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Midwifery as Mediation: Birthing Subjects and the Politics of Self-Determination

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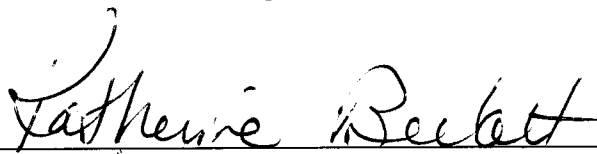
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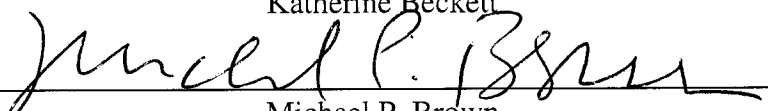


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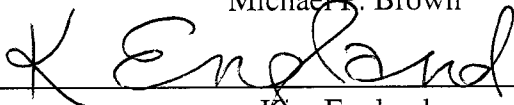
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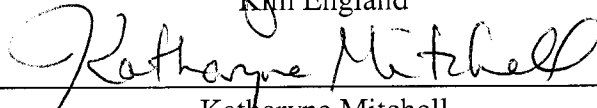
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Abstract

Midwifery as Mediation: Birthing Subjects and the Politics of Self-Determination

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The dissertation compares the emergence of midwifery in Québec with the renovations of midwifery practice in France. Midwifery, I argue, is implicated in new technologies of citizenship that take women's desires for self-determination and reproductive autonomy as their goal and target. In both Québec and France, the neoliberal restructuring of health care systems solicits greater responsibility for pregnancy and birth from individuals.

The dissertation demonstrates, however, that these new responsibilities are also experienced as burdens. The emergence of a "new" midwifery in Québec formalizes the role of the midwife as mediator in the changing relationship between the birthing subject, her body and the state. In France, midwives' affective labor in France is implicated in new forms of regulation. The exercise of reproductive self-determination, framed as a *right* by associations of health care "users," is also increasingly posited as an obligation. Midwifery thus permits the expression of a desire for a fully autonomous relationship to the body, acting on the capacities and the will of the woman to cultivate her own practices of self-reflection and self-government.

Scholarship on midwifery has tended to explain changes in midwifery practice and policy through the lens of gender and professional power, with struggles over the

status of midwifery linked to the devaluation of women's caring work. Recent work on midwifery, however, suggests that these dynamics are no longer adequate to the task of understanding the complexity of practices and policies surrounding pregnancy and birth. While it is clear that the pressures to rationalize health care in Québec and France are changing the nature of midwives' labor, a thesis of the devaluation of gendered labor and of professional competition among doctors and midwives cannot fully explain these transformations. The emergence of midwifery in Québec and its renovations in France can be more fully understood by considering the rationalities informing health care and reproduction that become powerful in particular places and times.

TABLE OF CONTENTS

	Page
Introduction	1
Chapter One: Law, Government and Territory: Midwifery and the State in France	34
Chapter Two: A Labor of Love? Midwives and Affective Labor in Contemporary France.....	70
Chapter Three: The Power to Act: The Rights of Mothers and Midwives in France	108
Chapter Four: Regulating Birth, Body, Self: New Midwifery in Québec.....	159
Chapter Five: Global Midwifery and Technologies of Emotion	202
Conclusion.....	247
Bibliography.....	255

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DEDICATION

To my sister, Margaret.

INTRODUCTION

The central claim of this dissertation is that the work of the midwife in contemporary French and Québécois societies is that of a mediator. But of what and between whom? In English, the etymology of “midwife” is often given as “with woman,” in its earliest usage, as a “woman (wife) who is with the mother at childbirth.” An alternative origin of the term in English is that of “the woman who mediates between mother and baby.” Yet the figurative uses of the term, “midwife,” are much broader, as “a person or thing which helps bring something into being.”¹ In contemporary France and Québec, midwives mediate women’s relationships to their bodies, relationships structured in part by the state’s continual attempts to intervene. The midwife, then, is an interlocutor in a discursive and embodied process that constitutes women as “birthing subjects.” Transformations in the political economy of health care toward more neoliberal models have endowed individuals with new responsibilities for their health. Midwifery in France and Québec is a lens through which to examine these transformations.

Many of these interests are reflected in my earlier work on the historical shifts in childbirth practices and locations in the United States. I traced the development of neoliberal governmental rhetorics of cost containment and profitability in the U.S. health care system in the 1970s through an examination of the architecture and design of contemporary obstetric wards in hospitals. In part, I examined how the domains of pregnancy and birth are linked to transformations in political economy. The

¹ Midwife. *Oxford English Dictionary*, Oxford University Press. Accessed May 7, 2006. <http://www.oed.com/>.

institutionalization of birth in hospitals provoked an American obstetrician to comment in 1953 that “we handle patients with the same assembly-line technique that has proved so efficient in turning out motor cars.”² Shifts in the practices surrounding pregnancy and birth toward more individualized notions of consumption were also spatial, and I focused my research on the emergence of “homelike” birthing rooms in U.S. hospitals designed to mimic domestic space.³

