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IN CULTURAL SOCIOLOGY

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BLESSED EVENTS

RELIGION AND HOME BIRTH
IN AMERICA

Pamela E. Klassen
The woman in my study was an expertly educated (except for the development of their educational process). The school I had attended was the professional level for women. Women in my community had no access to education, and because of this, they were often girls. Education was a commodity that was also largely inaccessible to women. Women were often raised in a culture that was deeply rooted in tradition, and education was not a priority for them. Women were often forced to rely on their own intuition and common sense to navigate the world.

Women in my community were often expected to marry and have children as soon as they reached adulthood. This was a significant factor in their lack of access to education, as they were often focused on caring for their families and household duties. Women were often expected to run their homes and care for their children without Outside of the home, women were often expected to work in domestic settings, such as kitchens, laundries, and bedrooms. Women were often left to their own devices to learn about the world and develop their minds.

Women in my community were often seen as inferior to men, and their lack of access to education only served to reinforce this belief. Women were often viewed as less intelligent and less capable than men, and this mindset was passed down from generation to generation.

Women in my community also lacked access to resources and opportunities that could help them further their education. Schools were often located in remote areas, and transportation was limited. Women who lived in rural areas were often forced to stay home and care for their families, further limiting their access to education.

Despite these challenges, women in my community were incredibly resilient. They found ways to learn and grow, even in the face of adversity. Women were often creative and resourceful, and they found ways to teach themselves and their children the skills they needed to survive.

Women in my community were often forced to rely on their own ingenuity and determination to make a better life for themselves and their families. Women were often strong and resilient, and their experiences and stories serve as a testament to their strength and perseverance.

Cultural Contexts of Home Birth

Who are the women who choose home birth? How do they choose it? Who supports them in their decision? What are the cultural, social, and economic factors that influence their choice? These are just a few of the questions that I hope to explore in this chapter. I also want to examine how women's experiences and choices around childbirth are influenced by their cultural, social, and economic backgrounds.
exploited medical perspectives and even methodologies for their own purposes.\textsuperscript{10} In the process, they “domesticated” medical forms of knowledge for the benefit of home birth.

Though getting information through reading is clearly important to a woman’s decision to give birth at home,\textsuperscript{11} it is not the only factor in her choice. In a study of women choosing between hospital and home birth, Carol Shepherd McClain found that women giving birth at the hospital made their decisions based mostly on knowledge gained from books. Women choosing home birth, however, not only relied on books, but also based their decisions on “concrete knowledge” achieved through social networks of friends. By this she meant “knowledge gained vividly from observation and participation,” such as going to the birth of a friend’s baby and discussing pregnancy and childbirth in detail with friends.\textsuperscript{12} Many of the women in my study had previous knowledge of home birth whether through observation or stories of the births of friends’ or family members’ children before electing that route on their own. With this concrete knowledge in mind, however, reading books and attending childbirth education classes still remained important ways these women prepared themselves for birth.

Several of the books women mentioned to me were classic advice books of the alternative childbirth movement, from British obstetrician Grantly Dick-Read’s pathbreaking \textit{Childbirth without Fear}, first published in the United States in 1944, to the 1975 book \textit{Spiritual Midwifery}, written by Ina May Gaskin and the Farm midwives. More recently, in 1991, Sheila Kitzinger, the prolific British anthropologist and childbirth activist, published an elegantly laid out how-to book, entitled \textit{Home Birth}. Though the women in my study did not always remember the names of the books they had read, these three books, along with a few others, were most frequently mentioned when I asked them about books they had read in preparation for childbirth.

Reading within the limited selection of home-birth advice books (at least when compared with the number of advice books based on the medical model), women encounter a diversity of perspectives from a movement with many leaders who share some views and who would debate others. Filled with assumptions and prescriptions about gender, sexuality, and the significance of birth to a woman’s identity, these books—even those one might consider to be “secular”—are also remarkably consistent in their portrayal of birth as a religious or spiritual event. Reading is a critical process, and I cannot suggest all the ways these women might have read these books. But as I turn to a discussion of the “big picture” of home birth, it is important to remember that many of the women in my study are aware of this big-picture view as well, although, as will become clear, their perspectives may be somewhat different from my own.

\section*{CULTURAL CONTEXTS OF HOME BIRTH}

\section*{Home-birthing Women: Who Are They?}

I use the phrase “home-birthing women” throughout this book, but within that phrase lie some differences that need spelling out. While most home-birthing women would very likely share a commitment to ensuring women’s access to giving birth at home with appropriate caregivers, they do not all take the same path to that commitment. Even though the number of American women who give birth at home every year is only around 1 percent of birthing women (in 1994 that meant around 40,000 women), this minority has some significant strands of diversity within it—one of the most pronounced being religious diversity.\textsuperscript{13}

Any attempt to draw a demographic portrait of home-birthing women is made difficult by at least three factors. First, the failure of birth certificates to distinguish (until recently) between planned and unplanned home birth, and second, the unwillingness of some home-birthing parents to disclose on a birth certificate who attended their child’s birth, for fear of legal action against a direct-entry midwife. Finally, a small number of home-birthing parents refuse altogether to secure birth certificates for their children immediately after birth.\textsuperscript{14} However, some patterns can be sketched in comparing a woman who gives birth at home to the average U.S. childbearing woman. According to a 1995 study, a home-birthing woman is more likely to be older, to be having a second or subsequent child, and to have less formal education. She is somewhat more likely to be married and white, and less likely to smoke or drink alcohol while pregnant. She is more likely to begin her prenatal care later, and is less likely to receive certain prenatal tests, like ultrasound or amniocentesis. She is also less likely to be diagnosed with a prenatal medical risk condition or obstetric complication. She is more likely to be attended during childbirth by someone other than a physician or certified nurse-midwife; for example, by a direct-entry midwife or by her husband or a friend. Finally, the health of her baby at birth is likely to be better than that of the average baby born in the United States.\textsuperscript{15}

In addition to this larger comparison with all childbearing women, a more focused comparison can be drawn showing that women having home births cluster in two groups. The first group is “older or more formally educated mothers who are likely to prepare themselves prenatally for a home birth.” The second is made up of “those who are younger or have less formal education for whom home birth may be a result of lack of planning or other manifestation of problems with health care access.”\textsuperscript{16}

When race is added to these distinctions, the effects of poverty and racism in limiting access to health care are more clearly evident. Euro-American home-birthers have more formal education and better birth outcomes
CULTURAL CONSIDERATIONS OF HOME BIRTH

CHAPTER TWO

The power of what I'm saying may be most apparent to those who have experienced childbirth. The power of that experience is in the way it challenges our assumptions about the world and ourselves. It is a transformation that happens within. It is not something that can be explained away or dismissed easily. It is a profound spiritual experience that can be compared to no other. It is a journey that we all take, whether we realize it or not. It is a journey that we all share, regardless of our place in the world.

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one of the women had planned to give birth at home. Of the eighty planned home births among the 45 women, the birth attendants divided evenly between direct-entry midwives and certified nurse-midwives, with another two births being attended by doctors, and three women giving birth unassisted by any professional caregiver.  

