Introduction
Pushing for Midwives

Homebirth Mothers and the Reproductive Rights Movement

> Access to professional midwifery care is a basic reproductive right that women in the United States have long been denied. Today American midwives are growing in numbers and in organizational and legal strength. Their excellent outcomes and women's high levels of satisfaction with their care are placing increasing pressure on the health care system to more fully incorporate them, but the battle to make midwifery care readily available to all women is far from won. [Certified nurse midwives] around the country all too often find themselves pushed out of practice by physicians seeking to eliminate the competition, and [direct-entry midwives] are still fighting in many states for the right to practice legally and under regulations that do not erode their autonomy. It is to be hoped that . . . American women will be able to reclaim their basic reproductive right to midwifery care.
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> —Deborah Cordero Fiedler and Robbie Davis-Floyd, "Midwifery as a Reproductive Right"

In 2008, the Big Push for Midwives launched a nationally coordinated campaign to gain legal access to certified professional midwives (CPMs), a national certification for direct-entry midwives (DEMs) who are independent birthcare practitioners and the primary attendants of homebirth in the United States.[1] Organized primarily by homebirth mothers, the Big Push advocates "women['s] right to choose their maternity care providers and birth settings."[2] A second national effort aimed at gaining federal recognition of CPMs was spearheaded in 2009 by the Midwives and Mothers in Action (MAMA) Campaign, a collaborative effort by several professional organizations for midwives and "consumer" groups supporting midwives.[3] Both of these campaigns have

drawn nationwide public attention to the recent efforts aimed at expanding women's reproductive rights to include access to midwifery care.

This intensified "push" is the continuation of growing support for access to midwives across the nation since the 1970s that has paralleled (but in some cases been at odds with) the broader reproductive rights movement. Many midwifery supporters have initially been hesitant to describe their struggle as one for reproductive rights because of associations with feminist efforts for women's choice regarding abortion and contraception. Yet midwifery organizers—including those who identify as pro-choice *and* pro-life—have adopted the language of "rights" and "choice" to describe the importance of expanding women's maternity care options. Recent scholarly and popular books have described midwifery as "a global feminist issue"[4] and have positioned the right to birth where and with whom one chooses as a "basic reproductive right."[5] Over the past decade, organizers have also begun to cast access to midwifery as a "consumer rights" issue—one in which a woman's "right to choose" has been restricted by ill-informed public policies concerning midwives and homebirth. Although, as of this writing in 2010, DEMs are legally authorized to practice in approximately half of the United States—owing largely to the successful state-by-state grassroots organizing efforts of homebirth mothers to legalize their practice—struggles for access to midwives continue throughout the country.[6]

It was as this movement was gaining steam in the late 1990s that I began to study and participate in efforts to increase access to midwives in Virginia—where performing midwifery services had been restricted to certified nurse-midwives (CNMs), and those who had been previously permitted, since 1976.[7] Although some CNMs offer homebirth and birth center care in Virginia, since they require "physician supervision" to practice, most currently practice in hospitals.[8] Beginning in the 1990s, homebirth mothers and other midwifery supporters worked for eight years to gain access to midwives who would—and could legally—attend their homebirths. They were finally successful when Virginia lawmakers voted to license and regulate nationally recognized CPMs in 2005 and to loosen restrictions on CNMs in 2006. These local victories in Virginia have also proved valuable on the national scene. Many organizers in other states have sought advice and support from Virginia midwives and their supporters as they now embark on efforts to gain legal access to midwives in their own state legislatures and in national efforts for federal recognition of CPMs.[9]

In this historical moment, when the growing demand for midwives is coalescing into successful lobbying efforts to loosen restrictions on their ability to provide homebirths throughout the United States, it is crucial for activists and scholars to reflect on these struggles for "access to midwifery care for all women" (as the Midwives Alliance of North America advocates[10]) in light of

the uneven access women have—and have historically had—to reproductive healthcare. Anthropologists Faye Ginsburg and Rayna Rapp have called this differential access to reproductive services "stratified reproduction"—the power relations that empower some women to nurture and reproduce but disempower and constrain others.[11] Using this framework to address struggles for reproductive rights—both historically and presently—it becomes evident that despite the best efforts of activists, reproductive healthcare reforms have not always succeeded in ameliorating uneven access to reproductive technologies and services, even when enhancing access to reproductive options for *all* women has been the stated goal of activist efforts. In this context, it is important for both activists and scholars to ask the following questions: How is the increasing commodification of maternity care in the United States affecting women's efforts to secure access to midwives? Are all women ultimately benefiting from the enhanced market of reproductive services emerging in the twenty-first century, including midwifery services? What are the possibilities and the limitations of the increasingly popular strategy of advocating for women's "consumer rights" to access midwives and, more broadly, reproductive rights?

Feminist scholars have a particularly important role to play in answering these questions. In fact, feminist social scientists in the natural childbirth movement during the 1960s and 1970s were among the first to offer important critiques of medicalized childbirth, and, as religious studies scholar and homebirth mother Pamela Klassen has explained, to encourage "women to challenge the system through exercising their *consumer power* . . . to turn from obstetricians and hospital birth to midwives and homebirth."[12] Yet while "consumer power" often resonates with middle-class and affluent homebirthers, it has been less applicable to the low-income families seeking midwifery care, who frequently have far fewer "choices" in their reproductive healthcare. While many feminist social scientists—including myself—actively support midwives and women's right to homebirth, we must also consider ways in which our rhetoric of consumer choice, particularly in the context of recent political and economic shifts, may have unintended negative consequences for the very women our strategic suggestions have sought to liberate.

