Anthropology of Childbirth

Cross-cultural approach

Rosana Davudsdóttir

Lokaverkefni til BA–gráðu í mannfræði

Félagsvísindasvið

HÁSKÓLI ÍSLANDS

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Leiðbeinandi: Sigríður Dúna Kristmundsdóttir

Félags- og mannvísindadeild

Félagsvísindasvið Háskóla Íslands

Júní 2012

Háskóli Íslands, Ísland 2012

Abstract

One of the purposes, and the red thread of this essay, is to explore some of the cross-cultural approaches to child birth and how they relate to the culture which they represent. Why do women make the choices that they make? Who has influence in decision making regarding pregnancy and childbirth? Do we have total personal freedom to control our bodies when it comes to health care or are we influenced by society and our cultural background?

Anthropology of childbirth: cross-cultural approach is not an original study, but an overview essay about the main theories, ideas, movements and etc. dominating in the field of Anthropology about the process of childbirth with a cross-cultural approach to it. I discuss hospitalized birth and caesarean birth and reasons for its increasing popularity. Natural birth, homebirth with ideas of *Sheila Kitzinger* is also presented in this paper. For theoretical background I chose the theories of Foucault and Bourdieu. Foucault's concepts of *power/knowledge* as well as Bourdieu's concepts of *power* and *habitus* are used to analyze data in this thesis.

Acknowledgements

There are several people who helped me with writing my final thesis for the Bachelor‘s Degree in the University of Iceland. I would like to thank my mentor in this essay, Sigríður Dúna Kristmundsdóttir, for constructive qritisism and incouregment wich helped me to countinue in the right direction. I also would like to thank my friend Jóhann Pétur Herbertsson for helping me with the English language and grammar. And at last my husband, Stefán Rósinkrans Pálsson, who supported me and helped me during this proccess.

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I. Introduction

A personal interest drove me to choose a theme for this thesis. I was pregnant with my daughter when I decided to write about childbirth or more specifically the Anthropology of Childbirth. Cultural diversity has worldwide proven to be unique and interesting in my opinion, and it can be expressed and revealed in many forms. Human birth is definitely one of many manifestations of cultural differences. " …Women´s health care in every society is a reflection of the total culture." (Kay,1982: vii).

Since this is not an original study, I decided to write an overview essay about the main theories, ideas, movements and etc. dominating in the field of Anthropology about the process of childbirth and I will give a cross-cultural approach to it.

Childbirth is termed as culmination of pregnancy. It is an intimate and complex transaction affected physically, mentally and spiritually. The experience of birth is different in each time period, in each culture and for each woman. Cultural and social surroundings have impacted differently on every woman giving birth, making each birth experience different. How different cultures perform the childbirth process, has drawn a lot of scholars attention, and I intend to present their work in this essay. Changes in the social-cultural systems articulated to health care, ultimately corresponds to changes in the birthing practices. Western women today can make their choices regarding birth-giving using information provided by official local institutions/ health care systems.(Holmqvist,2000:2). In non-Western cultures other aspects can shape women´s choices, such as poverty (Einarsdóttir, 2004), shame, pollution, issues of vulnerability and danger (Jeffery og Jeffery, 1993:12). Since the Anthropology of birth falls under the field of Medical Anthropology I will start this essay with a presentation of this field and I will point out main theories and concepts dominating in academical work of anthropology, sociology, medicine and other fields that overlap with the study of human birth. Especially theories by Foucault and Bourdieu. It shall discuss concepts of *power, bio-power,* and *knowledge*. A discussion on feminist perspectives on pregnancy and childbirth shall also be established as well as work of Sheila Kitzinger who is one of the biggest activists for natural birth. Other aspects of birth will be presented, such as hospitalized birth and homebirth. One of the purposes and the red thread of this essay is to explore some of the cross-cultural approaches to child birth and how they relate to the culture which they represent. Why do women make choices that they make? Who has

influence in decision making regarding pregnancy and childbirth? Do we have total personal freedom to control our bodies when it comes to health care or we are influenced by society and our cultural backgrounds?

II. Field of research and theoretical background.

2.1. Medical anthropology

Medical Anthropology is dedicated to the relationship between human behavior, social life and health from the anthropological perspective. It provides the means to look into how the knowledge, meaning, livelihood and power are developed and how these measurable facts form the pattern of disease, the experience of illness and health and planning of treatment. Medical Anthropology focuses on many different issues, including political ecology of disease, environmental context that affect health, political responsibility for health, health equality, moral and social context of physical suffering, and sociological meanings of the different disease categories and concepts of health. Emphasis is also placed on cultural and historical conditions that shape health care practice and policy, the social organization of clinical operations and the use and impact of technology in health care.

The concept of Medical Anthropology was first used in 1960-70 and during this period there where major changes. For example feminist perspective started to influence the Medical Anthropology, scientific criticism and the theories of Foucault became popular

2.2. Concepts of power and knowledge: Foucault

In *Medical gaze* (supervisory authority), and *Medical Power* Foucault examines how the state creates its citizens to have control over them even when it comes to health. All kinds of organizations and regulations control us and tell us what we should do and what not. Medical science and technology in general possess the knowledge and the knowledge possesses the power. According to Garðar Árnason (2003) Foucault was careful to present general assumptions of the relationship between power and knowledge, but considered that these links would be examined in each case. Although he described two types of relationships that can be considered generic; the power-

knowledge that leads on one hand to the classification of power and one for bio-power. Classification of power means men are classified, analyzed and studied. All belong to some group, such as gender, age group, social class and social status, to name a few. *Bio-power* is another common connection of power and knowledge and aims to have power over the living. Garðar Árnason (2003) says that according to Foucault (1991) *bio-power* appears in two ways in society: *bio-politics* of the population and *anatomo-politics* of the human body. *Bio-politics* of the population focus on humanity as species, to control groups of people, especially people of a country or region. *Anatomo-politics* of the human body are part of the new power and are intended to control the human body, not to decide whether people live or die, but how they live (Garðar Árnason 2003).