In terms of class, the women and their husbands spanned a range of occupations and incomes, from a husband who was an electrician making $20,000 per year to one who was a software designer making more than $100,000 per year, but for the most part they were middle class. More than three-quarters of the women cared for their children at home, and about a third of these women also worked part-time at jobs that ranged from assisting in their husband’s chiropractic office to being veterinarians. Six women had full-time employment, all in professional occupations such as teaching, nursing, ministry, or chiropractic.  

All of these women’s reasons for choosing home birth fit within Judith Rooks’s description of a “cluster of related reasons” for American women’s choice of home birth. These included being able to have control over the circumstances of their births; supportive caregivers and environments; avoidance of routine interventions in hospital birth (like episiotomies, epidurals, and fetal monitoring); family involvement in the birth; and lower cost. Another significant reason, according to Rooks and the women in my study, was the desire to “experience the beauty and spiritual potential of a simple, natural, birth.” What this spiritual potential entails, however, is not necessarily simple. Though in terms of class and race these women were somewhat homogenous, religiously they were very diverse—at least within the scope of Christianity, Judaism, and Goddess or “New Age” religions.  

Several scholars have acknowledged the importance of religion to women choosing home birth, although, as Judith Rooks put it, “there are no data to quantify it.” Perhaps the significance of religion to home birth (and to other social or cultural issues) is particularly difficult to quantify because, methodologically, religion is a slippery category to analyze. One regional study in 1977 comparing 60 women across different birth sites found home-birthing women to be less religious than hospital-birthing women, when religiosity was defined as affiliation with an organized religion. Levels of religiosity change with broader definitions, however, as a national study of 675 home-birthing couples found that almost half of the couples surveyed considered “spiritual beliefs” to be important to their choice of home birth. Another 9 percent felt “cultural beliefs” were important. The glossing of religion as a prevalence of “spiritual” concerns is a common way to address (or dispense with) the significance of religion to home-birthing women. Often, the particular content of this spirituality is not further explored, or several religious traditions are lumped together without detailed consideration of their similarities or differences.  

Robbie Davis-Floyd’s otherwise excellent analysis of both home- and hospital-birthing women is an example of how the way one defines “spirituality” or “religion” can affect one’s analysis. The only women Davis-Floyd categorized as understanding birth as a process of “spiritual growth” were those who gave birth at home. For Davis-Floyd this spirituality was synonymous with a “holistic” framework that sought mind-body and mother-baby integration and was “based on systems theory, which assumes the fundamental interconnectedness of all things.” While this definition may discount the understandings of “spiritual growth” held by some of the women who gave birth in the hospital, it also misses differences among home-birthing women’s understandings of spirituality. For example, Davis-Floyd described advocates of home birth as allies in holism with supporters of homeschooling, environmentalism, and alternative health practices, but specifically distinguished between “religious fundamentalist homeschoolers” and “holistic homeschoolers.” In my research this distinction did not always seem well founded. Women who embrace home birth come from a wide range of religions and political perspectives. I spoke with “fundamentalist” homeschoolers and “holistic” homeschoolers who chose home birth for some of the very same reasons.  

That the minority and very politicized practice of home birth attracts to it such a diversity of religiously inclined people is one of the main enigmas I address in the chapters that follow. As such, my study does not “quantify” the significance of religion to home birth, but explores the various qualities of this relationship. I explicitly address what other researchers of home birth have described as a “hard-to-define level of self-awareness” that is shown in women’s attention to the interaction between religion and the body and in their concern about good health and nutrition. I found this self-awareness lodged within a variety of religious allegiances, cutting across stereotypical views of liberal and conservative in the United States. Through a variety of circuitous paths, women arrived at some similar understandings of embodiment, self, and birth. All of these women’s paths are set within the controversial historical terrain of childbirth in America, sometimes consciously, and sometimes not.

Religion and the History of American Childbirth

Looking with a historical lens, the religious meanings invested in childbirth in North America are everywhere apparent. A seventeenth-century woman in labor in New England, fearing for her life in the midst of her pain, called on God to keep her safe, and an eighteenth-century midwife in Maine considered in part that “servant others was her way of serving God.” Several prominent women in American religious history have had
The two modes of childbirth are of a different nature according to whether or not the childbirth occurs in the presence of a skilled attendant. In the presence of a skilled attendant, the mother is more likely to experience a smoother, more controlled delivery. In the absence of a skilled attendant, the mother may experience more pain and discomfort, and the delivery may be more difficult. It is important for women to be aware of the importance of having a skilled attendant present during childbirth, as it can greatly impact the mother's and baby's health outcomes.
might be upgraded and organized" served to forward the activist ideology.\(^9\) Medicalization also encouraged the narrowing of meanings attributed to women's birthing bodies, which came to be seen primarily as reproductive machines, or, more narrowly still, as material for the obstetrical laboratory. Ironically, with this atrophy of meaning came the overdetermined meaning of the physician's role, as "physicians increasingly began to claim medical authority over all decisions—moral, ethical, religious, social, economic, even political—relating to childbirth."\(^6\) The rise of hospital births, then, contributed to the decline of religious authority—whether that of a tradition or an individual's faith—in matters of childbirth.\(^4\)

This decline was not immediate, however, as in the case of Jewish maternity hospitals. At the turn of the century, when these urban hospitals tried to attract Jewish women away from home births attended by traditional female (and Jewish) midwives, and to the hospital, they often used the very medium of religion to do so. As an 1892 report of the Jewish Maternity Hospital of Philadelphia stated: "The birthing mother 'will not be obliged to break the Dietary Laws'... and will be treated as though she were surrounded by her own kith and kin."\(^22\) Portraying hospital birth as modernized and safer but with the same social and religious support networks as home birth was a successful strategy, as Jewish women led the way in the shift to hospital birth among immigrant groups in America.\(^43\)

The situation of African-American midwives in the South shows a different side of the success of medical over religious authority—one in which the economic and educational resources of the community did not allow the same blend of medical and religious practice as effected in the Jewish case. As anthropologist Gertrude Fraser has shown, by the mid-twentieth century the "new secular medical authority" largely derailed the "spiritual authority" that buttressed the work of African-American midwives in rural Virginia.\(^44\) In their relationship with medical and state authorities, however, midwives were not entirely opposed to making use of the benefits of medical care that had long been denied them and their clients, as long as they could continue to work within their tradition of "creative improvisation."\(^65\) In Fraser's analysis, midwives were not initially threatened by medical regulation but instead saw it as potentially beneficial in keeping with the "history of syncretic medical and religious practice in Afro-American communities."\(^66\) In the end, however, African-American midwifery traditions of "mother wit" and notions of the body infused with religious meaning were overwhelmingly obscured in later generations of women, according to Fraser.\(^69\)

Taking several steps beyond the tentative collaboration that African-American midwives sought in selectively valuing some medical approaches to birth, many Euro-American women, both as patients and doctors, embraced the medical model that saw pregnancy and birth as pathological.\(^58\) Affluent women who actually had choices about what sort of birthing care they desired were especially active in demanding that doctors find ways to render birth less painful, regardless of the level of intervention. The "twilight sleep" movement of the 1910s was a case in point, as upper-middle-class feminists demanded that doctors in the United States adopt this German practice in which women were drugged so that their minds would not remember the pain of birth. Their bodies, however, felt the pain as they thrashed about in darkened rooms, ensconced in a specially designed version of a straitjacket.\(^59\)