Reproductive Rights as "Consumer Rights"

In the 1960s and 1970s, feminists in the women's health movement adopted the familiar slogan "a woman's right to choose" to demand reproductive rights in North America and throughout the world. This push to characterize reproductive healthcare options in terms of choice and rights is important to contextualize. As historian Rickie Solinger has emphasized in her extensive work on reproductive politics in the United States, the rights language and claims

to rights that emerged in the 1960s—particularly within the civil rights movement and feminist organizing of the time—fundamentally reshaped both American politics and culture.[13] Reproductive rights and struggles for "choice" became central to both of these movements, albeit not always for the same reasons. First, reproductive rights posed a dual threat to the status quo: access to abortion and contraception challenged male authority over women's reproductive capacity, and the right to be free of coerced sterilization and contraception, which had disproportionately affected women of color and poor women in the United States during the early 1900s, contested eugenic notions of white supremacy.[14] Solinger has argued, however, that the almost exclusive focus on women's "right to choose" that emerged within the feminist movement during this time became problematic for efforts to grant reproductive rights to *all* women, because the idea of choice was "intimately connected to the possession of resources. Many Americans . . . developed faith in the idea that women who exercise choice are supposed to be legitimate consumers, women with money."[15] The assumed access to the marketplace of reproductive options that this push for "choice" implied did not take into account the constraints that have historically and presently restricted the reproductive decisions of poor women and women of color. Although the civil rights movement had also sought legislation to guarantee "consumer choice" for African Americans[16]—who had long been denied access to goods and services or forced to seek them in segregated, often substandard, facilities—for many minority women, feminist struggles for the "right to choose" abortion smacked of the racism in previous population-control strategies that had been used to constrain reproduction for women of color and poor women.

Thus recent efforts spearheaded by women of color have criticized the singular focus of feminist organizing for abortion rights in the 1960s and 1970s and called instead for "reproductive justice." This term has been used instead of (and sometimes in addition to) "reproductive rights" to address access to quality, noncoercive reproductive healthcare for all women, especially as they are constrained by "the nexus of systems of oppression based on gender, race, class, sexuality, ability, age and immigration status."[17] Yet although the "choice paradigm" of reproductive rights activism has received much critical attention in recent years, it has remained central to many feminist organizing efforts into the twenty-first century.[18]

By the 1970s, even organizers in the natural childbirth movement—a movement that prided itself on attracting those who identified as both pro-choice *and* pro-life—had begun to envision nonmedicalized childbirth as an important aspect of women's right to choose. Many adopted the term "consumer" as what they felt was an empowering term and a calculated alternative

to paternalistic characterizations of the (female) patient and (male) doctor. As sociologist and longtime midwifery supporter Barbara Katz Rothman explains, "A 'consumer,' believe it or not, was a role with more dignity, more power, than that of 'patient.' . . . In a capitalist system, in a fully consumerist world, consumption and the language of consumers is what comes to hand."[19] Similarly, in a collection of studies entitled *Consuming Motherhood,* the authors vividly demonstrate how motherhood and consumption were thoroughly enmeshed in North American social life by the turn of the twenty-first century.[20] From the decisions that parents must make to have or adopt children to the commodification of maternity and childrearing practices to the commercial relationships between parents and childbirth practitioners, the "consequences of capitalism for motherhood" have become deeply ingrained in women's experience of childbirth and mothering.[21]

In the case of North American midwifery, for example, Robbie Davis-Floyd, who has described herself as an "anthropological activist who supports all sides of this midwifery story,"[22] argues that midwives engage in a form of "qualified commodification," through which they position themselves as valuable healthcare commodities to "sell" midwifery to legislators, nursing and medical societies, and regulatory boards: "Appropriating the notion of women as agentic consumers of maternity care (an image they [women] helped create), midwives have added themselves to the list of birthcare options from which women can now choose."[23] As Davis-Floyd suggests, mothers now frequently rely on their identities as consumers of maternity care in their struggle to convince legislators and medical officials that they should have the right to choose midwifery care.

In a discussion of how scholars should refer to women who seek midwifery care, anthropologist Margaret MacDonald explains further:

> The term "midwifery consumer" is not to be discarded entirely. . . . It implies a certain agency and choice on the part of women having midwifery care that has always been important to midwifery. Indeed, the consumer-based campaign for choices in childbirth was a key factor that fueled midwifery as a social movement over the last several decades. The idea of the midwifery consumer, however, is not simply a result of the self-conscious feminist agenda of woman-centered care and the critique of biomedicine. It also speaks to the political economy of reproduction within the context of late capitalism and demographic transition, specifically, the trend towards having fewer children later in life and the trend towards treating pregnancy and childbirth as valuable experiences.[24]

In fact, many scholars studying midwifery have also begun to identify themselves as "midwifery consumers" in their efforts to document the important role that women who seek midwives play in legislative efforts to support them.[25]

Yet as Klassen found in her study of religion and homebirth, women who live in the capitalist economy of North America accept the idea of maternity care as a commodity only with "considerable ambivalence."[26] Feminist homebirthers in Klassen's study, for example, resisted metaphors of consumption through religious-based criticisms of the "business of birth." Although many homebirth mothers reject the label "feminist" to describe their support of midwives (in contrast to the many feminist scholars studying midwifery), many express similar critiques of the "business of birth" and instead highlight the importance of the strong emotional bonds they have shared with their midwives and the way that hiring an independent midwife can contest the more dominant medicalized consumerism around childbirth.

Thus it becomes clear that midwifery advocates have a complicated relationship to their identity as consumers. For some homebirth mothers, the act of consumption has offered a way to perform "good" American motherhood, despite their unconventional choice of birth outside the hospital. By highlighting the educated choices they make within the market of reproductive healthcare, middle-class homebirthers are able to align themselves with core American values surrounding consumption. Of course, which practices and values constitute respectable motherhood shift over time, but what links activism for midwives to other historical struggles for reproductive healthcare over the past two hundred years is that in each effort organizers have sought to define participants as good American mothers, and this definition has mirrored the other political and economic concerns of the day. Over the course of the twentieth century, consumer identity became increasingly central to American identity, and thus to activist efforts for social change.

