

**The Political “Nature” of Pregnancy and Childbirth**  
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## **Abstract**

In this paper, I examine the theoretical debates concerning “medicalization” in relation to the empirical trend toward increased demand for “natural” options for childbirth. Many feminist theorists have argued that medical intervention in pregnancy and childbirth is both unwarranted and disempowering, and devalues women’s own abilities and experiences. Further, it is argued that medicalization (of seemingly natural events) is particularly damaging for women and other marginalized people. In this paper, I explore the claims (of both providers and consumers) concerning medical care for pregnancy and childbirth among privileged populations, and ask why rejection of medical care for pregnancy and childbirth is not proportional to disadvantage. It appears to be the case that criticism of medical intervention in pregnancy and childbirth is strongest among privileged women, and is expressed consistently as preference for “natural,” “traditional,” or “normal” approaches and practices. Reverence for the natural, I argue, is a political claim that asserts social position, identity, and resistance. I consider this political claim to be embodied and demonstrated in the occurrence of a physical and psychic duality, a “split subjectivity,” that is exacerbated by the sharpness of the public-private divide in women’s lives.

According to recent reports from the Canadian Institutes for Health Research, “the use of assisted reproductive technology (ART) has increased dramatically since the first in vitro fertilization in 1981.” (Fountain and Krulewitch, 2002, cited in CIHIa, 2004:3; see also CIHI, 2007). The range of permissible ARTs (defined through federal legislation in 2004) includes the donation, freezing and storage of eggs, the donation of sperm and other reproductive material, in vitro fertilization, and surrogate motherhood; on the horizons of medical research and ethical imagination sits human reproductive cloning (see Scala, Montpetit and Fortier, 2005; see also CBC, 2007). Future technological interventions are the subject of great speculation, as well as consternation, and have raised questions about the degree to which these sorts of interventions threaten to fundamentally alter human nature (see Fukuyama 2002, and Somerville, 2000), and while the CIHI indicates that in 2001 only 0.4% of all births in Canada were the products of in vitro fertilization (CIHI, 2004a:3), it is likely that the number of assisted conceptions will continue to rise, given that the current trend is toward women delaying reproduction until they have established careers or other goals (the average age at which a woman has her first child is approximately 29.7 (Statistics Canada, 2006)). Delay of pregnancy and childbirth can pose fertility challenges. And the benefits of scientific technological development offer to offset or diminish those challenges with an ever-expanding range of options.

Such possibilities, for better or worse, have created a profound historical moment, one in which reproductive technologies have outpaced ethical deliberations over their utility. For women and their partners, there are new possibilities for the creation of families. ARTs provide for the contestation of old, biologically determined

understandings of who qualifies as a parent and how patterns of career and family can be established. This moment provides unparalleled reproductive choices for women in navigating their reproductive lives. For many feminists, choice has been the goal of their political and scholarly activities, and so for them, this current moment should constitute a major victory.

But in this context of technological advancement, there are those that cling to the vestiges of nature, and in so doing, carve out contemporary understandings of what we are as women, or human beings. These defenders of “the natural” contribute to ethical debates concerning ARTs (see Somerville, 2000; Sherwin, 1998). This paper focuses on the return to nature that can be observed in the feminist debates (and trends in women’s preferences) concerning the “medicalization” of pregnancy and childbirth. Research for this paper draws on empirical evidence of a trend toward less medical intervention in pregnancy and childbirth (from care provided by midwives in hospitals or homes to “free births,” which are not attended by anyone at all), sometimes contrary to public health protocols. However, the main argument is mostly theoretical in its construction. It draws on empirical data to formulate the primary research questions, namely, why do some women (mostly privileged and in developed countries) demand less medical intervention in pregnancy and childbirth, while others (mostly vulnerable women in both developed and developing countries) demand more (regardless of actual need)? Why do the former, privileged women, tend to express their resistance to medical intervention in the language of “nature,” “tradition,” and “normalcy”? And why do there seem to be simultaneous trends toward greater medicalization of conception (from ovulation predictors to ARTs) and less medical intervention in pregnancy and childbirth? The exploration of possible

answers to these questions is conceptual; it draws on theoretical literatures concerning medicalization and the socio-political construction of nature, tradition, and identity, and is situated within ongoing debates within feminist political theory regarding public-private distinctions and split-subjectivity. The evidence seems to suggest that arguments about the negative impact of medical intervention in the lives of women, “medicalization,” seem to resonate only among privileged populations. As indicated by Laura Purdy, medical intervention in pregnancy and childbirth is evaluated very differently in different contexts, and the expression resistance among privileged women in developed countries often appeals to “nature”: “When we learn that African-American women in the United States die more often in childbirth than white women, and that horrifying numbers of Third World women are dying as we speak, nobody concludes that preventive action would be morally intrusive. Yet we tend to be bewitched by the claim that menstruation or pregnancy are natural processes and thus inappropriately dealt with in the medical realm.” (Purdy, 2001:254). In poor countries, communities or under-serviced areas, medical care is a necessity, upon which exercise of agency and autonomy is contingent. But the refusal of pharmaceuticals and clinical care among affluent or well accommodated (by a universal health system, for example) women is at once a form of political resistance and an assertion of identity.

### **Medicine, Midwifery and Maternal Health**

Recent trends in Canada toward increased utilization of midwives' services are evidence of suspicion of, and a desire for alternatives to, obstetrical care. According to a report by the Canadian Institute for Health Information (CIHI), "the number of publicly funded hospital births attended by midwives is increasing in several provinces... Ontario saw nearly a seven-fold increase between 1994- 1995 and 2000-2001" (CIHI, 2004b:12).