Race and class conditioned the accessibility of feminist-driven childbirth reforms like twilight sleep. Poor women used to manual labor were considered less needy of pain-relieving childbirth methods, because of their supposed higher tolerance for pain.\(^70\) Furthermore, the real benefit of twilight sleep in the eyes of the elite was that the prospect of painless childbirth would encourage the sensitive, white, upper-middle-class woman to have more children, thus ensuring a "better race for future generations."\(^71\) Though different mixtures of pain-relieving anaesthetics soon replaced the specific method of twilight sleep, the drugged birth had won converts among both doctors and birthing women alike.\(^72\) Between the wars, hospital birth grew in both popularity and acceptability, as pain-relieving drugs were increasingly available only in hospitals and not at home, and as clinics made medical care available to poorer women. After World War II, hospitals expanded at the same time that government regulations and doctors had driven most midwives out of practice except in the rural South, and fewer doctors would agree to attend home births.\(^73\)

In the midst of this shift to drugged birth in the hospital, some doctors advocated alternatives. British obstetrician Grantly Dick-Read was the most celebrated of the early "natural childbirth" doctors. In his 1944 U.S. edition of Childbirth without Fear, Dick-Read argued that the practice of drugging women in labor was depriving them and their babies of a fundamental experience. He advocated his specific method of natural childbirth as a way women could be fully sentient and aware at their births.\(^74\) Dick-Read's method centered around what he called the "Fear-Tension-Pain Syndrome," in which fear of childbirth, brought on by negative images of birth abounding in the culture around her, caused a woman in labor to tense up the muscles of her uterus. In so doing, she worked against the natural rhythms of labor, in which ideally the three layers of uterine muscles would contract in complementary ways to ease the baby out. Once fear produced the tension that counteracted the natural process of birth, pain set in, and childbirth became an almost unendurable agony.\(^75\)
PORTABLE ROLE IN THE LIFE OF MANY CHRISTIAN WOMEN: ORIENTING FOCUS OF READING AND PURPOSE OF READING

M ost of us who have been raised in Christian households were taught that reading the Bible is an important aspect of our spiritual lives. It is through the pages of Scripture that we come to know God and understand His will for our lives. As Christians, we are called to be living examples of the love and compassion that Christ commanded us to show towards one another. Reading the Bible helps us live a more Christ-centered life, following the example set by Jesus Himself.

In this chapter, we will explore the importance of reading the Bible and discuss ways in which it can be integrated into our daily lives. We will also examine some of the challenges that come with reading the Bible and offer practical tips for overcoming them. Whether you are a seasoned Bible reader or just starting out, this chapter is designed to help you deepen your understanding of God's Word and apply it to your daily life.
In a religious context that was spawning the Christian Family Movement and other groups that focused on ethics in the family, infusing birth with religious meaning was an attractive concept. Historians Richard W. Wertz and Dorothy C. Wertz claim that in the climate of the 1950s, “before the civil-rights movement made social action a viable choice for Christians, having a natural birth was perhaps the only ethical action, Christian or otherwise, that many women could take.”

Though this seems a limited view of ethical action, Christian childbirth activists like Helen Wessel, author of Natural Childbirth and the Christian Family (1963), might have heartily agreed. Even Dr. Robert Bradley, in his popular Husband-Coached Childbirth, first published in 1965, often couched his message in religious terms, as he considered women who gave birth without drugs to be especially open to birthing with God-given “serenity.”

By the late 1960s and early 1970s, however, feminism and the women’s health movement were bringing a new perspective to the significance of home birth, one with a decidedly less Christian ring. Feminist critics continued the tradition of earlier activists like Patricia Carter in their insistence on women’s right to knowledge and autonomy over their bodies and in their calls for a more accessible health-care system, but their critique extended beyond birth to mothering and marriage.

Woman-centered, not “family-centered,” birth was the concern of many feminists, who felt that a positive childbirth experience did not necessarily have to strengthen a male-female bond, but could foster a woman’s autonomy and nurture a diversity of relationships, including those between mothers and daughters, women friends, and lesbians.

Feminist critics of medicalized birth were not only childbearing women, but also certified nurse-midwives and direct-entry midwives who were taking practical steps to assist women to give birth at home. American certified nurse-midwifery grew out of public health nursing, in an effort to provide midwives with nursing training. Organizations like the Frontier Nursing Service, established in 1925, drew on British nurse-midwives to develop a school that could train nurse-midwives who would provide care to women in rural and hard-to-reach areas. Until the 1950s most births attended by certified nurse-midwives were at home, at which point many certified nurse-midwives stopped the practice in an effort to gain hospital privileges and professional legitimacy. Their professional organization, the American College of Nurse-Midwives (ACNM), insisted until 1980 that hospitals or birth centers were the only safe sites for birth. Even before the ACNM ended its censure of home birth, however, some certified nurse-midwives attended home births regardless of the policy against them.

Direct-entry midwifery (also known by the less precise term “lay midwifery”) grew in the 1960s and 1970s, as women began helping their friends to give birth and then gradually trained themselves with the help of books, doctors, and experience. Many of the early direct-entry midwives cited spiritual reasons for turning to midwifery, or did so within a religious (often countercultural) community. For example, Ina May Gaskin, author of Spiritual Midwifery, and the head midwife at the Farm, a countercultural community in Tennessee, is one of the most respected of direct-entry midwives.

Currently, direct-entry midwives seek their training primarily through direct experience, either in apprenticeship to another direct-entry midwife or in a midwifery school that is not a nursing program (though some may already be nurses). They work independently of doctors and practice in the home or sometimes in free-standing birth clinics. The legality of direct-entry midwives continues to vary state by state, with some practicing legally as licensed midwives and others forced to work “underground” with ambiguous legal status. The Midwives Alliance of North America (MANA) is the direct-entry midwives’ parallel to the ACNM, although MANA welcomes the membership of interested certified nurse-midwives, and there has been increased collaboration between the ACNM and MANA in recent years.

In addition to midwives, a small number of doctors, mostly family practitioners, began to attend home births in the 1970s and 1980s. Some even teamed up with direct-entry or certified nurse-midwives. By the mid-1980s, however, they began to move back to the hospital under mounting pressure from other doctors opposed to home birth, although many continued to provide back-up support for midwives. Those doctors hostile to home birth also tried to pressure home-birth midwives by denying certified nurse-midwives hospital privileges and not allowing direct-entry midwives to accompany their clients to the hospital when necessary.

