once I was formally trained with DONA to figure out [that] I'm helping this woman advocate for herself as opposed to me being on the verge of getting kicked out of the hospital for getting pissed off that a woman does not want to lay in the bed.

Both these doulas reveal that they had been speaking to care providers on behalf of their clients before they were trained, and that they experienced struggle and surprise when they realized that this was not "the doula's place." They both describe the conceptual revision of their original view of their advocacy role, and a realization that their job is to empower the woman or her partner to speak, rather than speaking for them.

Other doulas, however, find their attitudes shifting in the opposite direction with experience. Hazel Davis in Oregon expressed her doubts about not speaking for clients:

> I do not advocate "on their behalf" because of the doula scope of practice, and my commitment to their finding inner strength. Sometimes I think this is wrong because a laboring woman (and even a pregnant woman I think) really has limited self-advocacy capacity.

Jenny Schaefer in Edinburgh, Scotland describes changing the way she practices with regard to this issue:

> My training taught me not to advocate for my clients, that I should be support and advice but not an advocate. This was how I functioned for several years. This has changed some in the past few years, I have started to advocate more strongly for my clients.

Both these doulas came to question the advocacy role laid out in their training as they encountered limits to the capacity of laboring women to advocate for themselves.

The question of whether or not the doula speaks to staff on behalf of women is less interesting than the question of what conditions shape the doula's decisions about how she uses her voice. Doulas describe the ideal advocacy role in terms of both ethics and practicality. Because of the doula's position at the bottom of the hierarchy, many doulas develop advocacy strategies that are built on maintaining their own silence or invisibility, or at least giving the appearance of silence. The avoidance of conflict is one of motivation for doulas to maintain their silence, as is the desire not to be perceived as a bad doula. As Iowa doula Claire Peterson explains,

> [Speaking for the woman] can create a lot of hostility. I've heard of different doctors and nurses who have had negative experiences with those sorts of doulas who step over their role and speak on behalf of client. I'm sure you've had an experience where somebody is strongly against epidural, but *I'm* not going to push medical personnel out of the way. *I'm* not going to tell the nurses.

Claire avoids speaking to medical personnel at all costs in order to keep the peace in the birthing room, and to avoid being perceived as one of "those sorts" of doulas who speak out of turn and disregard the unspoken rules of the hospital.[3] By doing so, they preserve the hospital power structure and ensure their continued presence, which ensures their ability to support their client.

As doulas seek to moderate their voices in the hospital, we can see both the practical and ethical reasons they choose to do that. The self-disciplining of the doula's voice is more a function of their knowledge of the system than it is a function of their being apolitical, or unwilling to be public advocates for birthing women on a larger scale. The seeming "passiveness" of doulas is a strategic decision. As Miriam Perez said,

> When you're in the birthing room, that's not when you're going to make those big structural changes. The political piece comes outside the hospital. And it is a radical act to be with these women but your role really isn't to interfere in what's happening right then.

Sora Egger in Iowa expresses a similar sentiment:

> If you're entering the hospital, [you need to be] respectful of the institution and your role. If you're bringing conflict into that environment, then the family suffers. The feminist agenda shouldn't be happening in the labor room. Well…It is happening. But it needs to be done in a courteous way. You can always be polite.

Both these doulas recognize that their work is "radical" and "feminist," even though in the birthplace they are concentrating on "not interfering" and being "polite" and "courteous." Clearly, there are gendered norms of feminine behavior that come into play here, but adhering to these norms is perhaps strategic deployment of essentialism in the service of helping their clients attain a positive birth experience.

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[3] Christine Morton (2002) identifies this as one of the traits of "bad doulas," according to the women in her study.

While many doulas believe that speaking directly to staff can create conflict, there are also some doulas who take the opposite position: that conflict arises out of *not* communicating directly with health care providers. Beth Curtis in Iowa found the mandate not to speak to staff on behalf of the client to be problematic, and did not see speaking for their client's wishes as disempowering.

> I consider myself [an advocate], but in our doula training we were trained not to communicate with the care providers in the hospital. And that just seems to me to breed conflict if I'm in the room with somebody and not communicating with them. And I don't answer questions on the client's behalf or anything like that, but I will seek clarity if she needs it. I can't imagine following that [rule] … I just don't think that would work well or be a favorable environment.

Beth is careful to point out that she would never answer questions for her client, but in her perspective and experience, speaking only to clients and not to caregivers is not conducive to harmonious relationships in the birthing room.

In an effort to avoid conflict, doulas use a range of strategies in the birthing room that they describe as "subtle" or "private." Christine Morton refers to these as "backstage advocacy" (2002:264). Many doulas differentiate between public and private advocacy. Maggie Harper describes what this means to her:

> I can act as an advocate for their wishes when I'm talking to them, but when we're dealing with their care providers that's not my role. It's not part of the job description…I can advocate for their wishes with them and cheerlead them and give information but I can't be their *public* advocate. I mean doulas can do, you know, sneaky advocate stuff, like if you know the mom doesn't want an episiotomy and you see the OB reaching for a pair of scissors, you can say loudly to the mom, so how did you feel about that episiotomy again? But it has to be the mom or the partner who reaches up and grabs the OB's hand or kicks him [jokingly]. And again, the doula can remind someone of what they're aiming for but you can't be the interface between the client and health care provider. That's not your role.

Here, the doula's voice is not absent, but her speech is directed in a very particular, circumscribed way. This doula embodies the ideal: she speaks to her client, but not to the care provider. Perhaps paradoxically, she calls her advocacy "sneaky," even though she describes speaking loudly. The direction of the doula's speech relative to the other people

present in the room is what defines the acceptable form of advocacy, rather than simply the presence, absence, or even volume of the doula's voice. Here, the doula is, strictly speaking, simply asking her client a question about her desires, not assuming to know what they are. This is "sneaky" because by structuring her interactions in this manner, she is avoiding the appearance of being an advocate for any particular course of action, although it is clear that the doula knows that her client does not want to be cut, and is working to advocate for that specific desire.

The knowledge of different care providers' styles is essential information for doulas as they negotiate the options available to them for advocacy. With some care providers, the doula has to educate her client in secrecy, so as not to upset the balance of power and authoritative knowledge. It is a common experience that generally speaking, midwives tend to be more oriented toward working with doulas as part of the birth team, whereas physicians are less inclined to do so. Sora explained that the collegiality she typically feels with CNMs in the hospital was absent when working with an OB:

> When I worked with an OB I did feel like it was very uncomfortable. That's when I really had to be more aggressive and help be an advocate for them privately. So I kind of explained to them that these are your choices, and some of it was contradictory to what the nurse and [the OB were] saying.

Interestingly, here, the doula perceives her private, clandestine advocacy as being "more aggressive," rather than being passive or accommodating. Sora's appearance of silence is actually what gives her power and preserves her ability to help her client make an informed decision.

Another technique widely acknowledged by doulas is the "dumb doula" routine. This is when a doula challenges something said by hospital staff by "playing dumb" and asking a question that puts that person in a position of explaining themselves, and sometimes reevaluating or backtracking. A doula posting to an online message board describes this:

> My all time favorite is [the] 'dumb blonde.' [I will say things like:] "Really? I have seen that before in other hospitals" or "Maybe you should double check that." … A little head tilt and innocent voice

> helps with the dumb blonde questions. I go over all these tactics with clients in prenatals.

I have also used this tactic. A client was begging to have the dose of the IV drug she was being given lowered, since it was producing contractions that were unbearably hard and fast. The nurse said that if she were to do this, the woman's labor would stop and her cervix would begin to close back up. (This woman's cervix was 9 cm dilated, and as we would find out soon enough, she was about 15 minutes from pushing her baby out.) It would have been unacceptable for me to challenge the nurse directly, so instead, I asked a question: "Really? I have never heard of that before. Can that really happen?" In this case, my questions did not get the nurse to grant my client's request, but they did alert my client to the fact that the nurse's information was questionable, and reduced her fear that her body would "close up." In this way, doulas often challenge the power hierarchy through maintaining it. This is a kind of resistance through false compliance. Minimizing the perception of one's own knowledge as a doula can go a long way toward making hospital staff feel as though what power they have is not being usurped.

If doulas choose to use their voices in ways that indicate more equal footing with hospital staff, they often talk about subtle ways to "soften" their speech. Cray told me about an encounter she had with an anesthesiologist who came into the hospital room when she was working with a client who had specified on her birth plan that she did not want to be offered an epidural.

> He actually said to her, "Oh, well, you'll be seeing me later and you'll be sorry that you didn't listen to me now." And on his way out, I asked if I could talk to him for a second. And I said, "if for some reason you do have to come back, I just would like to make you aware of the fact that the way that you presented that information felt kind of aggressive." And he was kind of miffed a little at first. But then he did come back and his tune did change remarkably. So I don't know if what I said made the difference, or if now he was going to get to do his thing so he was happier about it. But I did feel really comfortable talking to him…Even if I can't control what someone is saying, I certainly have no problem saying something to that person in a way that is respectful and can create a little bit of a boundary or a little bit of awareness about how the woman might be receiving that information in that moment.

Cray takes care to emphasize that she is speaking respectfully, and that she is creating a "little bit of a boundary." She also takes an important step: she speaks to this doctor privately, rather than in front of the client, and in doing so, avoids a public display of advocacy. Sora tells a similar story, in which she recognizes that she is stepping outside the ideal doula's role, but feels that the stakes – the mother's full knowledge of the risks and benefits of cesarean surgery – are too high for her not to overstep that role.

> Sometimes I've had to kind of do what a doula's not supposed to do. An example was: the client was getting an epidural and the anesthesiologist comes in, and he's talking, and then she starts a contraction and he continues to talk. He was trying to get her consent. And I said, "Please wait a minute. Give her a minute." and he kept talking. And I said, "She's having a contraction. Wait 'til she's done." And he finally was quiet. And I knew I went beyond what I was supposed to do. I was giving him an instruction. But I also knew that this was really important information for her to know the risks, and to give her consent. And when she was done, I said, "she's back, she can hear you now." And he got the message. And when we were in surgery I apologized to him, and said I'm sorry I interrupted you but I wanted to make sure she could hear you.

Both Cray and Sora use tactics to soften their communications with staff, such as apologizing, or using qualifying words, as in "the way you presented that information felt *kind of* aggressive." By doing so, even as the doula is speaking to hospital personnel, she also signifies her deference to the care provider and thus preserves the proper power dynamic in the birthing room, and avoids upsetting the care providers, beyond them seeming "a little miffed." This extension of courtesy benefits both the doula and the client.

Prenatal Advocacy

Doulas also say that a large portion of their hidden advocacy happens before the birth. Because doulas typically work with women prenatally, they have the opportunity to educate their clients during pregnancy about hospital policies, common procedures, and decision-making tactics in advance of the birth itself. Doulas often speak of the difference between public and private advocacy in terms of education and educating their clients. Sora said:

> [The most important thing I do as a doula is] education…And once they know what their options are then they can make their decision and my job is to support whatever that decision is. But I want to make sure they know all the different options so that they're not skewed into one decision by someone scary in a white coat.

Here, Sora is enacting a kind of preventative intervention into the hierarchy of authoritative knowledge. She is anticipating the informed consent process, and seeking to inspire confidence in her client's decision-making abilities, in hopes that the birthing woman will not simply default to the authority of her doctor by virtue of his or her place of power. For many doulas, this is done during the prenatal period, and many doulas see their main role as advocates taking place before the birth. Maggie Harper said:

> Well, I am an advocate for information and knowledge and preparation. My job is to help my clients know their options BEFORE they go into labor. It's important to make sure a woman's care provider is going to have a philosophy of care that is in harmony with what the woman, and encourage her to find a new provider if this isn't turning out to be true. Once in the labor room, my role is to support the client and her partner, help keep the labor room peaceful and give them a sense of safety and security, and help them advocate for themselves if their health care provider suggests something that deviates from their birth plan that they don't want to go along with. My role at that point is not to fight with a doctor or nurse about hospital policies or care protocols.

The role of the doula as private and not public advocate indicates that what Christine Morton observed is still the case: that the profile of a "good doula" is a lot like that of a "good woman" (2002:201) By remaining engaged in private, rather than public forms of advocacy, and avoiding argument, the doula conforms to norms of femininity, and adhering to these norms is tied to her presence in the birthing room.

Another form of advocacy outside the birthing room is in preparing clients for how to negotiate within the rules and constraints of the hospital. As Sora said:

> I tell my clients this a lot: don't ask a question if you don't want the answer to be no. Just do it. And if it's something unacceptable, you'll be told. If you want to eat, don't ask, "may I eat?" Just eat!

This type of education forms a kind of hidden resistance: teaching women and their birth partners strategies for contending with hospital protocols to get their needs met before they even walk in the door. The doula must have specialized knowledge not just of the birth

process and common medical procedures, but also the workings of individual hospitals' policies, and the health care system itself. Several doulas in my survey described this aspect of their role. Judith Wolford in North Carolina said:

> I know how intimidated some people can be, especially in more formal healthcare environments such as clinics and hospitals. I am extremely comfortable in those environments, and can help people navigate situations and issues that may be less familiar to them.

One of the most important components of navigating the system is choice of care provider. Doulas emphasize this choice as one of the most, if not the most important choice a client can make for her birth. They encourage their clients to ask open-ended questions of their care providers to fully understand what their philosophy of care is. This is difficult because typically women see hospital based care providers for 10-15 minutes at the most, barely time to complete the physical assessments needed in a routine prenatal visit. Doulas often find that their clients do not get a full picture of what their care provider is really like. This is reflected in my interview with Claire Peterson:

> [Monica Basile]: What do you do if your client is working with a care provider you know is not supportive of the client's wishes?
>
> [Claire]: You tell me! You can't do anything! I feel like you're trapped as a doula…[It's] difficult to see a specific care provider who appears to agree with you, and then all of a sudden when it comes to your birth, it's like oh yeah, we're natural, and we give you more time and we have a different philosophy, but then when the reality of the situation occurs, it's not that way. And it's difficult for me knowing this when they come to me early on and they're 36 weeks and they say, oh yeah, we have this natural doctor with their natural philosophy and you hear their name and you're like, oh boy. And how do you not impose your views? You try very hard to give them a realistic idea and prepare them in some sense, but also not impose your own personal views and experiences because maybe this is exactly what they want.

Claire describes a common ethical dilemma doulas face: how to best support someone in her choice of care provider in the face of experiential knowledge that that care provider may be, in some way, misrepresenting his/her practice philosophy or the institutional protocols that may affect it.

It is clear that many doulas perceive that their clients are not getting adequate information from their care providers during the prenatal period, and that the doulas feel the need to fill that gap. Leah Summers from Iowa describes this role:

> I feel more [like an advocate] in pre-birth work vs. the actual birth itself. I do it by asking questions, and helping them to explore within themselves. A lot gets glossed over in prenatal appointments with a physician in a standard medical practice. Just taking the time – that's what I feel the work of a doula is. [I help them by] digging up the answers to questions that might not have been answered, to help them think fully through every option that's available and every possibility that's potentially out there.

Leah expresses the common sentiment that informational support is just as important prenatally as it is during birth, and that this is something doulas must do because their care providers are often not able to "take the time." Doulas typically describe their advocacy as giving information and discussing a range of choices that are not addressed with women in their meetings with their care providers. I experience this on a regular basis as a practicing doula: just about every client I have worked with has, at some point, called me just after a prenatal visit with their care provider to ask me questions that were not answered during that visit. This is one way in which doulas intervene in the power dynamic of informed consent.

Postpartum Advocacy

Doulas also help their clients understand and frame their births after the experience. The doula is supposed to "protect the birth memory" for the mother. This goal was defined in response to DONA founder Penny Simkin's studies of the significance of birth memories, which found that women often remembered the birth(s) of their child(ren) in vivid detail decades after the event (Simkin 1991; 1992). One way in which birth memories are formed is through the telling of the birth story. Doulas usually meet with their clients sometime in the first week after the baby is born to review the details of how the labor and birth unfolded, and to compare notes with the family on their perceptions of, and feelings about, the events of the birth. Sora said,

> An important part [of our work] is not only before [the birth] but also afterwards – [asking our clients] are you satisfied, what would you change, what would you improve, and with that reflection you can help *other* parents out. So hopefully, there's a kind of upcycling of positive information, positive birth energy.

As Sora indicates, many doulas see the articulation and dissemination of positive birth stories not just as an individual service to their clients, but as a form of social change.

When a woman or couple has a positive or uncomplicated birth, looking back on the events of labor is a fairly straightforward, and often quite satisfying, task. However, protecting the birth memory becomes a complex endeavor when a birth has been disappointing or traumatic for the mother. When there has been miscommunication or confusion, betrayal of trust, or an undesired outcome, the doula's job becomes more difficult. She must choose whether it is ultimately in the mother's best interests to help her frame her birth experience in a positive way, or whether she should join or assist her in criticizing or questioning what happened.

Sometimes simply listening to a client talk about what happened during the birth is a way that a doula helps a client release a negative experience. Gloria Rose explained,

> There's usually at least something one person in the hospital said that really hurt them. Some sort of verbal abuse that they need to process in order to release, whether they felt that person was impatient or unkind…You know, we try to laugh about it -- that's great therapy -- but it still needs to be voiced to be released.

In addition, sometimes doulas witness treatment in the hospital that they themselves feel is inappropriate, but their clients seem to not have a problem with it. Gloria went on to say,

> I have to do a lot of debriefing and releasing of things that affect *me* at the birth and then make sure that when I come back to the postpartum follow-up with my clients, that I'm not projecting any of *my* negative memories. I'm there to just let them process their experience and sometimes I have a hard time emotionally letting go of this or that experience.

In a situation like this, the doula has to find her own way of processing an experience that was traumatizing for her, without transferring her feelings on to a client. This is something that doulas are very careful about. In order to protect clients from feelings that are not their own, doulas have to practice a considerable amount of self-care and mutual support.

Doulas also try to balance helping women feel positively about their birth, while simultaneously avoiding casting unfortunate, or even abusive events in a positive light. Doulas must be careful to not induce negative feelings where they are not present in the client, while also taking care not to rob their clients of a valuable opportunity to contend with their birth experiences in an honest and proactive way. When clients voice dissatisfaction with their care, doulas sometimes encourage them to write letters of complaint. Claire told me that many of her clients have been unsatisfied with a particular health care provider.

> More and more of my clients who have this [care provider] want to write letters and I encourage them to do that. If you're unsatisfied then please, by all means, write a letter! Do what you need to do to feel you've done all you could.

While doulas are encouraged to help their clients see their births positively, they also recognize that birth activism often follows from negative birth memories, and in fact, many doulas are inspired to begin assisting at births because of their own dissatisfaction with previous births. In their postpartum advocacy, doulas attend to the ways in which the birth experience shapes the rest of a woman's life.

The Doula as Translator

Doulas commonly describe themselves as interpreters. Because doula training includes extensive education about common medical procedures and their risks and benefits, they are able to pass this information along to their clients. Doulas often speak about translating medical language of birth as a foreign language. Athena Quinn in Michigan describes this role:

> I help them navigate the muddy waters of hospital births. Additionally, I am able to explain to them what certain procedures or happenings at birth mean. Such as a resident telling a nurse "She is plus one, 100% and at about 5." I can translate this to something they understand, as many health care providers do not take the time to explain.

Doulas like Athena see themselves as empowering their clients with information about their own bodies that is often seen as the province of health care providers. Doulas make hospital jargon understandable to women in labor, making those "muddy waters" navigable. The translator role meets with varying degrees of acceptance, depending on the attitudes of the staff toward both doulas and the clients they are serving.

In addition to translating the language of care providers and their tools to women in labor, doulas also sometimes translate to the hospital staff on behalf of the client, as a "messenger" or an "echo" of her voice. Although the lines may become blurry here, this is slightly different from speaking for the client, because in the echo role, the doula is simply restating what the client has already communicated to staff or to the doula. The laboring woman's voice is present, but needs amplification. Cray Gardiner described her feelings about this role:

> Part of my role as a doula is that I get this really intimate position in being able to be the steward of what this person or couple wants for their birth experience. And if they communicate that to me and they want me to uphold that, then if I see tear in the fabric of that, and they're not able to attend to it because they're attending to the really direct experience of the birth process, then I feel like it really is my role to protect that. And if that means interfacing with the staff, then I don't feel like that's disempowering at all. I feel like I'm an extension of the woman's power, and that if she and her birth partner made a choice to have me there, then I'm advocating for her empowerment. I would never make a statement or do something that was about *my* agenda. But really clearly echoing what was shared with me [is] what I feel like I was hired to do.