2.3. Bourdieu

Bourdieu and his ideas about the symbolic power, *habitus, illusion* is also prevalent in social sciences. He tells us that our ideas, understanding and attitudes of the world depend on the circumstances around us. He shows that the views and visions of dominant authorities determine what is in demand and what is not. Bourdieu says that people behaving according to the socialization they have received through growing up in a particular society (Bourdieu, 2007). People will assimilate to the environment that is close to them. *Habitus* involves norms, values and perceptions of people and that it is all deeply rooted in us. The people who have grown up in the same community have the same or similar habitus. Both are marked by the environment and the culture they are brought up in (Bourdieu, 1990). *Habitus* and culture are thought of as not one and the same but the habitus involves bowed and learned behavior which is in certain context, in certain environments and in certain cultures. *Habitus* invites us to behave in a certain way under certain circumstances, although it is not registered in rules, but because of this it can be said that we do not have the freedom to do whatever we would like. (Bourdieu, 1990).

Bourdieu (2001) bases his ideas on a *power* in his *habitus* theory and points out specifically their effect on gender and class, the control that is built into our society and makes it such that men are in a better position to apply it than women. Because of this it is very difficult for people in general to realize the gender injustice and to try to change it as it is closely linked to all of our existence.

In the final chapter I will use the theories of Foucault and Bourdieu for the discussion, and analysis of data I will present in following chapters.

III. Anthropology of childbirth.

3.1. Cross-cultural approach

Many medical practices have to be viewed in the context of the society that created them, as they are "created by human beings in particular social settings and at particular times" (Lindenbaum & Lock, 1993, p.3). Women's healthcare, including childbirth, is an important part of medicine and treated differently across the globe. It is perhaps so important that the treatment of women's health is a "reflection of the total culture" (Kay, 1982:vii) as they are a reflection of so many aspects of society; equality, religion, leadership and health. Childbirth is important for the continuation of the human race, and different societies and cultures recognize this fact in a multitude of different ways.

I will compare and describe a few different societies and their views, understanding and practice during pregnancy and childbirth.

Childbirth in many societies is intertwined with the problems of marriage and lineage. In Biombo region in Guinea-Bissau, for a Papel[1] woman childbearing and birth is an important requirement because she needs to "not break her line of descent" (Einarsdottir, 2004:64). In this society, lineage is calculated on the mother's side, and this means that the woman has the added pressure of requiring a girl with pressure from her brothers who are considered to be more related to her children than her husband is (Einarsdottir, 2004). In this case, the Papal woman may be placed under pressure to have children against her will, and to continue having children until she has done her job. Evidently, this could cause a number of problems, particularly if the woman's health is not conducive to having multiple children, or even giving birth naturally.

In the same society, it is "normal, and in most cases preferred, either to be pregnant or breastfeeding a child" (Einarsdottir, 2004:67). This suggests that the society

[1] Papel land or *tchon di papel* is in Biombo region.

sees women as a necessary component of prolonging life, and that one of their main duties is in childrearing. Women can die from childbirth and pregnancy, which is seen as a contagious factor, and ceremonies are often performed to prevent the transmission of the "disease", even if it is not related to her pregnancy (Einarsdottir, 2004). After going through the long period of pregnancy, a woman has a choice of locations in which to have her child, and is supposed to ignore "the pains" (p.73) for as long as possible. Women may choose to give birth alone, as a way of avoiding the beatings that come from not giving birth quickly enough (Einarsdottir, 2004). Other women are choosing to give birth in a missionary hospital which is supervised by nuns. One of the main reasons why women go there is, because they are afraid that if their child would get sick later on, nuns will refuse to give it a treatment, because it was not born there. So in a way mothers are securing their children's future, by going to give birth there, even they do not feel completely comfortable. Papel women don't like that the placenta is thrown away or to give birth lying on their back (Einarsdóttir, 2004).

The way that the Papel people treat women and the related topics of menstruation, pregnancy and childbirth is different to that of other societies. If we take the example of the Yucatan, childbirth is not something which is performed alone but rather with a group of women. Those present include "the woman's immediate family, the village midwife, and other experienced women in the community" (Floyd & Sargent, 1997:60). This is all part of horizontal knowledge transfer, with no single entity being 'in charge' of the birth. Floyd & Sargent (1997) identified that technology was used where available to help assist women deal with the "unpredictability of pregnancy" (p.98). It could be suggested that, in the Yucatan, the availability and transfer of knowledge during childbirth has a similar function in reassurance, although technology is also available.

Among the Adyghes (Djandar, 2008), various rituals of birth have been practiced throughout their history and only a few of these practices still remain. The Adyghes (Djandar, 2008) believe that only after a woman has given birth can she actually attain the true state of womanhood. Moreover, pregnancy is the only way by which a woman can actually be a member of her husband's family. It is important to note that the Adyghes are a conservative people who have observed the traditional roles of men and women for thousands of years (Djandar, 2008). During their pregnancy, the Adyghes women are also not allowed to visit their parents during the last months of pregnancy.

Preparations for birth are often begun ahead of the due date, however, no diapers and clothes are stored ahead of births (Djandar, 2008). These women are also not allowed to visit cemeteries in order to prevent evil spirits from inhabiting them; they are also not allowed to blow out fires because their child may then die from a fire. (Djandar, 2008).

Actual childbirths have to be carried out at the house of the husband in a room designed for birthing and occupied by the parents of the husband (Djandar, 2008). A midwife is often invited to carry out the childbirth; no relatives are allowed to assist in the birthing process. A fire is kept alive by the family members until the end of the birth. The birthing women deliver on straw or felt; straw was perceived as having magical qualities which potentially could bring fortune to the child's life (Djandar, 2008).