In taking on childbirth as a political issue, the feminist movement for women’s health found itself with some unlikely allies, who would be more aptly called maternalist or traditionalist women—women such as the founders of La Leche League and Patricia Carter, author of Come Gently, Sweet Lucina. Feminists and traditionalists have been able to unite over their skepticism of the hegemony of medical approaches to birth and infant feeding and in their assertion that women have valuable knowledge about their own bodies. They have differed, however, over issues of abortion and family structure, with the traditionalists generally being anti-abortion and supportive of heterosexual, husband-headed marriage. By focusing on consumer advocacy and choice and avoiding conflicts around sexuality and abortion, these allies formed a grass-roots, if fragile and loosely organized, “alternative birth movement” that has had significant—
Making Meaning of Birth: Cultural Contexts of Home Birth
Set in an international context, where midwifery thrives in several European countries, the struggles of women in the United States who seek less interventionist births at home with experienced midwives appear quite reasonable in the international geography of childbirth. Seen only within the context of birth in the United States, however, home-birthing women represent a minority view considered extreme in both medical and less specialized circles. Condemned by some medical and legal professionals as child abuse, and vaunted by many midwives and childbirth activists as the safest and most satisfying method, home birth takes its place within a constellation of meanings that shape the practice of childbirth in the United States.

Anthropologists who have turned their attention to birth in the United States have argued that home birth is forced into its marginal position because of competing ideologies of birth. Robbie Davis-Floyd described two opposing models of childbirth operative in the late-twentieth-century United States as the "technocratic" and the "holistic" approach. According to Davis-Floyd, where the technocratic model considers the institution (i.e., the hospital) as the significant social unit, values technology, and considers pregnancy and birth inherently pathological, the holistic model sees the family as the essential social unit, esteems the natural, and views pregnancy and birth as inherently healthy.

The "ideological polarization" between these two models is largely rooted in contrary notions about who holds power over decision making, and who is considered knowledgeable about the body. In the technocratic model, doctors, based on their medical training and their readings of machines such as fetal monitors, make the significant decisions about how a woman's labor should progress. In the holistic model, midwives and birthing women collaborate to decide how best to assist a birth, based on the emotional and bodily experience of the laboring woman and the learned knowledge and (sometimes) intuition of a midwife. However, midwifery care within a hospital complicates this dualism, as do those doctors who are themselves critical of the medical model of childbirth. While some home-birth advocates argue that certified nurse-midwives working in hospitals have been co-opted, some of these same certified nurse-midwives are among those most dedicated to safeguarding home birth, and they work both in the hospital and in homes. And certainly most midwives, including direct-entry midwives, work with the support of at least one doctor.

In general, however, the tensions between doctors and midwives have overshadowed their cooperation. As well, since much health care in the United States is structured as a profit-making venture, ideological competition between the technocratic and holistic models is also about money. American obstetricians and hospitals, fearing for their business if women were to turn in large numbers to lower-cost, lower-technology births in the home, have aggressively sought to convince women that the hospital can be just like home, but better. Commercial billboards sponsored by hospitals picturing tiny newborns in their mothers' arms, or declaring the benefits of the nearby hospital's "birth pavilion," bring this struggle for market share directly to the consumer.

While feminist arguments about the patriarchal, class-bound, and racist character of the technocratic model of obstetrics are persuasive, some of these same feminist authors have complicated their portraits by describing women's own role in shaping this model. Questioning women's agency in shaping the medicalization of birth—arguing that women have both encouraged and resisted it—has led some scholars to caution against a romanticization of birth on the part of childbirth activists. Some women, these scholars remind us, insist that they prefer cesareans and epidurals to the sensations of vaginal birth. Issues of "false consciousness" and socialization complicate the "purity" of agency in any case, but the point is that birthing women make choices and are able (or not) to enact those choices based on a range of interconnecting social contexts, like education, class, race, and ethnicity. Women's subsequent interpretations of their experiences of childbirth also reflect the diversity of their cultural and social identities.

Hoping to address the social and cultural complexity of childbirth, home-birth practitioners have called for studies that go beyond issues of outcome and safety in home birth. They suggest that studies attending to factors of cultural diversity and satisfaction in childbirth would best be explored through a feminist, qualitative approach. Using such an approach here, my goal is to bring attention to one particular source of meaning and diversity—religion—in the range of factors that affect ways of birthing. Cultural anthropologists agree widely about the need to locate "fertility and birth within cosmological, social, psychological and spiritual contexts." Especially in the case of research on Asian and African women, anthropologists have considered the complex relationship between women's bodily experiences of pregnancy and childbirth and their religious experiences, including their negotiation of official theology, anthropocentric religious and familial authority, and personal beliefs and practices. Despite this insistence on attending to the religious dimensions of birth, the majority of childbirth research on Western women—those women most fully oriented to the biomedical obstetrical model—has neglected or skirted questions of religion in favor of a more conventionally political or sociocultural approach. Research that has considered birth as a "rite of passage" has paid some attention to the role of religion in Western women's experiences of childbirth, but even in this genre the ability and interest of scholars to analyze religion is mixed.
CULTURAL CONTEXTS OF HOME BIRTH

After birth, the question of how to engage with and interpret the cultural practices and beliefs of the birthing community is crucial. In many cultures, the role of family, community, and traditional birth attendants is significant. Understanding these practices and beliefs can provide insights into the birthing process and support during labor.

In some cultures, the presence of family and friends during labor is encouraged, while in others, it is considered unnecessary. The role of the midwife and other healthcare providers is also important, as they facilitate the transition of the mother and baby into their new home environment.

The decision to have a home birth is often influenced by personal beliefs, cultural traditions, and the support of family and community. It is important for healthcare providers to respect these choices and work to create a supportive and safe environment for the birthing process.

In conclusion, the cultural context of home birth plays a significant role in the birthing experience. Understanding and respecting these cultural practices can help healthcare providers support mothers in their journey towards healthy and fulfilling birthing experiences.
Risk, Fear, and the Ethics of Home Birth

KATHRYN MORRIS was sure she was dying in childbirth. Despite having planned a home birth, she found herself on an operating table in a hospital, undergoing an emergency cesarean. Kathryn had planned to give birth with the same certified nurse-midwives she had been using for several years for her gynecological or “well-woman” care. In the course of her labor at home, she became preeclamptic; her blood pressure rose to dangerously high levels, and her contractions followed heavily one upon the other.\(^1\) The midwives strongly advised that she move to the hospital, so she left home with her husband driving the car as the midwives followed close behind. As she lay on the operating table, she recalled, she could feel the obstetrician’s hands on her belly and reaching through the incision inside her. She had not received enough anesthetic, and her birth became a horrific ordeal in which she confronted the fragility of her own flesh in a most visceral way. The impelling force of her own physiology transformed Kathryn’s carefully laid plans for a peaceful birth. Death, instead of hovering at the margins of birth as an unspoken fear, claimed center stage.

Kathryn’s experience makes clear that childbirth is at once a cultural event and a physical happening. At times, the unpredictability of the physical process of childbirth can lay waste to religious or cultural expectations surrounding birth, as it did in Kathryn’s case. Though the physical and cultural aspects of birth are often closely intertwined—as with women in my study who viewed the physiology of the birthing body as designed by God—they can also be in conflict. This shifting line between the cultural and the physical is what causes many of the debates around home birth to arise. Do a woman’s cultural or religious expectations about birth validate her refusal to accept the biomedical approach to birth? Put simply, do women’s experiences of childbirth—religious or otherwise—matter enough to hazard what some call the physical risks of home birth?