Consumer identity has also offered what many minority organizers have seen as a palatable, perhaps even "neutral," identification (as opposed to, say, feminist activism or reproductive rights) to unify religiously and politically diverse women to support legislative efforts. Yet the focus on "consumer rights" is also intensifying the tensions that reproductive rights advocates have felt historically in the United States—between fighting for individual freedoms (such as a woman's "right to choose") and struggling to increase the availability and accessibility of reproductive healthcare services for all women, particularly those who have historically lacked such access in low-income communities.[27] In this way, the focus on consumption and women's ability to function as consumers has become at odds with broader efforts toward reproductive justice. For low-income women, the notion of claiming "consumers' rights" to hire midwives reveals the significance of socioeconomic divisions within contemporary

struggles for reproductive rights. To better understand these contemporary rifts, it is useful to begin with a discussion of historical efforts to enhance reproductive healthcare and their effects on inequities among women.

Revisiting the History of Reproductive Healthcare Struggles

Women have figured prominently in social and political debates over reproductive healthcare in the United States since the 1800s, when they joined the struggle to maintain access to female practitioners through the popular health movement. Women have also engaged in debates over access to fertility control (both for and against legal contraception and abortion) since the late 1800s. And female reformers led a variety of efforts aimed at improving maternal and infant health throughout the twentieth century. These historical movements have played an important role in reforming U.S. healthcare policy, particularly through the promotion of legislation to improve reproductive healthcare for women.[28] Yet far from being a unified "megamovement," as some women's health scholars have claimed,[29] these efforts were most often localized in particular areas and among particular groups of women. Thus despite shared concerns about reproductive healthcare and access to it for *all* women among many activists, these reforms frequently had uneven outcomes for different constituencies of women, based on location as well as on racialized and socioeconomic divisions.

For example, women's activism for the Sheppard-Towner Maternal and Infancy Protection Act in 1921, which led to the nation's first social welfare policy that directed public funds toward prenatal programs, was spearheaded in large part by northern, white, middle-class and affluent feminists. This effort was linked to women's rights groups' parallel struggle to secure their right to vote (which was successful in 1920). For these women, the act was a widely celebrated success for its improvements to maternal and infant health services in hospitals. For African American women, however, the act did not alter segregationist policies, which relegated their care to substandard wards and denied them access to medical care altogether in many hospitals. The act also led to increased state scrutiny into the childbirth practices of African American women and poor women of all backgrounds—particularly their use of community-based midwives. This increased surveillance generated policies that largely eliminated African American and immigrant midwives by the mid-1900s. Thus while historical policy shifts have frequently enhanced reproductive options for white, middle-class and affluent women, they have often been less successful for women of color and for poor women.

These decidedly unequal experiences have shaped women's concerns about reproduction in distinctive ways and initiated different—and at times contradictory—strategies in efforts to improve reproductive healthcare. In the case of contemporary midwives in the United States and women's efforts to support them, some scholars have expressed concern about "the almost reflexive link" that both activists and scholars have tended to draw between the struggles of African American midwives in the early 1900s and contemporary efforts to increase access to midwifery services.[30] In such accounts—which depict a history of "sisters in struggle" culminating in the "rebirth," "return," "revival," or "reclamation" of midwives—there is often scant attention to how women from different race and class backgrounds have experienced reproductive healthcare or the effects of activists' efforts to "improve" it.[31] As anthropologist Gertrude Fraser's research on the history of African American midwifery in the South makes clear, struggles for "natural childbirth" in the 1960s and 1970s made midwives available only to "low-risk," educated, primarily white women with insurance or the money to pay for their services out of pocket.[32] In contrast, women of color and poor women in the United States (and increasingly middle-class women without insurance) have continued to struggle for access to quality reproductive healthcare both in and out of the hospital.

This book marks a critical departure from romantic ideas about a seamless history of "sisters in struggle" for women's reproductive rights and access to midwives.[33] Instead, the history presented in the first few chapters of this book takes a new starting point: women's role as reproductive healthcare activists (rather than the well-documented history of midwives during the twentieth century). This allows for an important discussion of the historical divisions that have troubled reproductive healthcare movements in the United States—which have frequently centered on racial and socioeconomic tensions. Just as anthropologist Sandra Morgen has argued, "The legacy of racism [and, I would add, classism] within the reproductive and women's health movements remains, but it is contested and there are other voices. Moreover, predominately white [middle-class] women's health organizations have been challenged to better address the[se] injustices."[34] Indeed, it was the work of women of color, active in the reproductive rights movement during the late 1970s and 1980s, that led to the transformation of feminist efforts beyond a narrowly focused pro-choice campaign to one that encompassed a broader commitment to reproductive freedom.[35] This book aims to amplify and add to these critical voices to encourage further reflection on organizing strategies that are proving detrimental to cross-class organizing efforts in the twenty-first century.

The Current Context: The "Consumer Rights" Era

Choreographed against this broader history of reproductive healthcare activism, shifts in U.S public policy over the past few decades became central to the discussion of reproductive rights struggles at the turn of the twenty-first century. The ideology behind such policy changes has been called *neoliberalism*, a political philosophy that rests on the idea that shifting away from government responsibility for ensuring personal liberties toward a "free," or unregulated, market will ultimately resolve social inequities. Although scholars have rightly cautioned against the over-application of this term in recent scholarship—as an easy scapegoat to blame for all contemporary social and political ills—I draw on it here as one influential piece of the history that has participated in shaping contemporary activist strategies. Despite its influence, however, it is notable that neoliberalism is not a term familiar to many U.S. activists, and thus it is important to outline here in some detail.[36]

Scholars and political analysts have referred to recent political shifts as *neo*liberalism because they reembrace tenets from "classical liberalism," a political philosophy that dates to the seventeenth century, which stressed personal freedoms and limited government. Neoliberalism pushes liberalism's faith in the "free market" further by stressing the government's role in promoting market-based policies that favor the *privatization* of formerly public resources (by transferring ownership from the government to private companies) and the *deregulation* of economic markets (where governments reduce or remove restrictions on businesses with the intent of raising the level of corporate competitiveness to promote higher productivity and efficiency). Thus the state's role has moved beyond protecting the freedoms of individual citizens to safeguarding the ability of corporate entities to compete within the market. The notion of what freedom means in the context of citizenship has also changed.[37] Although neoliberalism still promises citizens "freedom," it is defined almost entirely by their ability to participate in financial markets.