That same report confirms that pregnancies and births attended by midwives are characterized by fewer medical interventions, which includes lower cesarean section rates (CIHI, 2004b:12). Midwifery care is also preferred by many women because the experiences of pregnancy and childbirth are validated through holistic approaches to understanding pregnancy and birth and are enhanced or developed through more extensive meetings, discussions and interactions than would be possible under the care of an obstetrician.<sup>1</sup> In addition, with care by midwives, home births are possible and fully supported. In short, care by midwives seems to provide avenues for the generation and exercise of greater agency for women. Choices are expanded for location and type of care, and women are included, recognized and respected as "subjects" in the experiences of pregnancy and childbirth (rather than treated as passive patients receiving care from medical personnel). Women have greater agency, it is argued, when choices are not determined by professionals on their behalf. Such determination extracts fundamental value from the experiences of pregnancy, childbirth, and motherhood, if not womanhood, and results in "disembodiment, imagined as existing elsewhere – outside the body" (Martínez, 2005:798).

Powerful forces that pull in the direction of less medical intervention, hospital-centered care and obstetrical oversight in some contexts are matched by forces that are equally powerful in the opposite direction in others. In developing countries with alarmingly high rates of maternal mortality, such as Haiti (523 per 100 000 live births), Bolivia (230), and Peru (185) (in the region of the Americas) (UN Millenium Project, 2005:79)<sup>2</sup>, both public health and (many) feminist voices call for increased medical intervention in pregnancy and childbirth, in the form of more prenatal care and monitoring, greater access to hospitals and clinics, and higher rates of births attended by fully trained medical personnel. Alicia Ely Yamin and Deborah P. Maine explain that “of the most commonly used health indicators, maternal mortality reveals the greatest disparity between developed and developing countries” (2005:430). They proceed to argue that

the great variation in frequency of maternal deaths between more developed and developing countries is in no way attributable to exotic complications of pregnancy and childbirth in developing countries... Indeed ...[there is] a remarkable similarity between the leading causes of maternal death in the world as a whole and in the United States in particular (2005:430).

Furthermore, their evidence (based on comprehensive reviews of public health literature) shows that “most life-threatening obstetric complications can neither be prevented nor predicted, though they can be treated” (2005:432). In other words, focus in many country contexts on preventative measures and processes such as improved prenatal care and education is misplaced. The leading causes of maternal mortality can be addressed only with improved medical care at the time of delivery (and in the eventuality that complications arise prior to the delivery). The UN Millennium Project explains that “recognizing that most women in high-mortality countries deliver at home, early

programs focused on training traditional birth attendants in safe and hygienic practices” (2005:81). However, studies have shown that “although training programs for traditional birth attendants may improve the care that mothers and newborns receive, these interventions proved ineffective in reducing maternal deaths (UN Millennium Project, 2005:81). Therefore, public health imperatives that insist on greater *medical care* or intervention in pregnancy and childbirth, seem to be correctly focused on treatment and medical service provision (in well equipped facilities and attended by trained personnel), particularly at time of delivery.<sup>3</sup> The transition from more traditional approaches (by traditional birth attendants, for example) to more advanced medical models in these contexts is evidence of development, empowerment and gender progressivity. Countries that do not prioritize the reduction of maternal mortality rates are denounced as failing women. Thus, it seems to be the case that in developing countries, agency and subjectivity for women is at least partially contingent on the availability (and encouraged use of) medical services. “Medicalization” (as the systematic preference of the technological over the natural) is not necessarily a problem for women in developing countries, for women in disadvantaged populations in developed countries. Rather, it seems to be a problem for privileged women, and is likely connected to the sharpness of the division between their public and private spheres of identity and existence.

### **Privileged Populations: Women in Canada**

Canada has the lowest maternal mortality ratio in the region of the Americas (7.8 per 100,000 live births (PAHO, 2005:10), and one of the lowest ratios in the world (WHO, 2004:22-26). This can be attributed to “relatively high levels of education and economic

well-being and an effective health care system” (Public Health Agency of Canada, 2005:4). Therefore, the evidence provided by these indicators confirms Canada’s success in achieving maternal and reproductive health. However, broader understandings of health and well-being reveal that biomedical approaches to women’s health have had negative consequences. According to feminist bioethicists and practitioners, many women feel as though they are constantly under medical surveillance (see Morgan, 1998; De Koninck, 1998). Women feel pressure, exerted by medical professionals, agencies of the state, women’s magazines and pharmaceutical marketers to monitor their diets, weight, appearance, activities, behaviours, and thoughts for any signs of abnormality or illness. During pregnancy this surveillance effort is increased, as medical doctors and nurses conduct tests to ensure that mothers are complying with best medical practices and fetuses are developing normally. For example, ultrasounds and genetic testing are routinely undertaken, regardless of whether the pregnancy indicates that intervention is necessary (see Mitchell and Georges, 1997; Taylor, 2000). This monitoring results in “disembodiment,” and “alienation,” and the “commodification” of fetuses (see Young, 1984; Goslinga-Roy, 2000; Taylor, 2000; Mitchell and Georges, 1997).

Iris Marion Young explains that “medicine’s self-identification as the curing profession encourages others as well as the woman to think of her pregnancy as a condition which deviates from normal health” (Young, 1984:46). To be in the care of a physician or obstetrician creates a relationship of dependency, as the medical professional possesses the knowledge necessary for “cure” and the woman/patient is reliant on the doctor for this knowledge; she is not a “knowing” subject (Young, 1984:46). This dependence enables the obstetrician to control the situation, and thereby, whether

intentional or not, control the experience of pregnancy and delivery. Such is the problem of “medicalization” of pregnancy and childbirth.

But how can this problem be taken seriously in light of the indicators noted above? Why does medicalization seem to be experienced much more acutely by privileged women in societies where options for excellent medical care are available in abundance? Possible explanations seem to go well beyond the effects of poverty and class to implicate social and political dynamics. It is not simply the case that the observed discrepancy can be explained by the fact that women in vulnerable communities are constrained by material conditions in ways that privileged women are not. Preferences in pregnancy and childbirth seem to reveal important dimensions of identity and intersectionality among women.