Technology also plays a huge part in pregnancy and interaction with the unborn child where it is available. With the increasing popularity of ultrasound scans, it seems that this "visual" representation of the baby is what makes it "real". (Floyd & Sargent, 1997:98). This appreciation for the interaction seems to be universal amongst women who have been socialized to television images, regardless of their race or class. This evidently is a huge contrast of the experiences of Papal women, who view (or are told to view) pregnancy as inevitable and without mystery (Einarsdottir, 2004). From this, it perhaps becomes clearer how Kay (1982) equates human birth to the society as a whole, with access to technology informing the ability to read ultrasound images (Floyd & Sargent, 1997) and the matrilineal nature of Papal culture defining the importance of child gender and the treatment of women during the birthing process.

The amount of control women have over their own birthing process also differs between cultures, and is an interesting representation of the authority of women in the relevant society. For example, in American culture, the choice of medical intervention and birthing methods are "more limited for poor women" (Floyd & Sargent, 1997:133). This is in part due to the culture of health insurance, which leaves many financially insecure women at a disadvantage as to the types of provision available to them. Those women in the middle classes, however, represented a much wider spectrum of wishes and desires associated with childbirth. Some preferred the idea of "natural" birthing, with others accepting total medical assistance. This suggests that the socioeconomic class of the woman defines the style of childbirth available, but Floyd & Sargent (1997)

found that the desire for an uncomplicated birth and what was perceived as "good" medical help was unanimous amongst all women.

3.2. Hospitalized birth

With increasing population, birth practices have taken a different turn deviating from the traditional practices. In addition, technological advancement has swayed people away from these traditional methods towards adopting modern technology.

Maher (2008) mentions that births in Western countries have been carried out in hospitals and that developing countries have relied on home deliveries for their childbirths. In data gathered in Melbourne, Australia, the author was able to discuss that obstetric control is a manipulation of women's birthing patterns. This is a firm stand taken by various feminists on this issue thereby implying contradictions within the childbirth process which eventually effects decision making of women (Maher, 2008).

From another view Barbara Bradby (1999) points out that the women are often stereotyped as "victims" when it comes to childbirth in a hospital, especially by feminist audience. Bradby (1999) discusses experiences of migrant rural women in Bolivia in relation to hospital births. These migrant women adhere to their practice of going to the hospital for their births but also controlling their choices within these settings. They negotiate with staff about what they want and what kind of interventions they don't want. And some women end up giving birth in a hospital, but alone in a room and in positions that they prefer or are familiar with from home birth. In effect, they would not go to the hospital to get help give birth, but to get medical care after birth, when the placenta is born. (Bradby, 1999). This study shows that that these women are in control, and they know what they want in birthing. It's a two-way process: "As women move to take advantage of what are explained to them as superior technologies which make birth "safe," they also bring to bear different understandings of these technologies and their action on the body. Their agency in rejecting some of them and actively pursuing others is grounded in cultural understandings of the body. These cultural understandings have proved remarkably resilient, adaptive, and flexible, and women's use of them forms the basis of the strategies of negotiation ..." (Bradby, 1999: 299).

Various factors influence choices in childbirth. In the rural Shanxi Province of northern China even with a national program for hospital deliveries, rates for hospital births are still low (Gao, et.al., 2010). Various barriers impact their choices, mostly for

economic and geographic reasons and poor maternal care; they also have problems with transport and they find traditional birth attendants a more convenient choice for them during their childbirth (Gao, et.al., 2010). These echo the trends seen in previous studies about trends effecting choices for childbirths.

The power of knowledge about birth was also emphasized by Baker, et.al., (2005) where the authors noted how their female respondents expressed that the lack of control they felt during birth was mostly attributed to their lack of information. Women who reported negative experiences in relation to lack of control, information provision, little influence over decision making, and to a lesser extent staff attitudes. (Baker, et.al.. 2005) Poor communication and staff attitudes during delivery are also relevant issues which women experience during the process of birth (Baker, et.al., 2005). As a result of these experiences, they often feel angry, disappointed, and inadequate. And because of that some women later choose home birth during their next pregnancy.

In the West, anthropologists discuss that much emphasis is often placed on science and technology (Wendland, 2007). Such an emphasis on technology has translated to reverence and faith on the use of these technologies, even without their proven benefit. Due to this growing faith in technology, the belief in the efficacy of c-sections have become practically unrepressed. On the other hand, vaginal deliveries have been labeled as unpredictable and uncontrollable (Wendland, 2007). This would largely explain the popularity of c-sections in many Western nations. With this assumption I will continue to next chapter were I will be focusing on Caesarean section.

3.3. Caesarean section

Caesarean section rates have increased in many countries during the past twenty years. So what are the reasons that cause the popularity of this procedure? Reasons of course can be medical, social and cultural.

"Caesarean section is promoted in the USA as a way of "keeping your vagina honeymoon fresh". It is sometimes referred to in the British press as "the sunroof option", and is invariably treated as life-saving for the baby and safeguard for the mother's health and sexuality. If you do not have a caesarean you risk your vagina getting flabby, your pelvic floor muscles collapsing, your bladder leaking and losing your man." (Kitzinger, 2005:73). As we see this medical procedure became a "target" of

marketing and advertisement as well. So partially it could be an explanation why Caesarean has become so popular in Western countries.

Issues which relate to the obstetrician's role, as well as his training and experience were given much notice and attention (Barros, et.al., 1996). On the other hand, anthropologists have started wondering why women seem to be accepting the application of these invasive procedures, especially when high-risk births are not the factors affecting their decision. One crucial element of the analysis expressed that the basic obstetric understanding is based on compelling technology and male ideals, eventually causing gender biases where women do not have much power to oppose medical interventions (Barros, et.al., 1996).