It is important to make clear, however, that neoliberalism was not initially the political project of liberal Democrats in the United States, as its name might first suggest. In fact, neoliberalism emerged in the 1980s as a *conservative* reaction to the welfare state in order to reduce what Republicans saw as "government handouts." In the 1990s, many Democrats joined Republicans in adopting a more market-based policy perspective to appear more moderate around issues such as welfare reform. Ultimately, neoliberalism's focus on consumerism and the government's role in encouraging "free markets" can be seen in the economic ideologies and government policies implemented by politicians

from across the political spectrum.[38] Accordingly, during the 1980s and 1990s and into the twenty-first century, legislators have elected to cut formerly public services and social programs (such as Medicaid and welfare) in favor of privatization and deregulation.

What critics have called the "magic of the market," which has captivated such a broad range of politicians throughout the world over the past few decades, is that proponents of neoliberalism consider the "free," deregulated market to be a neutral, fair, and even "beneficent" way of determining citizens' access to resources.[39] Yet what the "liberalized" market and the celebration of individual consumption have meant in the lives of many citizens is that their access to services has become based on their ability to pay for the resources that are available.[40] Not surprisingly, this outcome has had the most detrimental effects on the poor, including a marked increase in the imprisonment of impoverished people in the past few decades as increased government surveillance and unequal punishments (which have also disproportionately affected people of color) have taken the place of welfare and other social service programs.[41] Particularly relevant to discussions of mothering and reproductive healthcare, the incarceration of women—most of whom are mothers of young children and many of whom are pregnant—has also been on the rise, increasing sevenfold since 1980.[42]

Even more broadly, as social theorist David Harvey reminds us in *A Brief History of Neoliberalism*, this political philosophy has come to predominate *all* of our lives:

> The advocates of the neoliberal way now occupy positions of considerable influence in education (the universities and many "think tanks"), in the media, in corporate boardrooms and financial institutions, in key state institutions (treasury departments, the central banks), and also in those international institutions such as the International Monetary Fund (IMF), the World Bank, and the World Trade Organization (WTO) that regulate global finance and trade. Neoliberalism has, in short, become hegemonic as a mode of discourse. It has pervasive effects on ways of thought to the point where it has become incorporated into the common-sense way many of us interpret, live in, and understand the world.[43]

In this way, it is not surprising that the valorization of consumption within political and economic institutions seeped into the language of reproductive healthcare activists in the late twentieth century. As philosopher and social theorist Michel Foucault reminds us, ideologies that discipline our beliefs and behaviors most effectively not only emerge from the powers above (such

as medical institutions or the government) but are ideologies that we internalize ourselves and begin to expect of—and even police within—others.[44]

Yet neoliberalism cannot be seen as a complete or totalizing process—it has limits, fractures, and fissures, in part because it has been as much a social and political process as an economic one.[45] Rather, as anthropologists Catherine Kingfisher and Jeff Maskovsky argue, neoliberalism must be understood as "a set of cultural meanings and practices related to the constitution of personhood, markets, and the state that are emergent in a contested cultural field."[46] In midwifery advocacy, the shifting cultural expectations associated with American motherhood in the twenty-first century and the practice of adopting a consumer identity to advance political efforts for midwives must be placed within the complicated racialized and class-stratified history of reproductive healthcare activism and resulting policy shifts. Indeed, the inequities that these new developments have intensified are not new. In fact, they map quite neatly onto the race- and class-based divisions in access to (and activism for) reproductive healthcare that appear throughout U.S. history.

The neoliberal understanding of citizen rights as "consumer rights" has created a particularly troublesome paradox for contemporary reproductive rights activists—especially those who envision their struggle as one to guarantee reproductive rights for *all* women. The idea of "choice" that served as a central ethical framework for feminism in the 1960s and 1970s has become increasingly problematic, as it has merged with the neoliberal promotion of consumer identity that emerged during the 1980s and 1990s.[47] While contemporary organizers have found that arguing for "consumer rights" frequently plays well with politicians across the political spectrum, the intensified concern with consumer rights, as opposed to "women's rights" or "citizen rights," highlights—often inadvertently—the inequities between middle-class and wealthy homebirthers (who can lobby legislators as educated, savvy "consumers" of reproductive services) and low-income homebirthers (who lack access to many of the reproductive choices available to their more affluent counterparts). My interviews with low-income homebirthers indicate that this strategy is ultimately leading to contentious divisions among midwifery supporters. Yet these disparities have the potential of being overlooked by organizers from largely middle-class backgrounds who conceive of their efforts to support midwives as benefiting all women equally. As sociologist Sheryl Nestel has critically explored in her study of race and midwifery in Canada, however, "unexamined notions of 'global sisterhood' actually reproduce unequal relations of power between women."[48]

"Access to Midwifery Care for All Women": Virginia and Beyond

The legal status of DEMs, who train directly as midwives and specialize in out-of-hospital birth, has fluctuated dramatically from state to state in recent years, in part as a result of successful legislative efforts by midwifery supporters. At the time of publication in 2010, DEMs are legally authorized to practice in twenty-seven states, including Virginia.[49] Although CNMs, who practice primarily in hospitals, have legal status in all fifty states and in the District of Columbia, their practices are often restricted by legislation that requires physician supervision and limits prescriptive authority.

Perhaps because the particular goals and legal concerns of midwives and their supporters vary so widely across North America, no single "official" name has been adopted for this contemporary movement, though its national significance is evident in the emergence of national Listservs, online social networking groups, and organizations, such as the Big Push for Midwives and the MAMA Campaign, devoted to the support of midwives. Although some organizers have characterized these struggles as part of the alternative childbirth movement emerging from the natural childbirth movement of the 1960s and 1970s, the midwifery movement, and the homebirth movement, no single name seems to have stuck. Another complicating factor is that many midwifery supporters do not see themselves, or their participation in support of midwives, as explicitly political (discussed in further detail in Chapter 5). Nevertheless, there is a sense of solidarity among many midwifery supporters in their struggle to secure nationwide healthcare policies that support women's access to midwifery care.