Here, Cray understands herself as an "extension" of the client's voice and her power. In this narrative, the doula and the client are working together, the doula as a "steward" of the client's wishes. Cray is mindful of the politics of empowerment, and does not feel that speaking for her client in this capacity is a disempowering move.

However, because of the direction of this form of translation, from laboring woman to care provider, advocacy of this kind is a little trickier. When the doula is the messenger for the hospital staff, she facilitates the direction in which information is supposed to flow: from the top down. When doulas translate for laboring women, however, they are performing a

bottom-up transaction, and thus posing more of a challenge to the power hierarchy. Doulas typically translate two different types of information to hospital staff: information about their clients' bodily states, and information about their preferences for treatment. The translation of each of these types of information results in a slightly different kind of disruption.

One of the most valuable skills a doula can develop is the ability to assess how a woman's labor is progressing with no external measurements (or internal measurements, in the case of vaginal exams). This is done simply by paying keen attention to the mother's bodily signals, such as her vocalizations, movements, and emotions, by responding to her requests, and by asking her about the sensations of her labor. When a doula translates a laboring woman's bodily state to hospital staff, she is often simply reiterating the laboring woman's own assessment of herself, such as "she just said she needs to push." Even though the staff may not trust a message like this without insisting on a vaginal exam to "prove" the mother's readiness to push, they usually appreciate the doula for providing this kind of communication. The assumption is presumably that the doula is objective or detached enough to make an independent observation of the mother, even though the mother herself may have been trying to communicate the same thing.

By encouraging a birthing woman to trust and communicate her own bodily needs, the doula repositions the birthing woman as knower, instead of an object to be known, which is an important component of the empowerment doulas seek to bring to the women they work with. As Cray describes,

> I feel like the medical community, by and large, is such a tyrannical force that I feel like it really degrades people's personal sense of their personal knowledge that they have about their bodies and their experience of themselves, and rarely takes into consideration what a human being really knows about who they are. And so a doula, I think, provides a buffer -- I think of her providing space itself for this birthing mother to really have her voice and have her own experience of self and her knowledge of self in the room with the medical community. And for them to take it into consideration, to have someone there to help to advocate for that, so that it doesn't just get absorbed.

Here, Cray expresses the conviction that her presence helps render a birthing woman's experience intelligible in an environment in which it would not otherwise be. This is a subtle but significant challenge to the status quo, in which, as Brigitte Jordan describes, "business gets done with [the laboring woman] as an object but not an actor" (1997:71). While the doula may not actually be successfully repositioning the laboring woman as the primary knower in the room, her presence, as Cray describes, can provide a "buffer" around her, so that her own direct experience of her body is interpreted first through her own senses and her own knowing, rather than being "absorbed" into the clinical assessments of others.

When the doula echoes a laboring woman's voice by reiterating that woman's preferences about her care, she launches a more powerful challenge to the hegemony of standard medical management of birth. Again, the success or failure of this form of advocacy depends a great deal on the attitudes of the care providers involved in the birth. When care providers are receptive to considering the wishes of the client, and accepting of the doula as part of a team approach, the doula can speak to staff with no negative repercussions. Sora describes being a messenger while working with a specific group of care providers who are supportive of that role:

> I think of an advocate as being her voice. And within the contract it says I cannot speak on their behalf. However, I AM speaking on their behalf because that's what they hired me for. If I know exactly what their wishes are, she's told me, and she's not able to say it because she's in discomfort, then I feel like I can repeat what she said to me as the messenger. And I feel like that's acceptable. So I do feel like I'm an advocate. I don't feel like I'm in an environment where being an advocate is fighting against the stream, because we're just lucky to be in an environment where they [these care providers] are on the same page.

Because of the orientation of this group of care providers toward hearing both the laboring woman's voice and the doula's voice, this doula feels that she can speak for the laboring woman as her "messenger" without "fighting against the stream" or disrupting the power balance.

However, echoing a client's wishes can also put the doula in a precarious position, and even inspire conflict if the care provider feels this translation represents a breach of power and authority. In doula trainings and in publications such as DONA's *International Doula* (*ID*), communication with health care providers is a substantial topic. The doula's mediation and negotiation skills are considered essential for avoiding any conflict that might arise in the birthing room. A contributor to the *International Doula* writes, "Doulas never interfere with the relationship between client and care provider. It can be a challenging task at times – requiring tact, patience, and good reflective listening skills" (Worzer, quoted in Young 2002:16). Doulas go to great lengths to avoid conflict in the birthing room, but sometimes they do find themselves in situations in which a conflict arises, or in which communication is strained. Doulas' stories of these kinds of difficult situations are important in that they help us understand the ways in which a doula's advocacy role takes shape in the context of institutional and interpersonal power.

Gloria Rose described a situation in which the her willingness to speak up for her client led to an unusual conflict with a care provider:

> My client was side lying during the pushing stage and the baby was starting to crown. She was comfortable; she was drinking water; she was very calm. And there was progress with each push, but this practitioner was impatient and wanted her to change positions and my client tried it, tried being on her back, and the practitioner was scooping -- putting her fingers in around the crown, and my client was saying "That hurts!" And I think I finally just looked at the practitioner and said [in a soft, kind voice], "you know, I think she's really more comfortable on her side with your hands off." So the practitioner, in a huff, stripped off her gloves, sat down in the chair, with her arms crossed, and said "well, I'll just stay out of it." She sat back with her arms crossed and was like, "well I guess you don't need me." She did stand up for the final delivery. Mom was up on hands and knees, and so [the care provider] was there to catch baby. And the baby came out just fine. But she sat there a good long time. It was probably 25 minutes. So she was like this angry observer while I was just trying to keep it positive around the bed for the client and her husband.

This kind of interaction is precisely of the kind that doulas typically seek to avoid: the doula made a direct suggestion to the care provider, in front of the client, about the care provider's

conduct. Here, the care provider's response, to withdraw herself and sit angrily by as the woman's baby was crowning, seems meant to prove a point to Gloria: that the price for stepping out of her place by speaking to the care provider, even by simply echoing the client's wishes, is the very care being provided to the client. The client's body, here, had become the turf upon which this power play unfolded – by disavowing the fact that she was "needed" to deliver the baby, the care provider threatened to place the birthing woman in a potentially dangerous situation, and Gloria in a position for which she was not prepared or trained. While the doula is encouraged to not speak to care providers directly, hospital staff are free to speak to doulas however they wish, and sometimes doulas do take scolding and other forms of mistreatment from care providers. Doulas are not in a position to defend themselves, because the experience of the client – not that of the doula – is of utmost importance. Although Gloria was locked in an intense conflict with the care provider, she had to stay focused on "keeping it positive around the bed."

Wave Azul described a conflict situation in which she, as a young and not yet fully trained doula, chose to physically defend a client, who was also a personal friend, and a young single mother. This is the only story of its kind that I encountered during my research, but it is indicative of the desperation doulas sometimes feel as they work to advocate for their clients.

> I had one woman who had a back injury and did not want an epidural. She was adamant that she did not want it, and she was scared of what could happen afterwards. At one point she screamed bloody murder, a blood-curdling scream with a contraction. They came running in, and the OB started yelling to go get the anesthesiologist, that he couldn't deal with this anymore and she was going to get an epidural. So I told the OB, I started out really nice, and said, "she's not going to get an epidural." And [the doctor] kind of pushed past me and grabbed her arm and was like, "we're going to get back to the bed, you're going to get comfortable, and we're going to give you an epidural." And she kind of whimpered, and I just -- this was SO inappropriate, but I grabbed his arm and I spun him back around, and I said, "She is not getting an epidural. She does not want it. You're going to need to get security if there's going to be a problem." And it just got really quiet and there was kind of no resolution. After she had the baby, the nurses came and said that I had offended the doctor, and that I should think about apologizing.

> And I felt really bad that my client was hearing this. And then she [my client] said, "I think that you should tell the doctor that *he* offended *me*."

When Wave says that she "started out really nice," she means that she began her interactions with this doctor in a friendly way, not wanting to create conflict, much like Gloria did, when she tried to speak to the care provider in a kind voice. As the situation escalated, she felt that getting the doctor's attention physically was the only way in which her client's voice and wishes could be heard. She describes her client as screaming, and later whimpering; she seems unable to actually speak for herself until after the birth, when she intimates that her doula need not apologize to the doctor, and thus implies that she did not feel that Wave acted inappropriately. The politics of the apology in this scenario are particularly interesting to me, in that the circulation of apologies can be an indicator of power. Whereas in some of the other stories I shared, the doula's apology is what resets the power hierarchy and thus softens or mutes the effects of the doula's voice, in this story the refusal of the doula to apologize threatens to turn the hierarchy on its head, figuring the birthing woman herself as the deserving recipient of an apology (even though one was not extended to her). Wave also describes her thoughts about this experience in hindsight:

> Now I would probably handle that differently. I physically would not have touched him now because I think I would have been kicked out. Now, I think I would have asked for a moment to be alone with her and helped her figure out how she could voice what she wanted in between screaming. But it was intense. I was shaking…All I could think was that she did not want it in her back! And I didn't know what else to do.

Here, she realizes that she could have, and perhaps should have, done things other than confront the doctor directly, such as asking for time alone with the birthing woman, or involving the woman's partner in speaking up for her wishes. As we have seen, these are typical strategies doulas are trained to employ in lieu of speaking for clients. But without these strategies on hand, it can be hard for a doula to know what else to do when a client seems unable to speak for herself.

Many doulas in my study expressed feeling, at times, an urge to physically protect their clients. Sometimes, doulas say, they feel like they are bearing witness to interactions that feel like assault. This has led some childbirth advocates to coin the term "birthrape." One Iowa doula, Olivia Winter, describes such an experience. After a series of disrespectful encounters beween the nurses and the client, who was a sexual assault survivor, the following occurred:

> The doctor comes in the room, and my client is in knee-chest position, facing away from him, and I can see the nurse handing him an internal monitor [device that attaches to the baby's scalp and must be placed intravaginally]. He's gloving up and getting ready to put [the monitor] in without even so much as introducing himself. At this point, I have lost trust that anyone is going to obtain informed consent, and I say to the doctor directly, "she needs you to ask before you touch her, and to explain to her what you want to do." This goes against my training, but she was in such a vulnerable position. The doctor quickly tells her that they need to place an internal monitor right away, and then he puts his fingers inside her without warning. She is screaming, "Please stop" and "Get your hands off me." The nurse is yelling at her to be quiet, and restraining her. I didn't know what to do. I tried to comfort her, but it was like comforting someone through a rape. I just felt sick, like I wanted to just shove the doctor away and take her out of there. I feel sick thinking about it right now. It took her a long time to process that birth. She's probably still healing from it. I think I'm still healing from it.

This illustration of birthrape is quite disturbing, and it reminds us that birthing women and doulas alike can experience trauma in birth. It also exposes a little-recognized fact: that having a doula does not necessarily protect a birthing woman from having a negative or traumatic birth experience. The online group, Solace for Mothers, began in response to experiences like this "for the sole purpose of providing and creating support for women who have experienced childbirth as traumatic." Solace for Mothers provides two separate online forums: one for women who have had traumatic births, and one for caregivers and advocates who have witnessed such births.

Olivia went on to say that she felt that the staff treated her client in this manner because they could "get away with it" since she was a single parent, on Medicaid, and a

recovering drug addict, and that they seemed to be sending a message to her that "deviant women" deserve to have their bodies treated carelessly and recklessly. She said,

> Maybe this was just an instance of bad care providers, but I have never, in 10 years of work as a doula, seen a middle class, married, white woman treated like this. I have noticed that the more a woman in labor is stigmatized, the less I'm accepted as part of her birthing team. The attitude [of the nurses and doctor seemed to be that] some women don't deserve support in giving birth, because they shouldn't be having babies in the first place.

This perspective shows that the extent and quality of the support doulas are able to provide to women in labor is directly affected by the stereotypes and assumptions of health care professionals, who may be steeped in larger cultural attitudes that blame "deviant" mothers for social ills. In my research, I have been particularly interested in stories like this that illustrate how social power, privilege, and oppression circulate in the experiences of doulas as they provide labor support in the birthing room.

Baptism By Fire: Advocating for Vulnerable Women

The vast majority of doulas in my study, whether or not they are part of programs that specifically reach out to underserved women, have been involved in providing care to clients with unique challenges. More than half of the doulas in my survey report having assisted single parents, teen parents, low-income parents, abuse survivors, and women of a different racial/ethnic group than the doula. Almost half of the doulas in my study have assisted immigrants or refugees, English language learners, LGBT people, current or former substance abusers, and those affected by domestic violence. Fewer doulas have assisted clients who are homeless, incarcerated, disabled, planning to release a baby for adoption, or terminate a pregnancy, but the vast majority of doulas indicated that they would be willing to assist women in any of those categories.[4] (See Figures A-1 and A-2.)

[4] Of course, doulas or care providers may also fall into any of these categories. A full exploration of how social locations circulate in interactions in the birthing room is beyond the scope of this practice, but I address issues involving the doula's identity throughout this dissertation, particularly in chapters 1, 2, 5, and 6.

In their discussions of the advocacy role, doulas in my study approached the politics of voice differently depending on the social position of their client.[5] They frequently cited specific situations in which they would speak for clients who they felt might be especially vulnerable. Brandi Nolan in Nebraska said,

> I feel that I am source of research and information and ultimately assisting them to advocate for themselves. Yet, if the situation calls for it, I will step in. For example, I would never let a laboring mother that has a language barrier struggle to speak to a practitioner when I can help. I would also never let a teen mother feel she needs to argue for her rights to an older and more experienced practitioner alone.

Marie Carrell in Wisconsin also explained,

> I advocate and speak up for some of my clients in my low-income program because sometimes there is no one else to do that and they are too deep in labor to speak for themselves. I would prefer [them to speak for themselves] because I think they might prefer that, but better to cross a bit of a line than leave them be victimized.

Brandi and Marie both express a preference for the client speaking for herself, but at the same time, acknowledge that social gaps of language, age, and socioeconomic vulnerability might limit the extent to which a client feels capable of expressing her needs or wishes to hospital personnel. Their responses indicate that doulas are in the powerful position of apprehending, on a bodily level, how social and physical vulnerability overlap in the birthing room.

Doulas bear frequent witness to instances in which axes of privilege and oppression intersect with, and are even intensified by, the politics of power in the hospital room. Thus, they have special access to the reach of what Foucault and other scholars term biopower – the control of populations through the body. Explicating biopower, Dreyfus and Rabinow explain, "to understand power in its materiality, its day to day operation, we must go to the level of the micropractices, the political technologies in which our practices are formed" (1983:185). The day-to-day experiences of doulas are rich with illustrations of such

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[5] This was also true for the doulas interviewed by Morton (2002).

micropractices. Olivia's story was not the only one of its kind. I heard many stories of the differential treatment of clients. Jane Halliday in Wisconsin said,

> Most striking was the difference in treatment in the hospitals and by nurses for my clients who were women of color, low income or teenagers- many fitting into all of these categories. I have seen RNs say things to them that are so hurtful and discouraging and would never be said to a private client who was white well-educated and over 25.

Nancy Rich in New York noted,

> What I noticed was that the medical establishment took my clients less seriously when they were low-income combined with African-American. My doula training didn't touch these issues.

Kimberly Greenlee in Washington DC echoed this.

> L&D nurses are sometimes pretty rude to teen moms. I hear comments like, "you should have thought of how painful it was going to be before you went and got pregnant!"

And Norma Jameson in Connecticut observed,

> In caring for same sex couples, I find that there are more barriers to communication in the hospital. The non-pregnant mother is not seen as a parent by some caregivers.

In situations like these, the politics of the doula's voice take on a different significance. Seen through the lens of biopower, in advocating for her client, the doula is not only advocating for humanizing a particular birth experience, but for the humane treatment of a marginalized population.

While the majority of the doulas I surveyed are serving a wide range of clients with a wide array of needs, doula training still reflects an orientation toward working with a rather narrow range of families. Most doulas in my study said they were not prepared by their training for the advocacy circumstances they have encountered. As Marie McKay in Washington said, "I was only marginally prepared for [these] challenges by my doula training which focused mostly on supporting upper middle class, privileged families." Some doulas expressed the desire for a broader range of topics in their training, but most of the doulas in my survey seemed to think that there is no way the doula's brief training workshop can

prepare her for what she will encounter, and that doulas can only really learn these things on their own. Jill Schuck in Pennsylvania said,

> I think my trainer would have needed to spend another entire day to cover just half of these issues. You [have to be] the type of person to feel comfortable accepting people's stories and how they will affect their decisions and to be ok learning on the job. I've had many unique challenges, most of which I found emotional and psychological in nature, but I learn to deal with them better and better with experience with various people.

Overall, the doulas in my study seem resigned to the idea that is only through amassing experience that doulas can really learn how to deal with these circumstances. As Elaine Healey in Illinois put it, "I've always been a baptism by fire kind of gal anyways." Many doulas said that it was not their doula training, but their other life or educational experiences, that best prepared them to work with clients with unique needs. Jane Halliday in Wisconsin said,

> I believe my doula trainings did not prepare me for many of the special circumstances I have encountered working as a doula, however different educational and life experiences did prepare me in some cases. For example, I was a very young, single, low-income mother so that helped inform my work with certain clients. My Domestic Violence training and background in Women's Studies and Community Health helped me with other situations. Otherwise, just being intuitive and listening got me through other situations that I did not have a reference point for.

Bearing witness to the overlapping forces of social injustice and birthing injustice emerged as a significant source of stress for doulas, especially since so few doulas felt prepared for how to advocate in these situations. Merrie Whitley in Michican explained,

> Oh hell no, training doesn't prepare you for the reality. But could it? I mean we have stories, but even that isn't "real" until you've experienced those situations. I was really not prepared for the way that doctors and medical professionals will treat younger women who are opting to give birth. I have had women held down against their will for vaginal exams, women cut against their wishes, women plainly manipulated and emotionally abused as they are bringing children into the world; these women are viewed as "less than" and it is heart wrenching, vomit inducing, go-home-drink-a-fifth-of-whiskey-and-sob-in-the-shower horrible. Nothing could EVER have prepared me for that.

Brandi Nolan in Nebraska described a similar sentiment:

> Doula certification is a wonderful jumping off place and gives valuable education regarding pregnancy/labor/postpartum. However, it doesn't prepare you for an African refugee who has scarring all over her body from the rapes she endured in the camps. It doesn't give you the words to help her finally tell you what is holding her back emotionally when she's stuck at 8cm for 4 hours and looking at a [cesarean] section. And it doesn't prepare you to personally process the story of her 2 year old who died from starvation and sickness in her arms in those same camps. That is something only life, experience and in my opinion, God can prepare you for.

As these narratives show, doulas all around the country are struggling with how to advocate for women who often have very complex sets of needs, and doing so with little formalized help. Although in my local community and in many others, including online communities, doulas have the opportunity to debrief informally with each other to process difficult births, many doulas I surveyed and interviewed felt that national doula organizations could do more to help doulas both prepare for, and recover from, a wider range of experiences. As these quotes show, some doulas find themselves turning to God or to whiskey, rather than their doula organizations, for support.

In a recent qualitative study of the roles of community-based doulas working with adolescent mothers in Georgia, researchers found that "working with pregnant adolescents requires them to go beyond their assigned roles and duties in an effort to reach intended maternal and child outcomes" (Gentry et al 2010:38). Attending to needs far beyond those outlined in typical doula training, these doulas take on roles more usually expected of friends and family members, social and health service providers and advocates, and general life coaches and counselors.

Language translation is one specific area in which doulas sometimes find themselves called on to fill roles that exceed the ideal doula's role. Although the role of the doula is separate from that of a professional medical translator, bilingual doulas often play an important role in mediating language problems in the birthing room. A recent article in the *International Doula* deals with this issue, outlining the legal rights of parents with limited English proficiency to access medical translation services (Franzen 2011). However, it does not counsel doulas who may be working in underresourced areas where translators are not

available. This can be a difficult situation for a doula, and bilingual or multilingual doulas are often faced with the additional burden of translating, regardless of the legal rights of their clients. Karen Faulk from Pennsylvania explains,

> I am also fluent in Spanish, and as such tend to work with immigrant women (often undocumented). Having to act as a translator, doula, and social worker all rolled into one is difficult, and not part of my doula training. Unfortunately, where I live where are not adequate translation or social services for the women who come in, so I end up reluctantly fulfilling roles I was not trained to do.

While the ideal is to have a translator, in real life, doulas may fill this role, if reluctantly.