But we can´t forget that personal reasons as well exists. For example for some women, there is a major fear of vaginal childbirths, mostly stemming from a traumatic experience during the birthing process. Like in Australia, reasons for refusing vaginal childbirths were mostly due to trauma during previous childbirth; the respondents noted however that with a strong support system and with strong relationships with midwives, the birthing experience for them was improved (Kasai, et.al., 2010). Socio-cultural factors also seem to have a significant factor in the decisions of women regarding choices of childbirth. In Italy, 73% actually prefer vaginal births and women in Asia also prefer vaginal births (Kasai, et.al., 2010). And yet, 73% pregnant women surveyed in Singapore declared that they preferred cesarean births. In South Korea, the preference of women mostly runs towards vaginal births. These differences in preferences seem to be largely associated with attitudes of society about childbirth. A long history of infertility has registered to be one of the reasons why cesarean births have been preferred by pregnant women (Kasai, et.al., 2010).

Attitudes of counselors regarding childbirth also have a significant impact on women's choices in childbirth. Having a coping attitude on the part of the counselor usually helped ensure changes from c-section births to traditional births and sometimes vice versa. Horton-Salway and Locke (2010) also discuss the importance of choices and medical control for the woman during childbirth. These choices are also associated with the participation of leaders in health care on counseling for childbirth choices. The point in the end is the ability of the woman to make her own choice for childbirth, one which is not influenced by fears or illogical traditions and rituals.

Researchers have also established that many individuals actually prefer c-sections or any sort of medical assistance during child births (McClain, 1987). They believe that medical technology is a means of controlling their own health. However, the increased rates of c-sections from up to 70 to 80% in some private medical institutions cannot be sufficiently explained by rational desires to control their own body (Behague, 2002). There seems to be other elements at work and those which have influenced the decisions of women have become significant influences among them. Some experts point out that women and obstetricians have been motivated by the trend and culture of caesarean births where technologically advanced interventions are being touted as the safest, most painless, and ideal means of childbirth for women (Mello 1994). In societies which have increasingly campaigned for the protection of women's rights, allowing women's requests for operative childbirths seem to have become a moral issue in terms of equal access to medical technology (Mello, 1994).

Discussions which considered whether physicians should allow women's requests for c-sections have been rampant in recent years especially with the increased rates of preferences for c-sections (Peterson-Brown, 1998).

Those who argue against allowing women to choose c-sections for their child birthing believe that women's choices are being goaded by the lack of knowledge and emotional maturity for natural vaginal deliveries; and that it is based on their fear of pain and their desire to maintain their sexual bodies (Bastian, 1999). The main focus on non-medical elements has neutralized the discussion on the etiology between physicians and their actions and women's choices (Groom, et.al., 2001).

More studies set out to determine what people actually thought and how much of their choices could be credited to physicians and how much of it is their personal preference. Among physicians, the issue is often raised in terms of how their decision is attributed to financial considerations and how much is due to the fear of being sued (Behague, 2002). Are women actually making their decisions freely, or are the physicians imposing their own demands by describing normal births in negative terms? In an analysis by Hopkins (2000), the author set out to evaluate whether women actually wanted c-sections. This research was anchored on the belief that it is the physicians who often want to carry out the c-sections and they often end up influencing the woman into choosing c-sections for their birthing. Her research revealed that only a minority number of women actually verbalized their preference for c-sections (Hopkins, 2000).

This affirmed her contention that physicians often have a significant influence on women's decisions in relation to their choices in child-birth.

Dahlen, et.al., (2011) discussed how women use the English language internet blogs to discuss vaginal births after caesarean (VBAC) and how these discussions affect their decisions on future pregnancies. Most of the blogs came from the US and opinions revealed that most of the women made their decisions on VBAC based on their belief system which considers their personal choices first more than anything (Dahlen et.al., 2011).

Rates of c-sections are also higher in private than in public hospitals (Osis, et.al., 2001). Among women with higher educational background, the rates of c-sections are also higher than those with lower educational backgrounds. These types of birth are often based on financial considerations and for as long as the pregnant woman can afford to be admitted in a private hospital and have a c-section, then the choice is welcomed for women.

3.4. Feminist perspective, natural birth movement and ideas of Sheila Kitzinger

Social movements and two decades of feminist movements, including a natural childbirth movement have shifted birth practices and women's perspectives of childbirth (Lazarus, 1994). Specifically, reproductive choices have been at the very core of feminist activism. Improvements in technology have provided some new choices, but have closed others (Rothman, 1984). In effect, fetal monitoring may assist in the detection of fetal distress. After such detection, the choice and the decision can then be made by the woman on the type of birth she would choose. The woman has to decide whether or not the information she has received is accurate or is just an exaggeration by the physician. Nevertheless, women want to be reassured about the safety of their child and would often submit to their physicians in order to ensure the safety of their infants.

The feminist perspectives of childbirth have focused on the physical nature of women's experience in terms of pregnancy and childbirth as female functions (Houvouras, 2006). All in all, pregnancy and childbirth is a natural state which is said to contribute to the oppression of women (de Beauvior, 1989). Other feminists argue that the oppression often imposed on women is based on their ability to control the reproductive experience and on men's desire to control this naturally female process (Corea, 1985). Other feminists have also highlighted the different ways by which

pregnancy has created disruptions of anatomical boundaries with none having effectively surpassed the physical nature of the female body as the vessel for childbirth (Houvouras, 2006). Young (1990) also notes the doubling qualities of the female body, which is said to lead to alienation. The so-called doubling of self comes from the experience of having another person growing inside oneself and the trials of the pregnancy experience. There is a doubling of self where the body begins and it ends with the pregnancy progressing and taking up more physical space (Houvouras, 2006).

To limit and control women‘s power, doctors have used „science“ and „truth“ in the battle between midwives and doctors, according to Doering(1992). Doctors have by the usage of words like that used a power/knowledge structure to gain power over nurses.

Churchill(1995) says that given the fact that obstetricians are trained to identify and treat complications, it is no wonder that their view of pregnancy, birth and postpartum is that it is a dangerous time and that it can be loaded with diseases and complications. The whole ideology is that the circumstances are abnormal and dangerous, despite the fact, according to Churchill, that most pregnant women are healthy and as are their children.

