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Women's Role in their Reproductive Process: The Effects of Authoritative Knowledge and Biomedical Interventions on the American Birth Experience

Shannon Sheffey

Western Michigan University, spottedfrog4@yahoo.com

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WOMEN'S ROLE IN THEIR REPRODUCTIVE PROCESS: THE EFFECTS OF
AUTHORITATIVE KNOWLEDGE AND BIOMEDICAL INTERVENTIONS
ON THE AMERICAN BIRTH EXPERIENCE

by

Shannon Sheffey

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Master Thesis Committee:

Bilinda Straight, Ph.D., Chair
Vincent Lyon-Callo, Ph.D.
Kristina Wirtz, Ph.D.

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Shannon Sheffey, M.A.

Western Michigan University 2017

The primary focus of this study is to analyze the effects of authoritative knowledge and biomedical interventions on women's role within their reproductive process as it occurs within the US. I explore the technological advances surrounding childbirth practices within the United States and how through this technology, biomedical forms of authoritative knowledge of birth practices have developed and how these changes have benefitted as well as hindered women. Through interviews and interactions with mothers and pregnant women I evaluate how medical interventions emotionally and physically affect women; evaluate the necessity of increasing technological interventions as opposed to low technology midwifery assisted births; and consider the future of birth practices in the United States. This research should be carefully considered when looking at childbirth practices, risk to mothers, homebirth movements, as well as when analyzing authoritative voices within succinct systems of care.

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Shannon Sheffey

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INTRODUCTION

Authoritative Knowledge

The primary focus of this study is to analyze the effects of authoritative knowledge and biomedical interventions on women's role within their reproductive process as it occurs within the US. I explore the technological advances surrounding childbirth practices within the United States and how through this technology, biomedical forms of authoritative knowledge of birth practices have developed and how these changes have benefitted as well as hindered women. Through interviews and interactions with mothers and pregnant women I evaluate how medical interventions emotionally and physically affect women; evaluate the necessity of increasing technological interventions as opposed to low technology midwifery assisted births; and consider the future of birth practices in the United States.

Changes in technology and social expectations of birth have evolved and varied widely over time and, as most famously highlighted in Emily Martin's (1987) path breaking *The Woman in the Body* in many instances, women's bodies have been accorded less and less control as the process of childbirth is categorically placed in the hands of outsiders rather than in the minds and hearts of mothers themselves (see also: Denbow 2015, Lam 2015, Stanworth 1987). Once a woman's domain, birth has been progressively taken over by a prominently technologically driven medical field where scientific apparatuses are relied upon rather than a woman's intuition or her internal voice. The medical field, and the technology that is consistently growing within that field, stand as an authoritative source of care for reproductive health in the 21st century. Women are often forced to choose technological interventions and care even when it is unnecessary. The empirical and embodied knowledge of women and midwives has been shunned

and pushed aside by this authoritative, technological system which gives women choices within their system but allows little or no room for outside sources or care such as midwifery or home births. Stanworth points out specifically that “this type of control insists on, and facilitates, a disregard for the intellectuality and emotionality of women; it has now become technologically possible to ignore the status of pregnant women as human beings” (39, 1987). More recently there has been a shift in options for reproduction as midwifery and women’s choice to give birth at home is progressively making a comeback. Many mothers are choosing to give birth at home to avoid authoritative scrutiny and technological interventions during birth, while others are actively seeking low technology options within the system. It is this shift and the force driving women to seek other options that have guided my interest and research of childbirth and women’s reproductive choices.

There is a strong supporting research that demonstrates how technological advances affect the reproductive process, the female body, the fetus, and the birthing process. While I choose to emphasize the importance of encouraging medically uninhibited childbirth, I do not disregard the need and support for medical interventions. One researcher states that “scientific human curiosity is a noble part of our culture (Shore 298), thus advocating medical technology, from invitro fertilizations to begin the reproductive process, to cesarean sections designed to intervene during labor and delivery, as a natural part of human curiosity and the evolution of technology within the birthing system. The acceptance of birth technologies in North America has fueled my curiosity in how this acceptance alters the birth experience. Furthermore the more recent rejection of these technologies by some women has inspired a new choice for women entering childbirth that is equally attestable to the authority and alterations placed on women by

medical systems and technological interventions. *I propose that the choices women make during pregnancy and birth are directly influenced by biomedical forms of authoritative knowledge and a culturally constructed trust in biomedical technology, which can therefore directly affect their position as active participants within their own birth experiences. My thesis points to women's embodied experiences as forms of experiential authoritative knowledge in their own right.*

In the 1940's hospital births became the norm in the United States, pushing midwifery aside. By the early 1980's women were presented with new technologies for the birthing process that were advertised to improve medical safety and birthing outcomes. At the same time midwifery began to gain popularity again in tandem with feminist activism, midwives fought their way into the medical field and succeeded, but only so long as they worked in consultation with doctors. Medical devices and procedures such as fetal monitoring, epidural, ultrasound, invitro-fertilization, and embryology, presented women with advanced aspects of control that previously were unavailable in the reproductive world. While these new technologies gave women more choices and control over their reproductive process, they in turn have given more control to biomedical practitioners, limiting the abilities of midwives in the medical field. This functional change to the birthing system has presented a situation where women are offered access to midwifery care on one hand, and technologies for their safety and control on the other. Ironically, the beneficial aspects of control and associated technologies have an unfortunate tendency to set into motion physiological and bureaucratic processes that actually reduce women's control. "Women are also disembodied as they become increasingly absent from medical and popular discourse and images of birth/reproduction, or are spoken of as body parts, rather than the central subject of pregnancy" (Lam 30; 2015). Biomedical interventions have

dramatically changed the lived experience of childbirth and seemingly disembodied women from their own reproductive process.

METHODS AND MOTIVATION

Informing the Thesis

In order to better inform myself and to enhance my bibliographic research I spent approximately three years interviewing, having open discussions, handing out volunteer questionnaires, demographic surveys, and also attending some births in order to better understand women's role in their children's birth. To focus my study geographically and culturally I kept my research within the United States focusing on women in Michigan. In order to understand the variations within the US medical system over the course of the past 40 years the women I spoke with ranged in age from 18 to 80 years of age. Table I displays an assemblage of generalized information collected through the various avenues of this particular study.

Each woman that agreed to be interviewed met with me one on one at their own convenience to share their stories and to explain without bias how their births progressed. Some births were homebirths; some took place in a hospital setting but all were unique in their own right. In order to clearly represent how these women saw themselves during their birth experiences and to fully understand the care they received I am only including verbatim interviews from women who agreed to share their full story. I chose to focus on those birth stories with little alterations because I find that the voices of these women are often lost in statistics that cannot ever fully explore the role women occupy during their labor and delivery. The accounts of those who wished to keep their stories more personal I simply used bibliographic cites to highlight the thoughts and feelings of these women as they were expressed through their answers to questionnaires and told through their stories.

Compiled Participant Information

Pseudonym	Age Range During Birth	Number of Live Births	Birth Location	Complications	Biomedical procedures
Shannon	25-30	2	Hospital	Swollen Cervix	Cesarean birth with Second child
Lana	25-30	4	Hospital	Tilted Uterus Hemorrhage	Cesarean with All Births
Joann	20-35	4	Hospital	N/A	Episiotomy
Mary Jane	25-30;40- 45	2	Hospital	Failure to Progress	Episiotomy
Linda	18-25; 25-30	4	1- Hospital 2- Home 3- Hospital 4- Birthing Center	N/A	
Marissa	25-30	4	All Home Births	N/A	N/A
Mandy	18-25;30-35	3	1-Hospital 2-Hospital 3 Home	1 st birth-Failure to Progress, Denied VBAC for 2nd	Cesarean for 1 st and 2 nd Birth. 3 rd was a VBAC at home.
Carolyn	18-25	1	Home	N/A	N/A
Claire	18-25	1	Hospital	N/A	Episiotomy
Kyla	18-25; 25-30	3	Hospital	N/A	N/A
Angela	25-30	3	Hospital	Failure to Progress	Cesarean with all 3
Carrie	25-30	2	1-Home 2-Hospital	N/A	N/A
Rachel	18-25	1	Hospital	N/A	N/A
Ember	25-30	2	1-Birthing Center 2-Hospital	N/A	Episiotomy
Paula	25-30; 30-35	3	1-Navy Hospital 2-General Hospital 3-General Hospital	Tilted Pelvis, Failure to Progress	Cesarean for first two births. VBAC for the 3 rd .
Laura	25-30	2	Home Births	N/A	N/A
Mille	25-30	1	Hospital	N/A	N/A
Jean	25-30	2	1-Hospital 2-Home	N/A	N/A

Since the 1990s, many anthropologists have written in ways that demonstrate an awareness of their own biases, recognizing that science is not value-neutral. By presenting the voices of some of these women, including myself I present the culture of technological birth as well as the ingrained personal aspects that often go overlooked much like Clifford and Marcus discuss in *Writing Culture* (1986) or Ruth Behar and Deborah Gordon's feminist critique *Women Writing Culture* (1994). In order to demonstrate the value and loss of women's voices during the labor and delivery process I choose to write from the very form of experiential authoritative knowledge I accord the respondents of my study. This particular approach allows me to offer the empirical evidence of my respondents' words to support the arguments in this thesis. The dominant voices of biomedical authoritative knowledge are abundant. In this study I attempt to shed a much needed light and lend a necessary ear to the lost voices from the margins.