The dominance of the biomedical approach to childbirth has established a climate in which these questions are often answered with a resounding “no.” Seeking a fulfilling experience is considered secondary to or even incompatible with the safety of a woman’s baby in the eyes of some critics of home birth.\(^2\) As one scholar put it, “A woman’s interest in an aesthetically pleasing or emotionally satisfying birth should not be satisfied at the expense of the child’s safety.”\(^3\) In the course of presenting my research, I have often been asked the question, “What about the women whose babies die, or who die themselves?” This is a question so loaded with cultural expectations about the dangers of childbirth and, for many questioners, personal experience of difficult or traumatic labors, that I have often approached it gingerly. My usual answer is initially twofold: first, none of the women I interviewed had experienced the death of a baby in childbirth, so I did not directly address it in reflecting on their stories. Second—and this part of the answer enters into more sensitive and sometimes polemical territory—when compared to hospital births, planned, midwife-attended home births result in equal or lower rates of infant and maternal mortality.\(^4\)

But those answers do not get at the heart of the emotions—fear, anger, and confusion to name a few—that lie behind the questions. For most of human history, to give birth has been to approach death. In North America it was not long ago that women frequently died in childbirth, more often from postpartum infections or “childbed fever” than from complications of birth itself. Globally, the maternal mortality rate is still shockingly high, especially in poor countries.\(^5\) The fear of death in childbirth is still something that haunts all childbearing women, and often their partners.

The persistence of this fear can be found most readily in the genre of the “I almost died” or “the baby almost died” story—the kind of birth horror story told to many pregnant women. I have heard many of these stories as a pregnant woman and in the course of telling others of my work, both casually and in more professional settings. One of the most vociferous of these storytellers was a man, who, after he heard me present some of my work at an academic conference, approached me asking if I had children myself. When I said that I did, he asked me, “Did you birth naturally?” After I gave him a qualified yes—without embarking on a discussion of what he meant by “natural”—he launched into a monologue that according to my field notes went something like this:

Obviously I’m not a woman by nature, but I strongly disagree with home birth. My sister planned a home birth but didn’t have one. It’s a good thing she didn’t, because at the hospital she had complications that could have taken the life of her and her baby. Childbirth is not about an experience. It’s about procreating a new life into the world. If you want an experience, ride a roller coaster.

After a long day of sitting in uncomfortable chairs in a dark conference room, I had no desire to respond to this man. I could have asked him whether his sister’s midwife advised her to go to the hospital, but instead I quietly said that many women would not agree with him, and excused myself from his presence. But his angry, verging on threatening, words stuck with me.

This man’s response highlights the emotionally volatile hub of debates over childbirth: Is a woman the vessel for bringing about new life, or does
Birth as a Moral Act

...
That the human body has a changing life largely inaccessible to itself, that in various ways its behavior depends on unconscious routine and habit, that emotion, though necessary to every kind of reasoning, may render the ownership of actions a matter of conflicting descriptions—all of this problematizes both the intentional claim that the embodied subject is essentially engaged in resisting power or becoming more powerful, as well as the connected claim that the moral agent must always bear individual responsibility for her act. It also problematizes the larger assumption that agency must be defined, in the final analysis, by a historical future of universal emancipation from suffering.

The changing life—or lives—of the pregnant and birthing body are, to borrow from Asad, largely inaccessible, although decreasingly so with the burgeoning of reproductive technologies. Part of what home-birthing women seek in choosing a less medicalized approach to birth is a preservation of this inaccessibility. Ironically, in light of Asad’s contention, they must choose to retain the unconscious body—they forgo “emancipation” from the suffering of birth for the sake of their babies and themselves. Being neither complete self-determination nor complete submission, embodied agency implies a recognition of limits.

While this kind of embodied agency takes particular shapes in the context of home birth, the assertion that birth is an ethical act shaped by particular theories of procreation applies to all approaches to childbirth. Claims and assignments of responsibility, whether on the part of birthing women, midwives, doctors, or the state, are tied to understandings of who has obligations and knowledge in terms of childbirth. Those with differing approaches do not necessarily understand the physical stages and the pain of childbirth in the same way, and their understandings of the ethics of birth are even more contested.

Operating from within a biomedical model, some argue that the risks of birth demand that a woman give birth in a hospital. While some biomedical advocates urge women to give birth in hospital because it is “safer,” others go further and call home birth “child abuse.” In the most extreme version of this view a woman relinquishes her role as the arbiter of risk to the medical professional, who decides what is best for the baby and for the woman. The focus in this case is on the relationship between the doctor, backed up by particular forms of birth technology, and the fetus/baby. However, doctors differ in the extent of authority they claim over childbirth, and in response to the increased authority of midwifery they have had to confront directly in the issue of women’s autonomy in childbirth.

For example, after midwifery and midwife-attended home birth became legal in Ontario, the Ontario Medical Association rethought its opposition to home birth. Now the organization “does not support physician
CHAPTER THREE

RISK, PITY, AND ETHICS

According to the legal responsibilities of the

risks and consequences for the individual...
the body, illness, and healing with alternate practices such as homeopathy or faith healing. Home-birthing women themselves represent this religious diversity in their various ways of reconceiving risk. Some make their choices based on a commitment to a particular religious tradition, such as Christian Science or Pentecostalism, while others decide on the basis of less explicitly religious motivations, like a commitment to feminist visions of bodily empowerment or to following “nature.”

Languages of risk are culturally shaped, as anthropologists Patricia Kaufer and John O’Neill found in the context of debates over whether Canadian Inuit women could birth in their communities or whether they needed to be airlifted to southern hospitals. Lacking large-scale epidemiological statistics to prove the necessity of hospital birth for these Inuit women, medical professionals turned to a “clinical” language of risk, the professional cousin of what I have called the birth horror story. When challenged at a community meeting by an Inuit woman who questioned medical definitions of risk, a doctor turned to his own personal experience of seeing seven women die in childbirth during his twenty-five years of practice. Though none of these women had lived in Inuit communities, the doctor called on this clinical language of risk to argue against midwifery care in the North and as a way to express, perhaps tacitly, his “sense of vulnerability and responsibility” as a medical practitioner.27 Questionable use of statistics to back up official policy on the location of childbirth is also motivated by the medical community’s strong attachment to newly developed childbirth technology. Given the strength of the “belief in the power of technology to preserve life and, conversely, in lack of technology as a cause of death,”28 assenting to a community-based (or for southern women, home-based) model of childbirth care is contrary to many medical professionals’ understandings of risk.