It’s almost impossible to search for academic material about childbirth and feminism, without coming across the name of Sheila Kitzinger. She has written many books and articles on the subject of childbirth and everything that connects to it.

Kitzinger (1994) has stated that the ideas women have about pregnancy and childbirth are heavily influenced by culture. In each culture there is a message on how a woman should behave, what to expect and what is taking place inside her body. There are different messages in each culture given to women when they are pregnant.

Sheila is one of the biggest activists for natural childbirth. Sheila Kitzinger enlightens the society about the dangers of deviating from traditional birth practices through her ideas and research. She observes that the unparalleled technological expansion spells doom for natural methods of childbirth. Kitzinger asserts that the use of technocrat’s methods should *Birth in Crisis* only happen in extreme cases where the natural way has failed totally. She is a strong advocate of traditional mode of childbirth. Through her work, she sheds light on the birth procedures, which embraces technology and calls for a critical reflection of the home child delivery. Use of machines is more prevalent in the United States and Europe. (Kitzinger, 2005). She believes that birth

should only be under the control of the woman and a competent midwife but not through monitoring electronic machines. Kitzinger challenges potential mothers to deliver through a natural model. According to her, it is the safest way to bring life to this earth (Kitzinger, 2006). She examines closely the language the obstetrics use to the expectant mothers and thus she provides plausible alternative. (Kitzinger, 2006)

In the book, Kitzinger (2006) explores the stories and conditions of mothers who gave birth at home and in the health centers. Women express their satisfaction in the hands of midwives. She contrasts the home birth care with the pathetic situation in hospitals under obstetrics and massive use of machines. Kitzinger (2006) points out that research shows the hospital environment is the source of unnecessary trauma and depression for mothers. Though perceived to conduct their duties in a professional way, the General Practitioners fail to give the right medical diagnosis. This compromises the health of a mother and the child. The traumatizing experience in the health facilities with its post birth panics attacks scares women from successive pregnancies. It interferes with the sacred role of women to procreate and bring about continuity of life. (Kitzinger, 2006).

Kitzinger (2005) strongly criticizes the Western culture where parturition is a mother and doctor affair. They believe that expectant mothers should be under close observation of an obstetrician. The mother is required to co-operate for birth to occur in a smooth way. Her compliance with doctor's instruction is crucial to the outcome of childbirth. Kitzinger (2006) asserts that this is a deprivation of the mother's birth freedom and an unfair instilling of terror to mothers. The mother therefore deserves respect and control in this process. Kitzinger sees that the hospital rules clearly indicate the instructions of the birth procedure and mothers only have to comply blindly with the hospital regulations. This leaves them with a less voice about the very activity happening with their bodies. Kitzinger perceives this as victimization in its extreme. According to her, mothers have the right to seek information about the whole exercise and their health, which may be at stake (2006). Women are not encouraged to ask questions in many places. They are supposed to trust the health care professionals without asking too many questions. If women question the instructions of the health care professional, they might get back phrases like: „You don‘t want to hurt your baby, do you?“ (Kitzinger, 1994:142).

Kitzinger (2006) presents the images of women who suffer silently after the reality of childbirth in the hospitals. She examines them and discovers that many of those mothers keep their awful experience private. They contemplate whether to return to the medical centers or just stay at her comfortable home. Kitzinger (2006) supposes that it is possible to avoid the distressing events. Her solution is to acknowledge many benefits inherent in the home birth care under safe hands of midwives. She indicates that, the method of induction of labor incapacitates the expectant mothers. Kitzinger argues that the use of modern machines affects the normal functions of hormones in the mother's body. (2005) She concludes that it is the principle cause of Caesarian births. She alludes that the medical practitioners are quick to go for Caesarian even in obvious cases of normal vaginal parturition. The excessive use of painkillers affects the natural pain, which mothers have to go through during delivery. She proposes a therapeutic massage, which decreases labor pains and makes it short. Midwives also provide infant massage. This is advantageous to the infant because it reduces growth complications (Kitzinger, 2000).

Kitzinger links maternal mortality cause to the heavy intervention of electronic instruments in the hospitals (Kitzinger, 2000). She highlights some examples such as, the effects of labor-inducing drugs on the uterus, which leads to rupture and excessive application of anesthetics. Kitzinger notes that, it is possible to do away with these deaths through strict adherence to proper medical procedures.

Kitzinger expresses her discomfort on the way the media depicts birth process (Kitzinger, 2005). According to her, the media presents a scary picture of childbearing. To them, delivery is a death and life affair and the only hope is in the hands of medical practitioners. Programs, which appear on television and other types of media, paint childbirth process as a hospital responsibility. They intentionally focus on those mothers with child delivery complications and end up in the hospital beds. This is to a big extent an influence on the choices mothers make. Mothers change their initial decisions for the home birth and opt for the hospital care forthright. This is mainly because mothers fear they might experience pregnancy complications when they deliver in the home setting. She challenges the media fraternity to live to their ethics, not to instill fears in mothers, not to glorify hospital child bearing as the best option but rather to explicitly report unbiased information. (Kitzinger, 2005).

Kitzinger (2005) observes the dangers, which are inherent in the fragmentation of maternity care. She notes that efforts have concentrated on creating anti-natal clinics in the hospitals. She fears that the consequence of this action spells doom for the community clinics and midwifery fraternity. She observes that there will be a great shift from home childbirth to the hospital delivery. This will destabilize cultures and they will become over dependent on the care provided in the health centers (Kitzinger, 2005).

Kitzinger advocates the education of mothers and midwives in her ideas and theories (2005). She argues that women have little knowledge about scientific technology. She notes that application of electronic instruments in the maternity is on the women yet they have little voice on it. This is because science is patriarchal in its nature and segregates women. She encourages the mothers to question its negative and positive implications on their health. To her it is a threat to the rich social stratification and women should have a chance to make informed choices. She cautions midwifery to uphold their holistic roles of childbirth and to disallow the new wave of technocrats to sway them. According to the author (2005), the training of competent midwives can only happen away from the hospital settings. She calls for autonomy in the midwifery education system. The goal of such a system is to impart social norms to the midwives.