Medicalization of Childbirth: Silencing Reproductive Voices

Prior to the acceptance of technological birth and authoritative knowledge in prenatal care and childbirth, women gave birth at home with their families i.e.: mothers, sisters, husbands, etc and assisted by a professional midwife who cared for the woman throughout her pregnancy, labor, delivery, as well as post partum. Most women were hesitant to seek hospital births but the criminalization of midwifery in the late 1930's made home births increasingly difficult, if not impossible. In the early 1940's despite hesitation, many people felt that in comparison to a hospital setting and the knowledge of doctors, birthing women lacked "birth knowledge", a type of knowledge "comprised of awareness of biological processes, biological knowledge of pregnancy and birth, social knowledge, and an understanding of health care systems" (Lazarus, 26). Initially young women who lacked birth knowledge and/or family support sought the care of physicians outside of the home setting. These women were among the first to accept hospital assisted births and the newly emerging authoritative knowledge of preventative biomedicine. An augmentation from home births to hospital assisted births ensued, following an increase in media coverage and popularity of "Scopolamine," a morphine derivative that brought about what physicians and advertisers referred to as "twilight sleep", allowing women to unconsciously avoid natural labor (Rapp 1997, Wertz & Wertz 1989). Early on hospital births were primarily reserved for the lower class or high risk pregnancies, but as Wertz and Wertz (1989) point out, this view changed as upper class women were encouraged to defer the pain and agony of labor by seeking hospitals' assistance and the availability of the drug.

In the 1950's the birthing process became more hospital based and the further medicalization of birth began, as biomedical practitioners increasingly viewed women's bodies

as machines that needed to be tweaked and operated upon to fit the beliefs and desires of those who asserted biomedical knowledge as the norm (Martin 1987). Other forms of hospital assistance were quick to follow: in the 1970's forceps and episiotomies became prevalent in almost every hospital birth. Forceps deliveries were used to "expedite deliveries" and often caused injury to the baby or even worse "an increased risk of neonatal morbidity and mortality" (Steinitz & Orman 2001:34). Episiotomies are an incision made in the perineum of a woman's vagina. Episiotomies cause pain after labor, a longer healing process, and often scarring that can lead to discomfort during intercourse as well as extended tearing during subsequent births later in life. The fetal heart monitor also gained popularity in the 1970's. "Fetal Monitors are machines which electronically record the fetus heart rate during labor and the rate of contractions; there are two basic kinds of monitors: external (non-invasive) and internal (invasive)" (Boston Women's Collective 1971:285). As Wertz and Wertz point out "internal or external monitoring restricts the mother's mobility, increases her discomfort, and reduces the effectiveness of Lamaze breathing... and is likely responsible for the increase in cesarean sections" that quickly followed the acceptance of fetal monitors as a staple in the hospital birthing process (1989).

Fetal monitoring is used to indicate fetal distress through the rapid change in the baby's heart rate but often leads to unnecessary invasive medical procedures such as caesarean sections. A caesarean section is a surgical procedure that takes place when a laboring woman is experiencing lack of progression, maternal or fetal distress, and/or placental separation (Boston Women's Book Collective 1971). In order for a caesarean to take place, an epidural or general anesthesia is necessary to block all feeling to the abdominal area. Epidurals block the nerve impulses from the lower spinal segments, resulting in decreased sensation in the lower half of the

body. Caesarean sections also completely remove family and the mother from the processes. During the procedure only one family member if any are allowed in the surgical area and the mother is primarily incapacitated by epidurals and pain medications as well as being strapped down to a gurney or operating table throughout the procedure. More recent research shows that the negative effects of caesarean delivery are followed “with increased pain, slower recovery, more time away from family, increased maternal distress... and negative feelings about the birth and about the baby” (Wendland 2007:222).

Biomedical interventions have repeatedly been shown to increase the strain on the body’s natural progression through childbirth. Despite increased medical risks, interference with infant bonding and decrease in family emotional well-being in extreme cases, technological interferences in westernized birth systems have become the norm and are expected by most pregnant and birthing women. By insisting upon medical procedures and encouraging the pharmaceutical treatments for pain, medical professionals have paved the way to medicalize childbirth and disregard women’s birth knowledge. In order to technologically guide birth, medical professionals use authoritative knowledge in prenatal care, labor, and delivery to form a specific doctor/ patient understanding where the professional’s medical recommendations is the best and only option during their reproductive journey. Medical professionals may then use technologies as “recommendations intended to safeguard the health of pregnant women or her fetus” (Browner & Press 144) disregarding a woman’s choice to have a low technology birth.

Today when a woman finds out she is pregnant she immediately begins a journey into the medical world that is designed to guide her towards a medicalized birth. This guidance is backed by the authoritative type of knowledge of medical personnel considered to be specialists in

prenatal care, labor, and delivery. The embodied knowledge of women, intuition, and other forms of authoritative knowledge, such as the knowledge of midwives, is primarily disregarded. Medical technology continues to make life saving advances that beneficially assist women in birth; however, many women are often expected to unnecessarily conform to the medicalized birth practices regardless of their birth knowledge and have become the twenty-first century norm.

Generally speaking women who have access to adequate social networks and higher education may be in a position to control their birthing process to some extent more than those lacking these resources. Women who are prepared to question the doctor/patient relationship and their rights, and are willing to step outside of the box, make up the few who, through determination, experience natural uninhibited childbirth. I presume this research may show an emphasis on and reproduction of biomedical authoritative knowledge within modern birthing systems. As well as evidence supporting that biomedical authoritative knowledge may have pushed women to accept technological interventions during birth as opposed to naturally progressing through a medically unhindered birth, thus setting an expected technological framework for the North American birth system. I also consider that the potential lack of information shared with women throughout their pregnancy, about their birthing process leaves many options open ended with little time to discuss them if they arise in the throes of labor and delivery.

Empirical, Embodied, and Authoritative Knowledge

In Western culture medically assisted births have become normalized. Women spend a great deal of time considering their own embodied knowledge and reading about empirical techniques but they expect to receive high-technology care and tend to anticipate biomedical interventions. For purposes of my research I am focusing on various types of birth knowledge such as empirical, embodied and, particularly biomedical forms of authoritative birth knowledge and how they contribute to the North American birthing systems in order to show the choices women are often unconsciously faced with during pregnancy and childbirth. After careful consideration of the literature on authoritative knowledge I define authoritative birth knowledge as: the legitimization of biomedical birth knowledge in ways that compel trust and obedience toward medical professionals, which delegitimizes the knowledge of birthing women and other possible attendants. Empirically based knowledge is a practical form of “low technology” based practices that are derived from everyday knowledge (Jordan and Thatcher 2009). Empirical techniques such as nutritious food, relaxation techniques, upright births or hammocks used for giving birth, and herbs, as Thatcher and Jordan point out, are forms of “empirically-based knowledge about the processes of labor and birth provides women with emotional and spiritual support throughout their perinatal period that...promote mobility, position changes as labor progresses, and the assistance of trusted birth attendants” such as family members, birth assistance, and midwives” (2009: 4)

“Such spiritually- or empirically-based knowledge about the processes of labor and birth provides women with emotional and physical support throughout the perinatal period through artifacts that promote mobility, position changes as labor progresses, and the assistance of trusted birth attendants. In general, women in

developing countries (at least until Western medicine dictates otherwise) labor and give birth in upright or semi-upright positions, such as sitting, squatting, half-reclining, kneeling or standing—often using several of these positions in sequence. The combination of upright posture with frequent position changes and the assumption of asymmetrical positions facilitate the mechanism of labor that affects the passage of the baby’s body through the birth canal. The physiological and psychological advantages of upright positions are well known and include better oxygenation, more efficient contractions, less pain and an increase in the diameter of the pelvic outlet.” (2009: 5)

Initiating the use of these techniques allows women to channel their body and assist the body in its natural process. With emotional support and physical mobility women are more likely to believe in their body’s capability and therefore avoid some levels of technological intervention. Trusting in the process their body is going through rather than fearing the unknown, allows for some ease to the process and the courage to follow their own beliefs and bodily cues.

“With each one of my children I was alone in the birthing room; there were just the doctors and the nurses. Not even husbands were allowed in. I remember with each time I waited at home until the pains got stronger. Once I felt the pains were too strong then I went to the doctor and I was never there long before I was pushing. As soon as the baby would come Lars would join me in the room with the baby.” ~Joann reflects back on her births, the first being in 1956.

Along with their empirical knowledge women have historically relied on their own embodied knowledge, defined as “subjective knowledge derived from a woman’s perceptions of her body and its natural processes as these change throughout a pregnancy’s course” (Browner and Press, 1996 Pp142). Historically in the United States women were the primary advocates and authorities of their own birth experiences. The choices made in regards to the birth of a child were left to women and their families; birth was accomplished through the means of a woman’s embodied knowledge and a wealth of empirical knowledge obtained through their social and

cultural networks. A choice to include a midwife or even just a group of women from their family circle was not only acceptable but the norm for women and their unborn children. Women primarily relied on their own embodied knowledge, a source of information derived from their own rational mind, personal experiences, and general mother's intuition (Davis-Floyd 1997). As physicians became an active part in women's reproductive careers, technologically based births began to take place more frequently and previously more time consuming methods were disregarded.