In her study of issues of choice, control, and class in the birthplace, Ellen Lazarus demonstrates that both poor and middle class women wanted quality medical care, but middle class women had more access to information and expressed more of a desire for control, whereas poor women's concerns focused more on continuity of care (1997). This forces us to question whether the feminist preoccupation with who is in control in the birthplace reflects a middle-class perspective, unquestioningly taken as universal, and which may be less relevant to poor women. Similarly, many doulas in my study who work with marginalized women report that issues of choice tend to be less important than basic dignity. To illustrate, one doula described working with women at a domestic violence shelter. She said, "I learned that they really didn't care about 'birth choice' so much as being treated with dignity and respect."

Many doulas raised concerns about being coopted into the hospital system, which was perceived by some as a potential drawback of getting too comfortable in the hospital. The difficulty of negotiating these loyalties is expressed by those who work in hospital-based volunteer doula programs. Corie Gillis in Massachusetts said,

> In my heart I'm usually behind [my clients] 100% and will speak up when I'm able. A huge issue for me this past year has been that I'm a volunteer at a certain hospital and I don't think being connected to a hospital is the right place for a doula. The lines of loyalty are too entangled.

Doulas deal with a significant tension, in that they are accountable solely to the expectant parents who hire them, but at the same time, they must be extremely careful not to step on toes in the hospital. When a doula like Corie is an employee of the hospital, these relationships do indeed become "entangled." The importance of the doula's allegiance to the family, rather than to hospital staff, is a part of doulas' professional ethos, and has been recognized by researchers as an important component of what connects doula care with positive outcomes. The most recent literature review on labor support by researchers at the Cochrane institute concludes that "continuous support from a caregiver during labour appears to confer the greatest benefits when the provider is not an employee of the institution." This is attributed to the "divided loyalties, additional duties, self-selection, and the constraints of institutional policies and routine practices" that influence care providers like nurses (Hodnett et. al. 2003:20).

While the vast majority of doulas emphasized what Christine Morton terms "team player" approaches (2002:260), expressing wishes that the doulas, the doctors, and the hospitals could get along better, they also recognized that their presence might be a threat regardless of how deferential their behavior. The doulas who expressed these concerns felt that because the medical system is fundamentally set up to place laboring women's individual interests secondary to those of hospital and insurance protocols, and because the doula's purpose is to ensure the centrality of laboring women's decisions and experiences, there is no way to avoid being perceived as hostile or controversial. Hazel Davis, a recently retired doula in Oregon, says:

> I view doulas as being very important as outsiders and critics in the for-profit, monolithic institutional context that birth occurs in today. I oppose our profession's acceptance of taking an apolitical role. I believe in unequivocal support of the client's interests and agenda, and through experience have learned this is a actually viewed as a hostile and politicized role because hospitals (and sometimes homebirth professionals) agenda is supposed to supersede and dominate the client's. So I have accepted that my presence in carrying out my duty is controversial. I have worked hard to be diplomatic and passive and sweet to medical professionals, and never venture outside the doula scope of practice, only to find that this does not

> take me outside of controversy as was promised in my doula training. In fact, experience teaches the only way to stay out of the fire is to undermine my clients' interests and train them in hospital complacency.

Hazel voices a painful tension. She clearly feels she was misled in her doula training to believe that she could advocate effectively for her clients through diplomacy and passivity, and has come to believe that there is no way to stay "out of the fire" except by training clients to also be subservient. Many doulas in my study expressed concerns about doulas becoming too embedded in hospital systems. Cray asked:

> [It's important] that the doula doesn't just become a function of the larger institution, like, "Oh doulas really make our jobs easier as nurses and doctors." What happens when their role *doesn't* make it easier for [doctors and nurses]? What happens when their role makes it challenging to some of those rote operations? Are doulas still as welcome then? What kind of a line does a doula need to walk to be able to be in the hospital setting in an effective way?

This doula's sentiment stands as a counterpoint to the language in Kingston's doula ban, which proves that, in answer to her question, doulas are sometimes *not* welcomed when they make things more challenging to the rote operations of the labor and delivery unit.

The concern among doula organizations with the advocacy role and the proper circulation of the doula's voice reflects what Linda Alcoff calls "the current within feminism which holds that speaking for others is arrogant, vain, unethical, and politically illegitimate" (1991:6). Alcoff acknowledges that the impetus to speak for others can sometimes be a result of a "desire for mastery and domination," which is what doulas are so careful to avoid. But Alcoff also identifies problems with the stance that one should never speak for another. One such problem is that this perspective is based on an illusory Western ideology of individualism, "that a self is not constituted by multiple intersecting discourses but consists in a unified whole capable of autonomy from others" (21). Alcoff suggests that the "retreat response," or the position of only speaking for oneself, is fallacious in that it assumes a unified and autonomous selfhood that never touches or overlaps with others, and erases the possibility of effective coalitional work.

Alcoff's analysis helps illuminate the individualist ideology regarding personhood, selfhood, and relationality that DONA's standards of practice reflect, and that many doulas also embrace. It is common for doulas to use individualist rhetoric and the language of ownership to express their ideas about empowerment and autonomy in the birthing room, as in the commonly expressed sentiment that doulas try to encourage women to "take ownership" of their decisions and their voice. This reflects not just an individualist stance, but is influenced by capitalist notions of selfhood as well.

Ultimately Alcoff argues that whether or not speaking for others enacts a kind of discursive domination depends on the context in which the speech act takes place, and that the *effects* of the exchange are crucial to understand, even though we may only be able to understand them partially. In response to the refusal to speak for others, Alcoff also offers the question, "If I don't speak for those less privileged than myself, am I abandoning my political responsibility to speak out against oppression, a responsibility incurred by the very fact of my privilege?" (8). It is clear that this is also a question many doulas ask themselves, and it comes up especially when doulas are working with clients who are socially marginalized, often in multiple ways.

Conclusion

The tensions I explore here are not meant to paint a picture of the doula profession as conflict-ridden. Most birthing women who choose doulas enjoy the significant medical and interpersonal benefits of doula care, as well as pleasant, collegial, collaborative relationships between their doulas and their care providers. The perspectives of the doulas in my study show that although the efforts of the women's health movement have led to some significant changes in the way birth is conducted in the hospital, birthing women today are still confronted with hospital practices that are not only of questionable value for maternal and neonatal health, but also undervalue a woman's voice, bodily experience, and decision-making capability in the birthplace. However, rather than the overmedicalization of birth, the

doulas in my study identified abuses of power in the birthing room as the primary barrier to optimal birth experiences in the US. While they saw these issues as connected with the problem of medicalization, they seemed far more concerned with democratizing birth experiences than with demedicalizing them. This finding marks a significant shift in the priorities of doulas since the 1990s, when Christine Morton (2002) and Bari Norman (Simonds 2007) were conducting their research.

Rather than simply using their voices in service of accommodation or resistance, doulas are actively contending with the question Alcoff asks: "Is the discursive practice of speaking for others ever a valid practice, and, if so, what are the criteria for validity?" (1991:7). These questions become much more "tricky" when doulas are dealing with issues like addiction, welfare status, language barriers, or immigration status. These issues overlap with the circulation of power within the hospital to profoundly shape the doula's ability to effectively advocate for women during childbirth. If a doula has a client with a past or current drug addiction, her advocacy for that client will be touched by issues of drug policy. If a doula has a client who is facing deportation, her advocacy may spread into working for immigration reform. If a doula works with lesbian couples, whatever her sexual identification, she will likely have an investment in LGBT rights.

As I will show in Chapter six, many doulas act as advocates for reproductive rights and experiences outside the realm of the birthing room. For an increasing number of doulas, their work is not simply about helping someone to give birth, or to avoid unnecessary intervention; it's about advocating for a wider range of human rights in the context of reproductive experiences. As doulas increasingly connect their birth work to other types of social justice advocacy, they are in a powerful position from which to redefine the scope of childbirth reform in the U.S. in the 21st century.

CHAPTER 5
BIRTHWORKERS OF COLOR AND THE POLITICS OF "TRADITIONAL CHILDBIRTH"

As the childbirth movement has become a more powerful social force, interest in the culture, politics, history, and experience of childbirth has grown. Feminist scholars have effectively shown the often sexist power dynamics inherent in the philosophy and practice of American biomedical obstetrics (Arms 1975; Davis-Floyd 1992; Ehrenreich and English 1970; Oakley 1980; Rothman 1982; Stoller-Shaw 1974). However, the fact that the alternative birth movement is a largely white, middle class phenomenon has gone essentially unexamined by many researchers and childbirth advocates. In this chapter, I discuss the historical and contemporary landscape of midwifery and doula work in communities of color. I focus on the work of a key organization, the International Center for Traditional Childbearing (ICTC), which promotes and supports midwives and doulas of color; a key individual, Jennie Joseph, a CPM from Florida working to reduce racial disparities in maternal and infant health; and a key event, the 2010 Midwives Alliance of North America (MANA) regional conference, organized around the theme "Overcoming Disparity: Midwives Collaborating for Equality in Birth Outcomes." I argue that the perspectives and priorities of birthworkers of color contribute meaningfully to the paradigm shift that is occurring in the childbirth reform movement.

Efforts to revitalize midwifery and incorporate doula care in communities of color employ an intersectional approach that stands in contrast to critiques of mainstream obstetrical care and hospital birth that are solely gender-based. While second wave feminist accounts of the shifting status of midwifery offer insightful analyses of gendered power dynamics in women's health care, they do not adequately attend to the complexities of race and class. In contrast, the work of contemporary midwives and doulas of color and their

allies seeks to address the multilayered disparities in maternity care that women of color face, especially those who are socioeconomically marginalized. In contrast to the universalizing rhetoric of "natural" birth, the designation "traditional," as employed by the ICTC and others, refers not only to birthing practices, but also to a distinct tradition of grassroots activism in historically marginalized communities in America. By making social justice work central to the definition of tradition, birthworkers of color offer a historically grounded critique of how race, class, and gender influence maternal and child health in the U.S.

I use the term "birthworkers" here to refer to both midwives and doulas. Although my project as a whole focuses on doulas, I discuss midwives and doulas together in this chapter because these models of care are closely related in the ICTC, which specifically draws on African American midwifery traditions to train doulas in a midwifery model approach. My key sources for this chapter are concerned with the maternal and infant health of all people, and all racial minorities, but focus specifically on black Americans. For this reason, my analysis centers on the historical and contemporary practices and discourses of black birthworkers. However, where appropriate, I also use the term "birthworkers of color" in order to acknowledge the work of midwives and doulas of color who are not African American, and to acknowledge the racial inclusivity of the organizations I profile. My intention is to focus, where appropriate, on the specific work and experiences of black birthworkers, while also using inclusive language in a way that avoids using African American experiences to stand in for those of all people of color.

The Racial Politics of Midwifery: Past and Present

In July of 2010, I attended the Midwives Alliance of North America regional conference in Madison, Wisconsin, organized around the theme "Overcoming Disparity." Many important conversations took place at this gathering, especially related to issues of racial disparity in birth outcomes and racism within the midwifery and childbirth

movements.[1] On the first day, Daniela Garza, a young self-identified Chicana doula and aspiring midwife, addressed the conference as part of the opening panel. She said,

> The culture of midwifery is changing. The culture of natural childbirth is changing. We are standing on the shoulders of women of color on this continent. Granny midwives delivered America! Most books about midwifery erase the herstory of women of color midwives. How are we going to want to be midwives if we can't connect to that story? As we move forward with including the voices of marginalized women, we can't talk about midwifery starting in 1960!

At this, the audience applauded enthusiastically. That applause was both surprising and relieving to me. It revealed a long overdue recognition by the mostly white midwifery community (also demographically reflected in the conference attendance that day) that changes in childbirth practice have unfolded in significantly unique ways for communities of color in the U.S.

Throughout the first half of the twentieth century, American public health campaigns sought to systematically control, regulate, and eventually displace African-American and immigrant midwives, and often relied on racial prejudices to justify these efforts. In the 1970s, when middle class, white feminists initiated a "midwifery renaissance," African-American midwives were not, in large numbers, a part of this movement. As health activist Linda Janet Holmes explains, "while a new wave of primarily white middle class consumers were beginning to have an impact on increasing birth options, these groups never successfully championed the cause of the black lay midwife" (1990:99). Today, African American women plan homebirths about 1/4 as often as white women (MacDorman et al. 2012). While it is important to recognize and interrogate the relative racial homogeneity of the contemporary homebirth and midwifery movements, it is also crucial to avoid the assumption that women of color are entirely absent from these movements. This assumption

[1] Racial disparities were not the only forms of inequality that were dealt with at this conference. There were also panels on poverty, environmental justice, the needs of LGBTQ community, and others.

risks the erasure of not only the history of diverse midwifery traditions, but also the present-day work of contemporary birth workers of color.

In the early decades of the twentieth century, obstetrics, a relatively new medical specialization, began to replace midwifery as the preferred model of maternal health care in the United States (Leavitt 1986:175). American culture was in the process of developing an orientation toward science and efficiency as it was becoming increasingly industrialized, and the hospital, modeled after the factory assembly line, was promoted by physicians as a new and modern setting for childbearing[2] (Susie 1988:3). The process of distinction between midwives and obstetricians began in the nineteenth century, as physicians began using forceps and anesthesia. At the turn of the century, midwives attended about half of all births in America, and the majority of midwife-attended births took place within African-American and immigrant communities (Fraser 1995:5). In the 1920s, with the passage of immigration restriction laws, the drive toward Americanization, and the proliferation of ethnic stereotypes that portrayed immigrant birth attendants as dirty and backwards, midwives who served immigrant ethnic communities virtually disappeared (Susie 1988:7).

By 1930, midwives attended 15% of births in the U.S., and of those, 80% took place in the South (Leavitt 1986:268). As was the case with portrayals of immigrant midwives, representations of black midwives relied heavily on racist characterizations. An Alabama physician described the black midwife as "the typical, old, gin-fingering, guzzling midwife with her pockets full of forcing drops, her mouth full of snuff, her fingers full of dirt and her brains full of superstition" in the state's medical journal, and a similar article was published in Mississippi calling black midwives "filthy and ignorant and not far removed from the jungles of Africa" (quoted in Mathews 1992:65). These depictions were widely circulated in public information campaigns not as editorial, but as fact. The campaign to eliminate the

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[2] Physician attendance did not necessarily mean hospital birth. Although physicians attended 85% of births by 1930, rates of hospital birth would not exceed 50% until after 1940.

traditional midwife, however, ignored actual factual data that showed significantly better outcomes for births attended by immigrant and black midwives. Research available in the 1920s and 1930s showed that midwife-attended births of black, white, and mixed-race babies had significantly lower maternal mortality than those attended by physicians (Dawley 2003), many of whom had not even attended a birth by the time they graduated from medical school (Susie 1998:2) . However, it was also clear that infant mortality was significantly higher for black babies than it was for whites. Gertrude Fraser clarifies this paradox by explaining that it was poverty, not midwives' care, which was to blame for elevated mortality among blacks. Rather than recognize impoverishment and segregation as important factors, state officials saw sickness and disease as inherent traits of African-Americans, and faulted their community midwives' "nonscientific" methods (Fraser 1998:85)

Attitudes differed among state health officials regarding the necessity of midwives in areas where hospitals were segregated or nonexistent. Some believed these midwives were a "necessary evil" and advocated training programs as ends in themselves. Others recognized training and regulation as ways of limiting, controlling, and eventually ending their practice. Although on the surface, these midwifery training programs may have appeared to be aiding midwives, they were ultimately successful in weeding out those who were elderly, nonliterate, and poor (Susie 1998). Regulation brought many significant changes to the culture of midwifery, which was an important element of African-American communities. Black midwives generally saw themselves, and were understood by others to be spiritually called to their profession.[3] Alabama midwife Margaret Charles Smith speaks in her autobiography of women giving birth with "nobody but me and the Lord" in attendance (1996:50). Midwives were highly regarded, and the repositories of traditional healing ways, often assisting others in illness and death as well as birth. The realm of childbirth was one in which African-

[3] The experience of being spiritually "called" to midwifery is not unique to midwives of color, but is of particular significance in the context of the historical role of religion and spirituality in black communities.

American men deferred completely to women, and midwifery offered women access to incredibly high status. "She was the local wise woman who presided over the important occasion of birth. She was divinely called (in most cases) and the bearer of a family legacy. She was a trusted leader of her community" (Susie 1998:33). One Florida midwife explained the impact of elimination of midwives: "Someone killing your career is just like killing some member of the family that's real close" (Susie 1998:54).

Despite many midwives' suspicion of and opposition to the surveillance of medical professionals, they also had good reason to welcome their attention. In the segregated south, health care of any kind was hard to come by for African Americans, and the increased funding for maternal health care was a much-appreciated change. Although the spirituality of midwifery as a calling was being replaced by a model of rationalized scientific medicine, standardized and compliant midwifery was also framed as an important service to God and country, and this rhetoric appealed to the desire to be accepted and integrated into American culture. In addition, efforts at "racial uplift" were predicated on modernization and middle-class status, values that were both associated with birthing in hospitals with physicians in attendance. Thus, the efforts of public health campaigns combined with prevailing cultural attitudes to virtually extinguish the practice of midwifery by the 1950s and 60s.

The desire to retain or "go back" to traditional African-American midwifery is treated in various ways in the literature. It is generally agreed upon among scholars that traditional birthing practice played a vital role in the lives of African-Americans, especially women, in the first part of the twentieth century (and previous). Anthropologist Holly Mathews recommends that we "return to the past and reexamine the ways in which traditional healers operated in rural communities to that better models for the recruitment and training of new lay health advocates can be developed" (1992:78). Echoing these sentiments, anthropologist Gertrude Fraser describes her study as "a requiem to the knowledge, skills, and beliefs that have been lost" (1995:1). In contrast, however, Fraser does not emphasize efforts to revitalize midwifery in the black community. In her ethnographic

work, she has found that many of those in the community she studied did not see a return to midwifery as desirable or feasible.

Fraser reports that many people in this rural Virginia town, while they may have fond memories of the way midwives worked, conceive of people's bodies as irreversibly changed by modernization, and no longer receptive to traditional healing ways. Considering that racist ideologies have historically been so imbricated with the construction of blacks as "primitive" and "uncivilized," it is easy to understand a lack of desire to return to midwifery, which is still stigmatized as unscientific in our culture. Fraser also explains that significant "social trauma" was associated with the organized elimination of the midwife and everything she symbolized and offered to her communities. It would seem to follow that a return to midwifery might invite the renewal of such trauma and scrutiny. It seems to be unclear in Fraser's work whether midwives are a source of pride or shame for the people she interviewed (Fraser 1998:ch.8).

There have, however, been recent efforts to preserve and revitalize the practice of midwifery in many African-American communities.[4] The premier organization that presently supports, trains, and recruits midwives and doulas of color is the International Center for Traditional Childbearing (ICTC), based in Portland Oregon. The ICTC was founded in 1991 by midwife Shafia Monroe, who also founded the group's predecessor organization, the Traditional Childbearing Group of Boston in 1978 (Waite 1993). Monroe began this work "in part because of the need for better health within [the] Black community, but also because White women dominated the field and opportunities for aspiring Black midwives were few and far-between" (Sistah Midwife International, "Biography," 2012).

The organization offers midwifery services and training by and for women of color, including apprenticeship-based mentoring, and conceives of midwifery and doula care in

[4] So far, these have centered mainly in northern U.S. cities, which is significant because the history of midwifery in the North is in many ways very different from the South. In general, African American women in northern states gave birth in hospitals (Waite 209).

similar terms as did earlier black midwives in the South. ICTC midwives specialize in home birth and seek to support women of color not only in pregnancy and childbirth, but also in terms of community service, spiritual leadership, and broader social justice work. Today's "traditional" black midwives sometimes make a distinction between themselves and certified nurse midwives, who are trained in medical schools and practice primarily in hospital settings. This distinction is important for several reasons. The first nurse-midwives to practice in the U.S. were white women directly involved in displacing African American midwives in the South. The image of the clean, hygienic nurse-midwife was set in stark contrast to that of the filthy black "granny" in health promotional materials (Dawley 2003). As such, although some African American midwives proudly embraced training by nurse-midwives, the racial history of nurse midwifery as a profession is somewhat contentious.

The ICTC has also offered doula training since 2002. To date ICTC has trained over 400 doulas, with 75% being women of color. Doula training through ICTC "creates leaders to advocate the normalcy of birth, reduce infant mortality, support breastfeeding and develop entrepreneur skills to combat poverty" (ICTC Doula Training Program). The ICTC doula training model, known as the Full Circle Doula (FCD) program, was created by Shafia Monroe to combine midwifery-model labor and postpartum doula services with the goal of improving birth outcomes. The ICTC doula program's factsheet describes this model:

> The ICTC training teaches the one stop model to reduce poor birth outcomes, provides holistic care, and establishes trust in the community through wrap around services. This model has a cultural component that emulates the 20th century African American midwife's public health practice. The FCD training includes the midwifery model of care, public health, lead poisoning prevention, birth practices, breastfeeding support and postpartum care and rituals. The FCD model establishes a strong client relationship to reduce infant mortality, improve birth outcomes, increase breastfeeding rates, and reduce postpartum depression. [ICTC, *The ICTC Doula Training Program*, n.d.]

