# Anthropology and Birth Activism: What Do We Know?

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A few days ago, I attended a dinner for birth activists in Seattle. The 14 women (and one man) gathered there held our glasses aloft as a doula (a woman trained to provide support to the laboring mother) made the last toast—"*for all the women who don't know*."

My reactions trembled on the existential brink. As both an anthropologist and a birth activist, I am trained to honor and respect women's choices and the knowledge systems on which they base those choices, but also to deeply question the cultural conditioning underlying all "choice." And in both roles, I heard just as deeply the pity in the doula's voice, the regret, the sadness—this was not a toast of celebration made "to" these women, but rather one of longing, a hope "for" these women (who constitute over 90% of the American childbearing population) that they may come to "know"—to see the light and truth of what birth activists are sure they are missing—the deeply embodied, tremendously empowering experience of giving birth on one's own, without the artificial aids of drugs and technologies.

**Fault Line 1: Birth Activists and Birthing Women**

The sadness and pity that birth activists feel for women who "miss out on birth" is unappreciated or unnoticed by most American birthgiving women. The 100 interviews I conducted in the late 1980s and early 1990s clearly showed that only about 25% of my US interviewees even wanted a fully natural childbirth. 75% either desired or were relatively content with their highly technologized birth experiences. These data have been recently amplified by a 2002 Harris poll survey of 1800 American women designed by the Maternity Center Association, which showed that 63% of survey respondents received epidurals, 93% received electronic fetal monitoring and many other forms of technological intervention during labor, and over 90% expressed satisfaction with their childbearing experiences (www.maternitywise.org).

There was a ten-year period during which "natural childbirth" as a social movement flourished in the US and women welcomed the efforts of birth activists, who succeeded in achieving in hospitals humanistic rights to the supportive presence of family, friends, and doulas; more comfortable environments for labor and birth; and breastfeeding support. The current generation of US birthing women takes these rights for granted, right along with the epidural and the fetal monitor, which have served to ensure that American mothers use their choice and agency to reinforce biomedical hegemony and the increasing technologization of birth.

The endless dialogues birth activists engage in about how to effect changes in childbirth center around the need for education: if women "only understood" the disadvantages, indeed dangers, to their bodies and their babies from drugs and technologies, then surely they would be asking for better births. They would seek out midwives who can offer these better births, and who presently attend only 9% of American births because women don't demand them and doctors don't want the competition. They would give birth at home and in birth centers, where a holistic model of birth prevails and the focus is on facilitating women to give birth on their own and on avoiding unnecessary interventions. But in spite of the demonstrated safety of out-of-hospital birth, it has remained for the past 25 years at under one percent (.006).

**Fault Line 2: Evidence vs. Practice**

Birth activists have mountains of scientific data on their side, but this data has made little difference in the practice of birth. Routine electronic fetal monitoring remains pervasive, even though it does not improve outcomes but does raise the incidence of unnecessary cesareans. Induction of labor increases prematurity rates and labor complications, but its use has skyrocketed in the past decade to over 53%. Epidurals can slow labor, generate fevers, and necessitate further interventions for both mother and baby (who will end up in the NICU if the mother does develop a fever). Cesareans generate higher rates of infection and other complications (including death) than vaginal birth, but the cesarean rate in the US is at an all time high of 27.6%. The Cesarean rate in Brazil (39%) has long been cited as the highest in the world, but it is not. The Cesarean rate for Mexico is 40%, for

Chile, 43%, for Puerto Rico, 48%; for Taiwan and China, 50%. Cesarean rates in rural areas "underserved" by modern medicine are generally low, so in urban areas, the rates are much higher, especially in private hospitals, where they often range between 70% and 90%.

Given that much of what I have long called technocratic birth emerged and was transmitted around the world from the American technocracy, it is ironic that the US cesarean rate is lower than that of various Third World countries. Birth activists claim the credit for this fact, noting that there have (until quite recently) been no large and organized activist networks in the countries with the highest cesarean rates. They believe that their outcries against unnecessary interventions were what held obstetricians back from raising the US cesarean rate beyond 23% for 23 years (from 1979 until 2002). The present increase in the US can be traced to recent studies generating a decline in the once-popular vaginal birth after cesarean (VBAC) and the growing number of women choosing elective cesareans, an option the American College of Obstetricians and Gynecologists recently declared ethical.

**Ethnography as Activism**

Interestingly enough, although feminists sometimes accuse birth activists of essentialism, the large and growing body of anthropological ethnography about birth supports birth activist positions, often from feminist perspectives.

From the 1960s to the present, anthropologists have reported similar responses to biomedical birthways from women in developing countries around the world: "They shave you, they expose you, they cut you, they leave you alone to suffer and don't let your family members be with you, they give you nothing to eat or drink, and sometimes they yell at you and slap you." In the remotest rural clinics and the biggest urban hospitals, impoverished laboring women lie on narrow cots as (sometimes-reused) IV needles drip pitocin into their veins. The pain from pitocin-induced contractions can be terrible, and there are no doulas to mitigate it or epidurals to take it away.

Not surprisingly, many rural women resist hospital birth, leaving development planners to shake their heads over this regressive unwillingness to use modern facilities, attributing it to ignorance and close-mindedness. But Soheir Morsy notes that in Egypt's Nile Delta, the choice to birth at home with a traditional midwife is not a result of being tradition-bound, but rather a "measured judgment" about the inadequate care provided to the rural and urban poor in modern clinical settings—a conclusion confirmed by my own research on urban Mexican traditional midwives and by that of many others.

All anthropologists engaged in cross-cultural birth research criticize development policies that foster increased biomedicalization, often taking activist roles by working to improve these policies, to support traditional midwives to remain viable in the contemporary world, and to end the biomedical abuse of Third World women.

**Coercion and Choice**

In contrast to women's Third Worldly experiences, American women seem to have all the choice and agency in the world. These choices and agencies are the result of real struggles by resourced activists, from contemporary middle-class women seeking to bring humanism to technocratic birth, back to the Boston upper-crust ladies who worked hard in the 1920s to bring scopolamine from Germany to the US and to convince doctors to use it. Such choices were for decades denied to the American poor and underserved (who were "supposed to suffer"), who then turned around to demand all the technology they could get as soon as they had access to it. Because the privileged women had it, they "knew" it was the best.

Now that knowledge blankets the planet, convincing women that they should want technobirth and justifying its infliction if they don't. What is choice and privilege in one setting becomes an almost invisible coercion in another. What obstetricians *know* is that women are choosing drugs and technology, so forcing drugs and technology on women who don't choose them can be easily coded as "giving women what they want" and "respecting women's choice." Choice in the "First" World—the world of the resource-rich in every country—paradoxically serves to obscure and mystify coercion in the "Third" World of the resource-poor.

Doctors “know” that they are giving women “the best care,” and “what they really want.” Birth activists, including myself, know that this “best care” is too often a travesty of what birth can be. And yet on that existential brink I tremble at the birth activist coding of women as “not knowing.” So much anthropological research on reproduction highlights the carefully thought-out strategies behind the decisions women make within the context of their lived realities—an insight that must apply as equally to the American woman who schedules a cesarean as to the Tanzanian woman who returns to the traditional midwife. Teasing out the difference between birth activism and anthropology, I return to the core of our discipline: birth ethnographers only really know what the women they study show and tell them. It is our job to specify, contextualize, and render meaningful the choices these women make in all their diversity, so that we can tell the world what women know.