"I had never seen anyone give birth in real life. It would have been different had I been in a delivery room before....What happened was I was in labor, I didn't really move, I remember there was a bar she brought in for me to hold and she put a towel and she had me hold onto the towel and push, but always on my back always in a normal, I guess what you would call a normal birth position. After an hour of pushing I said this baby is not moving and there is nothing I can do to make this baby move and she could tell the baby wasn't moving. At the time the monitors showed no distress and she (the attending physician) still had me push another 2 ½ hours before listening to me say I can't do anymore, finally she decided there was no progress being made, we were going to go ahead with a c-section." Lana V

Surprisingly biomedical approaches disregard a wealth of empirical and embodied knowledge resorted to by women in a natural birth setting. As birth is increasingly altered by high-technology practices the use of empirical techniques are ignored and women are less inclined to follow their own beliefs and practices. Furthermore, in many situations women are pressured or given no other choice than to follow biomedical forms of authoritative knowledge -- defined by Bridgitte Jordan as the knowledge that participants agree counts in a particular situation, that *they* see as consequential, on the basis of which they make decisions and provide justification for

what *they* do” (1993: 154). Biomedical professionals tend to justify medical interventions with the health of a woman and her fetus.

In his book *BORN IN THE USA How a broken maternity System must be fixed to put women and children first* Doctor Marsden Wagner points out that “by embracing a medical model of birth and allowing obstetricians control of our maternity care, we Americans have accepted health care that is not only below standard for wealthy countries but often amounts to neglect and abuse” (2006:5). Wagner discusses how obstetricians are educated to view birth through a medical framework rather than as a natural bodily process. While scientific evidence shows that a woman’s labor pain is increased drastically by a number of factors especially undergoing labor in an unfamiliar place, having unfamiliar interventions and procedures, being left alone during labor, and especially by drugs used for labor induction; these factors are usually all present for birthing women in the US today. Midwives are trained to assist women through comfort and patience, seeing birth as a naturally progressing process that is different for every woman. More recently despite a shift in hospital births to home births the majority of women in society still seek hospital births on the premise of pain reduction and overall social fears of low technology home births. The difference is like day and night authoritative voice=no choice. As we can see with all the pressures placed on birthing women by medical professionals’ today authoritative knowledge and birth process and outcomes will stay in the hands of biomedical professionals, prenatal care and birth will continue to become further medicalized if we cannot rise up and find our voice.

THEORY AND RESEARCH

Culturally Constructed Systems of Knowledge and the Reproduction of Authoritative Birth Knowledge

In her 2011 article Faith Nibbs focuses on the medical rehabilitation of refugees coming to the United States. She notes how the initial process of medical examinations and the so called culturing of refugees all begins with hygiene and medical screenings through which “the refugee, who immigration authorities have read as diseased and deviant bodies in need of control, have taken their first step toward citizenry” (Nibbs 3). Nibbs goes on to posit that the treatment of women refugees entering the childbearing system in the United States following the initial medical induction into the country are further objectified and that authoritative birth knowledge acts as a continuation of governmentality used for “good citizen making” (Nibbs 4). To address these issues Nibbs conducted participant observation with a Hmong woman named Chouain at a Texas refugee camp in 2005, accompanying the woman through her entire pregnancy and attending the birth of her child. Nibbs also conducted interviews with Chouain, the physician, and nurses who cared for the woman and delivered her child.

During her interviews with Chouain, Nibbs found that Chouain endured what she expressed as, a great deal of invasive, yet routine westernized birth care, from blood and urine tests to vaginal exams and several encounters involving her removing all her clothes to have her body closely examined. Nibbs noted that “not only were they socializing her to the expected norms of patient behavior, but also teaching her their own interpretation of the signs and symptoms she would experience as the pregnancy proceeds (Browner & Press, 1995:316). This,

in essence, devalued her birth experiences in deference to biomedical authority and is an excellent example of the use and reproduction of authoritative birth knowledge in westernized birth systems.

From a woman's perspective and the perspective of cultural variation Chouain thought the monthly prenatal visits were excessive, a constant invasion of her body, and inferred that something must be wrong with her baby. "The biomedical reasons for these procedures were never quite understood". This is not an unusual feeling for women regardless of their status within the country (Nibbs 7). Nibbs went on to explain that as the birth approached, the doctor told Chouain that her baby would come Monday because the doctor feared Chouain would not be able to recognize labor pains despite already having one child. When Chouain went into labor she refused to go to the doctor as it was not Monday. She believed that this would have been perceived as non-compliance, given the knowledge she had endured through multiple prenatal visits.

Bridgitte Jordan's research and experiences like Nibbs' show how authoritative knowledge often guides women away from their own embodied knowledge; Chouain's "rapid abandonment of her own embodied knowledge suggests that refugee women might be particularly vulnerable to medical objectification" (Nibbs 9). During the birth Chouain and her husband experienced a very different birthing experience from that of their first child in Thailand, including a great deal of technology, epidurals, and lack of communication about the process at hand. Nibbs noted that "After the birth Chouain told me that the refugee camp stressed that they should do whatever the physicians tell them. She equated this blind obedience with

good citizenship”. (Nibbs10)This is often the case with many American citizens in that they feel it is the cultural norm for them to follow the strict birth regime and authoritative knowledge of biomedical professionals regardless of their own intuition or embodied knowledge.

Nibbs concluded that Authoritative Knowledge in childbirth has significant influence on refugees and facilitates them as “docile bodies that are objects of medicine” (Nibbs 12). Nibbs also agrees that American women who are often knowledgeable about the westernized birth process similarly feel as if they become objectified medical objects as they proceed through the American birth system. Nibbs referred to the discomfort Chouain felt after giving birth when the nurse would repeatedly remove the baby from Chouain’s bed telling her the baby will die. This type of controlling, authoritative, assertion of knowledge is inflicted upon American women every day and persuades them to disregard their own beliefs and their faith in their ability to care for their infants. For Chouain it made her feel inadequate in her previous knowledge and care of her first child as well as concerned about her position as an American citizen.

In my interviews for this thesis project, I asked women if they felt their providers listened to them and followed their requests during their birthing process. The results were astoundingly a “no” or “not necessarily” and were often a reason for seeking other forms of care during pregnancy as well as sparking consideration for a home birth.. Mary Jane described her second birth as being very textbook because the doctor told her what to do despite her giving birth previously unhindered without medication or medical interventions. The Doctor directed Mary Jane as if she was a child remaining reassuring but did not disclosing his own acts and intentions or giving any inclination that interventions may be necessary.

“I remember him telling me to push, but I didn’t feel the pressure of a push and then I yelled that it was burning and it hurt to push, by this time it was too late, he cut me without notice, over half an inch of my perineum, my daughter is 15 and I still have pain and a large area of scar tissue from that.” Mary Jane

Jane Szerek (1997) believes that many women are now coming to terms with the fact that these technologies are more often than not unnecessary and are arguing that “urban hospitals compromise women’s rights when it comes to the functioning of their bodies and their sense of self” (288). Szerek’s essay focuses on Italian birth systems and also parallels the birth system in the United States where political and economic context shape birth practices within our society. Women fear the risks implied if they lack technology and that is why hospital births are so common within westernized birth cultures. Authoritative knowledge varies and is prevalent regardless of high or low technology systems; therefore without birth activists and midwife practices the hospital systems would inevitably “monopolize birth”. Carla Lam discusses a type of feminist approach that focuses on resisting and embracing the changes within medical technology focusing on the ways in which the advances of medical interventions within reproductive technology are “neither naturally oppressive nor necessarily liberating” for women (12, 2015). If technologically based births become the only avenue for women it will forever change women’s role in their reproductive process and the effects of biomedical authoritative knowledge on the North American birth experience will be detrimental. As long as someone is seeking low-technology births, and at home, midwife assisted births are still practiced, there is still hope that politically and economically driven technological births will not become the only type of birth system for women to seek.

Women in western society are constantly conditioned to follow the guidelines of prenatal care and medically assisted childbirth professionals. I intend to examine how, when, why, and if women disregard their embodied knowledge during their own childbirth experiences as many of the women discussed in the literature on birthing and technology have done. I have explored how authoritative knowledge pushes women to obediently follow medical advice but I am also curious how, through multiple birth experiences and the sharing of birth stories, women come to accept authoritative birth knowledge as the norm and disregard their own empirical and embodied form of authoritative knowledge. I find it ironic that in dismissing their own empirical and embodied knowledge, women encounter complications in the natural process of labor, making medical interventions that much more prevalent. It is during this time of risk and fear that women seem to eagerly resort to medical technology and further medical interventions. As we all seek answers when faced with the unknown, biomedical technology only offers women a way out not a way through. I intend to explore the process by which American women come to view themselves as helpless and in need of assistance rather than rallying their strength and embodied knowledge to guide them in the direction of a naturally progressing birth.