Kevin White reminds that medicalization, as it emerged in the literature, was initially a matter of concern for developing countries:

The medicalisation debate has raged on, with much of the discussion being couched in terms of comparing the West with underdeveloped societies, in which medicine is fused with law and religion. In comparison with these societies it is argued that western society is not medicalised. This conclusion is systematically challenged by feminist research in two areas: the intrusion of medicine into the social and psychological aspects of mental health; and its colonization of women’s reproductive capacities (White, 1991:50).

Concerning the latter, Peter Conrad explains that “childbirth probably reached its zenith in the 1950s. Typically, at least in middle class families, doctors delivered babies while the mother was sedated or under anesthesia, often in stirrups. Episiotomies and pain medications were routine, formula feeding was recommended for newborns, and so forth” (Conrad, 2007: 158). This complete medical determination of pregnancy and childbirth gave rise to the “natural childbirth movement,” which “had considerable

success, especially promoting less intervention in childbirth, giving mothers more control and choices, and including fathers as labor coaches in the birth process” (Conrad, 2007: 158). The movement was also responsible for bringing about changes in hospital procedures and birthing strategies. Maternity wards in hospitals offered “more comfortable, even homelike, birthing rooms,” and “some women selected midwives for their births, and a few even chose to give birth at home” (Conrad, 2007: 158). However, Conrad qualifies, “as important as these changes were, they affected middle- and upper-class women much more than poorer women” (2007: 158). Therefore, the feminist challenge to the orthodox view of medicalization (as identified above by White), was launched (and sustained) largely in the interests of privileged women.

### **Medicalization and Agency**

At this point it will be useful to examine medicalization discourse and its various feminist formulations. The term, “medicalization” is used to describe a wide range of phenomena, from complete social control exercised by the institution of medicine (see Zola, 1972) to a complex system that is “a protean, dialectically shifting, social and political dynamic” (Morgan, 1998:86). And there is no consensus on the consequences of medicalization. For some contributors to the debate, medicalization condemns medical intervention in the lives of women. Heather Cahill claims that “the appropriation and medicalization of pregnancy and childbirth by men are rooted in a patriarchal model that has been centuries in the making” (2000:334), that pregnancy and childbirth have been inappropriately declared “abnormal,” “diseased,” (Cahill, 2000:338) and that the implications of medicalization are seriously negative: “Medicines’ continued dominance within

obstetrics has meant that not only are doctors able to control the nature and scope of their own work but also that of the midwives” (Cahill, 2000:340). Ann Garry, by way of contrast, separates the negative elements of medicalization from the proven benefits of medical care. She carefully explains that “many feminists are extremely critical of the practices and institutions that medicalize people’s lives, especially the lives of women and other marginalized groups; nevertheless, a critique of medicalization does not necessarily imply a rejection of medicine” (2001:262). Laura Purdy provides a skeptical feminist treatment of the concept. According to Purdy, “analyzing the pervasive and often subtle ways medicine now controls women as it provides care is important work, but the more I think about it, the more obvious it seems that the problem is sometimes the current culture of medicine rather than the fact of medicalization” (2001: 250).

What this contradiction might indicate is a “contested space” or “borderland,” “where there is a ‘continuous confrontation of two or more referential codes’” (Martínez, 2005:799). The borderland in this instance is occupied by the competing forces noted above: nature/ tradition and medicine/ technology. The coding of experiences in this space is inherently political, which is to say that it is both constitutive and demonstrative of power dynamics. This point, concerning pregnancy and childbirth as sites for the construction of identity, is confirmed by the work of Lorna Weir. In her examination of the biopolitical dimensions of pregnancy, Weir states that “the understanding of pregnancy as a state of health is both a task and a way of belonging for midwifery, a profoundly normative claim” (2006:79), and that the “contemporary midwifery ethos... forms a normative relation between midwifery and women during pregnancy and childbirth” (2006:79). It is this “normative” relation that I argue expresses resistance and

identity, and varies according to cultural contexts rather than medical or evidence-based indications. Put another way, it can be said that the body is politically significant, and reflects the power dynamics of different cultural and socio-economic contexts. Further, these contexts are overlapping, intersecting and multiple, and the ways in which women navigate these political spaces reveals a great deal about the power differentials that exist within them. Ann Garry makes this point in the following statement:

Although all people are subject to medicalizing practices, medicalization is a feminist issue because women, along with other marginalized people, are particularly disadvantaged by it. Medicalization is a means of social control that interlocks with other practices of domination to increase the damage caused to the lives of marginalized people (2001:264).

The purpose of this statement is twofold: It recognizes that medicalization affects everyone to some degree, and then declares women and other marginalized populations to be disproportionately affected. Garry continues: “In addition, insofar as marginalized people by definition ‘deviate’ from the norm, standard features (‘natural’ processes) of their lives stand at greater risk for medicalization” (2001:264).

This analysis seems to suggest that degree of medicalization would be proportional to disadvantage: that the most disadvantaged populations would also be the most “medicalized”. However, upon closer examination, the reverse seems to be true. In developing countries, appeals are continually made for more medical intervention in pregnancy and childbirth, not less. And with few exceptions (see De Koninck, 1998), there are no feminist complaints about inappropriateness of (scarce) medical care for pregnant and parturient women in countries with high rates of maternal mortality. Further, in the United States, higher rates of maternal mortality among African American women serve as evidence for the need for better access to medical care (Hoyert et al,

2000). And for indigenous populations in Canada and Australia, birth outcomes for women and infants are compromised by poor availability of medical services, although these populations remain suspicious of the institutions of western medicine (see Stewart, 2006: 302; Browne and Fiske, 2001: 128; Jasen, 1997: 399; SOGC 2006; Wenman et al, 2004; ITK, 2000; CIHI, 2004b; CIHI, 2004c). However, the preference expressed by many privileged women in affluent countries, such as Canada and the United States, for midwifery care and home births, is curiously at odds with public health data and ethical arguments. It is a rejection of privilege that simultaneously confirms it. Therefore, the problem of medicalization seems to apply disproportionately to privileged women. In fact, some of the most serious pronouncements of medical interference in pregnancy and childbirth as a “natural, normal, woman-centered event” (Parry, 2006:459) come from women of considerable privilege and authority. In the American context, Naomi Wolf states that:

The medical establishment too often produces a birth experience that is unnecessarily physically and psychologically harmful to the women involved, even according to its own standards of measurement. And American women are profoundly undersupported – by their families, their workplaces, and the larger society – in coping with the strains of new motherhood (Wolf, 2003:6).