The doula training model ICTC provides is unlike any other that currently exists, and as such, it is an important alternative to DONA trainings and those of other organizations like it. It was clear in my conversations with doulas working specifically with underserved

communities that ICTC trainings were highly sought after, though often inaccessible because of their limited offerings. Cassidy Wolfson, a prison doula in Washington, told me, "I got my [doula] certification through Seattle Midwifery School. I would have preferred ICTC but their class was in Atlanta. I'm going to go to ICTC in the future." The ICTC also currently runs a high school rprogram for young women interested in pursuing health careers.

In 2011, DONA International instituted a Doulas of Color Trainer Workshop Fellowship Program, designed to increase the diversity of DONA's trainers. Through this program, DONA hopes to "increase the diversity of DONA International's trainers, which will result in workshops taking place in the United States that are facilitated in the most culturally appropriate manner." In 2011-2012, nine fellows were chosen (Calareso 2012:22). This program does require a lengthy application process, which some doulas find problematic. Miriam Perez, doula and blogger at Radical Doula, told me, "I saw that on DONA's website they're promoting scholarships for people of color to become doula trainers, which I think is great. But looking at the other requirements, there are lots of hoops to jump through, and not a lot of people have access to the resources to meet all those requirements."

One of the weaknesses of doula trainings identified by those who took my survey was the lack of adequate diversity training. As Laura Krauss, a survey respondent from Pennsylvania, said, "[there was a] lack of support for the reality of doula work in a hospital for low-income and minority women. [I have witnessed] treatment of women that is disrespectful and occasionally borderline abusive - many doulas get vicarious trauma from these births." This doula raises two important issues: not only do doulas need to know how to best provide culturally-competent care to clients from diverse backgrounds, they also need to be prepared for what they might witness in terms of how those clients are treated. Many doulas in my study indicated that they see women of color treated more poorly, on the

whole, than white women.[5] The experience of doulas of color in the hospital is another important issue. One doula, Diana Crenshaw from Illinois, told me that as a black woman, she is often not recognized as a doula, as a professional. "People assume I'm an auntie or a grandmother or another family member," she said.

Racial Disparities in Perinatal Health

The Centers for Disease Control lists several glaring racial disparities in maternal and child health. The CDC collects and analyzes data for several racial categories, but for the purposes of this chapter, I will focus on comparisons between non-Hispanic white and non-Hispanic black populations, because they most clearly illustrate the extent of this inequality. In 2003, 17% of non-Hispanic black women received inadequate prenatal care, compared to 7% of non-Hispanic white women. The proportion of women with inadequate weight gain, which is correlated with low birth weight and its attendant health complications, was higher for blacks (17%) than whites (10%) (Martin 2005:11, 13). In 2009, low birth weight was at 7% for white infants, and almost 14% for black infants (Martin 2011:12). The infant mortality rate in 2007 for white babies was 5.6/1000 births and 13.3/1000 for black babies (Mathews 2011:3). It is clear that, as the International Center for Traditional Childbearing mission statement asserts, "the health status of the Black community is in crisis" (ICTC Mission Statement 2012).

In addition to clinical disparities, experiential disparities also exist for women of color in birth care. In 2009-2010, the ICTC conducted a survey to analyze the birth experiences of black women in Oregon. 245 black women between the ages of 16 and 25 answered questions regarding their hospital birth experiences. The survey revealed that black women frequently experience anxiety in their births, that many had no support during pregnancy and birth, and that two thirds did not attend childbirth education classes. Half

[5] This is beginning to be reflected in recent news reports about black women's birth experiences. See Bereman-Skelly 2011, Millner 2012.

reported fear, racism, or disrespect while in the hospital (ICTC, "2011 Black Women's Birth Survey," n.d.).

The response to these disparities by politicians and public health workers has focused primarily on expanding conventional biomedical health facilities and maternal-child health programs (Waite 1993:219). These programs have certainly not been disadvantageous, but Shafia Monroe argues that they do not go far enough in addressing the particular needs of low-income African American women. She explains,

> Community midwives provide comprehensive services – from nutritional guidelines to information on signs of labor to parenting advice – through one person and in one location. They have an advantage over clinical personnel because they see the environment in which their clients live and thus can develop a more accurate understanding of the kind of help they need. [quoted in Waite 1993:215]

Monroe and her colleagues believe that extending a holistic approach to the communities they serve is ultimately more helpful than increased medical attention alone. As Byllye Avery, black women's health advocate and founder of the Gainesville Women's Health Center, succinctly puts it, "Infant mortality is not a medical problem; it's a social problem" (1990:6). It is this attention to the social realities of living and birthing as a black woman in the U.S. today that makes African American birthworkers unique in their approach.

Midwives like Shafia Monroe contend that there is a limit to the care that women can receive from within the biomedical establishment because it is not culturally competent. The ICTC details the importance of prenatal care in reducing infant mortality rates, and states that "an African-centered style of prenatal care involves counseling, the laying on of hands (a hug) and teaching by example, communication and prayer" and that "prenatal care must go beyond the medical model of a fifteen-minute impersonal visit and offer culturally appropriate care" (Positively Peaceful, "ICTC Making a Difference," 2008). Like most midwives who practice in homebirth settings, Monroe describes her prenatal visits as typically lasting an hour, and including "hugs, talking, learning to cook and learning to eat well," all components of "helping to alleviate the stress of her clients' poverty" (Waite

1993:215). The ICTC sees this type of holistic care as imperative in addressing the pervasive health disparities that black women and children face.

Holistic care does not always follow the same script. At the MANA regional conference in 2010, I had the opportunity to meet and interview Jennie Joseph, a midwife originally from England, who now works in Florida. A CPM, she runs a clinic that provides prenatal (and sometimes birth) care to a client base that consists mostly of women of color who are uninsured, and through her program, has eliminated racial disparity in low birth weight and prematurity in her practice. Considering the national statistics, this is an astounding accomplishment. Joseph is adamant that prenatal care is more important than delivery, because it is through prenatal care that birth weight and infant mortality can be reduced. One of the most important components of her prenatal care model, known as "The JJ Way," is relationship building. In her conference presentation, she described this model:

> We promote bonding, not just to each other but to a community of extended family and friends. The midwives used to be the main staple of the black community. [In the same way at our clinic] we provide a team culture. The receptionist greets people, remembers everyone's names, and compliments them. Everyone is welcome every time. There is a peer educator in the room, and they just chat [with patients]. There are no powerpoints, no workbooks. The chairs in the waiting room are in a circle. Then they see a nurse who is a medical assistant, and then the midwife. So they have 3 chances to talk about their concerns. We see 50 patients a day. It's not about I [as the midwife] have to be *it*. It's not about we sit on a couch and hold hands for an hour. The women like it better if we don't spend forever lookin' in each other's eyes.

For Jennie Joseph, relationship building is vitally important, but in contrast to Shafia Monroe's approach, Joseph's clinic emphasizes a "team culture" rather than a one-on-one model of prenatal care.

Joseph acknowledges that the history of traditional midwifery care is important, but also emphasizes ways in which to incorporate technology and form alliances with social services and hospitals. She said,

> We need to support all educational routes. We can applaud traditional midwives, but there are barriers to [traditional, apprentice-based] education for women of color. Who has scholarships for midwifery

> students of color? We have to bring student midwives of color into apprenticeships, but we also need to work with healthy start home visiting programs, and with things like NST [non-stress test] machines. I push the technology because the women want the technology. Work with what women are saying they want. Trust them. [When we work with them in this way,] the babies are fat at term! These are the skills we have. We know how to be with women, and being with women makes a difference to the size, and the life, of their babies. It's more effective to focus on midwifery model of care rather than home birth.

Here, Joseph introduces a pragmatic shift by promoting the midwifery model of care -- "being with women" – while simultaneously understating home birth as a necessary component of that model. Joseph went on to explain that most of the women who receive prenatal care at her clinic don't want her to deliver their babies. She told me, "I used to be concerned about it. Then I got over myself."

In her conference presentation, Jennie Joseph addressed those present, further emphasizing this point:

> Does it matter that they're not in your birth center or their home? It might not be a safe place or a comfortable place at home. But maybe we can make a change in how they start. Isn't that what we stand for? What would be the point of all this? This is the new midwifery model of care. It's not about catching the baby. Consider letting go of it being about the birth. Our babies are dying. This is a life and death issue.

For Joseph, if the most pressing issue for communities of color, particularly African Americans, is low birth weight and infant mortality, then it is incumbent on birthworkers who are concerned about this problem to "get over themselves" and focus their energies on prenatal care rather than on labor and delivery. The de-emphasis of the moment of birth itself represents an important re-imagining of "traditional" midwifery.

In popular childbirth literature, there is an intense focus on labor and birth as the most centrally significant moment in the process of becoming a mother. Feminist analyses of medicalized birth have tended to concentrate on the gendered ways in which power and "authoritative knowledge" are wielded in the birthing room, and on the role of technology in mediating women's bodily experiences (Jordan 1978; 1997; Davis-Floyd 1992). The importance of the experience of childbirth did not assume significant cultural meaning in the

U.S. until the mid-1950s with the introduction of British physician Grantly Dick-Read's groundbreaking *Childbirth Without Fear* (1953). In this text, Read argued that the heavily medicated labors that were standard at the time robbed women of their right to participate in an event that was central to their identities as mothers. He was interested in making childbirth more pleasurable for women so that they would find their "natural" roles as mothers more appealing. This text was highly influential, and embodied a distinctly postwar, pronatalist politics. Read's glorification of motherhood not only advocated the return of women to their proper childbearing function, but also took place in the context of cultural anxiety about white "race suicide" and anti-natalist policies toward poor women and women of color.

The primacy of the birth experience is itself, historically and in the present, a function of privilege. As Dorothy Roberts' *Killing the Black Body* makes clear, for low-income women of color, it's not necessarily the birth experience itself that stands out as the most important part of having a baby (1997). Factors that occur on either side of that event are often far more significant – whether a woman has adequate social and economic support to raise a child, whether she is subject to surveillance or the removal of her child by state agencies, and whether she has experienced coercive birth control or sterilization procedures. With cuts to funding for social programs since the 1980s, poor women also face limited access to food resources, physical and mental health care, and decent education for themselves and their children. It is, in part, because more privileged women do not have to take these realities into consideration that they can focus so much attention on the event of labor and birth itself. It is also for this reason that more privileged birthworkers often do not outline such clear political agendas as do midwives and doulas of color.

The Traditional is Political

In 1990, in her essay entitled "Sick and Tired of Being Sick and Tired: The Politics of Black Women's Health," internationally recognized social activist Angela Davis writes,

> We have become cognizant of the urgency of contextualizing Black women's health in relation to the prevailing political conditions. While our health is undeniably assaulted by natural forces frequently beyond our control, all too often the enemies of our physical and emotional well-being are social and political. That is why we must strive to understand the complex politics of Black women's health. [1990:19]

The political dimension of maternity care for black women is a central topic of concern for the ICTC. The keynote speaker for the organization's 2005 conference in Atlanta insisted that:

> Politics and medicine are weaved together; which is why the rich have health care and the disenfranchised do not. Infant mortality is political, midwives being last hired and first fired is political, direct-entry midwives having to work underground in many states is political. Pregnant woman laboring while handcuffed, and the prison industrial complex – going from corrections to profits with low-income people on lockdown – is political.

This kind of attention to the politics of racism, poverty, and criminalization is glaringly absent from other midwifery organizations. It is not enough, according to this critique, to expand privileged women's choices in the birthing room. It is also necessary to ensure that those who are underprivileged have access to basic health care, human rights, and dignity. In the eyes of the ICTC, these needs are not separate from what happens in the birthplace.

The politicized work of the ICTC, however, is not an anomaly. In fact, the organization sees it as an indispensable part of the legacy of black midwifery. On its page describing the history of African American midwives, the ICTC's website explains, "the Traditional Midwife's calling expanded beyond catching babies; she was a healer, a spiritualist, a public health activist and a community organizer" (ICTC, "History," 2012). Tradition, here, is not limited to a list of non-pharmacological pain relief methods or herbal preparations dating from a time before the hegemony of biomedical obstetrics. The ICTC recognizes itself as part of a long history – a tradition – of grassroots organizing within a marginalized community fighting for survival. The organization's mission statement declares, "In returning to the ancient art of midwifery, we are no longer succumbing to overwhelming systemic racism…We are determined that the early death of babies and mothers, an

aftermath of slavery and a legacy of poverty, shall be reversed" (ICTC, "Mission," 2012). In no uncertain terms, the ICTC articulates a clear civil rights agenda. Shafia Monroe reiterates this sentiment, "I don't care how well you eat or how many herb teas you drink, you're going to have to fight racism on your job, in your neighborhood, and in your school system on a daily basis, and that's going to affect you" (quoted in Lee 1996:32). Here, Monroe makes a clear argument that for black women, the tradition of political awareness and the fight for social justice is, in many ways, more pertinent to one's health than other elements of health care that might be deemed traditional.

Work to address perinatal health disparities is fundamentally connected to histories of oppression and resistance. Many indigenous American birthworkers see their work as a means of healing the wounds of colonialism. Josefina Cavazos, a Native American doula in California who speaks both Spanish and English, said, "I like to focus on the decolonization of mother's minds, bodies, and spirits." Raeanne Madison, a young Ojibwe doula, also describes the need for doula care in Native American communities. In an article in *SQUAT* magazine, entitled, she begins by introducing the Ojibwe phrase for giving birth, Ondaadiziike. She writes,

> When I was writing this article, I was hoping to combine *ondaadiziike* with the Ojibwe words for safety and comfort. I was surprised that the dictionaries I consulted didn't include these words. So I was left with just *ondaadiziike*. No safety, no comfort to accompany it. This is reflective of modern birth culture in Native American communities. Modern day pre, ante, and post natal care for brown women in the United States is at times unsafe, and usually uncomfortable. Racism, sexism, poverty, and isolation have left women and their babies in desperate need for support, love, and compassion. [2011:10]

Madison goes on to describe the history that contributes to this state of affairs:

> It wasn't always this way. Native women were long respected as life givers…Women took care of each other, Aunties, Grannies, Mothers, and Sisters. Reproductive culture varied from tribe to tribe but one thing was constant: women's powers were sacred. Enter Western patriarchy. Native women were subjected to horrors manifested in all aspects of bodily harm. Our ancestors were kidnapped, gang raped, and fed to war dogs. Eaten for entertainment in circus like manner. Forced to marry white men and birth babies alone, without the help of their beloved Sisters. Traditional

> knowledge of menstruation, pregnancy, birth, and breastfeeding were lost, and Native women today still pay the price. Of all the ethnicities in the US, Native women suffer the most when it comes to birth. We have some of the highest teenage pregnancy rates, pre-term birth rates, maternal and neonatal morbidity rates, and some of the lowest breastfeeding rates. Reproduction in our community has become dangerous and unpredictable at worst, and casual at best as women forget just how powerful their bodies can be. [2011:10]

As Madison describes, one powerful way colonial powers have established political and economic dominance is through imposing medical dominance. This has involved the imposition of practices such as racial segregation as "health care" measures, and the demonization of indigenous mothering for not meeting the prescriptions of white, western femininity. For example, the forced relocation of native children to residential boarding schools in the early 20th century was ostensibly an effort to rescue them from their "retrogressive" and "negligent" mothers (Kelm1998). Kaufert and O'Neil (1990) describe the ways in which colonists blamed the "unsanitary" habits of native mothers for both social ills and infant mortality rates in the Northwest Territories, thus justifying surveillance and control of Inuit women's childbirth practices, which were constructed as "dangerous and often deadly" (438). Central to these projects was a designation of certain kinds of birthing and mothering as "traditional" and other forms as "modern."

Contemporary birthworkers often invoke the traditional/modern dichotomy – not to vilify the traditional, as colonial powers have, but to elevate it. This is not unusual; midwives and doulas often rely on the historical longevity – the tradition – of their work as one way to assert its value and legitimacy. Any longstanding cultural practice, however, involves historically specific interruptions, ruptures, and modifications. Like other birthworkers of color, R.M. must undertake the task of reconstructing traditions that have been suppressed.

The reclamation of traditional practices is central to Raeanne Madison's vision of how doulas can improve birth outcomes and experiences for Native women:

> I've been inflicted with the pain of my sisters. I have dreamt about it and received pleas for help from the ancestors who visit me in my sleep. Doula care is going to be incredibly important in mending the disparities in pregnancy, birth, and breastfeeding. I realize this. I need my sisters to realize this, too, and step up to fill that space along with

> me. We need Native women to become doulas, certified or not. We need a group of women to get together and create a resource for Native doulas and their families; a resource describing and honoring the traditions of our ancestors that includes a dictionary dedicated to Native birthing practices and care. [2011:10]

Here, Madison conceives of doula work as fundamentally connected to the reclamation of traditional Native ancestral knowledge and language, lost through the violence of colonialism.

The meaning of "tradition" is always constructed through the practices of the present. As Edward Shils writes, "Traditions are not independently self-reproductive or self-elaborating. Only living, knowing, desiring human beings can enact them and reenact them and modify them" (1981:14-15). Furthermore, Paul Connerton (1989) reminds us that these reenactments, as practices of memory, are communal undertakings, rather than individual ones. In order to reclaim particular birthing traditions, birthworkers like Raeanne Madison must first "imagine" a community[6] with which to enact the values and practices in question.

It is important to recognize that the socially constructed designations of traditional and modern are not fundamentally separate, nor is there a teleological relationship between them. As feminist anthropologist Margaret Jolly elucidates, "there is no straightforward temporal progression, whereby the traditional mother is a 'relic' of a premodern past which progress leaves stranded on the shores of time" (Jolly 1998:18). As I have demonstrated in chapter two, natural childbirth discourse often tends to romanticize the "traditional" in ways that ignore specificities of history. But in contrast to the universalizing discourse of "natural" childbirth, birthworkers of color more often invoke "tradition" in ways that are culturally and politically contextual.

The ICTC's use of the word "traditional" instead of "natural" to modify the word "childbearing" stands out as an important rhetorical choice. Historically, black bodies have

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[6] Benedict Anderson's *Imagined Communities* (2006) theorizes the cultural formation of human communities, nations in particular, and how their meanings have changed over time, increasingly commanding emotional legitimacy.

been constructed as inherently more natural or animal-like than white bodies, especially when it comes to having babies. This racial (and also class-related) construction has been used to justify myriad forms of social inequity. From the treatment of enslaved women as "breeders" who could be exploited for the economic gain and sexual pleasure of white slaveholders to contemporary beliefs about the excessive reproductive capacities of brown-skinned women in developing countries, ideas about nature and childbirth combine in problematic ways for women of color, as I discussed in chapter two.

The ICTC's use of the word "tradition" to describe contemporary African American midwifery works against the historically problematic association of women of color with nature, and recognizes the activities of black women as politically mobile agents of social change. Because black women's reproductive bodies have been essentialized and exoticized by both biomedical obstetrics and its feminist critics, the ICTC has recognized a need for maternity care that exists outside both the medicalized realm of hospital-based care and the multiculturally challenged realm of natural childbirth. For Shafia Monroe, midwifery practice "in the ancient traditions of our ancestors" recognizes that these early midwives "stood for justice and championed human rights." According to the ICTC's mission statement, "When we as a people know our history our self-esteem is raised, and thereafter health care and consciousness improve." For this organization, it is essential that black midwives avoid the ahistoricism that so often accompanies ideas about "natural" birth.

Expanding Access to Care

Despite the presence of the ICTC, the fact remains that women of color choose midwifery and doula care less often than white women. The ICTC is attempting to change this by offering community-based services to low-income women of color who lack the insurance, transportation, childcare, or time to seek care in hospitals or clinics. This work, however, is sometimes difficult to sustain. Midwives of color, especially direct-entry midwives, face the same hostility from the medical community as do other midwives, and

funding is often extremely limited to health initiatives that operate outside the scope of hospitals or community-based doula programs, such as the ones I describe in chapter six. The ICTC relies solely on public donations and volunteers to provide its services. Community-based doula programs are notable here in that they offer care that is similar to that of ICTC midwives. These programs provide one-on-one social support, referral services, and assistance during labor and the postpartum period to low-income women in dozens of urban locations around the country. Because doulas, unlike midwives, are not primary care providers, they do not threaten to displace physicians or hospitals, and have therefore been more easily replicable and readily funded than midwifery initiatives like the ICTC. However, one of the stated goals of the ICTC is to "reduce the need for and use of social services," which is in direct contrast to most other community-based doula programs, which encourage referrals to social service agencies, and depend on partnerships with them.