The proliferation of “homelike birthing rooms” in hospitals in the United States were part of a broader reconfiguration of hospital space that emphasizes the hospital’s marketability and the constitution of maternal subjects as health-care consumers. Homelike birthing rooms were one way in which hospitals in the United States attempted to further “privatize” social reproduction. In this work, the rhetorics of economic crisis in health care did not simply reflect macro-scale shifts in economic policy but were accompanied by an increasing emphasis on the reproductive body and on domestic space as a locus of private rights and responsibilities. Geographers have linked transformations of institutional hospital space in the late 20th century to the increasing privatization and corporatization of health care systems.⁴ My previous research on the new domestic landscapes of the “homelike” hospital room attempted to link the shift in birthing practices toward more individualized care and the development of a competitive “birthing

² Pollack, J. H. 1953. “The case for natural childbirth.” *Cosmopolitan* 135: 39.

³ See Maria Fannin. 2004. “Domesticated Space and Disciplined Bodies: Tracing the Emergence of ‘Homelike’ Birthing Rooms.” In *Life’s Work*. Cindi Katz, Sallie Marston, and Katharyne Mitchell, eds. London: Blackwell, pages 96-118. Sally Abel and Robin Kearns’ work on home birth in New Zealand emphasizes the experience of place of birth to women’s understanding of domestic and hospital space. Sally Abel and Robin. A. Kearns. 1991. “Birth Places: A Geographical Perspective on Planned Home Birth in New Zealand,” *Social Science & Medicine*, 33 (7): 825-34.

market” among hospitals to the emergence of new material and discursive spaces of reproduction.

My project on midwifery in Québec and France continues this concern with efforts to reconsider the political economy of social reproduction. In Québec, midwifery’s emergence as a new profession comes at a critical juncture in shifting state policies on health care. In France, midwives are implicated in efforts to “rationalize” the health care system in new ways. In both places, midwives have advocated for the greater participation of women in their care, and are intimately involved in the state’s efforts to reconfigure the responsibilities for reproduction around the individual. My research question is this: (1) how are neoliberal economic rationalities affecting the practices, spaces, and subjects of reproduction, and more specifically, childbirth in Québec and France? (2) What are the new spaces and new imaginaries of reproduction under contemporary neoliberalism? (3) How is the relationship between women and the state changing with regard to reproduction, and specifically, how are midwives implicated in these transformations?

Government of health and the body

As Wendy Larner notes in a 2003 commentary, much of the work on neoliberalism in geography tends to be narrowly focused on neoliberalism as a “top-down impositional discourse” in which the negative forms of neoliberal governmentality implicit in the privatization of public services (“removal,” “dismantling,” “roll-back,” for instance), are

⁴ Kearns, Robin A. and Barnett, J.R. 1999. “To boldly go? Place, metaphor and the marketing of Auckland’s

the focus of critical analysis. Excellent critical work has been done describing the shifting the role of the state: from providing goods and services that provide for a society's "security" from the instabilities of the market, i.e. the policy of *laissez-faire* and the welfare state, to the *direct* role of government in the development and functioning of markets: through privatization, marketization, and deregulation, and the redefinition of human decision-making as a process of calculated economic interest.⁵ Yet Larner asks, what if we consider neoliberalism not only as a new form of capitalist economic domination but as a more complex configuration of power "involving processes that *produce* spaces, states, and subjects in complex and multiple forms"?⁶

Larner cites work on governmentality as a possible site for considering these productive processes. Governmentality via the work of Michel Foucault has been described as the "conduct of conduct," meaning the attempts to rationally "deliberate on and to direct human behaviors, actions, comportments."⁷ The literature on governmentality in geography and elsewhere develops an analytic for understanding the disaggregation of state power, by examining the political programs, rationales and policies that attempt to shape human conduct. Many of the recent calls to rethink analyses of economic restructuring and privatization use theorizations of the "conduct of conduct" in an attempt to open up understandings of economic transformation, refusing to see political economic processes as solely disembodied, macro-level, or "top-down."

Starship Hospital." *Environment and Planning D: Society and Space* 17: 201-226.

⁵ Gordon, Colin. 1991. "Governmental rationality: an introduction" in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect*. Chicago: University of Chicago Press, 1-51, page 35.

⁶ Larner, Wendy. 2003. "Neoliberalism?" *Environment and Planning D: Society and Space* 21 (5): 509-512, page 511.

The dissertation draws from the literature on governmentality to link transformations in health care to the politics of *reproductive self-determination* circulating within the practice of midwifery, particularly works that theorize more contingent and grounded understandings of how neoliberalism is manifest in the changing forms of biopolitical power, such as the work of scholars like Larner, Barbara Cruikshank, and Lorna Weir. I also draw productively on the scholarship in France that continues the lines of thought developed by Foucault. The work of Didier Fassin and Dominique Memmi are among those who engage with Foucault's writings on the body in order to examine contemporary practices of health care and self-regulation. In this way, my research responds to the widespread call among geographers and others interested in the "productive" nature of contemporary neoliberal globalization to examine the simultaneous and often contradictory nature of processes of culture and political economy.