She appears very optimistic that the home birth care can prevail in Western nations. (Kitzinger, 2005). This is achievable through various ways. To start with, mothers should seek relevant information before they make their birth choices. Next, she argues the midwifery fraternity to devise friendly methods to deal with expectant mothers. This is a good strategy to strengthen their bonds, which will enable the mothers to appreciate home delivery care (Kitzinger, 2005).

3.5. Homebirth

Homebirthers who refuse medical monitoring often succeed in compromising the authority of medical childbirths; they also reject the docile body and live in their empowered body (Cheyney, 2006). These women support the democratization of the woman's choice during birthing. Those opting for homebirths discuss their attempts at avoiding medical assistance and they create a picture of a reality which does not in any way represent docility, but one which manifests personal power. Women opting for homebirth declare that they do not need all the medical interventions which are being

made available during childbirth; and they are also in disbelief of claims that 30% of women cannot deliver their babies naturally (Cheyney, 2006). These women declare that these beliefs are only used as a means of controlling women, disempowering them and "medicalizing" childbirths. Participants in Cheyney´s study also (2006) mentioned that the choise of homebirths is relative to their previous experiences with hospitalised birthies and the power of birth at home "to heal the scars of past medical abuses."

With knowledge and the experience of personal power during birth, women who choose homebirths with midwives declare more power and knowledge in their choice (Cheyney, 2006; Gordon, 1980).

The narratives from a study by Cheyney (2008) discuss that along with knowledge as a source of power, homebirth has also become a source of power for many women. The moment of touching their infants after childbirth often gives women power and exaltation. This exaltation and power often serves as basis for empowered parenting and breast-feeding. Empowerment is the goal for every delivery and is seen by many midwives as crucial to the goal of securing healthy deliveries (Cheyney, 2008).

Acquiring knowledge as power linked with the experience of birth at home with midwives has already led to mothers losing faith in the medical institutions that they have long respected. They describe how their blind faith in medical institutions has been replaced by their resentment for hospital deliveries and other unnecessary interventions (Cheyney, 2006). Successful home births have healed them and have restored their faith in themselves and their birthing bodies; it has reduced their confidence in the benefits of hospital deliveries. This transformation has unfolded due to direct actions, actions which have been embodied in the experience of power and personal accomplishment (Cheyney, 2006).

Home births are preferred for women in developing nations due to their convenience and financial viability (Bij de Vaate, et.al., 2001). This is the case in Namibia, West Africa where traditional birth attendants (TBA) usually delivered the infants. These attendants however admit that they usually experience problems with retained placenta and excessive blood loss; as a result, some of their patients die (Bij de Vaate, et.al., 2001). Similar incidents of poor financial conditions during childbirth have also been seen in the case of poor rural households in Bangladesh. Women in these settings consider pregnancy as any other event, except where complications arise and in which case they would then seek prenatal care. Their financial difficulties along with

their traditionalist beliefs often delay their health-seeking behavior (Choudhury and Ahmed, 2011). Under these poor settings, the childbirths are often carried out on the floor while squatting, with the assistance of attendants, who do not practice aseptic methods. The removal of the placenta has also been questionable and often harmful to the mothers. Moreover, multiple taboos within their society often restricted their knowledge and application of appropriate medical remedies (Choudhury and Ahmed, 2011).

In a study by Ali and Howden-Chapman (2007), the authors demonstrated that Malaysia has undergone significant developments in the last two decades. Malaysia has recognized the importance of applying medical technology to deliveries in order to assist women during their delivery. With these changes, rituals and traditions during childbirth were changed, some discarded. Home-birth also became an unpopular method of childbirth because of these modern ideals (Ali and Howden-Chapman, 2007). Women in these settings have become embarrassed to still practice their traditions because these practices have been deemed old fashioned. Modern medicine has become popular in the urban areas; however, in the rural settings, a combination of the traditional and the modern practices have been adopted (Ali and Howden-Chapman, 2007).

To give birth at home or at the hospital? Who should attend? What kind of medical intervention do I want during my labor if I want any? These and other decisions about what kind of birth do women want are usually taken during pregnancy. So in those matters prenatal care, educational courses and other activities women attend are really important during that period.

3.6. Prenatal care

Contemporary practices in prenatal care can be seen as a collection of moral acts which are taken from implied and expressed moral standards. The concept of caring for self provides a strong rationale for the assumption that prenatal care being more than mere guidelines for healthy pregnancy (Root and Browner, 2001). By understanding and reflecting on statements by a group of pregnant women on various issues relating to prenatal care, there is a chance of understanding the process of birth better. The authors argue that women often make the adjustments on authority and their knowledge in order

to fit their needs. Pregnancy is the point where women straddle two planes – that of being the authority and of being the subjugated (Root and Browner, 2001).

Women's compliance with prenatal trends seems to be credited to the fact that technologies and health experts are seen as the powerful authority on childbirth and pregnancies (Root and Browner, 2001). Prenatal care has become another means by which control over women is being exerted. For many years, prenatal care has not been an important need for pregnant women, but the subjugation of women's knowledge about childbirth has led to the perception that all pregnant women must undergo prenatal care (Root and Browner, 2001).

Sered (1993) discusses that among Jerusalem women, there are ritualistic packages they apply, including wearing amulets during pregnancy and requesting for blessings from their rabbis. Reciting psalms during the pregnancy and childbirth have also been seen among Jewish women. These are folk-religious practices in childbirth, mostly practiced during the prenatal periods, and are mostly meant to provide the pregnant women some form of comfort (Sered, 1993).

Despite rituals serving as comfort sources for pregnant women, a solid effort on the part of clinicians towards making the people in rural communities understand modern methods of medicine, have also ensured better choices for pregnant women. In a rural community in Canada, this was apparent when *fetal heart monitoring* (FHM) was used in order to help people in the community to better understand childbirth (Bassett, 1996). With the application of FHM, informed choices for women in rural towns have been improved.