While the issues surrounding childbirth that confront American home-birthing women and Canadian Inuit women are different, both groups of women do share an understanding of the larger implications of defining the risks of childbirth. For both, the question of “how much risk is acceptable to you?” is necessarily tied to the question “what kind of society do you want?”29 For their part, by including their own bodily, emotional, and spiritual well-being together with that of their newborn children within this calculation of risk, home-birthing women have placed childbirth within a larger social context of a woman’s and a family’s life. In the process, they have made explicit the ethical basis of decisions about childbirth—an ethics that the medicalization of birth has obscured. As medical ethicist Paul Komesaroff phrases it, medical modes of thought have transformed life experiences like childbirth and menopause by tacitly introducing an “implicit vision of the good life” under the guise of technical values that highlight rational forms of progress.30 Childbirth reformers of all sorts have reversed this obscuring of the social and personal meanings of childbirth by insisting that childbirth is not a mere technical process meant to achieve a certain end result, but instead is an experience with profound consequences for many different actors. The birthing women involved in this refocusing on the ethics of childbirth have also challenged deeply rooted assumptions about maternal sacrifice, by insisting that the quality of their own experiences of childbirth is positively linked to the health of their children—a challenge that I explore further in chapter seven.31 Acknowledging the paradox of ultimate power and utter lack of control in childbirth makes room for an ethics of birth that can encompass the limits and the possibilities of the body—an ethics that understands that one of the risks of birth and of all ways of living is death itself.

Birth and Death

Reconceiving risk entails confronting the possibility of death. To give birth is to bring a new, living creature into existence—who will necessarily eventually die. Moreover, it is to experience a surrendering of the flesh that itself may, however infrequently, lead to one’s own death. This paradoxically intimate relation between birth and death has long been a part of conscious and unconscious religious reflection. As writer Kathleen Norris phrases it, “One of the most astonishing and precious things about motherhood is the brave way in which women consent to give birth to creatures who will one day die.” She goes on to suggest the religious implications of such bravery: “That we all begin inside a woman and must emerge from her body is something that the male theologians of the world’s religions have yet to forgive us for.”32 Whether for children or for mothers, the stain of birth, at least according to much traditional theology, entraps the spirit in the suffering, polluted, and mortal body.33

But for women who are engaging in the ethics of birth from the perspective of practice—that is, through giving birth and reflecting on it—the paradox of birth and death has led to very different conclusions. While most women I interviewed felt that human relationships with family, friends, and the new baby were an important part of the spirituality of birth, several considered childbirth to allow for divine connection in a very particular and palpable way. Spiritual feminist Tessa Welland, age 34, and mother of four, was in many ways a stark opposite to several of the more conservative women I spoke with, who decried the sort of eclectic religious practices Tessa enjoyed. However, she shared these women’s conviction that childbirth brought one into direct contact with God.

Tessa’s God was immanent and without gender, in that for her “everybody is God,” yet God is still otherworldly. In Tessa’s experience, she approached this other world in childbirth: “I felt this more intensely each time I gave birth: there’s absolutely a point in every labor where it’s the
The reality is, however, measured in contraceptive efficacy, not just the presence of a contraceptive. Thus, if contraception is truly effective, then its failure rate should be zero. However, even with the most advanced technology, there is still a non-zero rate of contraceptive failure. This means that, while contraception can greatly reduce the risk of unintended pregnancy, it is not a 100% guarantee of preventing pregnancy. It is important to understand that even the most effective methods of contraception have a certain rate of failure, and that this rate can vary depending on how the method is used and the individual user's adherence to the instructions. Therefore, it is crucial to use contraception consistently and correctly to ensure its effectiveness.
worst rates of the industrialized countries. The 1992 fetal death rate was 7.4 per 1,000 live births, and the neonatal death rate was 5.4 per 1,000.43 Some studies suggest that home birth has better infant and maternal mortality rates, though the overall infant mortality rates between home and hospital births cannot be compared directly because most women who plan to give birth at home are prescreened for complications. A study of almost 12,000 CNM-attended home births found an overall perinatal (before, during, and after birth) mortality rate of 4.2 per 1,000. When third trimester fetal deaths and known congenital anomalies were excluded, the intrapartum and neonatal mortality rate was 0.9 per 1,000. There were no maternal deaths.44

None of the women with whom I spoke had suffered the death of their babies in childbirth, though several had experienced miscarriages. The baby of one woman's sister-in-law died at birth, and since this birth was a midwife-attended home birth, it was a particularly sensitive issue in the extended family when a short time later the woman I interviewed decided to have a home birth as well. A few women had undergone abortions, and all these women, including those who supported freedom of choice, felt some ambivalence about this. One woman in particular tied her initial fear of dying in childbirth to the regret she felt about her abortion. She recalled thinking: "I'm going to die in childbirth. I was going to die in childbirth. That was the fear. That was a big fear, and it came—part of that came through as guilt from the abortion, major guilt, and I had no place to put the guilt." For this woman, talking with a birth instructor helped her to overcome her fears somewhat, as did her subsequent births, but her regret remained, and perhaps even intensified as she became more religiously conservative over the course of her life.

Although no women I spoke with experienced the death of their babies, and obviously none died, Kathryn Morris, whose story began this chapter, did have a particularly traumatic labor during which she not only feared, but also actually felt, she was dying. In contrast to Tessa, she recalled reacting with panic, not curiosity. Considering the role of God and power in Kathryn's birth provides a helpful counterpoint to Tessa's experience. Kathryn, 31, called me after seeing a flyer I had posted at her midwives' office, and said that she wanted to talk with me about her home birth.45 When I arrived at her small cottage-like home, busy with two barking dogs and a singing bird, Kathryn was aflutter with moving the animals, but welcomed me warmly. A video producer, Kathryn was frank and articulate as she recounted her emergency cesarean birth:

They gave me all these things—anesthesia, all this stuff, that was in no way in our idea of what we were going to be doing.... When she [the doctor] said, "You have to have a cesarean," I was so relieved, because I couldn't take it any

more. I mean, it was really painful, so I was not that disappointed when she said that. And I just couldn't wait for them to put that mask on my face, because I wanted to be relieved of this. And, plus, my blood pressure was really high, so I probably was not feeling on top of all this stuff, probably that was affecting how I was feeling as well, when I think about it now.

So they gave me the anesthesia, and they didn't give me enough, because I could hear him, and could feel her hands on my belly. I didn't feel pain, but I felt her—it felt to me like I could feel her fingers inside, but who knows, I was totally anesthetized, except for that little bit more that I needed to be out. So I was trying to tell them, and I was trying to move my fingers, I was trying to signal to them in any way that I could that they didn't give me enough, but you can't move when you're under anesthesia, and you can't talk when you're under anesthesia.

So I was basically in a total panic, and my blood pressure went up while I was in there, and I think that might have been why, because I was in a panic. I was trying to do this—I couldn't even move my finger, I couldn't talk, and it was horrible. And the thought that went through my mind—the words, I remember the words exactly; they were, "I am going to die on this table." That was the thought—it was horrifying, it was a horrifying experience.

Kathryn's narrative of her birth was the most traumatic story I heard—at several points we were both in tears. This stemmed partly from the vividness of Kathryn's memories, since her baby was only three months old when we spoke. The direness of her narrative, however, also lay in what she called her "unrelenting story": once her baby was born, he was diagnosed with Down's syndrome.

Given the positive cast that spirituality holds in contemporary society, it is not surprising that Kathryn did not characterize her pregnancy and birth as spiritual experiences:

I thought that pregnancy and birth were going to be spiritual experiences. I thought they were going to be experiences that brought me to a higher state of consciousness while I was experiencing them. What I found to be the case is that pregnancy especially, and also birth... are very earthbound experiences. They are totally in your body. They are very, very physical. They are the ultimate physical experience. So I kept waiting for this "oohh," to feel this heavenly joy of some kind, and basically what I felt was, you know, uncomfortable—the real connecting to your body more than to the universe. I kept waiting to feel connected to the universe.