Virginia is a particularly useful starting point for exploring this national effort because of the socioeconomic diversity evident among homebirth mothers who engaged in efforts to legalize DEMs. Although low-income women in other states also seek out homebirth midwives, little has been written about the challenges of unifying socioeconomically diverse women in contemporary efforts to support midwives. In the wake of the neoliberal policy shifts discussed earlier, the socioeconomic diversity of contemporary homebirthers poses new challenges for midwifery organizers, particularly as they struggle to unify women who also come from across the political spectrum and from diverse religious backgrounds.[50]

In Virginia, midwifery organizers began this work in 1999, when they launched a successful campaign for a study of DEMs by Virginia's Joint Commission on Health Care. After lawmakers advised legalizing DEMs who had obtained the certified professional midwife credential, midwifery advocates lobbied for pro-midwifery legislation every year from 1999 to 2005. In 2003,

legislators struck down Virginia's 1976 statute prohibiting the practice of midwifery by those who were not licensed as nurse-midwives (or who held permits prior to that time). This change meant that DEMs could no longer be charged with the misdemeanor of "practicing midwifery without a license"—though they remained vulnerable to possible felony charges for "practicing medicine without a license" or "practicing nurse-midwifery without a license."

Fortunately, no midwives were charged before lawmakers passed a bill to license nationally recognized CPMs as independent professionals (able to practice without physician supervision) in 2005. Legislation in 2006 also reduced physician supervision requirements for CNMs (but did not altogether remove them, as I discuss further in the Epilogue). After these successes, Virginia served as a model for struggles to support midwives in other states. Thus it is an important time to reflect on not only Virginia's successful legislation but also the effects of organizing strategies that can prove divisive in current and future efforts to draw together women from diverse socioeconomic backgrounds in the support of midwives.

I want to be very clear, however, that my goal in encouraging this reflection is *not* to detract from efforts to support midwives. Throughout my research, I have engaged in struggles to support midwives at every step and identify myself as a strong advocate of midwives—both politically and personally. Thus I am keenly aware of the difficulty midwifery advocates face when considering ways that current strategies might undermine their own efforts to ensure access to midwives for all women. As historian of Canadian midwifery Lesley Biggs has written in a similar reflection on this conundrum, "Many midwifery advocates and supporters position themselves as 'progressives' and understand the struggle for midwifery to be part of the larger feminist health agenda, presumed to be beneficial to all women."[51] Although this standpoint understandably hampers criticisms that question the practical application of this goal, I hope that this book will encourage scholars of reproductive rights, as well as activists struggling for midwives throughout the United States, to engage in critical dialogue about the possibilities as well as the "costs" of envisioning access to reproductive options as a competition for consumer rights.

From Ethnography to Interdisciplinary Activist Scholarship

Ethnography, the descriptive study of human groups, has long been touted as the foundation of cultural anthropology.[52] Although my academic training is in anthropology, my introduction to ethnography came amid what some have called an "interdisciplinary phenomenon," where research methods involving

extended fieldwork, including in-depth interviewing and participant-observation, had become common throughout the social sciences.[53] Most influential to me were the feminist discussions that emerged from a variety of disciplines during the 1980s and 1990s that began to consider what *feminist* ethnography might look like—as a research method but also as a style of writing and application of research concerned with ending injustices and inequalities for women and other vulnerable groups. As an important caution, sociologist Judith Stacey's influential critique "Can There Be a Feminist Ethnography?" questioned whether "the appearance of greater respect for and equality with research subjects" in feminist ethnography could ultimately mask the potential for deeper forms of exploitation.[54] In a second article published (inadvertently) under the same title as Stacey's, anthropologist Lila Abu-Lughod suggested that feminist ethnographers contribute to research on inequality by critically examining ways in which women from privileged backgrounds often contribute to the oppression of more marginalized women by universalizing and romanticizing a shared "women's experience."[55] This concern is particularly relevant to research on and activism within struggles that draw together diverse groups of women. While the relationship between ethnographer and participants in research is always uneven, this tension is heightened when participants have experiences that differ substantially from one another, and thus in many cases from the ethnographer.

As one possibility for mediating the unavoidably imbalanced nature of fieldwork—where various participants often give much of their time and knowledge for little reward—many feminists have envisioned research as inseparable from feminist practice.[56] It is at this point that feminist ethnography goes beyond the scope of applying particular research methods. As anthropologist Faye Harrison explains:

> Methods are specific procedures, operations, or techniques for identifying and collecting the evidence necessary to answer research questions. In and of themselves, they are not feminist or non-feminist. Therefore, there are no "feminist methods" per se. However, there are "feminist methodologies," because methodologies articulate conceptual, theoretical, and ethical perspectives on the whats, whys and hows of research and the production of knowledge. . . . A feminist methodology clues us in on which combination of methods is likely to be most suitable for meeting the pragmatic and ethical objectives of a feminist research project.[57]

A core value of feminist ethnography is to produce research that is meaningful and useful to participants, often by contributing to efforts to combat the

injustices they face. This goal has emerged alongside similar work in the growing field of activist scholarship. Several recent publications have called for a more engaged, public, and activist orientation within the social sciences.[58] In *Engaged Observer*, for instance, anthropologist Victoria Sanford describes the importance of making scholarship relevant to the people we study: "Activist scholarship reminds us all that research is inherently political—even, and perhaps especially, that scholarship presented under the guise of 'objectivity,' which is no more than a veiled defense of the status quo."[59]

Like many feminist ethnographers, my public and activist work for midwives has stemmed both from previous personal commitment (for me, to reproductive justice)[60] and from my desire to "give back" to the participants in my study—for their generosity, with both time and resources—in both a meaningful and a useful way. This was also an expectation among many of those who granted me interviews. For example, in one small, rural community, I soon realized that each person I interviewed had talked with the participants I had spoken to earlier. Thus each new interview I conducted allowed them to collectively intensify their questions about the purpose of my research and express their desire that our interviews result in something "for the greater good . . . so that all women could get access to midwives," including the largely impoverished families in their community. Since so much of the published research on midwifery and the written testimonies of homebirthers have focused on middle-class women's experiences, a central part of my feminist ethnographic project has been to highlight the experiences of low-income women—both in my scholarly work and in conversations with midwifery supporters.