And in the Canadian context, the voices of feminist scholars such as Margaret Lock (1998) and Maria De Koninck (1998) echo this sentiment. Lock says the following about social constructions of health and disease:

Despite the availability of complex etiologies to buffer feelings of helplessness in the face of illness, the question of why some people become sick while others remain healthy, even when the sickness is widespread, or why some babies die at birth while others do not is always of concern. In attempting to quell such concerns, governments, communities, and individuals must either assume that chance is at work or, much more frequently, undertake practices, ranging from divination to

epidemiology and genetic testing and screening, to locate reasons and allocate responsibility for the unequal occurrence of distress and sickness (Lock, 1998:51).

Maria De Koninck extends this admonition to reproduction. She explains that “Obstetrical practices are permeated with technological developments and technological logic currently determines how events unfold. Women’s experiences all too often involve feelings of solitude, apprehension, fear, and disappointment” (1998:153). This assessment requires alternatives to medical intervention and care, even when medical services seem to be the shortest path to relief from illness, disease and suffering. According to De Koninck, overemphasis of biomedical approaches to pregnancy and childbirth are insufficient. What is needed is an approach or series of approaches that examine social, gender, and legal conditions for women. Without the latter, the former threatens to medicalize virtually any type of medical intervention, regardless of how well-intended it might be. De Koninck pushes her argument further in claiming that reduction in maternal and infant mortality rates might not be the most culturally appropriate goals, which renders most public health responses invalid. She draws from her experiences in the West African country of Benin, where maternal and infant mortality rates are alarmingly high, and explains that many women have come to understand that death is simply a part of the natural order of things, and should not be questioned (1998:160). However, this apparent acceptance seems to be consistent with Third World women’s ability to make virtue out of necessity, rather than evidence of a desirable and authentic experience of mother/ womanhood.

## **Returning to Nature**

Preservation of the “natural order of things” has become imperative for some women, while others have continued to demand medical options (such as assisted reproductive technologies and elective cesarean sections). Peter Conrad notes this paradox:

In the current era, we have a bifurcation of childbirth practices: some births are less medicalized (e.g., with childbirth classes, birthing rooms, and no anesthesia), while others are more medicalized (e.g., with internal fetal monitors, Cesarean sections, and attendant neonatal infant care units). In 2004 the C-section rate in the United States reached an all-time high of 29 percent (R. Rubin 2005). Of interest, the number of elective C-sections has risen in recent years; this number now constitutes approximately 2.5 percent of all births, including a significant increase in first-time mothers (Health-Grades, 2005). In short, there has been resistance to medicalized childbirth, but the overall medicalization of childbirth is still predominant and may be increasing in some quarters (Conrad, 2007: 158)

It is also important to recognize that the trend toward more births attended by midwives might be evidence of both resistance to medicalization and its increase (in that midwives are now part of a state-sanctioned and regulated health profession). However, the trend toward options that are “natural,” “normal,” or “traditional,” regardless of whether or not they are actually any of those things, is undeniable, and it is this set of claims that is the focus of this paper.<sup>4</sup> As explained by Margaret MacDonald, “identification with tradition is often used as a rhetorical strategy in political struggles of the present,” (MacDonald, 2004:50) or is used as a “political symbol” (2004:50). She elaborates: “In other words, calling something a tradition creates a sense of authenticity and ownership for the group making that claim. To understand tradition as invented does not invalidate its authenticity, nor the right of the group or culture to claim it, but rather draws analytical attention to the processes of its production and use” (MacDonald, 2004: 51).

Furthermore, this paradox offers the opportunity for examination of a threshold, as articulated by Lorna Weir, who explains that, “a threshold makes possible a relation between heterogeneous places, practices and perceptions,” and that “women in pregnancy bear the between, the entrance across which the unborn must pass in order to be distinguished from those who carry them” (Weir, 2006: 1). Critics of medical intervention in pregnancy and childbirth seem to emphasize the significance of this threshold, and claim that it requires recognition as a natural and/ or normal event. The official websites of the Canadian and provincial midwives Associations and Colleges tend to describe their profession as one that is dedicated to the facilitation of “normal birth”. For example, the Canadian Association of Midwives, which is “the national organization representing midwives and the profession of midwifery in Canada,” declares that “*we believe* that midwives have a unique and essential role to play in the facilitation and preservation of normal birth through the art and science of midwifery” (2008). The College of Midwives of Manitoba identifies “childbirth as a normal physiological process,” (2007a) and that “the entry level midwife should have the knowledge and skills to “promote normal birth” (2007b) and this commitment to the “promotion of normal birth” is echoed by the Colleges of Midwives of Ontario (2008) and British Columbia (2008) and the Association of Ontario Midwives. The Midwives Association of British Columbia states that the “midwifery model of care offers you... Non-interventive care based on the most recent medical research available” (2007). The Alberta Association of Midwives states that “midwifery is grounded in the belief that having a baby is a natural life process and an opportunity for considerable growth” (2007). The themes of non-

intervention and birthing as a natural process are perhaps most clearly stated by the Midwives Alliance of North America:

A midwife-attended birth gives a woman a measure of control generally unavailable with a physician—the freedom to move, eat, bathe, or whatever else might help her labor and birth more confidently. The role of a midwife is to monitor labor, guiding and supporting the birthing woman safely through the birth process. For many women, care with a midwife allows them to birth their way, safely and naturally, supported by the people they love. Many studies show that midwifery care through labor and delivery lowers complication rates and reduces the likelihood of unnecessary cesarean section. (Midwives Alliance of North America, 2007a)

In addition, personal and popular accounts overwhelmingly describe the ideal birth as natural (which seems to be what it intended by expressed commitments to “the normal”). For example, a recent article in Canadian Living Magazine online offers “10 tips for a natural birth,” (2008) and many personal and advocacy websites assert the superiority of “natural” and/ or “organic” childbirth.