It has been suggested that black Americans, as a group, are uninterested in midwifery care and homebirth as a result of the idealization of hospital delivery in dominant American culture and the association of biomedicalized childbirth with modernity (Fraser 1995; Waite 1993). Another theory about choice of maternity care posits that less educated women are less likely to choose midwives (Lazarus 1997). However, a recent study conducted in Michigan reported that African American mothers were less likely to choose midwives the more education they had (Raisler 2005:116). In her book *Midwifery and Childbirth in America,* Judith Pence Rooks suggests that black women might be wary of being assigned to midwives in hospital settings because of a fear of being referred to less qualified providers (1995:153). The lack of conclusive research on how women choose maternity care providers is reflective of the reality that 90% of all births in the U.S. are attended by physicians in hospitals (Hamilton et al 2011). It is evident that the vast majority of American women are either unaware or indifferent to the fact that they have a choice in the matter. In addition, restrictive state laws and hospital policies limit the availability of midwifery services – in home, hospital, and birth center settings – and further constrain women's choices. That

there is a dearth of research on how low income women of varying racial and ethnic identifications choose their birth attendants also reflects a larger cultural indifference regarding the health of the nation's poor and underprivileged.

In considering these questions, it is important to avoid stereotyping women of color as uninterested in having choices in childbirth. Shafia Monroe describes her first clients as women who "were talking about cultural genocide, didn't trust the system, and who were going back to our roots of self-determination. They didn't want to have their babies delivered into a kind of system that never did us justice" (quoted in Waite 1993:217). Most feminist accounts of midwifery in the U.S. leave out those midwives and advocates of childbirth reform whose strategies and actions were shaped in important ways by the struggle against racism, but it was not only white feminists who raised questions about the dominance of technological obstetrics in the late 1960s and 1970s. Given the realities of the Tuskegee experiment and the widespread practice of medical experimentation on enslaved men and women, suspicion of scientific medicine has a long legacy in anti-racist activism. Historian Jennifer Nelson (2003) carefully documents resistance to mainstream medicine of women within the black power movement, and many health care reformers emerged from the Civil Rights movement (White 1990).

A broader health care reform agenda is unmistakably present in the ICTC's mission: "We look to African American midwives who live among the people both to provide that care and to advocate for our rights in the health care system. ICTC is committed to the health and life of mothers and their children. We are committed to challenging the many barriers to the health of Black women." Angela Davis articulates an even more explicit vision when she states, "It is clearly in the interests of Afro-American women to demand a federally-subsidized, uniform national health insurance plan" (1990:24). Medical research has consistently demonstrated the cost effectiveness of midwifery care, as well as its association with lower instances of low birth weight and maternal and infant mortality, especially for vulnerable women (Raisler 2005). But the reality of an increasingly profit-driven health

system, with its increasing administrative costs and decreasing patient benefits, often means that many midwives have either lost their jobs altogether, or have had had to increase their client loads, severely limiting their ability to provide appropriate care to needy women (Raisler 2005:118).

Conclusion

The doulas of color I spoke with at the MANA conference underlined the fact that "there hasn't been enough attention to our experiences and priorities" within the childbirth movement. However, Juana Estrella, a Latina doula from New Mexico observed that "things are feeling different within the women of color community. We are part of the birthing world now." Jennie Joseph identifies the increased presence of doulas of color as "part of the birthing world" as an important avenue for social change, and in particular, the movement to end racial disparities in maternal-child health. She says,

> We need to get more doulas of color out there, and support doulas who serve clients of color who can't pay, because women who have empowering births want to do this work! Sometimes becoming a midwife is too hard, but doulas attend a one weekend workshop. Sponsor a doula. The doulas are the future midwives. Set aside a percentage from every birth to put a doula of color through training. We're here, but as long as we have blinders on, we can't see. We have ICTC, but it's struggling. Is there a will to support it? Become a member of these organizations. Go out into schools, mentor, and encourage young women of color.

Similarly, the International Center for Traditional Childbearing represents a unique vision for maternity care in the U.S. It works from the premise that community-based midwifery can allay not only gender imbalances of power and authority in the birthplace, but can also counteract forms of discrimination based on race and class in the health care system. The ICTC's rhetorical and organizational strategies draw on African American tradition, which it defines as encompassing specific methods of spiritual, mental, and physical healing, and also, importantly, a legacy of commitment to social change.

The childbirth reform efforts of birthworkers of color demonstrate that childbirth is best understood not in terms of a simple dichotomy between the medical and the natural,

but as a complex social and bodily event that can be influenced through collective political engagement. As Jennie Joseph told me, "birth is the only place where true social change and social justice work is taking place. Where else do women connect with each other on such a level? Little by little, step by step, small steps make big changes. Martin Luther King said that if we don't see it now, we set the stage for change in the next generation." These long-term strategies are meant not only to serve women and families of color on an individual level, but also to improve their lives as a whole, and their chances for healthy childbearing in the future.

CHAPTER 6

"CALL THEM FELLOW ACTIVISTS": REPRODUCTIVE JUSTICE AND NEW DIRECTIONS IN DOULA CARE

As a member of the doula community, I have observed a surge of interest in doula work, not just coming from an interest in birth, but also increasingly arising from a specific interest in advocacy work. The number of volunteer and community-based doula programs is growing steadily. There are now three prison doula programs in the U.S., and a groundbreaking doula program in New York City, being replicated around the country, that helps people through abortion and adoption experiences. Doula Miriam Perez, who I met at the NAPW conference, and who writes the "Radical Doula" blog, echoes this observation. She told me:

> I hear from a lot of young people who are wanting to do doula work as activism…I see that a lot of people are really yearning for more direct activism, more than just filling out an online petition or going to a rally. There's just something really fundamental about birth, and doula work as a form of activism is really helping people get what they want on a very material level.

Since the time of the NAPW conference in 2007, I have maintained and established contact with many of these people, and have observed that a strong and vibrant movement is emerging among doulas that is based on an intersectional understanding of the needs of pregnant and childbearing people.

For these doulas, it is important to recognize that birthing choices are part of the spectrum of reproductive rights, and are tied to struggles for social justice and human rights. This perspective has been conceptualized by the term "reproductive justice," which has the group Asian Communities for Reproductive Justice defines this way:

> Reproductive justice is the complete physical, mental, spiritual, political, economic, and social well-being of women and girls, and will be achieved when women and girls have the economic, social and political power and resources to make healthy decisions about our

> bodies, sexuality and reproduction for ourselves, our families and our communities in all areas of our lives. [2005:1]

A reproductive justice framework clarifies the connections between birth work and other seemingly unrelated forms of advocacy. The doulas I describe in this chapter, who I refer to as reproductive justice doulas, are highly attuned to these connections. They are developing critiques of not only the medicalization of childbirth, but also larger structural forces that profoundly affect women's lives and their ability to control not only when and if they have children, but also how they give birth, and the extent to which they are able to provide for their children. These doulas are expanding the familiar idea of choice in childbirth in much the same way as women of color have critiqued the pro-choice rhetoric of the abortion rights movement:

> "Choice" implies a marketplace of options in which women's right to determine what happens to their bodies is legally protected, ignoring the fact that for women of color, economic and institutional constraints often restrict their "choices." …In order to ensure appropriate treatment and access to healthcare and to address the issues of class, race, and gender that affect women of color, a comprehensive human rights-based approach to organizing that accounts for difference is necessary. [Silliman et al 2004: 5, 17]

In this chapter, I examine several emerging paradigms of doula care, and how they differ from the traditional model of private doula care, in philosophy, form, and function. I present case studies of organizations and publications that represent these new trends, as well as data from interviews and online surveys. I look specifically at community-based and prison doula programs and "full spectrum" doula projects, which apply the doula model of care to reproductive experiences such as pregnancy loss, abortion, and adoption. I examine the emerging identity category "radical doula," and outline the ways in which this category's meaning is currently still solidifying. I argue that these new directions in doula care are driving productive and vital connections between birthing rights advocacy and a broad-based reproductive justice approach linking reproductive health care and social justice.

Community-Based Doulas

Community-based doulas (CBDs), in contrast to private doulas, practice within programs that are designed to "serve communities that have been self-defined as underserved" (Abramson 2006: 31). CBDs are usually members of the same racial, ethnic, and/or socioeconomic background as the women they serve, and are often already leaders within those communities. The community-based doula model is becoming increasingly utilized in cities across the United States.[1] The organization Health Connect One is at the forefront of developing the CBD model, and assisting communities in creating CBD programs and securing funding for them. Currently, Health Connect One reports that there are at least 44 community-based doula programs operating in 16 states, and serving a diverse range of communities (Health Connect One 2012).

The CBD model is derived from the community health worker approach, wherein the community health worker is an "insider who is employed in a formal role that transforms her community" (Abramson 2006:23). The Chicago Doula Project, which began its pilot project in 1996, is the forerunner of many of the community-based doula programs that currently operate. Its success has led to the development of teams of trainers and consultants who partner with interested communities and assist them in establishing their own doula programs. The education of doulas in the Chicago Health Connection community-based doula program is based on a Freirean popular education model, and has been characterized as a process "by which people are supported in recognizing their own power to take action in their lives" (Abramson 2006:19). Trainers in this program explain that "training for change begins with personal awareness and connects to a more political analysis or 'critical consciousness'" (Abramson 2006:19). The community-based doulas in my study exemplify this type of consciousness in the ways in which they describe the larger impact of their work.

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[1] Every community-based doula program I am aware of operates in an urban setting.

For example, Ellen Ridley, a doula who works with a community-based program in Illinois, is attentive to the reverberations of her work into the community itself:

> Especially working with underprivileged teens like I do, a lot of what we do deals with making sure that young mothers are supported and bond with their babies in the hope that cycles of abuse and neglect that may have ravaged certain neighborhoods or families might come to an end. We hope for good beginnings with each baby.

For Ellen, supporting individual women is akin to supporting an entire neighborhood. Some of the community-based doulas in my study described the larger effects of their work as occurring generationally. Josefina Cavazos, a doula who works with a program serving indigenous women in Los Angeles, says, "I hope my work influences the next seven generations. I hope that my work influences my daughters and future granddaughters to believe in and want natural childbirth." Others also made connections between the power of birth in one's body and one's political power. Jessica Lomas, who works with the Open Arms collective in Washington says,

> It's powerful to feel like you are creating change in your own body. If you feel capable in your own skin of growing and birthing and raising a child, then how does that affect our involvement in other social justice issues? Powerfully! I think it's what Obama said: we can do it! It's gonna be tough, but it's not about instant gratification.

The ways in which these doulas conceive of the change they are working to bring about is slightly different from the familiar mantra among doulas, "changing the world one birth at a time."[2] Whereas the idea of one birth at a time reinforces the individuality of birth experiences – one mother, one family, one baby – the attitude toward social change described by many community-based doulas is more grounded in the effects of a birth experience on the families and communities that the birthing mother is connected to. They reflect the idea that a doula's involvement has the power to strengthen those connections and inspire people to come together around social justice issues, to pass certain values down

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[2] Morton (2002) and Norman (2007) have both noted and interrogated this phrase in their ethnographic work with doulas, and I, too, have identified its common usage.

to their children, and to put more energy into improving their neighborhoods and communities.

This perspective is perhaps related to the roles community-based doulas play outside the birthing room. Researchers Gentry et al. found, in their ethnographic study of community-based doulas in Atlanta's G-CAPP program, that these doulas often necessarily become activists because they take on roles that go "beyond the call of a doula" (2010). This study looks specifically at community-based doulas working with adolescents, and it found that these doulas, by virtue of their exposure to the many socioeconomic disparities their clients face, take on multiple roles as part of their support for these young mothers.

> Doulas recognize the unequal treatment pregnant and parenting adolescents experience in both public and private spaces. This disparity prompts doulas to take on additional roles to fill social, emotional, and economic voids in the adolescents' lives. Additional role-taking among doulas can be divided into three categories of role types: (1) family and friend, (2) social and health service provider and advocate, and (3) general life coach and counselor. [2010:32]

The CBDs they interviewed described taking on tasks as diverse as helping clients apply for housing and educational programs, counseling them about relationships with significant others and family members, and providing information about sex education and contraception. In these ways, the doula's advocacy role is extended far beyond the event of childbirth, and even beyond direct postpartum and newborn care. Sometimes these forms of advocacy and support are informal, and at other times, they may also represent the continuing education offered to many CBDs through their training programs. While CBDs are usually recruited from, and work in, underresourced communities, they may have more extensive opportunities for continuing education than do other doulas, by virtue of being connected to strong local doula organizations.

While this type of extended care is common among community-based doulas, it is not exclusive to them. Many of the private doulas I interviewed described assisting their clients similarly with needs outside the birthing room, such as helping low-income clients find free car seats and infant clothes. However, this kind of care seems less common for

private doulas to engage in, and private doulas seem more likely to refer clients to other social services, and less likely to work in communities where clients have extensive ummet needs for social, mental health, and other services.

The stated goals and accomplishments of community-based doula programs are also slightly different from those of many private doula practices. They revolve more around reducing disparities, reducing costs, and creating measurable long-term benefits for disadvantaged women and families, rather than demedicalizing birth. For example, Health Connect One's doula factsheet mentions the link between doula care and reduced cesarean and epidural rates, but highlights the cost savings that result from these reductions. It indicates increased rates of breastfeeding and bonding for teens who have doulas, compared to teens who do not, but it emphasizes the long-term benefits of these outcomes, such as delayed subsequent pregnancy, improved school readiness linked to better family bonding, reduced health disparities linked to doulas bridging language and cultural barriers, and reduced poverty linked to the training of unskilled women as doulas (Health Connect One 2012).

The fact that community-based doula programs serve an important job training and career development function in impoverished communities is another difference between CBD and private doula models. While private doulas often spend hundreds to upwards of one thousand dollars for training and travel to workshops, CBDs are usually trained at little to no cost through the programs they work for. Because training is more accessible through CBD programs, and priority is placed on recruitment from within communities in need, there is more socioeconomic, racial/ethnic, and linguistic diversity among CBDs than among private doulas. Advocates are currently working to fund doulas through the Obama administration's health care reform bill, and a number of states are working to secure Medicaid reimbursement for doulas.

Prison Doulas: "Bringing Back a Sense of Home"

The existence of pregnant and parenting women in prison in the U.S. is a reality that is often ignored by those on the outside, especially those without personal connections to the prison industrial complex. The number of women incarcerated in the U.S. has risen by 400% since the introduction of federal mandatory sentencing for drug offences in the 1980s, and the percentage of women incarcerated for drug offenses is now greater than that of males. (Sabol et al. 2009). About five percent of women entering state prisons are pregnant, and six percent of women in jails are pregnant. Most women in prison are survivors of sexual and physical abuse, and women of color are disproportionately imprisoned: African American, Hispanic, and other women of color comprise nearly two-thirds of all women held in federal, state, and local jails and prisons (Schroeder and Bell 2005:54). The Rebecca Project, which investigates policies affecting incarcerated mothers and their children, reports that pregnant women lack quality prenatal care. The organization's report explains that the inadequacy of services for pregnant and parenting women in prison

> is not limited to incarceration settings, but affects women at every point in their involvement with the criminal justice system. Pre-trial diversion and release services, court-sentenced alternatives and re-entry programs for mothers are restricted in number, size, and effectiveness because the system was developed to serve men. [National Women's Law Center 2010:10]

In 2008, The Federal Bureau of Prisons ended the routine shackling of pregnant inmates in federal correctional facilities. State governments have begun to follow suit, but only a handful of states have laws prohibiting shackling during labor. (National Women's Law Center 2010:11)

There are currently three prison doula projects in the U.S. The Birth Attendants in Olympia, Washington (founded in 2002), The Prison Birth Project in Amherst, MA (founded in 2008), and Isis Rising Prison Doula Program in Minneapolis, MN, which is currently in the process of forming. Isis Rising operates through a nonprofit organization called Everyday Miracles, founded in 2003, which provides childbirth classes, car seat

education, and doula services for low-income mothers. Among all the doulas on their staff, 11 languages are spoken, and childbirth educators offer classes in English, Spanish, and Somali. The forerunner to these programs in the U.S. is London's Birth Companions program, which started in 1996. Each of these prison doula programs integrates three main components. Doulas and childbirth educators provide classes and support groups to pregnant women and mothers in prison; they provide direct support during labor and birth; and they undertake networking, collaborations with other organizations, and community awareness related to incarcerated mothers' issues. For example, The Birth Attendants program holds a Reproductive Justice book club in the community to raise awareness about incarcerated mothers.

I conducted face-to-face interviews with Aliyah Jones, Alex Snyder, and Cassidy Wolfson, three of the Birth Attendants doulas in Olympia, WA. As members of the first such program in the U.S., they detailed the ways in which their work is unique, in the fields of both doula work and prison work. While private doulas provide some prenatal and postpartum support, these services are much more important for incarcerated women. Because incarcerated women have so many unique and unmet needs during pregnancy and the postpartum period, the doulas' work is much more focused on childbirth education, community building, and postpartum support. One striking difference is that because infants are routinely separated from their incarcerated mothers,[3] postpartum support for incarcerated women cannot revolve around everyday parenting tasks such as feeding, diapering, and bathing, but instead focuses on acknowledging the complex feelings that accompany parental separation and perhaps finding ways to create bonds with a child who is not currently in one's care.

[3] This is typically the case, although some prisons do have nursery programs. The prison in Olympia does have such a program, but women must meet tightly defined criteria to be eligible.

The creation of trusting relationships with both incarcerated women and correctional officials is an essential element of the prison doula's work. Like private doulas working to get along with hospital personnel, prison doulas must be careful to create and maintain hospitable connections with the prison in order to gain access. For this reason, the Birth Attendants doulas are reluctant to claim their work as advocacy or activism. Instead, they work to represent themselves as women's health professionals, in order to be accepted into the correctional system. As Cassidy told me,

> The word "activist" is dangerous to use in this community. If you're an activist, it's like putting the word activist and terrorist together. People could take that as violent. We do identify ourselves as activists, but we don't represent ourselves that way. 'Women's health professional' is one of those phrases [we use to describe ourselves]. We do have to work with systems with intense policies. It doesn't work to come in and push prison abolition with the department of corrections. "Women's health professional" is a phrase well known within the medical community. We have to recognize the systems that exist.

These choices about self-representation constitute a politically savvy decision to use language that is acceptable to the bureaucracy of correctional institutions, even though the doulas themselves may personally be politically opposed to the existence of those very institutions.

Prison doulas also work hard to build and maintain respectful relationships with incarcerated women. The doulas I interviewed discussed their approach to their educational groups, which not only cover childbirth education, but also healthy relationships, sexuality, and other relevant topics. Like the community-based doulas in Chicago, the Birth Attendants use a popular education approach. Aliyah describes their group structure:

> We don't believe in having a structured curriculum – our classes follow a popular education model. What are someone's needs right now? What happened at their last prenatal appointment? We have lots of books and videos for them to check out. Things are always changing. Depending on who comes, the topic changes. This works really well. It helps us to be sharpened in our skills, and we learn too. If we don't know an answer, we'll look at our resources together to try to figure it out.

By learning with and from the women in prison, these doulas create relationships that are non-hierarchical, and this is a core value that the Birth Attendants doulas hold. Another way

in which the Birth Attendants doulas are unique in terms of other prison workers is that they are not affiliated with religious or other institutions or organizations, particularly religions ones. Aliyah emphasizes the unconditional support their organization offers:

> We are special in that we're not Christian, like so many other groups that come into the prisons. We're not bringing in Bibles. The language used to describe the people is "offenders" and "inmates." We don't ever ask what they've done. If someone wants a cesarean, that's their choice. We just support them. We're not trying to convert anybody. Most other groups are religiously affiliated, but we're here to advocate and be conduits of information. Every person should be supported wherever they're at, from cesarean section to unassisted childbirth. People need access to information.

For the Birth Attendants doulas, a nonjudgmental attitude toward a person's criminal background is parallel to a nonjudgmental toward birth method and outcome. Aliyah is "not trying to convert" anyone, either in terms of religion, or in terms of birth method. Because the women prison doulas serve are already in a vulnerable place and subject to the most coercive of institutional constraints, it becomes even more important for prison doulas to afford them as much choice as possible about their birth experiences.