Yet claiming a politics for one's work while still publishing for a primarily academic audience has been disturbingly common among progressive academics.[61] Rather, recently scholars have argued that we must consciously move our research "off the shelf"[62] by making it both accessible and useful to groups that can ultimately put our work to use far beyond what we could do as individuals. For those of us who are committed to activist scholarship, burnout is perilously common because many of the organizations with which we work are often in dire need of volunteers with research skills. In addition to engaging (prudently, and sometimes cautiously) in these efforts ourselves, making our work accessible to activists allows us to more effectively put our research into service for the organizations, people, communities, and issues we study.[63] It is my belief, and the intent of this book, that feminist ethnography should speak to a range of audiences—from scholars concerned with social justice to students of anthropology and feminist research to reproductive rights activists themselves including midwifery supporters. As anthropologist Charles Hale has written, "Activist scholarship embodies a responsibility for results that these 'allies' can recognize as their own, value in their own terms, and use as they see fit."[64]

Thus I presented summarized data throughout my research process on Listservs and at gatherings of midwifery supporters to initiate discussions of the limits of "consumer rights" arguments for low-income women. Since many midwives and advocates did not have the time (or necessarily the inclination) to engage with my research on such a deep and involved level—as one organizer explained, "We only ever read one page, Christa, MAX!"—I also had productive conversations about these issues during visits or phone calls with participants, including those who did not have easy access to the Internet. Yet making my research process and analysis so "public" has often also meant entering into difficult conversations—particularly since midwifery supporters are subject to such sustained and unsympathetic critiques by medical officials and oftentimes legislators (as I further outline in Chapter 4). Many midwifery organizers with whom I spoke, particularly at the local and national conferences where I presented my research, saw little reason to question consumer-based language that had proven so useful in conversations with legislators.

While the collaborative strategies I attempted to employ during my fieldwork and writing processes by no means eliminate inequities in the ethnographic encounter (for instance, I ultimately chose the quotes that I include in this book from lengthy transcriptions), my goal has been to mediate the centrality of my own voice and highlight a variety of women's experiences and stories.[65] The collaborative work many midwifery supporters entered into with me during my research—reflecting with me on my initial analyses of interviews and on the themes emerging in legislative testimony,[66] and ultimately assessing my writing at various stages of development—has benefited this book immeasurably, and I am tremendously grateful for their efforts.

The goal of producing scholarship that is accessible—and useful—to a broad range of readers is also particularly challenging for those of us committed to feminist ethnography as a part of interdisciplinary activist scholarship. My research with midwifery supporters, for instance, has taken me on a journey not only through the extensive literature in anthropology and feminist studies on midwives, reproduction, women's activism, and neoliberalism but also through theoretical and empirical scholarship from fields as diverse as American studies, communications, cultural studies, English, ethnic studies, history, philosophy, political science, religious studies, social theory, and sociology. Without intending to absolve myself of appropriate scholarly responsibility, I feel it is important to acknowledge that it is impossible to be an expert in all of these fields. Inevitably, then, my treatment of some sources and theoretical debates is incomplete. Throughout this book, I indicate the disciplinary backgrounds of authors who have influenced my work in order to give the reader a sense of the interdisciplinary—and inherently collaborative—nature of historical and ethnographic inquiries.[67] I also do my best to provide exten-

sive endnotes explaining connections to particular resources in greater detail and referring to additional sources should the reader wish to pursue a topic that is not covered in great depth in my discussion.

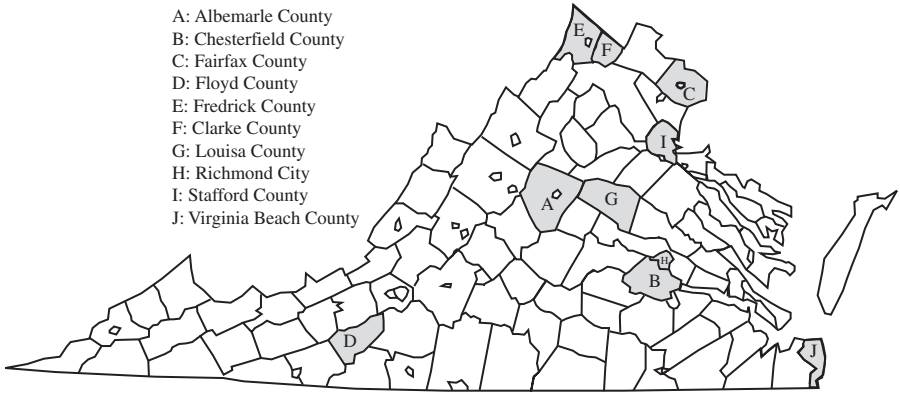
Methods for an Activist Ethnography

Despite my visible activism for midwives during my fieldwork, I was attentive to the highly controversial nature of homebirth and midwifery at the turn of the twenty-first century as I sought midwifery supporters to participate in my study. Because many midwives practiced underground when I conducted research in Virginia, I attempted to protect the identities of participants by performing multi-sited research instead of more traditional ethnographic fieldwork conducted in a single community.[68] Since legislative efforts emerged from groups throughout Virginia, and all Virginians would ultimately be governed by statewide legislative decisions, I also considered it important to assess differing reproductive healthcare needs in areas throughout the state.

Thus between 1999 and 2005 I conducted participant-observation with midwives and their supporters at a variety of public events. I attended legislative hearings in Richmond on midwifery laws during each of those years and the judicial proceedings for the trial of a prominent local midwife in 2000. I also joined numerous grassroots organizing meetings of midwifery supporters that occurred in communities throughout the state, with the intent of drawing in homebirthers who could not always travel to other meetings or hearings, and others that were strategically scheduled before or after legislative hearings in Richmond when members from throughout the state came together to support legislation.

After identifying zip codes where the majority of homebirths had been reported in Virginia in 2000,[69] I conducted semi-structured interviews with forty midwifery supporters during 2001 and 2002 in and around Albemarle County (around Charlottesville), Chesterfield County (near Richmond), Fairfax County (in northern Virginia), Floyd County (southwest of Roanoke), Fredrick and Clarke Counties (near Winchester), Louisa County (to the east of Charlottesville), Richmond City, Stafford County (in Central Virginia), and Virginia Beach County (in the Tidewater area). See the Virginia County Map that highlights my research areas.