In this sense, the work of scholars of neoliberalism in geography has been useful for my analysis of efforts to introduce market-oriented mechanisms into publicly-funded health care systems, and to analyze their productive effects. Health has now become "one of the most consensual of instruments through which states legitimize their public policy," evident in the ways the discipline of public health has developed to treat the social problems of marginalization and poverty through prevention and hygiene, for example.⁸ As scholarship in governmentality has demonstrated, health is also one of the

⁷ See Mitchell Dean, 1999. *Governmentality: Power and Rule in Modern Society*. Thousand Oaks and London: Sage.

⁸ Crignon-De Oliveira, Claire and Marie Gaille-Nikodimov. 2004. *À qui appartient le corps humain? Médecine, politique et droit*. Paris: Les Belles Lettres, page 27. Crignon-De Oliveira and Gaille-Nikodimov

primary means through which individuals develop a relationship to the self. This relationship is increasingly mediated by a discourse of risk. Whereas the calculation and responsibility of social risks were, under liberal welfare states, the province of the state, in new neoliberal regimes such risks have been located with ever more precision on the individual, and increasingly some argue, on the molecular level.

The development of genetic diagnostic technologies, for example, has produced new forms of what Carlos Novas and Nikolas Rose term “genetic responsibility.” Countering the claims that contemporary genetic testing revives older repressive modes of state-sponsored eugenics, Novas and Rose argue that the development of genetic testing creates new forms of subjectivity oriented not around a passive fatalism, but around developing “life strategies” for managing individual genetic risk.⁹ Others have examined the practices of genetic risk management with respect to pregnancy more closely. Ilpo Helén’s work on fetal genetic testing maintains that new individualized approaches to risk also parse the responsibility for risk management into two separate fields: that of the technical responsibility of reproductive health care assumed by “high-tech” medicine, and the ethical responsibility for the implications of genetic test that are assumed by the individual. Ethical responsibility, however, becomes defined in limited terms of choice. In Helén’s work, this choice was defined as an “intimate” decision by a woman and her family. Choice defines the relationship of the pregnant woman to her self, to “her aspirations and feelings related to having a child and, indeed, her own life as a

cite Didier Fassin, eds. *Les Figures Urbaines de la Santé Publique: Enquête sur des expériences locales*. Paris: Éditions La Découverte.

⁹ See Novas, Carlos and Nikolas Rose. 2000. “Genetic risk and the birth of the somatic individual” *Economy and Society* 29 (4): 485-513.

whole.”¹⁰ The implications of this choice, however, are characterized by what Helén terms “the anxiety generated by existential responsibility.”¹¹ In my work on midwifery politics in Québec, this anxiety is experienced as the burden of informed choice, yet efforts to exercise reproductive self-determination do not always take the form of choice. In France, for example, these efforts were framed as inviolable liberal rights to the body, rights that defined women’s engagements with medicine as an exercise of autonomy. Autonomy, however, mediated through the expression of one’s desires for pregnancy and birth.

While control over reproduction is not solely focused on women’s bodies, my research examines how state interest in reproduction implicates women in specific ways in the processes of producing governable citizens. My work thus draws fruitfully from feminist theorizations of the subject that engage with the maternal body as a locus of contemporary biopolitical and ethical concern.¹² By examining the emergence of midwifery in Québec and the renovations of midwifery in France, I demonstrate how neoliberal shifts to “privatize” reproduction engender both new forms of government and new spaces, practices, and subjects of birth. In both places, I focus on the specific struggles around women’s reproductive autonomy that produce the midwife as a mediator of new relationships between the state and the individual. While the historical role of the

¹⁰ Helén, Ilpo. 2004. “Technics over life: risk, ethics, and the existential condition in high-tech antenatal care.” *Economy and Society* 33 (1): 28-51.

¹¹ Helén, 2004, page 28.

¹² Bower, Lisa C. 1991. “Mother” in Law: Conceptions of Mother and the Maternal in Feminism and Feminist Legal Theory. *differences* 3, 20-38; Bracha Lichtenberg Ettinger. 1992. Matrix and metamorphosis. *differences* 4, 176-209; Iris Marion Young. 1990. *Throwing like a girl and other essays in feminist philosophy and social theory*. Bloomington: Indiana University Press; and Lorna Weir. 1996. “Recent developments in the government of pregnancy.” *Economy and Society* 25, 373-392.

midwife in Québec differs from that of France, a comparative analysis of liberal governmentality in both places makes clear the mediated character of biopolitical power that works in and through women's social movements for greater reproductive autonomy and appeals to liberal discourses of democratic rights and market individualism.