Emma Cohen (2010) discusses cultural transmission and the ability to be present and not present during particular events in life and how an altered state of mind easily changes our neurological paths, allowing us to be guided or persuaded in directions other than what we may instinctually follow. Through her research Emma Cohen discusses how “Cultural transmission – i.e. the emergence, acquisition, storage, and communication of ideas and practices – is powerfully influenced by the physical context in which it occurs.” (S193). Cohen contends that information and the retrieval of knowledge is multidimensional and could potentially be studied

on a multitude of levels. “Even retrieval of the most basic information pertaining to everyday objects and entities entails simulation of the situation of ‘being there’ with those objects and entities. (S195). Cohen further points out that retrieval of such knowledge is not just a neurological function but rather a full reenactment of the event in which it was learned or perceived.

I aim to relate Cohen’s argument to women’s birthing experiences, such as when women are asked to be in labor but not allowed to fully enact their embodied knowledge on the task at hand. By this I mean that biomedical authority within westernized birth systems expects women who have begun labor to progress quickly and complete the process in a timely fashion. However, the body works at its own speed, and progression is not always timely. Therefore it can be clearly understood why in many cases the body fails to progress and in some cases why labor stops. This lack of progression can often put stress on the laboring mother and her child and can further hinder the process – a situation which, in westernized culture, permits biomedical interventions. It is not uncommon for medical interventions to be permitted when progression does not meet the standards of a timely birth as understood by a particular birth assistant; As Martin points out, “good or poor birth is judged by the amount of progress made in certain periods of time” as it is monitored by medical professionals (Martin, 1987, 59).

In discussing spirit possession in Brazil Cohen notes accounts where possessed individuals have acted inappropriately and the observers found the individual, not the spirit, to be at fault, showing that “a considerable and growing literature investigating how human psychology reacts with bodily, social, and environmental stimuli now points to the presence of

significant constraints and predictable biases on human reasoning” (S198). This constraint and bias could in my opinion, apply to labor and birth just as well as spirit possession, since women are in an altered state of mind, body, emotion, and/or reasoning during birthing. Cohen believes that “anthropologists can strive to identify more precisely how body, brain, and environment inform and constrain the making of knowledge. What we mean by ‘embodiment’, as a term and perhaps even an ‘approach’ or ‘paradigm’ in anthropology, is all too frequently obscured in protracted chains of metaphorical reinterpretation and re-formulation” (Cohen, S196). I believe the same applies to childbirth, labor and delivery in so far as authoritative knowledge is interjected and culturally reproduced within westernized birth systems and women’s own embodied experiences obscured in the process.

Variations in knowledge perception and the implications of knowledge among women can, as Cohen believes, constrain the making of knowledge or in my opinion even the way knowledge is produced and reproduced. By looking at different birth assistants (doctors, nurses, and midwives) Szurek (1997) is able to analyze the role and degree of authoritative knowledge that controls and pressures women. She examines two types of essentialism: type one treats women mechanistically and type two honors the body far more than the machine. She advocates for birth activists and the use of type II essentialism in order to “ensure women not cede their biological capacities to Type I essentialists on which techno-economic development depends” (309). Both types ensure a certain degree of authoritative knowledge, each supporting their specific view of how a birth system should function. For example, one midwife interviewed noted that “everyone has a different physiology because each has a thinking mind” (307) and another doctor exclaimed “every doctor does a birth the way he wants it” (301). I would argue

that all of these assertions are intuitive and that in fact authoritative, like other forms of knowledge, is informed by an individual's prior experience, or in other words their personal intuition.

Szurek (1997) notes that, "without the political and practical knowledge of birth activists the medical establishment could assume full control, claiming a monopoly on authoritative knowledge about birth" (309). Szurek goes on to explain how social economy and political emphasis have pushed women to utilize hospital births through fear of risks in childbirth; "Fear is quite enough to sweep the majority of women willingly and obediently into a hospital birth" (Szurek 293), thus allowing hospitals guaranteed economic success as well as continued business among the childbearing population (Szurek, 292). The personal and physical repercussions for women include the acceptance of a woman's body as commodities, as technologies that are now profitable. Through their obedience of professionally expected rules and procedures women become passive, "she becomes a Cyborg...unopposing, renders her body for control and use... medical experts divest women of their power and confidence in themselves and in their unique sexual capacity to give birth" (Szurek, 299).

Midwifery, Home Birth, and Women's Intuition: A Legacy of Life and Love

In partnership with their clients Certified Professional Midwives carefully monitor the progress of the pregnancy, labor, birth, and postpartum period and recommend appropriate management if complications arise, collaborating with other healthcare providers when necessary. The key elements of these education, monitoring, and decision-making processes are based on evidence-based practices and informed consent. (Midwives Alliance of North America)

Ina May Gaskin and the Farm Midwives

By 1960 women's birth options had changed and were quickly becoming very limited to hospital, drugs, and doctor assisted deliveries. As with many other areas of life, women wanted change, they wanted to have a voice. In the 1970's as women were fighting for their rights so were midwives, educators, and doctors who supported women's rights and choices. Restrictions on midwives and women limited women to hospital births and forced midwives to risk their careers and lives as they faced prosecution for practicing. Many women searched for other options beyond hospitals. Ina May and her husband Stephen Gaskin traveled across the country along with a caravan of school bus campers delivering speeches and babies along their way. The first birth she attended was "a definite calling to be a midwife" Ina May said, and a great deal of education and a deep desire to uphold the spirituality of birth and assist women in their delivery becoming the head midwife for their caravan of families many who were expectant mothers. The group of women and their families had banded together over their desire to raise families, give birth, and help one another naturally bring life into this world. Eventually settling in Tennessee Pamela recalled "Our land consisted of a thousand acres, mostly woods, with a few fields, one house and a barn. One of the rooms in the house was given to the clinic crew, which now consisted of four women; Ina May, Margaret, Kathryn and myself...A few months after we settled in Tennessee... all of us were pregnant, and all due between June and August. We had

enough pregnant women that we were delivering between four to six babies a month. Starting families was one of our goals when we left San Francisco to find a place where we could live; we wanted to raise our families in the healthy environment of the country” (Gaskin, 179)

Ina May and all of the farm midwives felt a calling to help women deliver babies uninhibited, safely, comfortably and in a relaxed manor, at their own pace. Pamela disliked many of the negative aspects of medicalized birth and the distant business-like demeanor most physicians present during a birth.

“In college I studied interior decorating and fine art, and my studies brought me to the University of Guadalajara in Mexico for two years. Here, one of my art classes was a class in anatomy. One of the field trips for this class was to one of their state-run hospitals. While there, I observed two “natural” births and one cesarean birth. In all three births, when the doctor pulled the baby out, which he had to do because the women were given epidural anesthesia, he slapped the baby on the butt, swung it in the air and gave it to a nurse. Then he walked out of the room. All three mothers looked tired and forlorn after the births. Their husbands had not even been allowed in the room to comfort them. No one else did this either, and here was this class of anatomy students observing, a group of total strangers who didn’t know the first thing about birth. Why they arranged for us to be at these births and put these poor women up as models at this most vulnerable time in their lives, I’ll never know. We certainly didn’t learn any anatomy or compassion for the mother or baby... I was shocked. Is this what my mother went through? She, too, had an epidural with her babies. I didn’t really think she got this treatment when she had her babies, because she always looked so pretty when she came home from the hospital, but seeing that this could happen convinced me that I would find another way to have my babies.” Pamela (Spiritual Midwifery, 2002:22).

From tents and caravans to inflatable pools and townhouses, today’s homebirth Mom is nothing to chuckle over; generally speaking, her faith in herself, and her body, are beyond strong without question.

The loss of midwives contributes immensely to the biomedical technology involved in birth and an increase in hospital assisted births. As Thomasson and Treber point out, women who

prefer the assistance of midwives during labor and deliver but “who may have wanted to have hospital births to receive more sophisticated anesthesia, (found) midwives were not allowed to deliver in hospitals (and in some states physicians had encouraged the legislature to ban midwifery completely)” (2008:84). Women who may have wanted to have less technologically inhibited births assisted by midwives were denied this choice due to a biomedical disregard of midwives in the birth setting. As the cost of birth rose with technological advances many “physicians regarded midwives as inferior” and “may have felt threatened economically by midwives who typically received one-half the fee charged by physicians for performing obstetric services” Thomasson & Treber: 2008). A study in the late 90’s which compared nurse-midwife and biomedical practitioner care showed a distinct difference in the amount of technological care provided by midwives assisting births as opposed to those assisted by other kinds of biomedical practitioners, both of which occurred in hospital settings.

“Eighty-four percent of women attended by nurse midwives delivered vaginally, without the use of forceps or vacuum extractors, compared to 65-70% of women attended by physicians. And whereas 9% of nurse-midwives patients were referred for caesarean section, 14-15% of women attended by physicians had caesarean deliveries. Among women giving birth for the first time the difference in caesarean rates among specialists was even more pronounced: 12% for nurse-midwives, compared with 23-26% of those attended by physicians (Breslin 1997: 239-240).

It is apparent through this particular research that physicians’ use a greater amount of interventions that occur in the hospital setting the more compensation will be provided to the hospital and practitioners involved. Midwives take the time to focus on a woman and inform her of the process at hand, easing her through the transitions rather than rushing her and ignoring her needs. According to the American College of Obstetrics “About one-third of all births in the U.S. are done by C-section, and most of those are in first-time mothers. There's been a 60 percent increase in these deliveries since the 1990s, but childbirth hasn't become markedly safer for

babies or

mothers.”(http://www.acog.org/Resources_And_Publications/Obstetric_Care_Consensus_Series/Safe_Prevention_of_the_Primary_Cesarean_Delivery). More studies today are showing that the active process of labor varies greatly and can take a great deal of time for some women. A laboring mother should be given adequate time to assess her own body’s progress while allowing her body to naturally progress through labor; as opposed to being attached to a monitor awaiting major surgery if assessed performance is deemed to be inadequate.