Because participants frequently introduced me to other homebirthers when I visited their communities, many interviews occurred as a result of snowball sampling (though I met numerous organizers initially at legislative hearings in Richmond). Although interviews frequently took the form of a conversation between the participant and me (and often their children as they played nearby), I asked all participants to discuss (1) their reasons for supporting homebirth



Virginia County Map with research areas highlighted.

and midwifery; (2) the social, political, and economic barriers to that support; and (3) their expectations about political participation and grassroots organizing.[70] In 2007, I also conducted follow-up interviews with six of the original participants and several new midwives to assess what changes had occurred since the passage of the 2005 legislation that provided licensure for CPMs. Each interview was recorded, transcribed, and analyzed in the context of the public debates over midwifery and homebirth and the several thousand e-mails I collected during my participation on local and national Listservs dedicated to the support of midwifery from 1999 to 2005.

Although most participants were eager to tell their stories about homebirth and their support of midwives, and I have maintained contact with many who became good friends during my fieldwork, others refused interviews with all "reporters," and many participants admitted to "checking around about me" with other homebirthers before agreeing to interviews.[71] Others, citing my prominent involvement with a variety of grassroots organizations to support midwives, initially declined my requests for interviews, suggesting that they would not have anything to offer regarding the "political" struggle for midwifery. Although my dual role as researcher and activist was no doubt a limitation to the study in some cases, many participants also reported that our meetings had prompted them to reconnect with other midwifery supporters, and, for some, to (re)engage in organizing efforts to enhance access to homebirth midwifery services. Others requested updates on the current legislative developments and other grassroots organizing goals. Thus for many homebirthers I became not only a researcher but also a grassroots organizing resource.

Midwifery Supporters in Virginia

In contrast to many ethnographers who "thickly describe" the participants in their studies,[72] I often withhold identifying characteristics of individual participants, given that practicing midwifery (without a nurse-midwifery license) was a criminal offense during much of my fieldwork in Virginia. Despite the limitations I placed on my research questions—with the aim of focusing solely on grassroots organizing for midwifery—many women chose to share their childbirth experiences with me, often including narratives about their deliveries with underground midwives in Virginia. Thus, to protect the identity of the participants, the quotes from the interviews I conducted and the majority of Listserv correspondence I collected for this project are referenced only with pseudonyms and identified only by the year they took place. Quotes that identify a participant's practice as a midwife are referenced as "unnamed participant" to prevent identification of the speaker by quotes included elsewhere. I also made every effort to contact participants quoted in this book to secure their permission to publish the specific statements I chose to include. Accordingly, I respected the wishes of participants who preferred not to risk identification by removing their stories.

On the whole, it has been primarily educated, white women—from a broad range of political and religious backgrounds[73] and from both urban and rural areas of the state[74]—who have sought to enhance access to midwives in Virginia. While participants in my study mirrored national homebirth trends in many ways, they departed from the national statistics on those seeking homebirth as being largely middle class.[75] Although it was not the initial intent of my study to focus on socioeconomic differences among midwifery supporters, it became clear through my participant-observation at grassroots organizing meetings and legislative hearings, as well as through my interviews, that class tensions were impacting organizing efforts for midwives in Virginia.

Assessing socioeconomic class, however, has been a perennial challenge for social scientists. It is particularly difficult for researchers who study families that have chosen what scholars and proponents have called "simple living" or "voluntary downshifting," a trend that paralleled interest in homebirth in the late twentieth century.[76] Indeed, some—though certainly not all—of the participants in my study identified with this movement and indicated that they had grown up with more affluent backgrounds than their current circumstances suggested. Others, however, suggested, to the contrary, that they had grown up in poverty and now lived a largely middle-class lifestyle. Thus in any analysis of differing experiences related to relative wealth and poverty, it is important to remember that socioeconomic class can change over time.

In order to tease apart the complicated ways that socioeconomic status affects women's reproductive decisions and experiences, I offer participants' own narratives as often as I can (without risking anonymity) to explain the circumstances that influenced them individually.

I also took a more systematic approach to the sample as a whole. In each interview, among a list of fifteen other demographic questions about religious background, political affiliation, racial and ethnic background, age, household size, and the like, I asked the participant for an estimate of her or his household's annual income and the educational background and occupations of its members. My analysis of the differences between the experiences of low-income homebirthers and those of middle-class and more affluent homebirthers is based in part on these reports. For instance, the participants in my study reported a broad range of annual incomes, ranging from as low as $6,000 to more than $250,000. Two-thirds of the participants lived in households that fell below the median income levels for their county,[77] and nearly one-quarter lived in households that fell below the federal poverty line,[78] though only two acknowledged receiving federal assistance.

My data on occupation and education complicated the socioeconomic picture of midwifery supporters in Virginia. Participants had frequently worked at a variety of different jobs over their lifetimes (sometimes moving between jobs that required an advanced degree and service-level professions), and the education level of participants in my study was generally quite high: all but five participants had taken at least one college course.[79] Sixteen participants in my study had at least some training as midwives, though only six were currently practicing.[80] Of the thirty-four participants who were not practicing as midwives at the time of my study, approximately three-quarters referred to themselves primarily as "stay-at-home moms," although many of these women also worked outside of the home in occupations including work as childbirth-related specialists, alternative healthcare practitioners, teachers, farmers, migrant fruit harvesters, waitresses, and military personnel. Several participants were students, and almost half were homeschooling their children. Income level had frequently changed over the course of a participant's life, and although the participant's discussions of experiences with reproductive healthcare and support of midwives hovered at times around issues related to income, their stories were frequently punctuated by broader experiences of poverty, power, and access to (and experiences with) medical care. Thus measures such as education level, income, and occupation at the time of my study are admittedly imperfect in terms of assessing socioeconomic divides. Further complicating matters, federal poverty levels do not vary by county (which can be significant in states like Virginia, where median income levels vary by over $50,000 between rural and urban areas of the

state),[81] and median income levels by county do not take into account family size.