Unlike several other women who did speak of such mystical connection, Kathryn never did feel that union while her baby was in the womb or on the way out. Instead, for her, "the child is the religious experience."

Though Kathryn did not instill the bodiliness of pregnancy and birth with spiritual meaning, her pregnancy and birth did become catalysts for
The Effects of Connection: Home Birth

A call to action!

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that constitutes an ethics of connection. Relationships between a birthing woman and her partner, her other family members, her caregiver, her community, and her baby are all reconfigured over the course of pregnancy and birth. For many women, the human connections forged, and sometimes strained, in the course of bearing a child are augmented with a transformed knowledge of self and of powers beyond the human realm. This ethics of connection, both in human and superhuman terms, is at the base of much of the struggle for transforming childbirth in North America. As women, and many men, have questioned notions of risk and danger in childbirth, they have set on a course that employs this ethics of connection to challenge both biomedical practice and state authority. Examining this ethics of connection in the specific context of home birth shows how women and their families conceive of home birth as a political and ethical act and, in some cases, as an assertion of religious liberty in the face of state control.

One woman expressed this ethics of connection, both between humans and with a supernatural power, most emphatically. Elise Gold, a Reform Jewish woman, talked of spirituality as connection with other people in synagogue and in family life. Connection was equally important to her when giving birth with the help of a certified nurse-midwife, and was intimately tied to issues of power and responsibility:

My body definitely felt powerful. My mind felt powerful . . . I had taken full responsibility for my life, and the outcome was all in my hands. Yet I had these people [around me]—yet it wasn’t the kind of independence, like where you stand alone. I felt like I had that ability to stand alone, but I also could sway a little bit and lean on different people when I needed them, and that they were truly there to support me. Me, what I wanted, not what they would have wanted for me, or how they would do it themselves.

. . . Maybe [I was] the center of my own universe for a time. And . . . [that way] you don’t want to live, your whole life—it might sound like I’m talking power, power, power—not power to control other people, just power to control the space around me. And no, that’s not something that I want all the time, there are lots of opportunities for sharing. But for that, I think birth belongs to the woman birthing, and not to anybody else.

Unlike the conservative Christian women who gave God most of the credit, Elise felt strongly that the power in birthing should rest with the woman herself, though she also felt the need to nurture her claims for power by acknowledging the value of sharing. Elise later insisted that this power within and between was linked to “spiritual connection.” For Elise, the power in birth was tied to “spiritual energy” that did not float unanchored, but instead provided, in her words, the “connection” that allowed her to harness her own power.

Elise’s commitment to home birth is part of a broader commitment to what she called “home-based living,” which included honoring Jewish domestic rituals and homeschooling her children. At the center of this notion of home was Elise’s view of God as a pulsing energy, neither male nor female, manifested in each body—a God, however, that she carefully asserted was monotheistic. Elise’s sense of the quotidian nature of God’s immanence has early-twentieth-century precursors in her foremothers, who advocated “true Judaism”—the sense of God’s daily presence. Though in practice her life may hearken back to traditional Jewish women’s religious practices that one scholar described as “largely private . . . and emotional in nature.”

Elise’s home-based living is not well described by the reclusive and atomistic sense that “private” evokes. Family and friends infused the “privacy” of Elise’s religion, as did a political vision of the significance of her home-based life. She felt nourished by human and spiritual connection at home and at the synagogue, and tied this sense of connection to her place in a wider movement that reclaimed the home as both a religious and a political reservoir of action.

Home Birth and Religious Freedom

Elise’s assertion that her home-based living has both religious and political importance is mirrored in the broader home-birth movement. As I show in chapter five, the feminist, or for some postfeminist, home is an important site where political visions are created and nurtured. Home birth in particular is a form of cultural critique rooted in both religious and political motivations. Especially in the case of home births with unlicensed direct-entry midwives, home birth acts as a kind of civil disobedience undertaken by those suspicious of state regulation in the affairs of family life. Most home-birthing families, whether religious conservatives or progressives, would agree that planning to give birth at home is a civil or unspecified right. For example, in their “Declaration of Independence,” the National Association of Parents for Safe Alternatives in Childbirth (NAPSAC) declared women’s “right to a safe, natural birth assisted by and in the company of those who love them” to be inalienable. However, home-birthing women are not confronting a monolithic state in their assertion of home birth as a civil or religious liberty. As Paula Treichler has maintained, “U. S. policy toward human sex and reproduction . . . remains an inconsistent patchwork of federal and state laws, initiatives, clinical practice acts, programs, lobbying efforts, and ideological pronouncements that involve such concepts as individual rights, free enterprise, market forces, God’s will, and the family.”

Home-birthing women and their families draw their discourses of liberty from the same polyglot
Risk, Fear, and Ethics

Chapter Three

In one case in California where a directivity statute was at issue, the court interpreted the statute to require a finding of "proven and demonstrated risk" before liability could be imposed. This interpretation was based on the court's reading of the statute and the evidence presented in the case. The court noted that the statute was designed to protect against unreasonable risks and that the plaintiff had failed to meet the required burden of proof.

Another case involved a plaintiff who claimed that the defendant had violated a duty of care by failing to provide adequate safety measures. The court held that the plaintiff had failed to establish a prima facie case of negligence because he had not shown that the defendant had a duty to act or that the defendant's conduct was the proximate cause of the injury. The court also noted that the plaintiff had not presented any expert testimony to support his claim.

In the third case, the plaintiff alleged that the defendant had breached a contract by failing to perform under certain terms. The court dismissed the claim, finding that the plaintiff had failed to prove that the breach was material or that the defendant was in default. The court also noted that the plaintiff had not presented any evidence to show that he had suffered any damages as a result of the alleged breach.

In the final case, the plaintiff claimed that the defendant had negligently inflicted emotional distress on her. The court held that the plaintiff had failed to establish a prima facie case of negligence because she had not shown that the defendant's conduct was the proximate cause of her emotional distress. The court also noted that the plaintiff had not presented any evidence to show that she had suffered any damages as a result of the alleged conduct.
The homeschooled movement is a helpful parallel to the home-birth movement, both in its antieutropian, antistate intervention position, and in how it contains a confluence of diverse religious and political perspectives. Homeschoolers are motivated by both traditional religious reasons and more diffuse by alternative goals that may include spirituality. For example, homeschoolers include conservative Christians (Catholic and Protestant) who do not want their children influenced by secular messages about sexuality and, in some cases, evolution. They also include what are sometimes known as “unschoolers,” people like Elise Gold and her friend Alison Lind-Marriott, who do not want their children educated in what they consider to be an overly structured and standardized environment. In their fight against the state-sanctioned “experts,” homeschoolers have effected unlikely alliances. For example, Michael Farris, the conservative Christian president of the organization Home School Legal Defense Association (and past co-chair of Pat Buchanan’s presidential campaign), affirmed in a 2 February 1997 article in the New York Times Magazine that the “unschoolers’” results are good, and we’ll defend them to the hilt. There’s not one right way to do it.” Based in a common resistance to state structuring of education, homeschooling, like home birth, generates allegiances among those of diverse philosophies.