This view is taken to the extreme by the recent (predominantly American) trend toward unassisted childbirth, or “freebirth”. According to Laura Shanley, who is considered to be the foremost expert on the practice, “[unattended childbirth] made so much sense to me. Here is this thing that is insuring the continuation of the race, and it’s going to be fraught with peril. What kind of sense does that make?” (Maher, 2007:3). Shanley and other proponents of freebirth explain that childbirth has been transformed by the medical profession from a natural process into a disease, and that unassisted childbirth provides a way for women to reclaim their power (see Kelland, 2007). While it is important to acknowledge that this “trend” appeals to or affects a very small number of women in the US (current estimates are around 5,000 per year for North America (see Maher, 2007)), the underlying sentiment, that medical interference is inappropriate and

should be rejected when alternatives are available, is widespread. Many women who advocate for midwifery (such as Wolf) or free birth (such as Shanley; see also Bornfree! 2008) believe that medical intervention in pregnancy and childbirth *creates* complications (while it misleadingly claims to respond to or guard against them).

Both sets of claims (by midwives, who argue for the importance of reinstating woman-centered approaches to the natural and normal process of childbirth, and freebirthers, who suggest that through the instinctive direction of mind over matter, the birthing process can be self-controlled) seem to be philosophically oriented toward the ethical imperatives of biological determinism (see Sherwin, 1998; see Somerville, 2000). However, as Donna Haraway warns, “we must never again connect as parts to wholes, as marked beings incorporated into unmarked ones, as unitary and complimentary subjects serving the one Subject of monotheism and secular heresies. We must have agency – or agencies – without defended subjects” (1991:3). Yet many (privileged) women, critical of the medicalization of pregnancy and childbirth, through philosophical argument and political practice, try to do just that.

The debate between those who defend nature (Sherwin, 1998) and those who acknowledge the cyborgification of women (as well as men) is made problematic by the intersection of socio-economic status and race with understandings of “nature”. It is further complicated by the naïve assumption made by the defenders of nature that they can extract themselves (and others) from the technological, cultural and political dynamics of social domination. Sheryl Nestel’s examination of the re-emergence of midwifery in North America reveals that professional status was obtained by (mostly white) women through processes of racial and socio-economic domination. Prospective

Canadian midwives often traveled to birthing clinics on the US-Mexico border in order to gain practical experience in delivering babies. The parturient women who were attended by these midwives-in-training were poor, Mexican, Spanish-speaking women, whose status made them appropriate recipients of student care. However, Mexican women who had worked as midwives while living in Mexico did not have their experiences recognized when they immigrated to Canada. To the contrary, the same experiences gained by women of Mexican origin, practicing among the same populations, were not considered to be legitimate. Further, Mexican (and other foreign-born/ foreign-trained women) were required to pass difficult English language tests (which were routinely failed by native English speakers), as it was considered necessary that midwives could communicate easily with their clients. However, it was not considered necessary by Canadian regulating authorities that Canadian women were able to communicate effectively with Spanish-speaking birthing women in the bordertowns (Nestel, 2006:69-83).

Further, the culture of midwifery has simultaneously revered, appropriated, and devalued the myth of the primitive or Third World woman who is closer to nature. Nestel states that “Indigenous Latin American women have been awarded a particularly revered status in natural childbirth iconography... The theme is that women in the West have lost the innate ability to give birth naturally, while those in the Third World, frozen in time, have retained it” (2006:73). The fantasy of the natural, Third World woman is also a possible means for Western women to congeal their own identities or subjectivity, to search for and find a whole meaning, a consistent narrative, for their lives. Haraway posits that “the search for a ‘full’ and total position is the search for the fetishized perfect

subject of oppositional history, sometimes appearing in feminist theory as the essentialized Third World Woman” (1991:193). In addition, for bell hooks, subordinated women are accorded by dominant groups an exaggerated power or false agency, which diminishes evidence of disadvantage:

By projecting onto black women a mythical power and strength, white women both promote a false image of themselves as powerless, passive victims and deflect attention away from their aggressiveness, their power (however limited in a white supremacist, male-dominated state), their willingness to dominate and control others. These unacknowledged aspects of the social status of many white women prevent them from transcending racism and limit the scope of their understanding of women’s overall social status in the United States (2000: 15).

This total position, as identified by Haraway, appears, at a superficial level, more honest and powerful (hooks, 2000:15) than it actually is. Its legitimacy is further compromised by the fact that it is mostly white women who consume and provide midwives’ services. In part, this is due to the purposeful exclusion of women of color from the practice of midwifery (Nestel, 2006: 17-36). It is also due, it seems, to the different views of the self (relative to nature) and to differentially politicized personal and public spaces.

The role of midwives and traditional birth attendants in subordinate or subaltern cultures and societies is highly contested. Analyses are disparate, contradictory, as they are taken from a variety of literatures and contexts, and often do not come from the women who are the focus of the study.<sup>5</sup> For example, Patricia Jasen’s historical account of race and childbirth in Northern Canada reveals an enduring ambivalence between mythical or romanticized notions of “primitive” childbirth and the markers of disadvantage (see Jasen, 1997). Jasen explains that

Whether the differences among races were due to nature or culture was always a matter of debate among Europeans, but the notion that women in ‘savage lands’ were fundamentally different from European women

gained a wide following through the myth of painless childbirth. Eighteenth century naturalist comte de Buffon reported that the women of Africa 'bring forth their children with great ease, and require no assistance', and the same was frequently said of indigenous women elsewhere (Jasen, 1997:384).