Some pregnant women in Iceland prefer not to attend educational courses about birth organized by local health care institutions (Einarsdóttir, 2007). Their motive is that they don't want to be influenced in advance about what to expect and what not to. They want their birth experience to be absolutely fresh without formed opinions in advance. (Einarsdóttir, 2007).

Some women chose "untraditional" activities during pregnancy, such as prenatal yoga. Research in Iceland has showed that prenatal yoga has a very positive effect on women during pregnancy and birth (Ármannsdóttir, 2009). Besides exercise women get more confident, secure and in control going to labor. They learn how to breathe correctly, and how to control their bodies and mind during birth (Ármannsdóttir, 2009). In the same study women who attended yoga, mentioned that they felt very prepared,

ready and informed about the birthing process (Ármannsdóttir, 2009). Women are encouraged to think about natural birth, with or without minimum medical interventions, using breathing, self-confidence and other techniques they learn in yoga.

3.7. Who attends?

In recent years, midwifery has been revived in developing countries, especially among feminists and other women seeking alternative means of birth (Ginsburg and Rapp, 1991). Most studies on indigenous birth attendants are based on assessments of medical remedies. Midwives are considered neutralizing elements in resisting the centralized tendency towards medical births. Many Western nations have adopted the practice of removing births from homes and on to hospitals (Ginsburg and Rapp, 1991). This practice however has reduced the power of passing the knowledge of childbirth to women and future generations of women. Midwife-assisted childbirths are now strong practices in developing countries and developed nations have now richly considered its prospects and possibilities in terms of protecting their power and control over their body (Ginsburg and Rapp, 1991).

In Guatemala, indigenous midwives have attended many births and some have even received government-assisted medical training (Ginsburg and Rapp, 1991). Medical professionals have not expressed their support of these types of births, nor have they expressed belief for indigenous theories on child birth and other illnesses. There is a desperate element of wanting to control the power of women over their bodies; this control also seems to refer to the need to eliminate the concept of female heroism in the medical setting (Ginsburg and Rapp, 1991).

In Mexico, traditional birth attendants are the accepted types of childbirth (Camey, et.al., 1996). These attendants have been in existence in their society since pre-Hispanic times making these attendants their principal birth attendants. These attendants have been known to cater to the needs of about 44.5% of all births. They also provide prenatal and birthing services, including family planning services, herbal remedies, and child care (Camey, et.al., 1996). Women in these communities seeking prenatal and birthing services mostly experience economic and geographic difficulties which makes it difficult for them to access hospital services. For women who have no financial and geographical difficulties, they often choose to access both medical and traditional birthing services in their community. Understandably, there is a greater cultural

identification towards traditional birth attendants in relation to traditional cures like herbs, massage, and even religious resources (Camey, et.al., 1996).

In Iceland both hospital and home birth, which is said to be normal, is attended by midwifes. However in the hospital it's not guaranteed that the same midwife will be present through the whole birth process (http://www.ljosmodir.is/Data/yfirseta_studningur_faeding.pdf). Midwifes not only give medical attention during birth process or deliver babies, but also supports women mentally and physically. They encourage women, praise them and give them more confidence. They also give light massages, cold-hot compresses and other support women need. For the last few decades it has been very common for women to have their birthing partner with them during labor and birth process. It's usually the woman's husband, boyfriend or life partner, but it could also be any family member or friend. Research suggests that the right support of a birthing partner or midwife during birth process can influence how a woman will experience the whole process. Right support reduces usage of epidural and other medical interventions to speed up the birthing process and even reduce caesarean rates. Women feel satisfied and confident afterwards and positive feelings after birth reduce chances of postpartum depression (http://www.ljosmodir.is/Data/yfirseta_studningur_faeding.pdf).

IV. Discussion and summary.

In my final discussion I would like to use the concepts and theories of power/knowledge and habitus by Foucault and Bourdieu to analyze the data I presented in previous chapters and at the same time to sum up the material of this essay.

For Papel women it's important to "not break her line of descent" (Einarsdóttir, 2004, p. 64) and have children. So in a way society puts pressure on women to be pregnant and have children. We can interpret this as symbolic power in Bourdieu's theory of *habitus* (see p. 7), but at the same time for Papel women it is normal and preferred to be pregnant or to breastfeed a child (Einarsdóttir, 2004) so they may not experience themselves as powerless. Women there also have a choice on where and how to give birth. Some of them choose to give birth alone, others give birth at their husband's or their parent's home (Einarsdóttir, 2004). Other women go to the nuns at the missionary hospital. So here we see a freedom of personal choice. I mentioned reasons for giving birth at the missionary hospital. And this specific relation between

women and nuns is an example of medical power/knowledge concept in Foucault's theory (see p. 6). Women are afraid that their children would not get medicine and treatment if they get sick, because nuns can refuse to treat children who are not born in the missionary hospital. In that way nuns have power to control women, how and where they should give birth.

Based on a feminist perspective, the practices of birth rituals of Adyghes people which I mentioned in previous chapters seem to imply a loss of a woman's power over her body and her activities. In fact, the choice which is supposed to be attributed to her as a woman carrying her baby is eliminated. She is controlled in effect by the rituals of her ethnic grouping. It is however important to note that based on the Adyghes's point of view, they view these rituals and traditions as a crucial part of their identity (Djandar, 2008). Many of them do not see these rituals as an exercise of power or control over their actions and their bodies; instead, they view these rituals as their means of appeasing their traditions, and of finding comfort in their traditions. We can also understand this behavior through ideas of Bourdieu about *habitus* (see p. 7). Norms, values, believes and perceptions of Adyghes people are deeply rooted in them and they behave according to the socialization they have received growing up in their *habitus*.