Through Your Voice: The One and Only Birth Experience is Your Own

Pregnancy is an unpredictable journey and you never know what the next day will bring. You will endure much anticipation, excitement, new feelings, and yes even pain. There will be labor pain but there will also be pain in your rib, pain in your side, growing pains, and leg cramps just to name a few. If you are an American Pregnant Woman then your experience may include many tools that others in the world may not necessarily have to endure or have at their disposal. In America there is a great emphasis on medicalization and the assistance of the medical community in the monitoring and birth of your child. You will also find at your disposal countless books that tell you how it is and "What to Expect When You're Expecting". Many of these books are full of endless information that will tell you a great deal and very little about your journey ahead. No pregnancy is alike and no woman is the same we will all experience similar and very different types of pregnancies.

The best part about pregnancy is that the experience is yours and yours alone; you can share it with your spouse or a friend and you may have similarities with your BFF or your mother but in the end the experience is all yours. What follows is a detailed account of my first pregnancy and birth experience as well as the experiences several other mothers have had that they have willingly shared with me throughout my research process. I share these with you to not only emphasize the broad experiences birthing women in the US have but to share the beauty of birth regardless of the situation.

Shannon's First Pregnancy and Birth 2009

My husband of two years and myself decided it was time to have a baby after spending the last nine years getting to know each other, growing together and growing up in general. We decided that we had spent a great deal of time learning how much we appreciated and valued each other and we cared for each other so much that we wanted to bring our best and worst features and personality traits together to produce a being of our love and of each other. This is the easy part of the journey. You want to say "hey lets kick the pill and have a free for all" that makes life simple; however it really makes life all that more complicated.

For a year and a half we tried to conceive a child and were unsuccessful. How funny is it that all you learn in sex education is how simple it is to have a child and here we were two competent educated individuals and all we had to do was have sex right, um no. We knew we could be successful since throughout the first year we had three miscarriages so our efforts weren't all a loss but they were not a gain at this point either. I had become stricken with a great amount of stress over the situations and was becoming depressed by the amount of loss I experienced throughout our journey. At this point we chose to give it a break and toss our trials to the side. As I have heard many times before once you are not so focused on the act and you relax it will happen, and it did.

Now pregnant and almost shocked it had happened we were so happy. Despite our excitement I was scared, we had been able to get pregnant before but the pregnancies had not lasted and that was the hardest thing to get past. I believe I was nearly 5 months along when I finally decided that things would be ok. Once we had the 20 wk ultrasound and the doctor assured us the baby was healthy and there was no longer any logical reason for a loss I began to

relax. We could feel and see the baby move: it finally became real and we accepted that things would be ok. Don't get me wrong I still had days where I was nervous or thought something was wrong with the baby but I could calm myself down just as fast as I could get myself worked up. I was worried about what to do next, you tell yourself that you're suppose to go to a doctor and get regular checkups, be monitored, right? In reality your body knows what to do and will do it on its own whether a doctor monitors your progress or not, we were designed to reproduce and grow a child within our bodies that is our upmost duty as women. However over the years the medical world has determined that we are not capable of this job without assistance; we have been socially and culturally constructed to seek out technological assistance for our birth.

We are conditioned through biomedical culture to believe reproduction is predictable and structured, this is not the case; pregnancy is anything but structured and predictable. In our society I think control and authority are some of the biggest pressures we face. We are taught to be in control of ourselves, to let the medical world be in control of our health and functions, to let society be in control of our place in this world, but pregnancy goes against all of this. When a woman conceives she is forced to look deep in herself to assess how her body will react, change, grow, and feel. But more often than not we are told how to feel and what to Expect When you're expecting. Despite the efforts of the medical world, pregnancy and unborn infants do not usually conform to their ideas, concepts, and procedures unless forced to do otherwise. This issue of unpredictability is difficult for a woman to accept and even more difficult for the medical world to accept. Midwifery is the only practice that conforms to pregnancy, labor, and delivery not the other way around. Through misrepresentation it is widely believed in our culture that midwifery's lack the care and knowledge and that the medical society or a hospital setting is the most conducive to the childbirth process.

As Naomi Wolf points out in her book “Misconceptions” “the amount of control that you feel you have as a pregnant woman, can directly affect the physical outcome of your birth and your recovery from it” (21). I searched for a place where there were midwives and alternate birthing methods to the standard medical practice of our society. I had high hopes of giving birth in a tub of water, with a midwife, using relaxation techniques that would allow me to labor naturally and easily give birth to my child without interventions. I wanted to be in control of my personal birthing process. I found a small practice that housed doctors and midwives and I chose a midwife that was caring and who claimed Ina May was her hero. I was pleased with this arrangement and I was comfortable that both the doctor and midwife both seemed to be accepting of my wishes early on, I felt that I had a voice. For the most part I had a very normal pregnancy, I had very little morning sickness, and my belly grew as it should. While my baby was healthy and growing as expected there were disappointments along the way.

I had read all about creating a birth plan so naturally I wanted to have a birth plan but as I reached the end of my pregnancy I felt as if it was pointless. When I asked the doctor if I should write up a birth plan I was told as long as I tell the office that we prefer a midwife or a doctor and what we want as far as drugs that’s all they care about. Since I have also been told that the doctor or midwife on call will deliver the baby it doesn't really matter if we wanted a certain doctor or midwife. As I mentioned I would like to try to deliver with a midwife and I would really like to have a water birth but at 36 wks I was told there are weight restrictions and I have gained 46lbs which is over the weight limit allowed so a water birth is out of the question. In a reassuring way I was told I can still get into the tub to relax if I want but once it is time to deliver I must get out, so what is the point? I felt my voice slipping away, all the things I had hoped my

birth would be were just hopes. I know that things can always change even when you have a plan or know what will happen so I told myself that this shouldn't be a concern.

Over time I accepted that I could not have a water birth but remained optimistic that I would have a midwife assisted birth using relaxation techniques allowing me to avoid medical interventions such as inducers, episiotomies, and ac-section. That was until my 37 week appointment when we were informed that the strep b test that I was given the week before came back positive. We were told this meant that I am a carrier of strep b and while this doesn't make me sick it could very well make my baby sick during the descent down the birth canal. So to prevent her from being sick or contracting a virus the first weeks of her life I will need to be hooked up to an IV of antibiotics during the second phase of labor or once my water breaks.

The hospital will initiate intervals of antibiotics every few hours as I go thru labor and delivery. At this point it is scary to think that the baby will get sick but I was also nervous that I have to be tied down to an IV during the process. We were assured that 40-60% of women test positive for strep b during their pregnancy and all women are tested due to the fact that some babies have become sick when they previously did not test for it routinely. Again we have been assured that things should go well and the baby will be healthy. However at this point I saw my normal midwife assisted labor and delivery slipping away I felt certain now that things were beyond my control, my voice was a mere whisper and meant little if nothing at all with no one to encourage it.

Since the rise of biomedical birth knowledge in our culture, pregnancy has become highly medicalized and midwives are now forced to take a back seat to doctors and the contractual obligations of hospitals; my midwife was limited in assisting me beyond her encouraging voice in my ear to persevere. According to Emily Martin in her book "The Woman in the Body " while

discussing the shift from midwifery to a medicalized system she notes that "In the development of obstetrics, the metaphor of the Uterus as a machine combines with the use of actual mechanical devices (such as forceps), which played a part in the replacement of midwives hands by male hands using tools" (Martin 54). As I got closer to my labor and delivery process I began to see the truth in this statement and how the doctor viewed my body and what I felt was my unique labor and delivery experience. Once I reached 40 weeks I felt that there was no way my goals could be met unless I stood my ground and demanded things go my way as much as possible. Since being demanding and controlling has always come easy to me I felt I could maintain a voice for myself despite the fact that I was now being told I would have to have tests done to check the baby since she had not arrived and her medically expected date had past in order to determine whether intervention was necessary to apprehend this delay.

I went to the doctor at the beginning of wk 40 and again towards the end of wk 40 still no baby. We were scheduled for an nst (non stress test) to check the baby's heart rate during activity and rest periods. The test was to last an hour but according to the nurses our baby was doing so well at the test so we only had to be hooked up to the machine for about 25 minutes. The midwife reviewing the test said that the baby looked very healthy and her heartbeat is normal and strong. At this point there was no concern for the baby we were told just to wait. Of course we were scheduled for another test the following week to monitor the baby and determine a course of action if by this time I did not go into labor on my own. They wanted me to return for another NST test and an ultrasound to check the fluid around the baby. Being overdue I was now starting to fear intervention to begin my labor or further complications leading to further interventions.