I also draw from literatures on the crisis in social reproduction engendered by transformations in political economy. The dislocation of capitalism's ideological production from specific state institutions requires a shift in attention to other sites and practices of state control. Scholarship on social reproduction provides an instructive counterpoint to work on the demise of institutional forms of regulation, not simply as a way of extending inquiry to new "scales" of analysis (the family, the individual, the body), but also as a means to demonstrate more clearly the importance of "labor in the bodily mode" to new forms of production.¹³ The value of comparative work is the ability to trace the contours of these complex and contingent political formations. Attention to the kinds of language used within childbirth and midwifery activism in Québec and France is instructive for thinking comparatively about the effects of neoliberalism. For in addition to thinking about neoliberalism as a set of *economic policies*, I consider neoliberalism more broadly as a *form of government*, that is, as a set of rationalities about what makes some activities thinkable and others not.

Midwifery, then, is a lens through which to interrogate how neoliberalism as both an economic and a political rationality works out in practice and in different locations.

¹³ See Dorothy Smith, 1987. *The Everyday World as Problematic: A Feminist Sociology*. Boston: Northeastern University Press, cited in Michael Hardt and Antonio Negri. 2001. *Empire*. Cambridge, MA: Harvard University Press, page 293.

For although much of the theoretical work on governmentality discusses the production of new forms of subjection, the discussions of the self-regulating individual are often abstracted from specific geographical or historical contexts. Very little comparative work has been done to examine how the formation of the self-regulating individual and other key concepts within the literature on governmentality play out in specific sites.¹⁴ This work examines the discourses surrounding midwifery's specificity in two sites where the development of midwifery have been different, but where practitioners have also attempted to translate each other's practices into their respective local contexts.

My research relies primarily on written texts and interviews conducted over a nine-month period in France and Québec. In France, I gathered texts published in midwifery journals relative to their professional practice; to the effect of reforms to the French health care system on their practice; and to efforts by "lay" organizations (women's associations, parents' associations, patient activist associations) as well as organized groups of midwives (some involving "users" of the health care system, others grouping only medical professionals) to develop their own projects aimed at transforming maternal and infant health care in France. I also gathered accounts in national newspapers as well as midwifery journals of the 2001 strike, the first strike called by midwives in an effort to renegotiate the terms and conditions of their work in both the public and private sectors of health care. I examine legal texts relative to midwives' long history as medical

¹⁴ See, however, Banu Gökariksel and Katharyne Mitchell's examination of the formation of the neoliberal subject of assimilation discourse in France and Turkey. In debates over veiling, it is the discourse of state secularism that assumes the power to define women's path to full autonomy. For it is only through state secularism (i.e. protection against religious oppression) that women "can *become* individuated neoliberal subjects (non-particularist and unaffiliated) and thus assume their rightful place as modern productive

professionals in France, and policy documents discussing efforts aimed at “rationalizing” the French health care system. These efforts have increased since the 1970s and form a large part of my analysis of how the state management of reproduction has shifted over time.

In addition, I collected brochures and other documents (flyers, newsletters, commentaries) produced by what I refer to as “activist associations.” These “lay” organizations may identify themselves, as I mentioned earlier, as women’s associations, as associations of parents or families, as groups of “users” (*usagers*) of the health care system in France, but also as organizations grouping users and medical professionals (which in France includes midwives as well as doctors). Some of these associations have a particularly strong presence on the Internet and I draw from members’ essays and discussions posted on their public websites.

In France, I conducted interviews with thirty-eight midwives. Fifteen work in hospitals or clinics, twelve in independent practice (referred in French as *exercice libérale*), and three in a form of social services, *Protection Maternelle et Infantile* or PMI. Two midwives I interviewed were employed as teachers in midwifery schools, and I also interviewed the directors of three midwifery schools in Lyon, Toulouse, and Paris. In addition, one of the midwives I interviewed was employed as a researcher in a publicly funded research institute. One midwife is retired, but worked extensively in PMI. However, many of the midwives I interviewed had worked in other capacities earlier in their careers (for the teachers and directors of schools, this was a requirement; for private

practice midwives, the typical route to independent practice). Some also worked in several capacities, in private clinics part-time while maintaining a private practice, for example. In one private clinic and three public hospitals, I accompanied midwives as they taught childbirth preparation classes, assisted women giving birth in hospitals, and conducted pre- and post-natal visits. I accompanied two midwives as they visited women in their homes, one under home surveillance for a high-risk pregnancy and another the day after her home birth with the midwife. I also attended a regional meeting of the *Ordre National des Sages-Femmes*, the professional body governing midwifery, as well as a conference on the history of birth in France attended in large part by midwives.

I also conducted interviews with three activists in France who participate in parents' or users' associations; two caring aides (one employed at a public hospital, the other at a private clinic); and six women working as "birthing assistants" who either identified as doulas (the term is also used in the U.S.) or *accompagnantes à la naissance*. The practice of professional accompaniment at births is not widespread in France. One of the doulas and one of the *accompagnantes* have established training programs for others in the practice, however, which consists of providing emotional support for women during and after their births.