Social scientists have also shown that analyses of socioeconomic status cannot be separated from discussions of how racialized identity is also infused in experiences of medical access, political power, and poverty.[82] Much like the national midwifery movement, participants in my study were predominately white and of northern European descent. Only four women of color (10 percent of my sample)—including African American and American Indian participants, as well as those who identified as "mixed"—agreed to be interviewed for my study, and they were especially concerned about being vulnerable to state intervention as a result of their choice to give birth at home. Thus although I discuss the historical elimination of African American midwives in depth, I withhold the racial or ethnic backgrounds of participants because women of color would be easily identified within contemporary midwifery organizing in Virginia. Instead I rely on participants' own narratives about their (lack of) reproductive choices and their efforts to support midwives to address how their particular circumstances influenced their experiences.[83]

Overview of the Book

This book has two primary sections, reflecting the dual goal of providing a nuanced history of women's reproductive healthcare activism in the United States and examining contemporary organizing strategies for reproductive rights in an era increasingly driven by political rhetoric which prioritizes "consumer rights." Accordingly, Chapters 1–3 offer a historical discussion of struggles over reproductive healthcare in the United States, and Chapters 4–6 address how women's contemporary legislative efforts for midwives—and reproductive rights—have changed in the wake of neoliberalism. Chapter 1 revisits the history of women's political organizing in the popular health movement in the early 1800s, the fertility control debates of the late 1800s, the struggle for access to pain medication in childbirth during the early 1900s, and efforts to improve maternal and infant healthcare, which culminated in the passage of the Sheppard-Towner Maternal and Infancy Protection Act in 1921. The chapter highlights how, despite vast improvements in reproductive healthcare over the past two hundred years (such as lower mortality rates for both mothers and infants), the public policy shifts sought by women's rights activists have often contributed to the further stratification of healthcare options on the basis of race and class.

Chapter 2 takes a more detailed look at the emergence of consumer activism for midwives and the politics surrounding race and class disparities in the natural childbirth movement, a social movement many cite as the impetus for

the "midwifery renaissance."[84] Acknowledging some striking similarities to the uneven effects achieved by earlier reproductive healthcare movements, this chapter reviews examples of birthing reform in several states to highlight the mixed effects that successful efforts to legalize and license midwives have had on the ability of women—particularly poor women and African American women—to gain access to them. This history brings up a crucial question about contemporary advocacy strategies: Will market-based advocacy strategies ultimately lead to policies that make midwives available only to middle-class and affluent "consumers"?

Parallel to this broader national history, Chapter 3 provides a rich local history of midwifery and grassroots organizing among homebirth mothers in Virginia. I review the state's efforts to "educate" and ultimately eliminate African American midwives during the early to mid-1900s, the subsequent criminalization of "lay midwifery," and the "rediscovery" of midwives with the resurgence of interest in homebirth during the 1980s and 1990s in Virginia. Ultimately, several "histories of midwifery" emerge that highlight the racialized and classed rhetoric and prejudices that led to the different political, economic, and social climates for midwives during the twentieth century.

Chapter 4 examines the contemporary legislative debates over midwives in Virginia and how they became, vicariously, about the childbirth choices of homebirth mothers. Medical officials (and often legislators) frequently argued that mothers, particularly those who appeared to be politically active in support of midwives, were not competent to make the choice to have a homebirth and that their mothering choices should be protected and regulated by the state. Many challenged the mothering practices of homebirthers by linking them with women they deemed "pathological"—child abusers, negligent mothers, and drug users—and placing them outside the cadre of "normal" American mothers who acknowledge the "natural" superiority of medical childbirth practices. In response, grassroots organizers for midwives sought to reclaim their status as respectable mothers by highlighting their identity as educated consumers struggling in opposition to a powerful, and highly paid, medical lobby.

Chapter 5 explores midwifery supporters' responses to the damaging stereotypes they faced in the legislature. Throughout my fieldwork, it became increasingly clear that the homebirth mothers involved in these efforts avoided labels such as "political activist" or "grassroots organizer" to describe their support of midwifery. Even though most women denied participating in political activism, yet paradoxically engaged in activities that they described as "political," their reasons for doing so were often quite varied. Middle-class women had begun to redefine themselves as consumers (rather than as citizens or activists) to highlight their economic power in the face of well-paid lobbyists, physicians, and public health officials. While they discussed feeling "empowered"

and "energized" by their experiences going to the legislature to support midwives, low-income women were frequently more concerned with the potential of state repercussions both for hiring midwives and for participating in political efforts to support them.

In Chapter 6, I consider how the legislative and organizing experiences of homebirth mothers have intersected with neoliberal political ideology to encourage the promotion of "consumer rights" in efforts to gain access to reproductive healthcare services. I begin with a broad overview of "rights discourse" in the United States and consider how key legal cases have shaped (and to a certain extent have been shaped by) activist strategies for supporting reproductive rights. In the contemporary midwifery movement, efforts to secure access to midwives as a "consumer's right" have allowed some homebirthers to claim respectability as mothers who make educated choices in their consumption of childbirth services, but this focus has also restricted the participation of low-income midwifery supporters who do not have the ability to consume such varied childbirth options. In fact, I document how low-income homebirthers encountered challenges to creating coalitions with more affluent homebirthers when their "choice" to use a midwife was influenced by their experiences of poverty and alienation as well as their desire for a personal, warm, and noninterventionist birth experience.

In the Epilogue, I provide an update on the current state of affairs for midwives in Virginia and consider the future for reproductive rights activism in the wake of neoliberalism. In effect, the meaning of a "right" has changed for all citizens in this new political and economic climate. The state's support of "consumer rights"—instead of the protection of *all* citizens' rights—ultimately forces women to compete for their reproductive choices. It is my hope that this book on the growing push for midwives in this "consumer rights" era will serve as a cautionary tale for reproductive rights advocates more generally. Within the midwifery movement itself, it is intended to encourage critical conversation about both the possibilities and limitations of market-based activist strategies and their effects on access to midwives for *all* women.