The simultaneous reverence and dismissal of 'primitive' women as different from European women is well documented and central to post-colonial and critical analyses. It is also one of the products of the Enlightenment, as evidenced by the work of Jean-Jacques Rousseau. At the heart of the debate was the question of "how close other races might be to a state of nature, and whether that condition was an enviable one or not" (Jasen, 1997:386). For Rousseau, the 'natural' was enviable, and fundamental to freedom. Yet for others, such as John Locke and Immanuel Kant, the 'natural' was inferior, uneducated, uncivilized. And in contemporary feminist theory, this debate is reproduced through the countervailing arguments of Simone de Beauvoir (1952), Shulamith Firestone (1970), and Adrienne Rich (1986), who claim that women's essence (regardless of race) is not determined by nature, but by societal and material relations, and those such as Caroline Whitbeck (1972), Carol Gilligan (1993), and Sarah Ruddick (1995), who defend and explain the distinctness of women's biological character, especially in relation to their reproductive and mothering functions. It is further represented in debates concerning the degree to which medical/ cultural/ technological interventions are appropriate in pregnancy and childbirth, or whether the relatively "natural" condition procured by midwives and traditional birth attendants is an "enviable" one or not.

The myth of painless childbirth, as explained by Jasen, served and continues to serve at least three political purposes. First, it provides "evidence" for racial difference

that goes beyond mere skin colour to include more fundamental traits (see Appiah, 1996). Second, it declares this difference to be a marker of inferiority: “painful childbirth [was associated] with a higher level of human development, a belief that would become more pronounced under the influence of evolutionary theory (Jasen, 1997:388). And third, it declared as “natural” European women’s delicate constitutions and passive roles in pregnancy and childbirth. And while science seemed to confirm these propositions in the eighteenth and nineteenth centuries, advances in the twentieth century would turn them on their heads, leaving not complete reversal, but disruption and disorientation concerning women, nature and childbirth.

### **Subjectivity, Identity, and the Public/Private Dichotomy**

In an earlier section I made reference to Iris Marion Young’s influential article on pregnant embodiment. Young argues that obstetrics (in the US) alienates women from their experiences of pregnancy and childbirth. She argues that pregnancy “reveals a paradigm of bodily experience in which the transparent unity of self dissolves and the body attends positively to itself at the same time that it enacts its projects” (Young, 1984: 46). And while the first part of her argument implicates medical systems (of power, control, and knowledge) in the disembodiment and disempowerment of pregnant women, the second part of her argument implicates a very different source: the psychological event of split subjectivity. On this matter, Young quotes Julia Kristeva: “Pregnancy seems to be experienced as the radical ordeal of the splitting of the subject: redoubling up of the body, separation and coexistence of the self and an other, of nature and consciousness, of physiology and speech” (Kristeva in Young, 1984:48). Such a splitting

of the self is exemplified by Wolf, who states that “Although few women in the West actually die in childbirth today, we deny the many symbolic deaths a contemporary pregnant woman undergoes: from the end of her solitary selfhood to the eclipse of her psychologically carefree identity, to the transformation of her marriage, to the decline in her status as a professional or worker.” (Wolf, 2003:7). Throughout her book, Wolf describes her divided self during her pregnancy and subsequent motherhood. In a chapter entitled, “Losses,” she recalls visiting an elaborate playspace with a friend and her daughter. Upon entering the playspace, each mother and child pair were given nametags that identified the parent-child coupling as a unit. She reflects on this experience:

For perhaps the first time, I had an inkling of the radical loss of privacy that lay ahead. I remembered the new mothers who had told me, “I’m not able to go to the bathroom alone.” I realized that my identity was about to be cloven in two, my independence cut by half. It was the first time I could see it spelled out for me in all its sweetness and regret, in all its ambiguity (Wolf, 2003:60).

Iris Young tells similar stories of her split subjectivity, of walking through the stacks of books at the library, looking for a copy of the *Critique of Dialectical Reason*, while experiencing false contractions; of sitting with friends in a jazz bar, listening to the music while feeling the kicking of the fetus (Young, 1984:51). Young explains that “in attending to my pregnant body in such circumstances, I do not feel alienated from it, as in illness. I merely notice its borders and rumblings with interest, sometimes with pleasure, and this aesthetic does not divert me from my business” (1984:51).

The concept of split-subjectivity as advanced by Young has its modern roots in psychoanalytic theory, and is often attributed to feminist interpretations of Jacques Lacan (see Chodorow, 1978 and 1989; Mahoney and Yngvesson, 1992; Pizzato, 2003).

However, its genesis can be traced to the work of Rene Descartes, who revealed that the

subject recognizes and analyses itself, and thereby creates an internal-external (reflexive) duality (Strozier, 2002: 236). Split-subjectivity can be defined as the occupation of two or more psychic spaces, which compete with one another and shape (or frustrate) identity. In the example offered by Young, the self is divided into two co-existent identities: academic and mother. Naomi Wolf's experience at the playspace demonstrates the same duality: the identity of the individual woman competes with the identity of mother for recognition and agency. This view of split-subjectivity as competitive has also been applied to several other discussions, such as race and colonization (Bamiro, 1991), masculinity (Somerson, 2004), ethnographic research methodology (Wacquant, 2004), country music (Fox, 1993), and the requirements of citizenship and capitalism (Miller, 1993). Current research by Robin Root and C.H. Browner (2004), Mignolo and Tlostanova (2006), and Somerson (2004), have used the concept to delineate the negotiation of the duality. This entails examination of (both conceptual and political) "borderlands" (see also Weir 2006; Martínez 2004). For example, Root and Browner state that "...women negotiate diverse subjugated and authoritative knowledges to suit their individual needs and desires. We suggest that pregnancy is, above all, characterized by a split-subjectivity in which women straddle the authoritative and the subjugated, in telling and often strategic ways" (2001; 196). The negotiation of the contested space reveals "a broad spectrum between compliance and resistance" (197). Their research considers the ways in which women comply with and/ or resist prenatal (biomedical) norms. The women who participated in their study demonstrated contradictory cognitions and behaviors concerning prenatal care. As subjects and the subjugated, they experienced the liberating and regulating effects of the cultural norms of good