In Québec, I visited three birthing centers: one in Montréal, another 12 miles west of Montréal, and a third in Nicolet, 96 miles northwest of Montréal. I interviewed eight midwives, all in the birth centers where they worked, in one case observing the midwife's consultations with clients (couples, in all cases), and accompanying her on a post-natal

home visit. I interviewed the director of the midwifery program at Trois-Rivières located near Nicolet and approximately 88 miles northwest of Montréal, as well as six activists and the representative of a First Nations women's association. I attended a meeting of the activist group, *Groupe Maman*, as well as a conference sponsored by a provincial public health association, *Association pour la Santé Public du Québec*.

I also conducted archival work on midwifery's legal status and its development as a new profession in Québec through both texts produced by women's associations as well as policy documents. I examined newspaper accounts of the experimental project to develop birthing centers in Québec as well as the efforts to establish conditions for midwives' practice in hospital, a development which had only recently occurred when I arrived in October of 2004. I drew primarily from French-language papers in Montréal.

Interview participants are identified by position (head midwife, director of midwifery school, caring aide, etc.) and by the place of work (birth center in Québec, public hospital, private clinic, or independent "liberal" practice in France). Some were contacted initially at midwifery conferences or through their work in associations; others were identified through interviews with other midwives or activists. Interviews were conducted in French in France and in both French and English in Québec. Unless otherwise noted, all translations from French are mine.

In addition, I draw on observations and informal interviews conducted at two conferences sponsored by *Midwifery Today*, a North American midwifery journal, held in Paris in November of 2003 and in Philadelphia in April 2004. In May and June of 2004, I conducted archival research in the Wellcome Library for the History and Understanding

of Medicine in London. I also attended two conferences sponsored by the International Confederation of Midwives, the first in Port of Spain, Trinidad in April 2004, and the second in Brisbane, Australia in July 2005.

My discursive analysis of how midwives describe their work thus relies on multiple productive sites. Discourse is not a pre-determined frame through which subjects speak ideology, but rather is “a system of meaning that constitutes institutions, practices and identities in contradictory and disjunctive ways.”¹⁵ As the following chapters will demonstrate, the liberal discourses of “choice,” “responsibility,” “risk,” “autonomy,” and “rights” constitute the practice of midwifery as well as the identities of the birthing subject in new ways. In both France and Québec, the efforts to redefine the practice of midwifery are articulated, I argue, within broader changes in the political economy of health care.

Comparative work on midwifery has explored the differences in practice and status of midwifery in different historical and geographical contexts, such as the recent anthology of essays on midwifery in 19th and 20th century Europe edited by Hilary Marland and Anne Marie Rafferty. Much of this work tends to focus on the variety of techniques midwives use and the comparative variations in midwifery’s legal and social status.¹⁶ This scholarship is important because the practices of midwives differ greatly from place to place. In the scholarly and activist-oriented literature coming out of the

¹⁵ Larner, Wendy. 2000. “Neo-liberalism: Policy, Ideology, Governmentality” *Studies in Political Economy* 63: 5-25, page 12.

¹⁶ The classic text is Brigitte Jordan’s early work in anthropology on birthing practices in Mexico, Holland, Sweden, and the United States. See Brigitte Jordan. 1978. *Birth in Four Cultures*. Montreal: Eden Press; Hilary Marland and Anne Marie Rafferty, eds. 1997. *Midwives, Society, and Childbirth*. London:

alternative birth and midwifery movements, women's dissatisfaction with the normative practices surrounding pregnancy and childbirth during the 1970s and 1980s often drew on cross-cultural comparisons to demonstrate the geographical and historical specificity of birthing practices and thus their malleability.

As Ellen Annandale and Judith Clark note, "the fact that the alternative form of maternity care proposed in research in the 1970s and 1980s was not explicitly stated as a need for all groups of women (ethnic minorities, different social classes, ages, etc.), and instead that potential different needs were silenced, only serves to underscore the universalistic assumptions of much of this research."¹⁷ More recent works, such as the edited book by Ivy Lynn Bourgeault, Cecilia Benoit and Robbie Davis-Floyd on the "re-emergence" of midwifery in Canada, have begun to examine the politicization of contemporary midwifery with more attention to these issues: from the questions of equity and accessibility for users of midwifery care to the ways both institutional and "routine" racism excluded minority women from the professionalization of midwifery in Ontario.¹⁸ Other works have examined midwifery's development under French and British colonialism, placing the practices and "professionalization" of midwifery in broader social and political contexts.¹⁹

Routledge; and Robbie Davis-Floyd and Carolyn F. Sargent, eds. 1997. *Childbirth and Authoritative Knowledge*. Berkeley: University of California Press.

¹⁷ Annandale, Ellen and Judith Clark. 1996. "What is gender? Feminist theory and the sociology of human reproduction" *Sociology of Health and Illness*. 18 (1): 17-44.

¹⁸ Bourgeault, Ivy Lynn, Cecilia Benoit and Robbie Davis-Floyd, eds. 2004. *Reconceiving Midwifery*. Montréal and Kingston: McGill-Queen's University Press.