Like many reproductive justice doulas, Cassidy points out that the Birth Attendants' work with prisoners does not just revolve around the birth experience itself, but instead is attentive to birth within the larger context of a person's life.

> Doula work is a really small piece [of what we do]. We are prisoner advocates. People think they can get experience with their doula certification through the prisons and that is not the case. It's good to have a social justice background, and be knowledgeable about laws that affect women in prison.

Recognizing that many doulas-in-training attend births for free as they work toward their certification, The Birth Attendants doulas are careful to defend those they work with, who constitute a vulnerable population, with from being used by student doulas for training purposes. A prospective doula who wants to work with the Birth Attendants must be committed to understanding prison issues, social justice, and consensus-model decision making to be involved with the group, which proudly operates as a non-hierarchical collective.

The Birth Attendants doulas describe a similar mixture of emotional strain and fulfillment to that which characterizes the emotional texture of doula work in general. Alex admitted that the work is "taxing and hard on your soul sometimes." This difficulty is mostly related to witnessing the effects of prisoners' lack of resources and agency in the prison system. As Aliyah said, "Witnessing the amount of human rights violations that happens is the hardest part of this work." For instance, Aliyah describes a collection of frustrations:

> So much power is taken away from them already. It's really difficult. There used to be a female dietician. Now it's a male. Their dietary needs used to be taken into consideration. But now, the physician says talk to the dietician, and they say they can't do anything.

The Birth Attendants doulas voiced frustration not only about the prison personnel's lack of motivation to meet women's basic nutritional needs, but also about their own inability to do so. Cassidy said,

> In class on the first day, they told us they get an extra snack, which is a pack of saltines and peanut butter, and if they work hard, they can get milk. Macaroni and cheese is dinner. [exasperated sigh] I wish we could bring in food.

The Birth Attendants doulas also witness the powerful ways in which the power structures of the prison intersect with those in the hospital. Cassidy describes what it is like to support an incarcerated woman during labor and delivery:

> Advocating for women in prison is the hardest. People [working at the hospital] have preconceived notions, and sometimes assumptions that people are less educated. [Hospital staff] are frustrated when a client [from the prison] comes in with a birth plan. The idea is: what makes you think you have the right? They're looked at as people who shouldn't be having a baby.

This observation mirrors those of many doulas around the country who work with women who may be socially coded as not "legitimate mothers" (Solinger 2007).

The Birth Attendants doulas report that despite the injustices they and their clients contend with, they have not yet had anyone leave the collective because of the difficulty of the work. Rather, the Birth Attendants doulas describe a prevailing sense of inspiration, described here by Aliyah:

> The experiences in this collective are invaluable. I've learned so much about women and culture. It's so alive, these ideas about consensus and collective. [The first time going into the prison] I'd never been on the inside. It was intense, just the experience of walking behind gates, being told when to move and not move. And this is their home. But the women were so positive and open, and willing to share. I was really touched by a lot of women.

Aliyah describes deriving meaning and a sense of aliveness both from her work with the women in prison, and also from being a part of the Birth Attendants organization. This sense of solidarity with other doulas is described by many of the doulas in my study, but is especially emphasized by reproductive justice doulas. Like community-based doulas, the Birth Attendants doulas see their work not so much as working to make small changes one birth at a time, but as breaking down barriers and creating connections. Alex said,

> Prison is an energy force that thrives on breaking down community. It thrives on divisions, like racism. We are not affiliated with anyone, and that breaks down barriers, creates community on the inside. There's not always an opportunity for people from minimum and maximum security to meet. There's not that ability to talk with your sister. We're bringing it back to the simplicity of "we're human," bringing back a sense of home.

This emphasis on interdependence, both on an individual, "human" level and an organizational level may be because community-based, volunteer, and prison doula programs must necessarily be connected to other institutions and community resources in order to be sustainable. Cassidy describes both the hardships and the potential virtues of the financial situation of the Birth Attendants:

> Doula work has to be sustainable for one's self and family. It tends to be those who have money [who are doulas]. And a lot of women who support this work are low income. It's hard to find time. We are funded by the Third Wave Foundation and community donations. Most of our work is volunteer. We have an annual auction and an appeal letter to past and new donors. The hope is that we continue to be active in a reproductive justice network. We need a human rights movement in the U.S.

The sustainability of prison doula work is linked to fundraising and networking, and perhaps it is precisely by virtue of these connections that a larger human rights movement may be able to grow out of programs such as the Birth Attendants.

Radical Doulas

I first met Miriam Zoila Perez, who writes the Radical Doula blog, and whose name is now associated with Radical Doulas, at the NAPW conference, along with several of the Birth Attendants doulas. Miriam was the first person who I had ever heard identify herself as a Radical Doula, and the identification resonated with me and a handful of others present. She tells the story of coming to distinguish herself in this way on the Feministing blog:

> I stood up and introduced myself as a radical doula. This was a designation that I came to assume for myself through an understanding that my beliefs (which seemed to me completely logical and altogether natural) placed me apart from a large part of what I have come to call the "birth activist" community (midwives, doulas and advocates who work toward changing the standards of care for birthing women in the US). This conference highlighted many of the ways my politics are a seeming contradiction: I'm a doula and I'm a pro-choice abortion advocate. I'm a doula and I'm a lesbian. I'm a doula and I may never have children. I'm a doula and I'm Latina. I'm doula and I'm not entirely comfortable with the gender/sex binary. [Perez 2007]

An increasing contingent of the doula community is coming to embody these "seeming contradictions," and is striving to live them through their birth work. Some work as abortion doulas in addition to birth doula work, which I discuss later in this chapter. Miriam Perez, in an effort to foster this community, has started a "Radical Doula Profiles" section on her Radical Doula blog, which currently features 31 doulas who identify with that title.

The two main traits that link those who call themselves radical doulas are an intersectional politics that embraces a reproductive justice approach to birth work, and a commitment to making doula care accessible to marginalized communities. Many of those who identify themselves as radical doulas indicate that this means a particular way of identifying systemic forms of oppression, and how they relate to birth. In response to the question, "do you consider yourself a radical doula?" Sara Young in New York said,

> Yes. I understand the systemic roots of hetero-patriarchy, class oppression, racial oppression, and power dynamics that have a direct effect on the US birth system. I bring this understanding to my doula practice and work to subvert oppression by helping clients to radically transform their relationships with their bodies, partners, sexual identities, and families. I am pro-choice and support my clients

> in making empowered choices about their own bodies and reproductive lives.

Similarly, Shelley Walter in Rhode Island explains that choice in childbirth relates to the social and political systems that affect our lives:

> Yes. Being a radical doula means recognizing that the kind of birth options available to women depend on things like race/class/sexual orientation/socioeconomic status/religion/education level, etc. As a radical doula, I'd like to make my services available to women of all backgrounds. Recognizing the different forms of oppression that women face is just the first step in breaking down those barriers.

Those who identify themselves as radical doulas tend to see their work as being about activism as much as about birth. The medicalization of birth is not their central concern; for radical doulas, the birth of a child is a key point of intersectionality, where larger patterns of privilege, oppression, and resistance converge on a highly personal level.

Self-identified radical doulas are not the first people to suggest an intersectional framework for understanding birth. As I outline in chapter five, midwives and doulas of color have been making these arguments for decades, long before the advent of the Internet. Heather Dillaway and Sarah Jane Brubaker (2006) investigate how women from different social locations discuss epidural use epidural use, arguing that "feminist critiques of the medicalization of childbirth should be expanded to address race, class, and age as structures of oppression and privilege that shape women's reproductive experiences." (16). Doulas are often in a unique position to develop these critiques, as regular attendants of births who are not clinical care providers or giving birth themselves. As I describe in chapter four, they bear witness on a regular basis to the ways in which medical treatment differs based upon their clients' social location.

The social location of a doula's clients is the other primary criterion by which doulas identify themselves as "radical doulas." In particular, they prioritize providing labor support for those who are underserved and underrepresented. As Shelley Whittier in California put it, "there is not a single family that I would feel discomfort serving." For many radical

doulas, like Carrie Autry in South Carolina, this is an essential corrective to the inequitable dynamics of most private doula care:

> I find that my area concentrates on only natural birth. This means wealthy, white, married, Christian women are getting doula support. I serve all women, regardless of birthing preference, ability to pay, or family situation, religious or ethnicity.

Carrie identifies a connection between the ideal of natural childbirth and the social position of those seeking it. Sheri Hawkes in California also indicates that her willingness to work with clientele outside the "wealthy, white, married, Christian" profile makes her a radical doula:

> Well, considering that my first volunteer client was a vegan, transgendered birth parent (biologically female, but considers himself to be a man, and calls himself "Papa") in a bi-racial relationship with a bio-man, living in the serious 'hood in East Oakland; and my second volunteer client was a bi-racial teen mom living in OHA apartments, I'm pretty sure that I'm a radical doula.

Sheri bases her identification with the term "radical doula" on the level to which her clients' identities are non-normative.

Many doulas I surveyed indicated that they feel especially drawn to expanding access to doula care, and for many of them, this is tied to their own racial, ethnic, sexual, gender, or political identities. For instance, Joanna Tilley in Minnesota said,

> Yes. It means I practice as an OUT lesbian in my community. It means I work with the choice community to bring women's reproductive freedom to the clinic as well as the birth room. It means I push women to think for themselves and take their birth to a spiritual level, make it a life altering experience. It means I encourage women to let go of shame about their bodies, their sex, their fears.

For Joanna, her own visibility as a lesbian doula and the public presentation of pro-choice, feminist politics is a key part of the service she provides.

When I began my research, I did not expect that I would encounter any male doulas, but four doulas in my study identified themselves as male, and one as genderqueer. Jason Epstein, one of male-identified doulas in my study, also experiences his identity as a radical quality on multiple levels:

> I feel like it is radical to really be willing to support people in birth in the way that is truly safe and comfortable for them. I am also queer socialized and sex positive which feels important for many people in birth. Although I don't think it should be, apparently being a male doula is radical. I also offer abortion doula support.

Jason implies here that there are childbearing families who do not seek doula services from more heteronormative doulas because it does not feel "truly safe and comfortable." In this case, having a doula who is "queer socialized and sex positive" would indeed be important. Like doulas working in community-based programs, many radical doulas recognize the importance and safety of shared identities between doula and client.

The question of whether identity politics belongs in the birthing room, or in the doula relationship, is not agreed upon by all doulas, however. Some doulas say that they consider themselves radical in their own politics, but that they work hard to keep those beliefs out of their professional work, and out of the birthing room. As Joanna Gillman in California said, "I consider myself pretty radical, but most of my clients are decidedly not...and my work is about them, not me." For Regina Samuelson in Washigton, the expression of political beliefs is a breach of professionalism.

> As a queer and feminist doula, I would consider myself a "radical doula," yet my clients may not see me as such because I am very conscientious of my role as a professional doula and try to remain unbiased and evidence-based in my support. While I try to bring my whole self to my work, my personal beliefs and politics are not something that I impose on my clients.

This doula's response is not unrelated to the discussion of what constitutes evidence-based practice. She is contending here with the question of whether, and how, one's identity and personal views can interact with an objective, "unbiased" approach to care provision. For this doula, her "whole self" is ideally present, but muted, so as not to be "imposed" on anyone.

Many self-identified radical doulas are seasoned activists who find birth work to be the most effective form of activism they have encountered. Katie Bergin in California said, "I am a radical doula because being a doula is the most effective way to be an activist for

reproductive justice and feminism that I have found." For Rosalie Picard in Colorado, being a doula is a way to make one's politics manifest on a regular basis:

> Being a radical doula is an identity, a way that your worldview and belief system manifest in your work. For me, doula work is just one of the ways that I engage in my beliefs on a daily basis--beliefs in community engagement, personal autonomy, and advocacy. Doula work is a form of daily activism for me.

Rosalie's response shows another layer of meaning of doula care in the lives of those who provide it – doula work is a way for a doula to live in accordance with his or her politics, and is therefore experienced as an identity. Again, because of this, the formation of community is important to those who identify as radical doulas. On February 26, 2012, the fifth anniversary of the Radical Doula blog, Miriam Perez wrote:

> I started this blog because I felt alone in the doula world. I felt alienated in the birth activist community because of my identity and my politics. Today what I am grateful for is that I no longer feel alone. I actually feel surrounded, both online and off, with people who have a similar passion for doula work and birth activism, and have the politics to bring alongside it.

This post indicates the effects of the steady growth of the reproductive justice doula community over the past five years.

Some doulas in my study say they are aspiring radical doulas, indicating that they would like to do more work with more women and families in vulnerable or marginalized communities. Maggie Harper in Iowa said:

> If I had lots of time, I would love to get a prison doula program up and running, offer prenatal education to incarcerated women who are pregnant, have a volunteer doula support them during birth and afterwards, advocate for a mothers-in-prisons rule that would allow them to keep their babies with them for as long as possible, have a prison nursery, etc. But, I have too many other things going on, so I haven't done more than think about this. If I actually did it, then I'd be a radical doula.

For Maggie, being "radical" is not just about one's politics or identity, but whether or not the doula is currently taking action on behalf of underserved people. Like many doulas, she indicates that she does not "have the time" to undertake such work. Another similar response lists the doula's other life priorities that are getting in the way of calling herself a

radical doula. Corrie Gillis in Massachusetts says, "I just haven't had the time to branch out yet as I've only been at it for a year and have been since employed, in grad school, pregnant with my second child and parenting." The responses of aspiring radical doulas illustrate the fact that most doulas are involved with other work, both paid and unpaid, and many, perhaps ironically, find that they lack the resources necessary to support themselves in serving marginalized populations.

While the term radical doula is becoming more well-defined and more widely embraced, this term remains confusing to many doulas. In my survey, I asked "do you consider yourself a radical doula? If so, what does this mean to you?" Out of 164 respondents, 64 either said no, or that they did not understand the question. The remaining responses span an extremely wide range of relationships to this term, and I outline them here because they illuminate some key debates within the doula community at large.

Some doulas like Flora Ledford in California explicitly disavow the term radical doula because they dislike the connotation of a "fringe and extreme activist." Like other doulas who say that it is politically risky to call themselves activists, these doulas fear that identification with the term "radical doula" could be off-putting to hospital staff and others, and impede their work. As one doula Jodie Eversole from South Carolina said,

> Actually, I am a pretty boring, straight-arrowed doula. I work for a hospital program, so I don't have the opportunity to meet with clients prenatally and discuss their options or to push for change. I also don't try to test my limits with doctors or nurses because I want to make sure they will be on my side when I need them later.

For Jodie, pushing for change and upsetting the balance of power by doing so constitute radical acts that she does not see as helpful to her clients or her relationships with hospital staff. Other doulas espouse many of the same principles as do Miriam Perez and other self-identified radical doulas, but see the term "radical" as implying combativeness. Cynthia Alessi says,

> I'm not sure what the term means, so I guess I don't consider myself to be radical. But I support women and their choices (including genderqueer people), and I have provided doula support for women

> having abortions. I don't believe in "radical" in the sense of blatantly causing difficulty with hospital staff (going against rules and policies and getting doulas as a whole in trouble). But I do believe unjust and non-evidence-based practices should be challenged and changed.

Cynthia does not understand the term as relating to a doula's political stance on abortion, gender issues, or birthing practices on a systemic level, but as referring to an attitude toward hospital staff that could get her and other doulas "in trouble."

Several respondents indicated that they didn't personally identify themselves as radical doulas, but thought that others might. Lisa Greenaway from Nebraska said, "some consider being pro-choice as being a radical doula, so if you consider that radical, then sign me up." Two doulas who are profiled on the Radical Doula website, Charlie Rae and Megan, also describe initially being labeled radical doulas by others, and then coming to embrace that term:

> We would have never labeled ourselves as 'radical doulas', however, we suddenly found ourselves being titled by other more mainstream birth professionals as 'radical' and 'rogue.' After feeling hurt and confused by the title, we began to dissect the meaning a bit more. We found that if standing up for what we believe in, and providing women with the care and education that we KNOW they deserve is radical- the we will embrace it whole heartedly. [*Radical Doula*, 2012]

For these doulas, embracing a negative label that other "more mainstream" doulas gave them has become a source of power.

Some doulas defined being a radical doula as working outside the widely accepted scope of practice. Yolanda Kastner from Washington responded to the question "Do you consider yourself a radical doula?" "No. Radical means to me someone who steps outside of their scope of practice. More women are injured that way than helped even if the other person is well meaning." For this doula, the term is a negative one, but for other doulas who define the term similarly, it is a point of pride. One such doula, Heidi Collins from Ontario, CA, responded, "Sure! I do UC [unassisted] births. Being radical to me is a positive word. I often do births that many doulas won't touch due to fears. I worked through my fears to get here." Participation in unassisted births – where the woman or family has chosen to have no midwife, physician, or other primary clinical care provider present – is indeed quite

controversial among doulas. Many fear that the doula could be subject to prosecution in the event that a complication such as an apneic baby or a hemorrhage took place. Although the doula is a non-clinical provider, she could be seen as the most knowledgeable person present, and therefore liable for the birth outcome, or seen as a rogue midwife, especially in states where direct-entry midwifery is still illegal.

Some doulas indicate that they understand "radical doula" to refer to a doula who will only work with people who desire a certain type of birth outcome, most typically a drug-free birth. The vast majority of doulas who defined the term this way said that they would not identify themselves as radical doulas because they do not restrict their work to clients who plan drug-free births. As Jeanne Blythe in Illinois put it, "No. I believe that interventions have their place. I'd think a radical doula would not believe that interventions are ever warranted." Responses such as this reveal the perspective that while there are some doulas who restrict their clientele, this is an outlying – radical – behavior. Others understand "radical doula" to mean just the opposite: a doula who will work with any client, regardless of whether or not she invites drugs or other medical procedures into her birth experience. This understanding of the term illustrates the recognition among doulas that the emphasis on "natural childbirth" is the norm among doulas. For these doulas, the belief that "interventions have their place" is radical, meaning outside the norm.

This range of responses illuminates a contradiction in doula care. Is it the norm for doulas to espouse natural childbirth, or for them to disavow attachment to that goal? The results of my survey indicate that the answer to this may differ according to local community doula cultures, but I would argue that for the doula movement at large, the answer is both. Most doulas personally believe that drug-free childbirth with minimal interventions is healthiest for most women, but they constantly put their personal beliefs aside to support their clients whatever their wishes and circumstances may be, and to adapt to the medical practices that most women inevitably face as part of birthing in the hospital. As Rhonda Latham in Colorado said, "I honor the natural process of birth but still understand that

medical interventions have their place. This has been a hard balance to achieve and maintain."

Still others said that they believe being a doula is inherently radical, in that doulas regularly question mainstream birth practices, and strive to empower women within a patriarchal medical system. For these doulas, such as Ginger Rossi in Colorado, "it means I do the work of supporting women in remembering that they have authority over their own bodies and can trust in their intuition." Victoria Avery in Indiana said, "I think I'm only radical in the sense that, compared to many people, I trust in the normal process of birth - but I think that's a trait common to ALL doulas." Evelyn Saldana in California agrees: "Asking a naked woman who is in the grip of contractions and feeling vulnerable to stand up to the medical establishment is pretty radical." Evelyn outlines a key argument about the politics of doula care. The picture she paints of the naked woman standing up to the medical establishment exemplifies the sentiments of many of the doulas I interviewed: that doula work is inherently feminist, in that facilitating a laboring woman's expression of power while in a vulnerable, liminal state and embedded in an institutional setting is inherently a feminist act.

Full Spectrum Doulas: "On The Threshold of Being and Not Being"

In 2007, two doulas in New York City began The Abortion Doula Project with the intention of providing information, emotional support, relaxation techniques, and physical support to people choosing to terminate pregnancies. As they became more involved in this work, they found that the needs of their clients were larger than anticipated. This evolution is described in the organizational history outlined on the website of what is now known simply as The Doula Project:

> While the Project did originally intend to center on abortion, the presence of those who came to abortion clinics because of miscarriage and lethal fetal anomaly began a shift in the way we approached the project. Likewise, as our trained birth doulas worked

> with birth mothers through our partnership with the pro-choice adoption agency Spence-Chapin, it became less and less appropriate to consider ourselves solely as "abortion doulas." In early 2009, we changed our name to The Doula Project and adjusted our mission, vision, values, and constituent base. [The Doula Project, "History," 2012]

The Doula Project, a non-profit organization, now contracts with several clinics and organizations in New York City to provide the doula model of care to those experiencing birth, abortion, miscarriage, stillbirth induction, and adoption. Since 2008, The Doula Project's 50 trained doulas have provided services to more than 5,000 women in New York City, and the organization has developed a replication model for full spectrum doula programs. At this time, there are full spectrum doula services in many cities across the country, including Seattle, Atlanta, Chicago, Boston, Philadelphia, and Asheville, North Carolina (*Radical Doula*, "Volunteer Programs," 2012). An online community, called the Full Spectrum Doula Network, formed in 2010, stating on its website that "there are unique challenges to being pro-choice, feminist, queer, or a person of color in a doula world that is predominantly none of those things." There are currently 581 members of this network (Full Spectrum Doula Network, "Members," 2012).