I was eight days overdue when I finally went into labor. Along with what I read in "What to Expect When You're Expecting" the doctor and the midwife discussed various scenarios as to

when to come to the hospital. We were told by the doctor to come to the hospital when contractions are 5 min apart and 1 min in length; however I had questioned this because I had read that contractions are not always consistent and can vary so how do we know? The midwife advised us to come of course if they are consistent and follow that pattern or are even closer together, but she also told us that real contractions will be so intense that I will not be able to talk through them and that while I will want to move around it will be extremely difficult. She also said to come if my water breaks even if there are no contractions or mild ones, as they will want to start antibiotics because of the strep b and the contact of fluid to the baby once my water breaks. And of course if there is any bleeding that occurs. I had read all I could in the pertinent book "What to Expect When You're Expecting" and taken all the doctor and midwife's advice but when it came down to go time I was clueless.

I began having contractions in the evening after an active day of pie making with my Grandmother. My husband and I had dinner and enjoyed some homemade pie for dessert when I noticed my contractions didn't seem like the Braxton hicks I had been experiencing for several months. However they did not match the scenario given to me in my pregnancy handbook by Heidi Murkoff and Sharon Mazel, "What to Expect When You're Expecting" which advises in the beginning stages of labor "Contractions in this phase are usually 30-45 seconds, though they can be shorter. They are mild to moderately strong, may be regular or irregular and may become progressively closer together." (381). For me this was not the case at all, my contractions at this point were eight minutes apart and two minutes long. Since my book and my doctor had advised me to come to the hospital when my contractions were about five minutes apart and one minute long or my water had broke, we waited.

I had been having consistent contractions since 10pm that evening. At two in the morning my contractions were still eight minutes apart and two minutes long but were getting stronger. So I called the hospital, I told them I was 8 days overdue and that I knew my contractions were suppose to be closer together but they had been 8 minutes apart and 2 minutes long for the past 4 hours or more and that they were becoming painful. I was asked if my water had broke and I told the nurse I wasn't sure; I had not had a big rush of water. I was advised to stay home as long as possible because I would be more comfortable. She told me to take a shower to try and relax and get some rest. I felt alone and ill advised. I thought things would progress as the doctors and the books had told us they would but nothing was changing except the intensity of the contractions. While experiencing a similar situation Jenny McCarthy advises in her book "Belly Laughs" to "listen to your body... not even your doc" while doctors think they have the most knowledge about the subject at hand you are the only one who really knows your body (118). I felt as if I knew nothing and didn't know what to expect next, but I did know I was in labor.

Around 4am my contractions were still consistent in time 8 and 2 but were continuing to be more painful. I had cramping and back pain. We had been packed for three weeks or more and all we needed to do was to get dressed and gather some personal things. As we drove to the hospital I couldn't believe how painful it was to sit in the car, it was raining out and still dark it was close to 5 am, my husband did his best to avoid potholes and not drive too slow or too fast. Once we arrived at the hospital I couldn't believe that we had to sit (I stood) in reception and fill out paperwork to get checked in before they would take me upstairs.

Each person we spoke to asked me if my water had broke and I finally began to respond I don't know because I thought it had but it did not fit the "rush of water" description we had been told would happen. Once we were all checked in we were escorted upstairs and we were met by

the nurse I had spoken to on the phone. Her first question was has your water broke and I told her I didn't know and she said that I would know it would feel like someone dumped a five gallon bucket between my legs. As I said before the medical world knows so much about this process so it was assumed as a first time pregnant lady I was overreacting about the whole process. I was spoken too much like a child who just didn't understand, instead of an educated woman capable of understanding aspects of birth. Nonchalantly I was taken into a room, put in a gown, and the nurse began hooking me up to a machine to check my contractions. I asked which midwife was on call and I was informed that it was not the midwife I had chosen and that the other midwife was sick anyway so I would be seen by the doctor. They began monitoring me and said the doctor would be in soon. My heart sank, no midwife, uninformed and losing my voice once again I had doubting myself and this process again. The nurses had a shift change and that's when Nurse Rita our new knight in shining armor came on duty and took over our situation.

Rita informed me that the doctor would be very quick to induce to move my contractions up since they were still 8 minutes apart and 2 minutes long. She also advised that he would probably want to break my water since they were all sure it had not broken yet, and then give pitocin to move contractions along. Then if I did not progress he would recommend an epidural, and possibly a c-section. I told her I didn't want any of those things. I wanted things to be as natural and uninhibited as possible. She vowed she would be my advocate and as long as the baby was not in danger she would do her best to be my voice and ensure that I could give birth to my baby the way I wanted to. As she told me what the doctor would do I became scared but it eased me to know that she would help anyway that she could.

As the nurse had informed me when the doctor came in to see me and he immediately recommended that I have pitocin to move my contractions along he also wanted to check my

cervix and see if my water had broken. I was only dilated to 2 cm and I was not totally effaced yet meaning my cervix was not completely open. He didn't think my water had broken and he told me that it would be better to try and break the sack of water to move things along. Before I had a chance to respond he requested a needle to break the water sack, upon trying to break the sack he determined that my water had already broken and that it was crucial to have an ultrasound to check the amount of fluid around the baby to make sure she was ok. The monitor showed her heart rate was good and she was not in stress at the moment. I told the doctor I did not want to have a c-section or pitocin and no epidural; he replied that we would do what was best for the baby, but for right now we would wait for the ultrasound since she was not stressed and see if things progressed on their own.

This progress would be determined by the readings produced by the monitors, “good or poor labor is judged by the amount of progress made in certain periods of time” (Martin 59). Because of these time stipulations put upon laboring women Naomi Wolf points out in her book "Misconceptions" that the hospital setting is not conducive to the labor and delivery process. Women are hooked up to monitors and are forced to labor in unproductive positions lying on their backs. These monitor's "produce a visual record that can be used in a lawsuit to bolster a hospital's legal position in the event of a lawsuit" (Wolf 157). Even though we had planned a birth with the midwife, we had talked to the doctor about doing things as natural as possible in the event that he was going to deliver our baby so it made me a bit uneasy that he acted as if that conversation had not occurred. The fact that he was willing to give me some time to progress made it a little easier to handle, since I quickly became upset and very nervous that he wanted to rush into medicalizing my birth process.

Nurse Rita informed me that she talked to the doctor and he was willing to wait two hours before starting a pit drip, and when that time came she would start one unit at a time instead of the recommended three units so hopefully I would not get sick. I was thankful that she was on my side as much as she could be and that she had some training with the midwives and was therefore willing to help me keep things as natural as possible. Despite our patience my contractions did not progress and Nurse Rita returned to start my pit drip which quickly began to make my contractions more intense. Following this the ultrasound tech showed up and began her job, it was nice to see the baby, hear her heartbeat, and find out there was still fluid around her but it was difficult because I was having contractions and didn't want to be touched. When the ultrasound was over I was left to labor on a table until things progressed.

Now surrounded by my family my contractions began to pick up and I started to dilate more, at first I went to 3 1/2cm then the next time I was checked it was 7 cm the time I had reached 7 cm I was having intense contractions and beginning to feel the need to push, my best friend Lisa had showed up to help my husband coach me through my contractions. Nurse Rita came in and checked my cervix then ran off to get the doctor. He came in to check me and then informed me that I could not push that my cervix had swollen and was still not fully effaced, things had progressed too quickly and the cervix was stuck on my babies head. If I attempted to push the cervix would swell more and I would have to have a c-section because the baby would not be able to come out vaginally. Again I became scared and was worried that things would get further out of my control. Rita told me when the doctor left that getting on my knees would help the baby's head drop and hopefully the cervix would slip off her head. So over I went on my knees, face in a pillow, hot as hell, and ready to push.

Again Nurse Rita came in and checked my cervix this time it was heavenly news, the cervix had moved off her head and I was fully dilated, she said I could roll over and push when I felt the need to get the ball rolling so over I went and the process began. The doctor was called in he said he felt the process would take an hour maybe an hour and a half to work through my contractions then he left nurse Rita to help me work things out. It was finally go time, I began to push when I felt the need and Nurse Rita informed me of how and where to focus my pushing, as well as how to breathe through them. She advised my coaches to hold me up so I was crunched in a ball and was focusing my pushes as low and hard as possible. I was so grateful for the insight the nurse gave and that she was able to continue to encourage me and my coaches on how to get the most out of my pushes without pressure from the doctor.

As I pushed the baby's head kept crowning but was not making it past my pelvic bone and kept slipping backwards after I pushed it forward. I spent an hour pushing her head back and forth and then finally it was time to get the baby out I had to focus my on pushing longer and harder in order to work the head out and past my pelvic bone, a few more good pushes and Nurse Rita sent for the doctor as she felt it would only take a few more pushes to get the baby out all the way. The doctor came in and said he was pleased with my progress and that it was time to focus my pushes and get this baby out.

With the next few contractions I pushed long and hard and finally I was able to push her head past my pelvic bone, this was probably the most painful part of the process as you can feel an intense amount of pressure against each side of your pelvis and you have to wait for the next contraction to push again. As her head came out my husband gasped and said that was amazing honey her head is out you can do this, my best friend and coach told me the baby was coming out she could see Ciara and that all I had to do was push and she would be out as soon as I was ready

she would count and watch for me. I heard the doctor as he sucked the fluid from her mouth and nose and she let out a little cry. The doctor reiterated what Lisa had said and with that another contraction came and I pushed long and hard the pressure released and the rest of her body slipped out. My husband began to cry and said "honey you did it that was amazing she is out". They laid her on me and I gasped at how beautiful she was.