¹⁹ See Lynn M. Thomas. 2003. *Politics of the Womb*, Berkeley: University of California Press; Carol Summers. 1991. "Intimate Colonialism: The Imperial Production of Reproduction in Uganda, 1907-1925," *Signs* 16, 787-807; and Harriet Deacon. 1998. "Midwives and Medical Men in the Cape Colony Before 1860," *The Journal of African History* 39, 271-292.

Midwifery is often cited in North American texts as a “humanization” of birth within technocratic, medicalized systems of knowledge. This characterization of midwifery often compares the virtual absence of midwifery in North America with the widespread acceptance and integration of midwifery in Europe. As my research will demonstrate, this understanding of midwifery should be considered contextually and geographically specific, given that midwives in France are both thoroughly integrated into the French health care system and have often claimed their technical, medical proficiency as a professional specificity. A closer examination of the politics of birth and midwifery between Québec, where midwifery has “re-emerged,” and France, where midwifery retained its professional status over the course of the 20th century, could shed light on the ways midwifery is articulated within broader contexts and on the comparisons midwives themselves make between their practices in different locations.

The impact of midwifery activism over the last several decades has been substantial, particularly in North America, where legislation on midwifery resulted in the legalization of midwifery, the integration of midwifery care into hospitals, and the establishment in many states of birthing centers that offered midwifery care outside of hospitals. While midwifery has increased some women’s access to less costly maternal health care, grassroots activism around childbirth has played a significant role in the recognition by medical professionals and hospital administrators of the importance of the emotional aspects of care. The momentous changes since the 1960s in how hospitals approach the care of birthing women is evidenced by efforts to provide more home-like

settings for childbirth that attend to birthing women's emotional as well as physical needs.

The recognition that health is not merely a physical condition but a psychological and emotional one has had widespread effects on how physicians treat their patients, how architects design hospitals, as well as how governments and private industries provide goods and services to those in need of care. My analysis of midwifery, as a lens onto the constitution of new practices and identities surrounding birth, is not simply to provide a new "interpretation" of midwifery, but to attempt a more genealogical approach to its emergence in Québec, and its transformations in France, to "decompose the particular series along which events have been organized in order to create a different series for those events," that is, to analyze the geographical and historical specificity of midwifery as a part of practices constituting new problems and new identities for the "birthing subject."²⁰

Health and welfare in France and Canada

The domain of daily life, that "great 'Other' of the market," has been continually transformed by changes and crises in capitalist production.²¹ However, in their book, *States, Markets, Families*, Julia O'Connor, Ann Orloff and Sheila Shaver claim that little of the attention paid to the shrinking of the welfare state since the 1970s has addressed

²⁰ Colwell, Chauncey. 1997. "Deleuze and Foucault: Series, Event, Genealogy" *Theory and Event* 1 (2): 28 pars. Accessed 28 February 2006. http://muse.jhu.edu/journals/theory_and_event/v001/1.2colwell.html, para. 2.

²¹ See C. George Caffentzis. 1999 "On the notion of a crisis of social reproduction: a theoretical review." In Mariarosa Dalla Costa and Giovanna F. Dalla Costa, eds. *Women, Development and Labor of Reproduction*. Trenton, NJ: Africa World Press, pages 153-187.

changes to “the reproductive and sexual lives of citizens.”²² Efforts to “rationalize” health care systems in both France and Canada, whether by the introduction of market-oriented mechanisms of financial control, or by the increasing delegation of the responsibilities for care from the state to the individual, however, have affected social welfare policies on the family; the use of technologies that promote the exercise of control over reproduction, and the legal understandings of the state’s relationship to the individual that inform debates over medical ethics and practice. These more neoliberal forms of governance, however, take different forms in different places, and this section provides an overview of the history and organization of the health care systems in both places.

In both France and Canada, the post-war welfare state developed in part through the establishment of national systems of health care and welfare provision. In France, the modern social welfare system, influenced in part by efforts in Britain to develop a universal system of social protection, emerged out of (and to a certain extent remains) a patchwork of “private charity, public assistance, compulsory social insurance, mutual and voluntary aid.”²³ Prior to the development of a public system, private insurance plans existed, with mutual benefit associations providing insurance among small groups of people, usually grouped by occupation, to cover income losses due to illness, injury and

²² O’Connor, Julia S., Ann Shola Orloff and Sheila Shaver. 1999. *States, Markets, Families: Gender, Liberalism and Social Policy in Australia, Canada, Great Britain and the United States*. Cambridge: Cambridge University Press.