motherhood and good medicine (220). Moreover, they constructed knowledge from “expert” (external) and internal sources, and resisted the former in order to develop a “subjectivity that heeds its own self-determined rules” (217). Therefore, there is a double duality presented: one of internal – external or subject – subjected dialogue, and one of the pregnant woman and the fetus. According to the authors, “it is a split-subjectivity that serves to highlight the almost necessary co-habitation of the one (authoritative) with the other (subjugated) as each derives its status only in relation to the other” (217).

This duality is also demonstrated through the research of Deborah Lupton. First-time mothers in advanced industrialized countries, explains Lupton, experience a much sharper split-subjectivity than did their forbears. She states that “motherhood in western societies at the end of the twentieth century is a site of cultural and social contradictions and tensions. Over the past quarter-century, women with children have been encouraged to construct their identities increasingly through the public domain, including through paid labour. Yet they are still also expected to conform to ideals of ‘good motherhood’” (2000:50). Furthermore, and borrowing from psychoanalytic theory, she posits that “bodily boundaries may be experienced as more permeable and fluid for women who mother. It has been argued that at the psychodynamic level of identity women experience the self, or ‘ego boundaries’, as more diffuse and less differentiated than men because of the ways in which they are socialized from infancy” (60). The result of this duality is a “love/hate relationship of women with their infants” (50) (and presumably with themselves). Lupton concludes that the division of the (pregnant) self has intensified and is likely to continue to intensify as the pressures for the development of the autonomous self and the good mother increase (61).

My own research supports Lupton's findings. It also reinforces the understanding of the pregnant and/or mothering subject as doubly divided (internal – external dialogue and mother – fetus cohabitation). Consistent with arguments of Root and Browner, I have suggested that nature has been reclaimed as a resistance strategy, and as a means of negotiating split-subjectivity in developed countries and among privileged populations (although the embracing of medical technology (even when unnecessary) is an effective resistance strategy in developing countries and/or among vulnerable populations).

The ambivalence produced by these experiences of split subjectivity seems to be reproduced and amplified by the persistence of the public/ private distinction in North American societies. The continued expectation that women will serve different functions, perform different roles, assume different identities in private and public spheres, reinforces the division of the subject. Therefore, experiences in one sphere require that women are separated or alienated from fundamental experiences and characteristics that are the domain of the other sphere. As noted, the sharpness of the division between public and private spheres does not seem to be maintained to the same extent, or in the same form, in many developing countries. Women's lives, while limited in many other ways, seem not to be divided, split or "cleaved" into public and private obligations, opportunities or experiences. But in Western societies, like Canada and the United States, women's "emancipation" from lives of domestic servitude (with no political rights or independent social status) has been replaced by an impossible choice between two options: public or private fulfillment. One need only to look at the low numbers of women in senior positions in the workforce, absence of public daycare programs, rates of declining births and delayed age of pregnancies, and the countless

magazine articles and television talk shows that address the difficulty of balancing work and home life for evidence that women do not embody a unified subjectivity.

It seems to be possible, therefore, that feminist critiques of the medicalization of childbirth serve as political commentaries on, and sites of resistance to, the split subjectivity/ private-public dilemmas. Resistance to structural disadvantages for women is recoded as resistance to medical control over our lives, or to technological intervention in our most intimate and prized experiences. Economic, political and social systems are, in many respects, impossible targets, whereas the dominant medical “gaze” of obstetricians is more easily identified and connected to the feelings of loss of self, identity and control. Therefore, the impediment to agency and unified subjectivity in pregnancy and childbirth becomes medicine and not capitalism, liberalism or patriarchy. The feminist project is redirected – oppression, a common theme in feminist political theory, is reframed as “medicalization.” And with this reframing comes the substitution of narratives of cold, medical control with narratives of natural, traditional, woman-centered approaches to the elusive nature of the authenticity of motherhood.

As explained in a previous section, Third World women’s experiences with traditional or natural birthing practices have been appropriated and romanticized by first world women, often to the detriment of the subaltern women. Sheryl Nestel claims that “conceptually, images of Third World women have served to define middle-class white women’s midwifery identities through both negative comparison and fantasized idealization” (Nestel, 2006:17-18). The Canadian Association of Midwives states that “*We believe* in a primary care model of midwifery that is community-based and collaborative. This model is founded upon principles of woman-centred care, informed

choice, continuity of care and choice of birth place. We recognize and value the richness of diversity that is inherent in women, the community, and the midwives who serve them.” (2007). Further, it is worth recognizing that “fantasized idealization” and commitments to “woman-centred care” are selective and not universal. Laura Purdy notes that abortion has been spared from feminist critiques of medical intrusiveness in areas that were previously the exclusive domain of women. She asks: Suppose we rejected the paradigm of medicalization for abortion? Over time, women have developed various folk methods of aborting themselves, and perhaps those methods should be revisited” (Purdy, 2001:256).