Lindenbaum & Lock (1993) identify that there is a cultural construction of childbirth, as well as childbirth representing the culture, and accordingly there is a wide variety of how cultures view childbirth. For example, the Papal people (Einarsdottir, 2004) feel that women should be pregnant as much as possible, as part of a duty. The American women in Floyd & Sargent (1997) tend to see it as a medical event, purely dictated by the availability of certain technologies. Other tribes see the event as something mystical, where the childbirth process is dictated by certain traditions that would fall under a more general religious category. In these cases, women tend to be held by that society in a more sacred role, although that does not necessarily dictate the treatment of women in general with respect to work and marriage (Lindenbaum & Lock, 1993).

Women today believe that the current interventions available for pregnant women are improving their reproductive choices and the control they can exert on the process of giving birth (Hubbard, 1984). For one, doctors are acting as if current technologies can decide the outcome of births and solve major issues. What used to be tools of doctors were suddenly considered as machines to influence their decisions and to replace their

medical discretion (Lazarus, 1994). On the part of the women, they seem to have developed an expectation for a perfect outcome of all babies being born healthy. Moreover, with the medical community capitalizing on their success, many individuals have been convinced about the invincibility of medical procedures (Lazarus, 1994). In any case, the combination of these elements seems to have led to more women seeking caesarean births.

In a study by Baker, et.al., (2005) female respondents expressed that the lack of control they felt during birth in a hospital was mostly attributed to their lack of information. They felt helpless and not in control over decision making during labor and birth. Here we see strong connection between knowledge and power. In this case medical staff had power to "control" women's body or according to Foucault's theory *of anatomo-politics*, power to control the human body. As Barbara Bradby (1999) pointed out that women are often stereotyped as "victims" in the settings of hospitalized birth. This victimizing is often seen in feministic work. But in her study of migrant rural women in Bolivia she showed that women were in control of their birth in a hospital. They come with their own ideas and believes about how birth should be and adapt perfectly in hospital settings.

Caesarean rates have increased in many countries during the past twenty years and I pointed out reasons that caused popularity of this procedure. Marketing and promoting caesarean procedure became popular in USA and Britain with slogans like "keeping your vagina honeymoon fresh" (Kitzinger,2005:73). Barros, et.al., 1996) pointed out that basic obstetric understanding is based on compelling technology and males ideals, eventually causing gender biases where women do not have much power to oppose medical interventions. Bourdieu's idea on a power in his habitus theory supports this assumption. *Power* specifically effects gender, the control that is built into our society and makes it such that men are in a better position to apply it than women. In an analysis by Hopkins (2000) the author affirmed that physicians often have a significant influence on women's decisions in relation to their choices in childbirth, in this case caesarean section. As Sheila Kitzinger pointed out, health care professionals control women with phrases like: "You don't want to hurt your baby, do you? " (Kitzinger, 1994:142). But Caesarean procedure can be the personal choice of a woman. Some women believe that in that way they are in control of their own health. Those who argue against allowing women to choose c-section for their child birthing believe that

women's choice are being goaded by lack of knowledge and emotional maturity for natural vaginal deliveries; and that is based on their fear of pain and their desire to maintain their sexual bodies (Bastian, 1999). Socio cultural factors seem to have a significant factor in the decisions of women regarding birth choices. Women in Singapore declared that they preferred c-sections births and 73% of women in Italy support vaginal birth. This difference seem to be largely associated with the attitudes of society about childbirth (Kasai, et.al., 2010). This assumption is supported by Bourdieu's (1990) theory, that people who have grown up in the same community have the same or similar habitus. Both are marked by the environment and the culture they are brought up in.

Anthropologist Sheila Kitzinger is an activist for natural childbirth. She believes that use of technocrat's methods should only happen in extreme cases where natural way has failed totally and that birth should only be under the control of a woman and a competent midwife. She argues that the use of modern machines affects the normal function of hormones in the mother's body and she points out that it is probably the principle cause of Caesarean births. She is very optimistic that the home birth care can prevail in Western nations. The narrative study of Cheyney (2008) discuss that along with knowledge as a source of power, homebirth has also become a source of power for many women. With knowledge and the experience of personal power during birth, women who choose homebirths with midwifes declare more power and knowledge in their choice (Cheyney, 2006; Gordon, 1980).

Prenatal care can be ritualistic as in Jerusalem and can be medical as in Western countries. Some women choose activities such as prenatal yoga. And it all can have effect on women's understanding how birth should be. From my own personal experience I can tell that going to prenatal yoga classes, changed my opinion on how I want to give birth. At first I wanted "painless" labor with help of epidural procedure. But in yoga classes natural birth was "romantized" and encouraged by the yoga teacher. And little by little in a few months I was very fond of the idea of natural birth, without any medical interventions, in total control of my body through breathing that I learned in prenatal yoga. So I would analyze this change of mind with Foucault's theory of power. The yoga instructor was an "authority" and possessed knowledge and had power to influence my decision. But when I went to the hospital to give birth I was very confident in what I wanted. I felt in control at first, I was breathing correctly, but after

very long labor, I asked for epidural and in a few hours I had my daughter. So my personal experience does not fit Sheila's idea that most of the women who give birth in a hospital with medical interventions are "victimized". I was totally happy and content with my birth experience.

Evidently, there are a number of different ways in which culture both presents and influences childbirth, and other aspects of women's healthcare. Childbirth can be seen as a right of the father, with women having to fulfill a duty. Childbirth can be seen as a medical or religious phenomenon, with the actions at the birth event being dictated accordingly to these rules. What is perhaps most usefully attained from this analysis is that there is a huge variety of practices and attitudes towards pregnancy and childbirth, and these very much depend on the nature of the culture and the position of the women (and men) within the society. Even without looking at far-off cultures and tribes, we can see that the experiences of women in childbirth vary greatly within a culture, depending on the views of the woman, her socioeconomic status, in some cases her habitus and authoritative power. There are a lot of interesting lessons to be learnt for anthropology from the treatment of childbirth within the culture.

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