²³ Faure, Olivier. 2002, “Health Care Provision and Poor Relief in 19th Century Provincial France” in Ole Peter Grell, Andrew Cunningham and Robert Jütte, eds. *Health Care and Poor Relief in 19th and 19th Century Northern Europe*, Aldershot: Ashgate, page 321.

death.²⁴ The system of socialized insurance, rather than direct provision of health care by the state, was to become the model for the national health care system.²⁵

The law of April 9, 1898 established workers' compensation and was the first form of mandatory social protection required by the French state. In the same year, a law relating to mutual insurance furthered the development of mutual aid societies by loosening restrictions on the number of members and the territorial range of the societies, and permitted the development of insurance to cover retirement, life, death, and accident. This law also allowed private mutual insurance groups among workers in industry and trade to develop health care establishments and pharmacies for their members.²⁶

The role of private organizations and charities in the provision of health care was to be complemented, rather than replaced, by state programs and funded by employer and employee contributions. The French social security system established in 1945 was administered by the national government to cover income and medical needs of the sick, the retired, the disabled, pregnant women, and the unemployed. The system left certain

²⁴ See Daniel Defert's work on the establishment of insurance claims that produced two modes of capital accumulation: one produced "national" capital, the other the development of capitalism in Indo-China. See Daniel Defert, 1991. "'Popular Life' and insurance technology." In Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect* Chicago: University of Chicago Press, 211-234.

²⁵ The system of health care provision through socialized insurance has been termed "Bismarckian" after the development of this system in Germany. This model is also found in Austria, the Netherlands, Belgium, Luxembourg, and France. Nationalized systems of state-provided health care are often termed "Beveridgian" after the author of the Beveridge Report published in 1942 that proposed the development of a national health system in the United Kingdom. In Europe, this model is found in Ireland, Sweden, Denmark, Finland, Italy, Spain, Portugal and Greece. See Alain Letourmy, 2000. "Les politiques de santé en Europe: une vue d'ensemble" *Sociologie du Travail* 42: 13-30.

²⁶ Georges Dorian and André Guionnet, 2003, *La sécurité sociale*, Paris: Presses Universitaires de France, page 9.

older forms of mutual aid in place for workers in particular industries: miners, railway workers, sailors and agricultural workers.²⁷

In 1946, 53% of the population in France received protection against illness.²⁸ The passage of the May 22, 1946 act extended health insurance coverage to the entire working population. The social security system in France put in place in the years after World War II grouped three kinds of social aid: worker's compensation, social assistance, and family provisions in the form of family allowances. These three components of social aid was first administered in total by the state, but persistent deficits in the health insurance scheme during the 1960s led to a financial crisis.

The health insurance program was using the gains from the programs for family allowances and for the elderly to remain solvent. In 1966 and 1967, the social welfare program had to borrow 1.9 billion and 3.0 billion francs from the Treasury, a crisis that led to the division of social welfare schemes into separate programs in 1967.²⁹ Initially, a legal mechanism was introduced to prevent the "abuse" of the health care system, prohibiting private insurance from covering 100% of the *ticket modérateur*, i.e. the amount above what social insurance will cover that is the financial responsibility of the individual. This law was over turned in 1968. Regardless, the reforms of 1967 were undertaken to "give to actors in the health insurance program the means of exercising greater responsibilities in the management and control of expenses."³⁰

²⁷ Dorion and Guionnet, page 11-12.

²⁸ Economic Models Ltd., 1976, *The French health care system*, Chicago: American Medical Association, page 7.

²⁹ Economic Models Ltd., 1976, *The French health care system*, Chicago: American Medical Association, page vi.

³⁰ Dorion and Guionnet, page 17.

The 1996 reform of the French health care system extends the reforms begun in 1967. The health care insurance system was modified in two ways: through a reorganization of the role of the government, and specifically, the Parliament; and through more “technical” changes to the health care system. The February 22, 1996 law to the Constitution in France stipulates that the Parliament has the power to determine the general conditions for health care expenditure during the year. The Parliament has the power to determine the objectives of the health care system, and to indicate budgetary limits on the funding of specific health care insurance schemes.³¹ Over the latter half of the 20th century, state provisions for health care and retirement were extended to virtually all workers (agricultural workers, artisans), students, detainees, and those engaged in the “liberal” professions, i.e. those in white-collar professional jobs.

The “generalization of coverage for social risks” was virtually total in 1980, and with the passage of the law of July 27, 1999, coverage for illness was extended to the entire population, even for those with little income. Although policies of decentralization have sought to devolve greater authority onto local or regional bodies, these have been primarily aimed at “decentralizing” the administration of health care, rather than its financing.³² At the same time, efforts to introduce market mechanisms into the French health care system have proceeded through measures designed to implicate the user as a “consumer” of services in the health care system, as well as the introduction of competitive mechanisms into the insurance market.³³

³¹ Dorion and Guionnet, page 19.

³² Letourmy, 2000, page 22.

³³ Letourmy, 2000, page 21.

In contrast, Canada's system of health care provision is a provincial, not a national system. The British North American Act of 1867 delegated responsibility for health care onto the provinces.³⁴ Efforts to develop a publicly funded system were inaugurated in 1919 although debated more fully in the 1940s. By 1947, provinces had begun to develop their own plans for national health insurance, with federal laws enacted in the succeeding years to provide coverage for portions of patients' hospital care and for the development of institutions and training programs in the provinces. The model of contemporary health care services was put in place in the late 1960s, initially through the funding by the federal government of 50% of provincial health care services. In 1977, this open-ended funding scheme was discontinued and replaced by a block grant system of transfers to provinces, in an effort to control health care costs.³⁵ A 1995 reform transferred further responsibility to the provinces and reduced the level of federal spending on health care.³⁶ Reform of health care services in Canada has resulted in a de-institutionalization of some forms of care toward the home, particularly long-term care. Increasingly, competitive management and other techniques oriented toward market-based efficiency and cost-control are being introduced into the health care systems of

³⁴ Armstrong, Pat and Hugh Armstrong. 2002. *Wasting Away: the Undermining of Canadian Health Care*. Oxford: Oxford University Press, page 147.