Of course, this seems to be an absurd proposition, although it might be worth asking why abortion is treated as distinct from other reproductive rights (such as those associated with pregnancy/ childbirth and new reproductive technologies) in medicalization debates. Part of the reason would no doubt relate to the centrality of pregnancy and childbirth in women’s lives, and to their deep and enduring significance. It is precisely this significance that is implicated in the problematic dualities of split subjectivity and private/public existences examined above. The political dimensions of women’s lives are investigated, questioned and resisted in their experiences in pregnancy and childbirth. And while maternal health might not be at stake in privileged populations, identity and agency (as the power to exert control over directing that identity) clearly are.

But this analysis only addresses one part of the observed trend in pregnancy and childbirth – reverence for “the natural”. What about the countervailing trend, the increased medicalization of these events through ART and elective C-sections? Further

analysis of the latter is beyond the scope of this paper and deserves full consideration elsewhere. However, it is possible that in addition to pregnancy and childbirth as a site of resistance for women, it is also a site for the construction of identity. As such, natural childbirth, exclusive breastfeeding, ARTs, and elective C-sections form a range of reproductive choices, the extremes of which are sought as cultural markers of one's place in society. One extreme affirms the natural events of pregnancy, childbirth and motherhood, and the other allows for greater control over the birthing process, which can be painful, risky, and unpredictable, and thereby affirms the narratives of choice, control and the defiance of other natural events (infertility, labour complications). The one extreme reveres the birthing mother as a force of nature, whereas the other provides elevated status to a woman for the degree of control that she can exercise over her own body. Both extremes are socially constructed as simultaneously empowering and oppressive. And they are decidedly oppositional – they do not seem, in either feminist analysis or practice, to coexist happily as possible choices for pregnant and parturient women. Interestingly, this debate might also shed light on the importance of an individual or group's relative position in the medico-cultural context. In a press release addressing the trend toward elective cesarean sections, the Society of Obstetricians and Gynecologists of Canada (SOGC) stated the following: "The Society is concerned that a natural process would be transformed into a surgical process... The SOGC will continue to promote natural childbirth and make strong representation to have adequate resources available for women in labor and during childbirth in Canada" (cited in Michael C. Klein, 2004:161). This statement confirms nature as a contested political space. As such, it

provides further evidence that women are continuously renegotiating their cultural position, in this instance by reclaiming, redefining and, in some cases, rejecting nature.

### **Conclusion**

The differences in treatment of women subjects in pregnancy and childbirth require greater attention to the intersectionality of disadvantage among vulnerable populations and the fragile dimensions of identity among privileged populations. Such an investigation will help to clarify the value and limitations of medicalization critiques and shed light on the political dynamics of pregnancy and childbirth in various contexts. Because body politics are different in Canada, the United States, Haiti, Bolivia and Benin, the applicability of medicalization discourse is highly variable. But such variability is problematic for feminist theory that claims to be not only universal, but integrative of women's experiences. The fantasy of Third World women's natural experiences of childbirth has become iconic among first world women, even if these experiences are more imagined than real. This creates multiple opportunities for exploitation, as the experiences of Third World women are used as a means for first world women to acquire knowledge, experience and perspective on 'natural' or 'traditional' birthing practices (see Nestel, 2006), while denying the importance of medical services that privileged women take for granted.

It is also important to consider the reasons why medicalization resonates more strongly in privileged populations than in disadvantaged ones, when the latter are much more vulnerable to dominant institutions (like medicine). As explained in the preceding section, the sharpness of the public/ private distinction in North American societies seems

to intensify the split subjectivity of pregnancy, childbirth and motherhood. Resistance to this phenomenon creates reverence for the natural and the traditional; at the very least it demands the restoration of a focus on caring. Iris Marion Young concludes that “the alienation experienced by the pregnant and birthing woman would probably be lessened if caring were distinguished from curing, and took on a practical value that did not subordinate to curing” (1984:59). Such is the approach taken by midwives in distinguishing themselves from obstetricians, which seems, in many respects, eminently sensible. However, such arguments need further examination in privileged populations in North America (and elsewhere), as well as in vulnerable populations in both developed and developing countries, where feminist care ethics tend to be cultural imperatives, most often in the absence of advanced medical services.

## Notes

<sup>1</sup> It should be noted that it is possible that women are choosing the services of midwives with greater frequency precisely because midwifery has been recognized as a legitimate health profession in many provinces and is regulated by provincial governments. Therefore, midwives’ services are not necessarily institutionally distinct from medical services, and might be conceptually and practically positioned as part of a range of medical services. However, it does appear that these services are offered, and embraced, as fundamentally different options, which are purported to be more “natural” and/ or “normal” than their medical counterparts.

<sup>2</sup> As a region, Latin America and the Caribbean has lower maternal mortality rates than Africa and Asia. The global average maternal mortality rate is 400 per 100 000 live births (UN Millennium Project, 2005: 79).

<sup>3</sup> In this article, I use the terms “medical intervention” and “medical care” interchangeably to indicate the provision of care or services by medical doctors (general practitioners and obstetricians). In the literature, the only difference in the use of the terms is that the former, “medical intervention” seems to be used pejoratively, and as such tends to imply *unnecessary* medical surveillance or procedures.

<sup>4</sup> See CIHI 2004: 12. This document provides evidence of the increase in number of births attended by midwives. To be explained subsequently in this article, midwives’ associations in Canada describe their approach to pregnancy and childbirth as “natural,” “normal,” and “woman-centred.” See also Newnham 2006; and Gunn et al 2006.

<sup>5</sup> One notable exception is the recently completed documentation of Inuit midwifery and birthing practices. Pauktuutit, an organization representing Inuit women of Canada, has produced a database of “seventy-seven historical interviews, describing 516 births, conducted in the early 1990s with Inuit about their birthing experiences over the last several generations” (Pauktuutit Media Advisory, October 16, 2006, [http://www.pauktuutit.ca/pdf/MediaRelease-16Oct2006\\_e.pdf](http://www.pauktuutit.ca/pdf/MediaRelease-16Oct2006_e.pdf) Site visited May 18, 2007).

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