Lana's First Birth

Lana who was 20 at the time she became pregnant with her first child expresses her lack of birth knowledge and absence of her voice within her own birthing process. "I just expected the fairy tale "oh yea my water is going to break I'll go into labor and out pops a kid" She assumed her pregnancy would progress in a textbook manner, she would become a mother and all would be well. "Through my first pregnancy I attended prenatal visits regularly once a month then every few weeks until I was overdue."With no complications and healthy baby growth Lana anticipated a simple birth and was excited to meet her newborn son. "I remember them asking me with the epidural or a natural birth. C-section was never discussed...In the birthing class or Lamaze class them saying there's 28 people in this room and 4 of you will have a c-section. And here's me, little naive Lana and sitting there, thinking, I don't need to listen to this there's 24 other people in here who won't and I'm one of them. Same thing with the mycomium in the womb of the 28 of you one of you will have that, and I knew that wasn't me turned out I had both."Lana had few expectations for her birth but she didn't anticipate any issues or setbacks, nor had her doctor discussed any with her.

Once Lana was in labor and had checked in at the hospital the fairy tale was coming to an end and reality was creeping up with every contraction. “After I was dilated to ten and he was not coming down far enough in to the birth canal to start pushing, so they decided to give me pitocin to make the contractions stronger to help push him down into the birth canal. I pushed for 3 1/2 hours the whole time I was pushing I remember the doctor pushing her hand up in me trying to push this bone out of the way and that hurt so bad but she couldn’t. And that’s what she said was blocking my son from coming down, I don’t really know at all ,but I do know that he never moved at all.

There was no Lamaze coaching or assistance from the doctor advising Lana what to do next or how to focus her energy. Lana recalled “when she finally decided yes there was no progress being made and we were going to go ahead with the c-section, she then came back in and said we’ve contacted the anesthesiologist and he won’t be here for 45 min, so just breathe through the pain and just go ahead and maybe get on your hands and knees and see if that will work and see, anything you can do to make yourself more comfortable” and left the room

With a normal c-section usually one person a spouse or family member can be in the surgery room for a birth. “My sister, um, she was there actually when my son wasn’t breathing. They tied me down; they literally had tied me down to this table. And she told me afterwards that they mouthed to her across the room to her to tell me that everything was fine and don’t let her know anything was wrong. But at that time they were really holding my son down, and were sucking out his lungs and trying to get him to breath and trying to keep him alive. I repeated whatever happens they will sew me up but go be with him, he can’t be alone”. Lana’s son was born blue with mycomium in his lungs, likely from the stress of a long labor and all the pushing

his mother endured. While Lana's pregnancy was fairly normal and easy, her labor and delivery was far from textbook.

Linda's Knowledgeable Births and Valuable Voice

Linda was only a freshman in college when she delivered her first born, but she was not naive to the birthing system. "My birth knowledge was higher than most people, because of my psych professor she told me about lots of things at that time, that was when I learned about the farm and I read everything I could read about the homebirth movement. I read about mobile birthing units in Holland and all kinds of different practices in every country. My knowledge was high the whole time"

Linda knew what she wanted and what she didn't want to experience during her births. Even with her first she knew she wanted a natural birth and she wanted to be able to trust her body. "With the first birth, I was told I could deliver anywhere I felt, but when it got down to it he shepherded me to the bed and I gave birth in a very conservative position on a hospital bed. That was the most traditional position I gave birth in". During the birth of her first child in the 80's Linda recalled "they pressured heavily to give me medication with the first birth. And at some point I was at a tipping point, because I was at the most weak place I have ever been psychologically and I was in a lot of pain, ya know my husband was there and he was massaging me, I mean the man massaged me forever, he was physically a wreck afterward. So he was my support and my psych professor was my coach. And at one point they came in and I would have given in but I looked at her and she smiled and said no and I said no and we kept going. I never had anything".

Feeling a great deal of pressure with the hospital setting during the first birth Linda continued her research and remained vocal with what she wanted for her birth. “I got more radical for the second which is why I decided to have him at home, but there was a complication and he wasn’t breathing and he had to be massaged into breathing, he was blue. He had great muscle tone but lack of oxygen was an issue. And I had an issue with oxygen with the first birth and thought maybe I needed oxygen with him, and so that was scary and it sort of put me on pause... “There was a lot of blaming that happened, with the second born. He (the Doctor) knew I was doing a home birth and He reluctantly agreed to do the prenatal care, even though I was doing a home birth and told him ahead of time. Then I brought my son back like 3 weeks later to have the circumcision and when I had the complication of the circumcision, when we were driving home we had a problem with him bleeding in his diaper, his diaper filled with blood and we turned around and rushed back and they blamed us saying, it was because we had a home birth. They gave him a vitamin K shot and cauterized him or whatever but they told us that it was all our fault they blamed us for having a home birth and said we could’ve killed our child and that they did nothing wrong with the circumcision. There was another problem too, with that one so I had a little bit of a tear which is not unusual after the first. I was cleaning shortly afterwards, like 48hours later and I was crouched down and I didn’t even think about it I was 21 years old and I ripped things worse. Didn’t even think about it and I got an infection. So a few weeks later I had to go to this same doctor and he had to cauterize my perineum and stitch me at that point. I don’t know if the stitches were necessary or if the cauterize there would have been enough, but I just remember the doctor talking the whole time and it was just this blaming thing again, like you’ve done this to yourself this was because you had a home birth and had you been in the office you wouldn’t have these issues.”

Despite being pressured early on with her first birth and struggling with negativity and backlash for her homebirth choices, Linda had a great social system and made sure her voice was heard throughout her birthing experiences. “That was the one thing, they did let me do even with the first one; It’s been a party every time. With the first birth in the hospital my husband, my mother, my psychology professor were all there. With my second at home, my husband, my mother, my psych professor again, plus a fellow student taking pictures; My step daughter was there, she was 12 at the time and she was holding my first born and my step father arrived at some point, So it was just a revolving door most of the time. With my third we were in my bedroom, my sister in law was there, my second born and my parents. My first born missed it he really wanted to be there. My fourth born, all three of my older children were there and my husband; and my oldest was actually the one who caught my fourth child. The midwife said go wash your hands if you want to catch and he did so he caught his brother.”

With each birth Linda’s ideas changed but she still knew the best thing was to have a voice and to make her beliefs known especially as she became more familiar with her body through each of her birth experiences. “I still wanted no intervention, everything to be natural but I wasn’t necessarily geared for home birth unless they were going to bring oxygen, or were closely tied to someone that could provide interventions if I needed them. That’s what I had for the 3rd and 4th I had the most, I mean I would have like to have a free standing birthing clinic they have stuff there but it’s independent from a hospital so no one is walking over and saying oh we are going to do this now...At the free standing birth center they have minimal things like oxygen, IVs, etc. So yes my ideas did change over time and I still believe in homebirth I just think the best option is a van parked outside with the stuff in case you need oxygen or little

things because to me being at home the chance of infection is minimal and your more comfortable but I just think it would be better with a van full of stuff.”

Marissa’s Fourth Home Birth: Strength in Obtained Birth Knowledge

“For the fourth pregnancy I was very sick. I was sick throughout the entire pregnancy. By the final stage I was ready to give birth. On July 3rd at 10 pm my contractions started. The starting contractions were ten minutes apart and only about 1 minute long, so I didn’t really have any issues. I didn’t even wake my husband until later when they became more intense. At 4 am my husband called the midwife and she headed my direction. The contractions were getting closer together and stronger. They were 5 minutes apart and over a minute long. As they became more intense I couldn’t talk between them I just focused.

During my labor I didn’t want my midwife to check me; I don’t bother with that stuff, my body will tell me when I am ready. This labor was different from the others because I was very laid back during the end of stage 2 and throughout stage 3 of my labor. I was very focused during contractions and wouldn’t talk at all. But in between I just lay back in the birthing tub and chatted with the midwife, her assistant, and my friend and family that was there. This birth was also different from the others because he dropped into the birth canal very quickly and I felt it. I did not have to push very long her was born within five minutes of him dropping into the birth canal, only two hours after the midwife arrived.

The coolest thing about this birth was that the kids were able to see the birth and my daughter who was 4 at the time was right by my side for the whole thing. My son was born close to 7 am on the fourth of July, the kids were just waking up so my friend who was present for the

birth helped get cartoons going and such, then as I felt him drop into the birth canal and I told the midwife he has just dropped she said go get the kids and they were all there as he entered the world. Having the older children there made it even more special this last time. And as you give birth, all the sickness and fatigue leaves you and you feel amazing; even though you are still recovering it's so amazing how you feel after birth".

CONCLUSION

Voices Equal Choices

By choosing to embrace their embodied knowledge and speaking out during their pregnancy and birth, women may find their own authoritative voice that allows them to communicate their needs and wants as well as understanding the medical processes and possible interventions they are facing. My research has aimed to contribute to the call for advocacy of low-technology births by examining how women accept biomedical authoritative knowledge and how they resist it. Many women in the state of Michigan and even more so across the country are beginning to resist hospital births and textbook monitored deliveries by seeking home birth midwives and giving birth at their own pace in the comfort of their own homes. While these wonderful midwives are few and far between in this area they are more than willing to travel and to set up shop in a woman's home, assisting women with their birthing needs but more importantly guiding women to trust and listen to their bodies, allowing for more positive, comfortable, and empirically guided births. So how exactly do home births empower women and change the birth knowledge of a culture that so strongly emphasizes scientific knowledge, authority, and technological control?