Even with this attitude of resistance to state intervention in terms of birth, many women who birth at home with direct-entry midwives still fight for state approval; they would rather birth at home with direct-entry midwives legally than illegally. They would rather be able to request medical backup for their home births openly without needing to lie to their doctors. To this end, they join groups like Friends of Midwives and Citizens for Midwifery that do such things as lobby the government to approve certification for direct-entry midwives and educate women about birth options, especially home birth. They also launch court challenges based on everything from what might be conservative arguments about religious affiliation to expressly feminist arguments about the right to privacy in procreation, with the assertion that childbirth is a sexual act.

Their collective action situates home-birthing women in a long tradition of female reform efforts in the United States. As anthropologist Faye Ginsburg has shown in her work on the abortion debate in the contemporary United States, despite their suspicions of the state, women activists have worked to “domesticate church and state to serve what they see as women’s interests.” Where abortion activists on both sides of the issue have considered both the church and the state as worthwhile places to direct some of their reform efforts, home-birthers, despite their insistence

on the spirituality of birth, have focused more often on the state as the place to effect change. Perhaps this is partly because of the presumed universality of the spirituality infusing birth—utilizing institutional religion to spread the message of home birth might be considered an inappropriately sectarian venture. Certain activists are religious reformers, like the devoutly Catholic Marilyn Monroe, who regularly writes letters to the Vatican about her views on husband-assisted childbirth, or Pentecostal Carol Balzotti, who considers her midwifery practice to be a form of ministry. For the most part, however, their voices are marginal both to the home-birth movement and to their religious traditions.

Another reason for the more common overlooking of institutional religion lies in the differences between the contours of the abortion debate and those of the home-birth movement. The terms “debate” and “movement” encapsulate these differences: abortion vividly separates women into opposing views, while home-birth advocates consider women who birth in hospitals—without knowledge of alternatives—not their enemies, but the victims of a profit-driven, woman-degrading, technocratic medical system. The home-birth movement is in some ways the mirror image of the abortion debate. Underlying the acrimony of the abortion debate are similarities in terms of women’s views on the value of nurture and family. However, underlying the unity of the home-birth movement (which is rooted in those same values of nurture and family) are subsumed political and religious differences over such issues as abortion and sexual orientation. Addressing religion more specifically than espousing a presumed universal “spirituality”—similar to its nation-building version of “civil religion”—would risk raising differences that might threaten the unity home-birthing women find in their support of choice in the place of birth.

This unity has its tensions, however, that both threaten the movement’s cohesion and give it strength. As a Christian midwife who organizes workshops on “Midwifery as a Ministry” contended: “I’m not trying to shove Christianity on anyone, but I really hope to turn the table on new age midwifery.” Similarly, while most women I interviewed were comfortable with midwives not of their own religious tradition, others—namely, two Pentecostal women—were very concerned that the midwives who attended their births be Christian. These tensions were felt at the level of choice of midwife, and did not detract, for all women, from the wider commitment to choice in the place of birth.

The collective commitment to home birth across diverse political and religious affiliations is evident at a wider institutional level as well. In Ohio, where direct-entry midwifery was investigated recently by a legislative study council, several hundred people came forth to give their testimonies to the benefits of home birth. These women and men included conservative Christians, mainstream Christians, “secular” folk, and Old Order
Body Boundaries

Productive Rejection

Perhaps, we can think of our bodies as protective layers that filter through which we receive and reject different stimuli. Our bodies are not just passive receptacles for external influences but active, selective agents in shaping our experiences. Repetitive actions, such as touching or caressing, can activate the nervous system and lead to increased sensitivity to certain stimuli. This process is not only physical but also psychological, as our perceptions and expectations influence how we experience our bodies.

The boundaries of the body are dynamic, constantly adapting to the environment and the impact of various stimuli.
very contentious disagreements over other issues related to the regulation of the body; namely, abortion and gay and lesbian rights.

Advocates of home birth make choice in childbirth a political issue that encompasses physiology, sexuality, religion, and personal history. As such, they argue that "cultural" or "religious" commitments are not mere luxuries meant only for calm times of meditation, or for consolation in times of grief or crisis. In this sense, they are in accord with anthropologist Stacey Pigg, whose study of development training programs for traditional birth attendants in Nepal teased out the ways biomedical approaches to childbirth are seen as "transcendent" and authoritative by the development community. According to Pigg, biomedical approaches to childbirth in Nepal are based on the belief that "the physiological must clearly be separated from social, moral, and religious concerns."Ironically, as Western biomedical practice is increasingly exported to "developing" countries, many Western women are critiquing and resisting the assumption that religion and culture can or should be fragmented from physiology when it comes to childbirth. They are insisting that the boundaries separating the religious from the secular and the cultural from the physiological not be enacted on their birthing bodies. In the process, they bring forth an ethics of birth that grapples with questions of responsibility to self and another in what may be one of the most boundary-blurring of human relationships, that of a birthing woman and her baby. In the midst of that blurry relationship, as we will see, they find room for a diverse array of spiritualities embodied in the act of bearing and birthing a child.

Procreating Religion: Spirituality, Religion, and the Transformations of Birth

Surrounding herself with pictures of voluptuous Goddesses and inviting a sympathetic circle of women friends to the births of her third and fourth children, Valerie Auretta felt she was finally getting birth right. Valerie chose to give birth to her third child at home with direct-entry midwives in part because she wanted to honor and explore her developing fascination with feminist spirituality and empower herself in the process. By contrast, Janet Stein, who lived about an hour away from Valerie, chose to give birth at home without any midwifery or medical care because she wanted to follow the commandments of her Christian God. For Janet, these included submitting to her husband’s headship and not letting any figures of authority, be they doctors or midwives, stand in the way of the divinely ordained chain of command from God to husband to wife. Both Valerie and Janet turned to religion to back up their rejection of the medical and legal authorities that would regulate their birthing bodies, but they did so with radically different views of what religion called women to be. My goal in this chapter is to show that despite such marked differences in terms of religious tradition and doctrine, these women developed similar religiously informed approaches to childbirth that depended on seeing birth as not simply a bodily process to undergo, but an experience to be chosen.

Despite the gulf separating Valerie’s and Janet’s theological visions of women, they shared one thing: a commitment to insisting that birth could and should be a religious experience. Though nineteenth-century doctors and clerics had similar interests in the theological meanings of childbirth (especially regarding the vexing question of pain in the dawning era of anesthesia), in the twentieth century representatives of religions such as Christianity and Judaism left the actual practice of childbirth largely in medical hands. While long fascinated with abstracting metaphors and ideas about birth as fodder for theological rumination or symbolic systems, traditional religious thinkers have ignored the bloodiness and painfulness of birth, and have disregarded what this blood and pain might mean for birthing women. Whether due to repulsion for the messiness of birth, to long-held fears of women’s bodies as polluted, or by virtue of a general