Abortion Doulas

Because of the politicization of abortion, the emotional context of the abortion experience has been politicized as well; anti-abortion advocates make claims about its traumatic effects, and abortion rights advocates argue that most women feel happy and relieved about their choice to terminate an unwanted pregnancy. As a clinic administrator quoted in Faye Ginsberg's study of abortion activists put it, "if anything is guilt and trauma inducing, it's these people picketing in front of our clinic" (1998:2). The idea of supporting a person through the abortion experience, therefore, is potentially off-putting to some supporters of abortion rights, even though abortion doulas identify across the board as pro-choice. Mary Mahoney, one of the founders of The Doula Project, explains her response to

this dilemma in an interview with Aspen Baker, published on the "Exhale" blog in 2010. She explains,

> Some people in the reproductive health and rights movement have asked us, why do you assume women having abortions need emotional support? In the beginning, that question scared me. I thought, is that what our project is doing? Are we setting the movement back in some way by thinking that this is an emotional time for a woman? Two years later, our project has served more than 1,000 women having abortions, and I can say that there is no simple answer to such a simple question. What I've learned is that everyone experiences abortion, and pregnancy for that matter, differently. So I've stopped making generalizations or trying to predict how a woman will react before, during, or after her abortion because each person's life looks different, even within a shared physical experience. And I stopped being scared of the movement when I started getting to know the individual having the abortion. Nearly all of the individuals we've encountered in the clinic have benefited from doula support, whether on an emotional (which can have a variety of meanings), physical, or informational level. [*Exhale* 2010]

By refusing to make abortion doula work fit neatly and completely into pro-choice arguments about the emotions surrounding abortion, Mahoney makes room for people's real life experiences to exceed the heightened rhetoric on either side of the abortion debate. In doing so, she echoes Lynn Paltrow's assertion that the abortion debate distracts from the real, multifaceted needs of families and the ways in which health, economic, criminal justice, environmental and drug policies affect the ability of all women to exercise multiple forms of agency in their reproductive lives.

Mahoney also contends with the objection that abortion doulas are not needed since clinic staff already perform a supportive role for their patients. In the same interview, Mahoney describes how the roles of clinic staff and abortion doulas overlap and diverge:

> Compassionate care and emotional support are not new to the practice of abortion. Counselors and patient advocates have been serving as 'doulas' for years, providing a hand to hold and an ear to listen during procedures. However, many clinics do not have the resources to provide this intensive one-on-one care. The Doula Project began its services with this in mind, as a way to support not only pregnant people seeking abortions, but the clinics providing them. Many components contribute to the well-being of a pregnant person terminating a pregnancy and different medical staff supply different components of care. The doula's primary role is to serve as a continuous uninterrupted presence before, during and after each

> client's abortion, and to provide various emotional, informational, and physical comfort measures. This can include massage, hand holding, reassurance, providing clarity around procedures and birth control methods, or engaging them in conversation. [*Exhale* 2010]

Describing a typical day in the life of an abortion doula, Mahoney explains the wide variety of kinds of support she might provide:

> I can highlight the diversity by giving an account of my most recent day in the clinic with four patients who were having 2nd trimester abortions. Since patients are normally under general anesthesia during this procedure, doulas spend the majority of our time with them before they enter the operating room. The first woman I supported that morning was in her early 30s, Spanish-speaking, religious, and scared. I spent my time with her holding her hand, wiping her tears, and telling her it was going to be ok and that she would be safe, in my own broken Spanish. My next client was having strong cramps from measures that were taken to dilate her cervix, and so I gave her a lower back rub and massaged a pressure point on her hand. After her procedure, at her request, I went to the waiting room to tell her husband and sister that she was fine and would be discharged in a couple of hours. The next woman I met mostly wanted to be alone, so I checked in with her every few minutes to see if she needed anything and pulled the curtain closed around her bed. My final patient was a gregarious, talkative young mother. I brought a warm blanket and a hot water bottle for her cramps, and spent the next 30 minutes with her talking about her future job prospects, different kinds of birth control she might like, and just joking around. [Mahoney 2010]

This description mirrors the various types of support different women might need or desire in the birthing room. Like birth doulas, abortion doulas fill a unique role in that they only care for one person at a time, continuously, and are present to meet basic needs for physical, emotional, and social support without the added responsibility, or some would say, distraction, of clinical care.

Adoption Doulas

The work of adoption doulas is also just beginning to be understood. The need for adoption services in The Doula Project came from the organization's founders hearing stories from allied professionals working in an adoption agency. In an article entitled "The Doula Movement: Making the Radical a Reality by Trusting Pregnant Women," Mahoney describes learning about "nurses and doctors not respecting the mothers' wishes to have the

baby taken out of the room following the birth, or just the opposite, nurses not letting the mothers hold or breastfeed their newborns since they were choosing not to parent." Aside from facing a pervasive lack of respect for their wishes in the hospital setting, often completely alone, the experiences of birth mothers releasing a baby for adoption are also shaped by poverty and other factors that limit the choices available to them.

> Most people face similar issues in giving birth, such as where they are going to deliver, how they will deliver, and with whom. For those choosing adoption, these issues can be even more complex and barriers in their lives can make them nearly impossible to resolve. For example, most of the mothers we've worked with don't shop for doctors, midwives, or hospitals. They go to the one closest to where they live, the one that takes Medicaid, and they aren't given any information outside of what their doctor tells them. [Mahoney 2010]

Mahoney describes her experience supporting a young Tibetan woman giving birth to a baby she was placing for adoption in a New York hospital. The woman was denied an interpreter, and when she refused a cesarean, she was told she would be forced by court order to undergo surgical birth, and was "branded a murderer," admonished that "Just because you don't want the baby doesn't mean he should die." This mother did go on to have a vaginal birth, because she had assistance in advocating for herself. Mahoney emphasizes that not all experiences of mothers choosing adoption are like this, and that many do have the support of family and friends. She clarifies that "Our doulas work with those who need extra support and feel otherwise isolated in their pregnancies" (Mahoney 2010).

Adoption doulas provide support to both birth parents and adoptive parents. They typically offer private, adoption-specific childbirth education, postpartum support that includes assistance and support for various choices regarding breastfeeding and pumping, escorting the birth mother home from the hospital if she is alone, and referral to other counseling or support resources as needed, as well as uninterrupted labor support and assistance making birth plans. They also may serve adoptive families by offering childbirth education specific to the needs of adopting families and postpartum support with bonding, infant feeding choices, and general newborn care. Often, the adoption doula facilitates

smooth relationships between the birth mother and adoptive parents by describing the birth mother's strength to the adoptive family and by helping the adoptive family to feel a part of the birth experience in the way and extent that they and the birth mother are comfortable. For example Mahoney describes speaking to the adoptive parents working with her Tibetan client and emphasizing the "strength of their new child's birth mother and the grace with which she delivered."

Doulas in my survey who work with birth mothers choosing adoption report some significant differences between working with these clients. One common comfort measure doulas use is to remind the birthing mother of her baby during labor. Phrases like, "soon you'll be holding your baby in your arms" and "send your love to your baby" are commonly heard in birthing rooms, from doulas, midwives, doctors, and nurses alike. But for those working with a laboring woman who will not be continuing a relationship with the child to whom she is giving birth, this language, which is such a habitual part of the fabric of doula speak is inappropriate. As Kayla Blackwell in Wisconsin reported,

> I worked with a teen who was planning to release her baby for adoption. It was a beautiful experience but I had to rethink all my "baby talk". She did hold the baby and had the baby for a bit, but all the things one normally does: "your" baby, "your baby is almost here," was different.

Athena Quinn in Michigan echoes this experience, and also reports the challenges of supporting a woman whose family members questioned her adoption decision while she was in labor.

> Having a client who was giving their baby up for adoption was very unique. What posed a challenge was keeping the other people attending her birth in the same mindset my client was in. I remember an aunt of my client asking her over and over again if she wanted to "stick with the plan." My client did, but I found it exceedingly frustrating to continue to remind her family of this. Additionally, the framework changes during birth because you don't have the stereotypical reminder "you're doing this for your baby." Using that can be risky. I found it challenging to match the mood of the mother throughout labor. It was overall a wonderful experience, but definitely posed unique challenges.

The doulas in my study who work with adoption and abortion fall into two main categories in terms of their training. They are either trained specifically by full spectrum programs specializing in this kind of care, or they are finding their own way to best provide care to these clients with little or no training in these areas. As with radical doulas, several doulas in my study indicated that they would like to move into providing support for reproductive experiences other than birth, but that they have not yet had the opportunity, the training, or the community support to do so.

Doulas who are attracted to full spectrum work cite many of the same motivations as do those who identify as "radical doulas." For some, the terms are overlapping or interchangeable, but for others they are not. In either case, what they have in common is a commitment to serving the underserved, and to recognizing an intersectional approach to reproductive health care. In my survey, I asked, "do you consider yourself a full spectrum doula? If so, what does this mean to you?" Janna Malloy in California describes her interest in this work:

> [I consider myself a full spectrum doula] much more than a "radical" doula. All it means to me is that I'm pulled to working with pregnancy because I'm pulled to work on the threshold of being and not being. Every pregnant person is walking that threshold all the time--whether she's going to give birth or terminate her pregnancy--and I've been fascinated with that threshold my entire life.

Janna's response echoes Rickie Solinger's argument that questions of "who has power over matters of pregnancy and its consequences" are "one of the most fiercely contested and most complicated subjects about power in American society" (2007:3). It is also attentive to the powerful liminality of reproductive experiences, where, as Robbie Davis-Floyd discusses, profound interior and social change can take place (1992). Those in liminal states "transgress classificatory boundaries," and the opportunity for subversion in these settings exists because liminal subjects are "both cultural and natural creatures, human and animal" (Turner 1977: 37).

The both/and nature of liminality contradicts the dualism upon which hierarchical oppression rests. Patricia Hill Collins outlines the way in which dichotomous thinking leads to opposition and objectification in Black Feminist Thought. The either/or paradigm "categorizes people, things and ideas in terms of their difference from one another." This difference is defined in "oppositional terms" and once oppositional difference is established, "one element is objectified as the Other, and is viewed as an object to be manipulated and controlled" (1991:68, 69). But the dichotomous model is overturned in the liminal state as "opposites…constitute one another and are mutually indispensable. Actuality, in the liminal state, gives way to possibility." (Turner 1969: 97). In many ways, this doula's draw to liminality echoes the non-binary thinking of the reproductive justice model itself.

By drawing connections between birth, abortion, adoption, pregnancy loss, and other reproductive experiences, full spectrum doulas recognize that the needs of pregnant women go far beyond, and are far more complicated than, the politically opposing poles of pro- and anti-choice. Kimberly Greenlee, who is a community-based doula in Washington, DC as well as a rape crisis counselor, explains this connection:

> Having a baby (or not having a baby) the way you want to is part of the spectrum of reproductive rights feminists advocate for. Limiting what decisions a woman can make about her birth begins the slippery slope to limiting what else a woman can do with her body and her life.

Doulas of many different backgrounds and belief systems indicated that they felt attracted to full spectrum doula work. For instance, Brandi Nolan in Iowa identifies closely with her Christianity. She says,

> To my understanding Radical/Full Spectrum doulas work with women in all areas of pregnancy, "including abortion, adoption, surrogacy, miscarriage and stillbirth" and are open to taking clients of varied ethnic, socio-economic, political, sexual backgrounds. I identify with this more and more as I have gone along in my doula journey, yet I don't feel very radical. I am working with a GLTB identified couple right now and they are wonderful. I also volunteer at [a Christian home for pregnant girls] as a doula for pregnant teens who are either choosing to parent or to explore adoption. My sister was a carrier for a couple and I would be happy to attend the birth of a carrier. I have had clients that were Bosnian, African Refugees,

> White and middle class, mentally ill, IVF/IUI, had previous abortions, had miscarriages, etc. I believe in a woman's right to choose and would fight to protect those rights so that women don't end up with back door abortions. I wouldn't want to attend an abortion as a doula. However, I love the thought that there are doulas out there that are willing and able to provide this service. It's wonderful.

Brandi's experience reflects that of many doulas: after being involved in doula work for a while, the range of reproductive experiences one encounters only grows wider.

Regardless of whether a doula supports abortion rights or works with abortion care, she will likely, at some point, be called on to support someone who has a miscarriage or stillbirth, even if she sets out to work solely as a birth doula. In addition to grief support and other forms of emotional support, those experiencing pregnancy losses face bodily experiences and medical treatment options that can be difficult to navigate without the benefit of informational support. As Linda Layne argues, pregnancy loss is rendered all but invisible within the mainstream natural childbirth movement, with its emphasis on joyful, ecstatic depictions of birth. Layne calls for a woman-centered and accessible model of care for those experiencing loss (2006), and her recommendations closely mirror the support doulas are increasingly providing. Full spectrum doulas are in a powerful position to challenge the erasure of pregnancy loss within the childbirth movement.

Gender Neutral Language

As I discuss earlier in this chapter, it can be important for LGBTQ parents to connect to doulas who are also LGBTQ. Many doulas also act as allies to these communities, even if they do not identify this way themselves. The use of the term "partner" to refer to a pregnant client's significant other has become all but standard in the past 5-10 years among doulas and other childbirth professionals. This is evidenced in literature, websites, and common language usage. For many of the reproductive justice doulas in my survey, it has also become important to use gender neutral language to refer to pregnant people. While this has not made its way into mainstream birth culture, reproductive justice doulas are becoming increasingly sensitive to the presence of transgender and gender nonconforming parents, the

use of gender inclusive language has become more widespread among this community of doulas.

One of the earliest instances of this I encountered was in a post on the "Bloody Show" blog. The author of this blog, known online as emvee, describes herself as a "direct-entry midwifery student interested in the intersections of health and race, class, sex, gender, sexuality and disability." On May 8, 2010, in a post titled "Trans-Inclusive Language and Midwifery," emvee writes:

> From here on out, Bloody Show will only use trans and genderqueer inclusive language to talk about pregnancy and birth. Yes, the majority of people who are pregnant or who have given birth identify as women. But really that's no excuse for not using trans-inclusive language when writing/talking about pregnancy and birth. Once upon a time I read a birth book and the author wrote a disclaimer in the beginning recognizing that although there are queer women with female partners who give birth, she was just going to use "he" and "father" to refer to the partner of the pregnant person since most partners were male. It made me outrageously mad to read that as a queer woman and to see my reality and life erased and made lesser than simply because I was not in the majority. So in that way, I've decided it's outrageous for me not to be actively inclusive when I write and talk about pregnancy and birth. I've just gotten to the point where I recognize that I can't call myself a trans-ally or say that I'm interested in intersections of sex and gender and birth unless I am actively conscious about using inclusive language. So that's what I've decided to do and I hope you'll join me.

An increasing number of birth workers are joining this blogger: midwives, doulas, and doula practices are increasingly using the term "pregnant people" or "pregnant clients" rather than "women" or "mothers." [4]

The existence of pregnant transmen began to be recogized in American culture at large with the first high profile pregnancy of Thomas Beatie, a transman who appeared on magazine covers displaying his pregnant belly in 2007, and has since been interviewed by Oprah Winfrey and Barbara Walters. Beatie is certainly not the only transman who has

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[4] This has been a challenge to me in my writing. At times in this dissertation, I use gender neutral language, and at times, it still feels important to me to use the term woman, because most of the people I am talking about identify and experience themselves in that way, and because of the gendered dimensions of birth and other reproductive politics.

carried a pregnancy and given birth, or the only trans-identified person to experience parenthood.[5] At this time, demographers have not yet collected reliable statistics on the number of trans parents. The Kids of Trans program within the organization COLAGE, a group for people with a lesbian, gay, bisexual, transgender, or queer parent, currently has a listserv with 60 members. Several other organizations and websites, such as TransParentcy.org, and a campaign make the first Sunday in November National Trans Parent Day, exist to provide support and visibility for families with trans parents. Health care providers are beginning to integrate cultural competency for trans people, including in obstetrics and gynecology (Adams 2010). Doulas are making this issue more visible, and those on the Full Spectrum Doula Network can join a group for those interested in providing transgender support.

Laurel Ripple Carpenter draws attention to the need for gender inclusivity among birthworkers in an article in *SQUAT Birth Journal*. She reminds the reader that "We are not all women" and that "There are doulas and midwives across the whole spectrum of gender diversity who are challenging the notion that midwifery is women's work" (2011:28). Ripple shares an interview with a transgender doula who struggles with feeling "alienated" in the birth community, and who wonders, "As someone who wants to prioritize being accessible to people, and being able to be a competent care provider, how am I potentially restricting myself by transitioning?" (29). Carpenter points out that "there are birthing families who embrace gender diversity as an element of the vibrant world around us, or who are themselves gender-non-conforming" (29). She says that "for me, the existence of male, transgender, genderqueer, and other non-gender-conforming birthworkers is not a contradiction. It's a statement of how far the birth world has come toward meeting the

[5] He is, however, the first to write about the experience in his own words in his 2008 memoir, *Labor of Love: The story of One Man's Extraordinary Pregnancy*. He has now given birth to three children.

needs of the vastly diverse folks who seek midwifery care, and embracing ourselves as a true community" (29).

The use of gender-neutral language, and the recognition of trans and gender variant experiences of parenthood, de-links gender from pregnancy and childbirth – experiences that are generally considered quintessentially female. As such, this move among some doulas represents a radical rethinking of the meaning of sex and gender, and a profound challenge to an essentialist, binary gender system. The use of gender inclusive language in this context mirrors the strategies of third wave feminist menstrual activists, described by Chris Bobel (2010) who use the term "menstruator" rather "woman," and thereby acknowledge that not only women menstruate, and also that menstruation is not a part of every woman's experience. Following Bobel's argument, I am convinced that reproductive justice doulas represent a similar enactment of third wave feminism, centered on bodily experience, but interested in deconstructing essentialist ideas of womanhood and gendered embodiment. As radical menstrual activists view menstruation as "a bodily process that exists not independently of, but in relationship to, the gendered body" (Bobel 2010:156), so do many reproductive justice doulas view childbirth and birthwork.

Conclusion

Reproductive Justice doulas are forging new pathways in bringing together social justice activism and birthwork. Incorporating a truly intersectional approach to birth that situates birth within structures of oppression that shape women's reproductive experiences, they are shifting the questions childbirth reformers raise about birth practice away from medicalization and toward equality, access, and justice. By centering new priorities and expanding the scope of services offered, reproductive justice doulas are finding connections among contradictions, and challenging binary ways of thinking about bodies and reproductive issues. In this way, childbirth becomes not just a one-time event in the life of a woman or family, but an important opportunity for the creation of community. Birth

becomes everyone's business. As Aliyah, one of the Birth Attendants prison doulas told me, "anyone who is alive has been involved in birth."

Daniela Garza suggested, at the National Advocates for Pregnant Women conference, that doulas could call the people they serve "fellow activists." I also see this question operating in the other direction: Can clients call their doulas fellow activists? Can doulas call each other fellow activists? Reproductive justice doulas seem to be answering in the affirmative. In 2002, Christine Morton observed that doulas are not in the business of creating social change, which may have been the case for the majority of doulas in the 1990s, but I argue that this landscape is changing dramatically in the new millennium.

CONCLUSION

In 2002, Christine Morton observed, based on her ethnographic research with doulas, that "many doulas see woman-to-woman care as a solution to problems that are in fact systemic, structural, and beyond the reach of one-on-one emotional support" (16). This perspective is summed up in the common sentiment among doulas that they are changing the culture of childbirth "one woman at a time." In my research, I also found that many doulas take this approach. However, I have also observed that an increasing number of doulas are joining together to think about, and enact, practices that seek explicitly to intervene into systemic forms of oppression as they provide individualized care to their clients. Megan Tate in Oregon explained this position succinctly:

> I have worked with groups that organized around independent media, anti-war activism, globalization, water privatization, and local community building. Ultimately, birth work is the most rewarding and satisfying work that I have done. I appreciate this work because it is obviously very personal and intimate and allows me to cultivate one-on-one connections with people, but I also know that it's bigger than the individuals that I serve. When women reclaim the right to birth on their own terms they might feel more empowered to challenge other forms of oppression and discrimination in their lives.