Through my research I have found that women who actively seek a home birth experience have a desire to trust in their bodies to progress uninhibited through the birthing process, As well as a level of knowledge regarding the invasiveness of medically assisted birth. Among the women I spoke with there was a great variance in birth knowledge as well as variance in age and period of time between these birth experiences, however for all of the women regardless of age, number of births, or level of medical assistance each and everyone found a

louder more active voice with each new birth experience. The births women discussed with me also varied from homebirth and uninhibited hospital birth to births receiving small medical interventions during birth, c-section and emergency c-sections. Among the women who struggled through a birth, needed medical assistance, or received medical interventions almost all of them felt they had little or no options other than those presented by their doctor. Out of fifteen women one dozen of them felt pressured by their doctors during labor and delivery and six of them mentioned their doctors blatantly ignoring their requests to avoid unnecessary procedures such as episiotomies.

If there is a medical need for an intervention or if the mother chooses to have one once given the proper information, that is acceptable; but no woman should ever be bullied or feel as if a minor yet invasive cut or a major surgical procedure is the only option doctors will allow for her. We all must understand time is not always available and emergencies do happen, but millions of babies are born everyday to undereducated, under-informed women because doctors clearly do not want to take the time to wait on a pregnant woman in any way. The OCC currently recommends that “Women giving birth for the first time should be allowed to push for at least three hours, the guidelines say. And if epidural anesthesia is used, they can push even longer. Early labor should also be given more time, the doctors say, with the start of active labor redefined to cervical dilation of 6 centimeters, rather than 4.”

According to Dr. Marsden Wagner cesarean section rates are continuously on the rise, and many women are beginning to move towards homebirth and away from medicalized births he points out that the proof is evident through numerous federal studies and the top reasons are as follows: 1. The percentage of US births that happen Monday to Friday Nine to five is rapidly

increasing; 2. Obstetricians want women to have more c-sections to avoid litigation. 3.

Politicians, HMO's and the American public are realizing that it is wrong to have highly trained surgical specialists caring for healthy pregnant women and catching perfectly normal babies at low-risk births. Doctors are trained to be accurate and to the point and to stick strictly to a regimen, this type of practice leaves little to no room for a woman's own birth choices and quickly drowns out her voice. So, why will most doctors not take the time to explain the process? The answer is simple, because they are not trained to do so. Most will not explain in depth any possible interventions nor will they wait for a woman's body to labor naturally, a process that varies for each woman and is unknown to everyone other than the woman herself. A midwife is trained specifically in following the cues of a woman's body and allowing a laboring woman to progress on her own, as well as trained in many medical processes giving a woman various options for care as well as the time and patience she deserves.

The Obstetric Care Consensus is beginning to see a shift in women's birth, a resilience if you will towards the pressures and authoritative knowledge that medical professionals extend to women in labor and often throughout their birthing process. It is becoming apparent that medical professionals have depersonalized birth; they have removed all but their hands and medical options from the process by imposing authoritative knowledge on women. This imposition has pushed women to seek out their own options when it comes to birth women are asking *Where is my Midwife?* To remedy this several organizations and activists groups have established an imperative demand to overhaul the birthing practices in the United States. The MAMA campaign is a collaborative partnership consisting of the Midwives Alliance of North America (MAN), National Association of Certified Professional Midwives (NACPM), Citizens for Midwifery

(CfM), International Center for Traditional Childbearing (ICTC), North American Registry of Midwives (NARM), and the Midwifery Education Accreditation Council (MEAC). This partnership is now at work to gain federal recognition of Certified Professional Midwives so that women and families will have increased access to quality, affordable maternity care in the setting of their choice. The *Coalition for Quality Maternity Care* is an organization that works to establish strategies to ensure access to affordable, high quality maternity care for all women and infants. (mana.org/healthcarepolicy/advocacy-activism, accessed May 2016). It seeks to achieve this goal by removing barriers to optimal maternal health practice, promoting models of care that are evidence based, improving maternity care choices for women, and reducing disparities in maternal and newborn health outcomes. My research has revealed to me that unless a woman embodies her strength, researches her own options, and makes her voice heard *the choices women make during pregnancy and birth are directly influenced by biomedical forms of authoritative knowledge and a culturally constructed trust in biomedical technology, which can therefore directly affect their position as active participants within their own birth experience.*

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Appendix A

Human Subjects Institutional Review Board Letter of Approval

Project #13-04-22

WESTERN MICHIGAN UNIVERSITY



Human Subjects Institutional Review Board

Date: May 22, 2013
To: Bilinda Straight, Principal Investigator
Shannon Sheffey, Student Investigator-for thesis
From: Amy Naugle, Ph.D., Chair *Amy Naugle*
Re: HSIRB Project Number 13-04-22

This letter will serve as confirmation that your research project titled "Women's Role in their Reproductive Process: The Effects of Authoritative Knowledge and Biomedical Interventions on the American Birth Experience" has been **approved** under the **expedited** category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may **only** be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., ***you must request a post approval change to enroll subjects beyond the number stated in your application under "Number of subjects you want to complete the study."*** Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: May 22, 2014

Walwood Hall, Kalamazoo, MI 49008-5456
PHONE: (269) 387-8293 FAX: (269) 387-8276

Appendix B
Demographic Survey

Appendix B

Demographic Survey

**Western Michigan University
Department of Anthropology**

Principal Investigator: Bilinda Straight

Student Investigator: Shannon Sheffey

Title of Study: Women's Role in their Reproductive Process: The Effects of Authoritative Knowledge and Biomedical Interventions on the American Birth Experience.

Demographic Survey

What age category best describes you?

18-25 _____ 30-35 _____ 45-50 _____ 55-60 _____
25-30 _____ 35-40 _____ 50-55 _____ 60+ _____

What is your ethnicity? (Optional) _____

How many pregnancies have you had in your life?

0-1 _____ 2 _____ 3 _____ 4 _____ 5 _____ 6 _____ # _____

Are you currently pregnant or expecting?

Yes _____ No _____

Were all of your births vaginal or natural births?

Yes _____ No _____

Were any of your children born through a cesarean section?

Yes_____

No_____

If you answered yes how many? #_____

Have you experienced any pregnancies that did not end in live birth?

Yes_____

No_____

Did you seek a doctor or midwife to assist you with your birth(s)? *If you have given birth more than once please list an answer for each pregnancy*

Did you give birth at a hospital, at home, or in another location when it came time delivery? *If you have given birth more than once please list an answer for each pregnancy.*

Appendix C:
General Participant Interview Questions

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General Participant Interview Questions

**Western Michigan University
Department of Anthropology**

Principal Investigator: Bilinda Straight

Student Investigator: Shannon Sheffey

Title of Study: Women's Role in their Reproductive Process: The Effects of Authoritative Knowledge and Biomedical Interventions on the American Birth Experience.

Interview Questions

- 1. Do you wish to discuss your pregnancies and labor and delivery experiences with me today?**

- 2. During your pregnancies did you attend a physician's office for regular prenatal visits?**

- 3. Did you seek a doctor or midwife to assist you with your birth?**

- 4. Did you give birth at a hospital or at home or in another location?**

- 5. During your prenatal visits do you recall your medical professional discussing birth options with you such as natural birth, epidurals, cesarean sections, and other possible medical interventions?**

- 6. What do you know about having a birth plan?**

- 7. Did your provider discuss a birth plan with you or did you question your provider about a birth plan?**

- 8. During your pregnancy did you have a birth plan of your own or an idea of how your birth would go?**
- 9. Were all or some of your births vaginal or natural births, please explain?**
- 10. Were any of your children born through a cesarean section?**
- 11. Was your doctor or midwife present during your birth or another practitioner who was on call?**
- 12. Were you connected to a fetal monitoring system during your delivery?**
- 13. Did your provider suggest various positions for giving birth that would assist with your delivery**
- 14. What types of labor and delivery techniques did you use during your birth experience, i.e.: Lamaze breathing, hot bath or showers, etc?**
- 15. Do you feel that your provider listened and followed your requests during your birthing process?**
- 16. Were you able to have family and/or friends present during your births?**
- 17. What would you say was your level of knowledge about birth in general before enduring it yourself?**
- 18. During your labor and delivery did you feel pressured to accept medical interventions for pain?**

- 19. During your labor and delivery did you feel pressured or like you had no other options but to allow medical interventions to assist you with your delivery?**
- 20. When you gave birth did you have family assist you as well as medical personnel?**
- 21. At anytime did you feel unsafe or alone during your birthing process?**
- 22. If you have more than one child, how did your ideas about birth change from one pregnancy to the next?**

Appendix D

Table Presenting Cesarean Rates by Country per 100 births

Cesarean Rates by Country per 100 births

Turkey	50.4
Mexico	45.2
Italy	36.1
South Korea	36.0
Poland	34.6
United States	32.5
Australia	32.1
Germany	30.9
Ireland	28.5
Canada	26.3
Spain	25.2
United Kingdom	23.0
France	20.8
Sweden	16.4
Netherlands	15.6

Source: 2013 OECD Forbes

<https://www.forbes.com/sites/niallmccarthy/2016/01/12/which-countries-have-the-highest-caesarean-section-rates-infographic>