This new movement in doula care centralizes connected struggles for equality and justice, rather than simply seeking to demedicalize childbirth.

Medical anthropologists have argued that health is not just physical, but also inherently social and political. It is a dynamic process, rather than a static, quantifiable physical state. (Adelson 2000). Lock and Scheper-Hughes (1987) assert that there are "three bodies" that merit analytical attention: the individual body; the social body, in which the body functions symbolically; and the body politic, encompassing the social "regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality, work, leisure, and sickness" (45). I argue that doulas are increasingly attending not only to the individual body, but also to the social body and the body politic. As they do so, they

draw on perspectives that Mann and Huffman (2005) identify as "common threads" in third wave feminism: "intersectionality theory as developed by women of color and ethnicity; postmodernist and poststructuralist feminist approaches; feminist postcolonial theory, often referred to as global feminism; and the agenda of the new generation of younger feminists" (2005:57).

Antiracist, postcolonial, and third wave feminist theory is highly applicable and relevant to women's health, reproduction, and childbirth. These perspectives have contributed fruitfully to the understanding of how bodies come to be discursively and politically positioned (and therefore experienced) through the insistence that categories of race, class, gender, and sexuality are always intertwined, and mutually constitutive of each other. They have also strategized importantly about ways to create solidarity and alliances in ways that do not erase difference, but avoid investing difference with hierarchical thinking. The politics of race, class, gender, and sexuality are fundamentally about bodies: bodies differentially situated within economic and social orders that allow or limit access to health care resources, and within ideological orders that define the very meanings of what constitutes health or disease, on both an individual and social level. Angela Davis (1990) wrote, "the pursuit of health in body, mind, and spirit weaves in and out of every major struggle women have ever waged in our quest for social, economic, and political emancipation" (19).

Issues of reproduction and motherhood surface as central concerns for postcolonial and antiracist perspectives on women's health. Dorothy Roberts (1997) exposes the racism inherent in coerced sterilization programs and the promotion and restriction of assisted reproductive technologies. She argues not only that black motherhood has been degraded and devalued in American culture at large, but also that the feminist reproductive health agenda has failed to take into account black women's reproductive concerns. The eugenics movement in the United States (and welfare policies that have been influenced by it) and structural adjustment programs on the global scale have focused their attention on limiting

reproduction for third world women and women of color.[1] For these reasons, the rights to reproduce and to mother have been a major site of antiracist feminist struggle worldwide. At the same time, abortion rights are also affected by race and class inequalities. Access to abortion remains out of reach for millions of women because of government denial of public funding for abortion and barriers related to location, lack of transportation, increasing shortage of services, legal restrictions such as parental consent laws, and the presence of threats and violence (Silliman et al 2004).

On a global scale, we can see similar policies at work, policies Jaqui Alexander argues are really part of the same project and are intimately wrapped up with issues of sexuality (2005: 221). The World Bank and other international lending organizations continue to incorporate population control programs as a requirement for economic aid in many parts of the "developing" world. The underlying assumption is the same: that impoverished women are to blame for their poverty because of their uncontrollable fertility. Anti-imperialist feminist considerations of the worldwide distribution of resources contend that it is overconsumption and militarism in the First World, not overpopulation in the Third World, that is the cause for the persistence of extreme gaps of wealth and poverty (Silliman et al 1999). They also point out that the dynamics of international lending and structural adjustment programs also limit the amount of money national governments can spend on health care, which further impacts the well being of (especially) women and children.

The medicalization of birth must also be understood in a postcolonial context. Margaret Jolly (1998) discusses how the medicalization, rationalization, and scientization of pregnancy and childbirth was a fundamentally modernizing project, and therefore constitutive of not only patriarchal, but also colonial control. The ramifications of colonial

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[1] These terms are contested. They should be understood here as referring to nonhomogenous, highly diverse groups of women, occupying varying class positions, but subject to similar totalizing and controlling discourses. Mohanty (2003) argues that the term "third world" can be "defined through geographical location as well as particular sociohistorical conjunctures. It thus incorporates so-called minority peoples or people of color in the United States" (44).

control include the institutional disempowerment of midwives and other female healers, and the devaluation of women's bodily knowledge and authority as mothers. But Jolly also cautions against "idyllic constructions of maternity in the 'state of nature'" and the romanticization of maternal bodies or practices constructed as "traditional" (1998:4). As I demonstrate, this kind of romanticization is rampant in contemporary constructions of natural childbirth in the U.S., but is also being challenged by many birthworkers, especially birthworkers of color, who see their work, on both a private and public level, as part of a tradition of resistance.

The practice and philosophy of birthworkers of color has laid the foundation for a new, coalitional movement among doulas that is working to highlight issues of disparity in maternity care, bringing attention to social justice concerns into the childbirth reform movement as a whole. Reproductive justice doulas are increasingly working to incorporate what Jayati Lal describes as "a nonuniversalizing feminist methodology" (1996:185) to redefine the childbirth reform movement's goal of improving childbirth for all women. By making connections between power imbalances inherent both in institutionalized childbirth and in larger society, they are developing an intersectional understanding of the meaning and practice of childbirth that acknowledges the histories of racism, class oppression, and colonialism, as well as gender oppression. Their work challenges a consumerist framework for childbirth reform, blurs epistemological boundaries of scientific and embodied knowledge, and questions distinctions between public and private forms of activism.

This movement is not without difficulty. It involves the decentering of many of the goals that more privileged childbirth activists in North America have defined as primary, such as freedom from medical intervention. Advocating for the repositioning of these goals does not mean their abandonment, however; rather, these activists argue that they need to be understood in connection with other forms of power, and to the "full spectrum" of reproductive experience. Chandra Mohanty urges that "Western feminist scholarship cannot avoid the challenge of situating itself and examining its role in such a global economic and

political framework" (2003:20). Likewise, the childbirth reform movement can avoid this challenge no longer.

When I began my research, I expected to study two distinct groups of doulas: those who are more radical, and those who are more mainstream; those who come from more privileged backgrounds and serve more privileged women, and those serving minoritized communities of which they are a part. Instead, what I found is an overlap, a blurring of boundaries, in every category I set out to explore. Though many doulas claim and experience designations such as "radical doula" as identity labels, the ideas that are coming out of the new coalitional politics of doula care are infusing the mainstream doula movement, as well. As a whole, doulas are increasingly looking for ways to use their skills to improve the birth outcomes that underserved communities define for themselves as priorities.

The new directions doula care is taking are only important theoretically or ideologically. Doulas are not just "extras" in childbirth. They do important physical, emotional, educational, and community work that improves health outcomes in quantifiable ways. For this reason, the group Health Connect One is working to secure public funding for doula programs on the federal level as part of ongoing health care negotiations. Last year, in Oregon, the state legislature passed a house bill that required the Oregon Health Authority to investigate how doulas and other community health workers could improve birth outcomes for the state's underserved women. In February 2012, it released a report from that investigation finding that doula care is an effective way to decrease health inequities, and recommending that doulas be incorporated into the Oregon Health Plan and reimbursed by Medicaid and Medicare. Tricia Tillman, the director of the Oregon Health Authority's office of Equity and Inclusion described doulas as "a new healthcare workforce that we haven't paid much attention to." As this workforce grows and changes, doulas are in a powerful position to launch an important intervention in the maternity care crisis in the U.S. The time has come to pay attention to doulas.

APPENDIX A

DOULAS AND THEIR CLIENTS

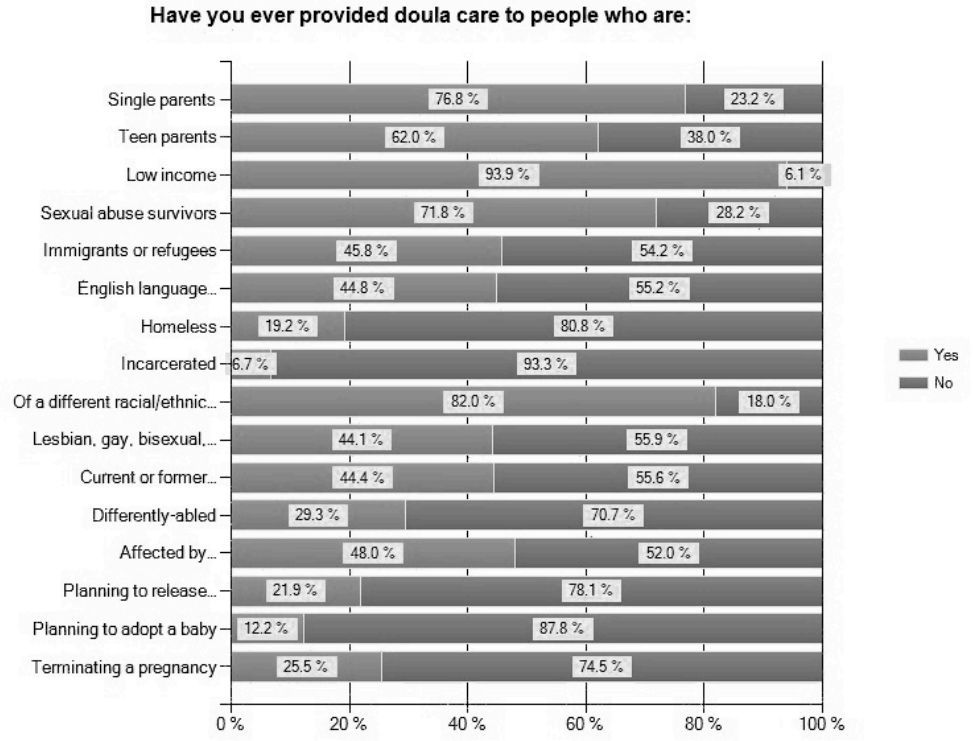

Figure A-1. Survey results: People to whom doulas have provided care

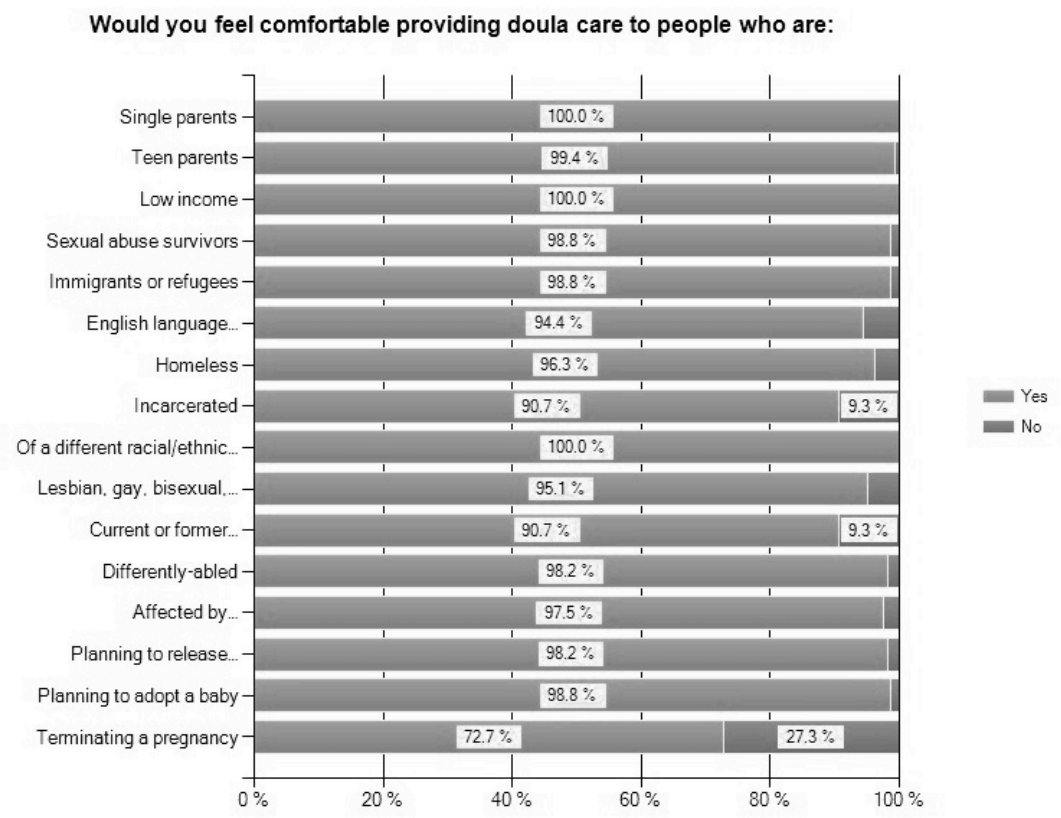

Figure A-2. Survey Results: People to whom doulas would feel comfortable providing care

APPENDIX B

QUESTIONNAIRE AND INTERVIEW QUESTIONS

FOR INDIVIDUAL INTERVIEWS

Questionnaire

Full name _____ E-mail _____

Mailing Address _____zip_____

Date of birth _____ Phone number (_____) _____

Age at first pregnancy _____ Number of pregnancies _____

Number of live births _____

Current ages of children _____

With what racial/ethnic group do you most identify? _____

Are you a US citizen? Yes No

Do you currently have a spouse or partner?

What is your approximate yearly household income?

Approximately how much do you make a year from doula income?

What grade of school have you completed?

For how many years have you been working as a doula?

Approximately what percentage of births you attend as a doula occur in a

Hospital _____ birthing center _____ home _____

How many births have you attended as a doula?

What percentage of these births were paid births?

Do you currently attend any unpaid births?

What is your fee range for doula services?

Do you have a sliding scale for doula clients? Yes No

If so, please describe:

Do you belong to any professional organizations? Yes No If so, please list:

Have you ever provided doula care to women who are:

Single mothers	Yes	No
Teen mothers	Yes	No
Low-income	Yes	No
Sexual abuse survivors	Yes	No
Immigrants or refugees	Yes	No
English language learners	Yes	No
Homeless	Yes	No
Incarcerated	Yes	No
Women of color	Yes	No
Lesbian, Bisexual, Transgender	Yes	No
Current or former substance abusers	Yes	No
Disabled	Yes	No
Affected by domestic violence	Yes	No
Planning to release their baby for adoption	Yes	No

Would you feel comfortable providing care to women who are:

Single mothers	Yes	No
Teen mothers	Yes	No
Low-income	Yes	No
Sexual abuse survivors	Yes	No
Immigrants or refugees	Yes	No
English language learners	Yes	No
Homeless	Yes	No
Incarcerated	Yes	No
Women of color	Yes	No
Lesbian, Bisexual, Transgender	Yes	No
Current or former substance abusers	Yes	No
Disabled	Yes	No
Affected by domestic violence	Yes	No
Planning to release their baby for adoption	Yes	No

Do you, or have you ever identified yourself with any of these groups? If so, which one(s)?

Do you do any additional paid work in addition to being a doula? Yes No

If so, what type(s) of work do you do?

Do you volunteer? Yes No

If so, for what organizations/causes?

Individual Interview Questions

1. How did you decide to become a doula?

2. Tell me about your training.

3. Do you feel you were well prepared by your doula training?

4. Is there any situation for which you feel your training did not prepare you well?

5. Are you certified, or working on becoming certified? If so, through what organization?

6. What is the most important thing you do as a doula?

7. Do you think of yourself as an advocate for your clients? Why or why not?

8. Do you consider yourself a feminist? Do you see your doula work as feminist in any way?

9. How would you define the term "natural childbirth?" How many of the women you work with see this as a goal?

10. How do your clients find you or contact you?

11. Tell me about your clients. How often do you work with women who have low incomes, special needs or challenges, or nontraditional family structures? (Refer to questionnaire)

12. Are there unique challenges or issues that come up when you are working with those women?

13. Do you feel you were prepared for those issues/challenges in your doula training?

14. What makes for a good birth, in your opinion?
How do you feel after a birth like this?

15. What makes for a challenging or difficult birth, in your opinion?
How do you feel after a birth like this?

16. Have you ever felt it necessary to step outside the doula code of ethics? (For example, have you ever been in a situation where you felt it was necessary to speak for a client?) If so, when and why?

17. Have you ever assisted a client in navigating a power struggle with a health care provider? If so, can you tell me more about that? What was the situation and what did you do about it? How was the situation resolved? How often do you find yourself in this situation?

18. Have you ever felt yourself in a power struggle with a health care provider? If so, can you tell me more about that? What was the situation, and what did you do about it? How was the situation resolved? How often do you find yourself in this situation?

19. Have you ever attended a birth that was experienced as traumatic for a birthing woman? If so, can you tell me more about that birth? What happened that was traumatic? How did you help the woman?

20. For any of the occurrences in questions 17-19, did you seek the advice of other doulas or doula organizations, listserves, etc.? If so, was it helpful?

21. Is there anything doula organizations could do that would better help you or your clients in dealing with challenging births?

22. What do you see as the major strengths of the doula profession as a whole?

23. What do you see as the weaknesses?

24. What kind of work do you do outside doula work, either paid or unpaid? Do you see that work as connected to your doula work? If so, how?

25. In general, what are the biggest barriers women face in achieving the kinds of birth experiences they desire?

26. In a perfect world, what changes do you think would be necessary to improve birth for women and families?

APPENDIX C

ONLINE SURVEY QUESTIONS

Eligibility question
I certify that I am 18 years of age or older, and that I am a practicing doula, doula in training, or a doula who has recently retired (within the past year).

Introduction and Demographics
1. Please indicate if you would like me to assign you a pseudonym, or if you would like to choose your own pseudonym.

2. May I contact you if I have follow-up questions? If so, what is the best way to contact you?

3. State (or province/country) of residence

4. Gender

5. Age

6. Race/ethnicity

7. Marital/relationship status

8. Your occupation and education level

9. Your significant other's occupation and education level

10. For how many years have you been working as a doula?

11. About how many births have you attended as a doula?

12. As a doula, do you attend births in:
    Homes?
    Hospitals?
    Birth centers?

13. What is your fee range for doula services?

14. Do you offer low- or no-cost services?
    Exclusively
    Often
    Sometimes
    No

15. Are you part of a volunteer or community-based doula program?

Your doula practice and philosophy

1. How did you decide to become a doula?

2. What training or certification have you done as a doula?

3. What would you consider the biggest strengths and weaknesses of your training?

4. Do you consider yourself a radical doula? If so, what does this mean to you?

5. Do you consider yourself a full spectrum doula? If so, what does this mean to you?

6. Do you think of yourself as an advocate for your clients? Why or why not?

7. Do you consider yourself a feminist? Do you see your doula work as feminist? Why or why not?

8. How would you define the term "natural childbirth?" Do you, or the people you work with as a doula, see this as a goal? Do you see any problems with this term?

9. Have you ever provided doula care to people who are:

Single parents	Yes	No
Teen parents	Yes	No
Low-income	Yes	No
Sexual abuse survivors	Yes	No
Immigrants or refugees	Yes	No
English language learners	Yes	No
Homeless	Yes	No
Incarcerated	Yes	No
People of a different race or ethnicity than you	Yes	No
Gay, Lesbian, Bisexual, or Transgender	Yes	No
Current or former substance abusers	Yes	No
Differently-abled	Yes	No
Affected by domestic violence	Yes	No
Planning to release their baby for adoption	Yes	No
Planning to adopt a baby	Yes	No
Terminating a pregnancy	Yes	No

10. Would you feel comfortable providing care to people who are:

Single parents	Yes	No
Teen parents	Yes	No
Low-income	Yes	No
Sexual abuse survivors	Yes	No
Immigrants or refugees	Yes	No
English language learners	Yes	No
Homeless	Yes	No
Incarcerated	Yes	No
People of a different race or ethnicity than you	Yes	No
Gay, Lesbian, Bisexual, or Transgender	Yes	No

Current or former substance abusers	Yes	No
Differently-abled	Yes	No
Affected by domestic violence	Yes	No
Planning to release their baby for adoption	Yes	No
Planning to adopt a baby	Yes	No
Terminating a pregnancy	Yes	No

11. If you have provided care to clients who fall into one of the above categories: What, if any, unique issues/challenges came up? Were you prepared by your doula training for those issues/challenges?

Your views about doula work in larger context

1. Are you part of any existing doula organizations? If so, which ones?

2. Is there anything doula organizations could do that could better help you or your clients?

3. What do you see as the major strengths and weaknesses of the doula profession as a whole?

4. Do you see your doula work as part of a larger childbirth movement?

5. Do you see your doula work as part of a larger social justice movement?

6. What kind of work do you do outside doula work, either paid or unpaid? Do you see that work as connected to your doula work? If so, how?

7. In general, what do you see as the biggest barriers people face in achieving the kinds of births, or other reproductive experiences they desire?

8. What changes would you most like to see to improve birth/reproductive health care?

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