³⁵ Charles, Catherine A. and Robin F. Badgley. 1999. "Canadian National Health Insurance: Evolution and Unresolved Policy Issues" in Francis D. Powell and Albert F. Wessen, eds. *Health Care Systems in Transition: An International Perspective*. Thousand Oaks and London: Sage, pages 115-150.

³⁶ Armstrong and Armstrong, 2002, page 155.

provinces across Québec, leading some to describe the recent transformations of health care services as a “neoliberalization” of health care.³⁷

In Québec, reforms to the health care system from the early 1970s through the 1990s attempted in part to decentralize health care services and integrate citizens into health care management.³⁸ The establishment, in 1972, of a system of local community health and social service agencies, *Centres Locaux de Services Communautaires* or CLSCs, attempted to put in place a system of preventive health care and were given a greater role in the provision of health care services; by 1992, 160 CLSCs were operating and provided both conventional medical care as well as social services, nursing, home care services and psychosocial care.³⁹ In some rural areas, the CLSC may play a large role in the delivery of medical care, but its role in most parts of Québec is as an “alternative model.”⁴⁰ Efforts to cut costs in the Québec health care system have focused on removing certain services from provincial health care coverage and instituting user fees. These proposals have been articulated alongside efforts to encourage more citizen participation in health care decision-making, in the inclusion, for example, of representatives of community groups on hospital boards.⁴¹

³⁷ See England, Kim, Joan Eakin, Denise Gastaldo, and Patricia McKeever. Forthcoming. “Neoliberalizing home care: Managed competition and restructuring home care in Ontario.” In Kim England and Kevin Ward, eds. *Neo-liberalization: Networks, States, Peoples*. Malden, MA and Oxford: Blackwell Publishing.

³⁸ Pineault, R., P.A. Lamarche, F. Champagne, A. P. Contandriopoulos, and J.L. Denis. 1993. “The reform of the Québec health care system: potential for innovation?” *Journal of Public Health Policy* 14(2): 198-219.

³⁹ Béland, François. 1999. “Preventive and Primary Care Access Systems: CLSCs as Neighborhood and Social Service Centers in Québec.” in Francis D. Powell and Albert F. Wessen, eds. *Health Care Systems in Transition: An International Perspective*. Thousand Oaks and London: Sage, pages 173-198.

⁴⁰ Béland, 1999, page 194.

⁴¹ Church, John, Duncan Saunders, Margaret Wanke, Raymond Pong, Carol Spooner and Marlene Dorgan. 2002. “Citizen Participation in Health Decision-Making: Past Experience and Future Prospects” *Journal of Public Health Policy* 23 (1): 12-32

In France, historians of midwifery argue that the state's concern for midwifery was directly linked to nascent interest in managing the health of the population. Jacques Gélis notes that the empirically trained midwives of the French countryside were considered detrimental to the nation only when the state took an interest in the rationalization, however modest at first, of the reproduction of the populace.⁴² The “maintenance and supervision of midwives” were one of the myriad aspects of the government by what Michel Foucault identified as the “police science” of German states and what Nikolas Rose identifies as characteristic of 16th and 17th century European states.⁴³ The “science of police” implies a technique that “concerned ‘everything’ in the field between the pronouncement of a law and the prosperity, health, life and conduct of subjects.”⁴⁴

The widespread formal training of midwives developed in earnest in the late 18th century, at a time when concerns among European rulers began to extend to the demographic health of the population. This new concern for the demographic health of the population is the focus of Michel Foucault's analysis of the development of modern state power. In 1976, Foucault described the emergence of a form of “noso-politics” particular to the 18th century, which the developments of 19th century medicine were to elaborate more fully, “a politics of health, the consideration of disease as a political and economic problem for social collectivities which they must seek to resolve as a matter of

⁴² Gélis, Jacques. 2004. “Former des accoucheuses au XVIIIe siècle” *La “machine” de Madame Du Coudray*. Bonsecours: Édition Point de vues, pages 5-8.

⁴³ See Thomas Osborne. 1996. “Security and vitality: drains, liberalism, and power in the nineteenth century” in Andrew Barry, Thomas Osborne, and Nikolas Rose, eds. *Foucault and Political Reason*. Chicago: University of Chicago Press, pages 99-121.

⁴⁴ Rose, Nikolas. 1999. *Governing the Soul*. London: Free Association Books, page 225.

policy.”⁴⁵ The significance of the individual body and of collective bodies, i.e. the “population,” as an explicitly *economic* preoccupation begins to appear over the course of the early modern period in Europe.

Foucault writes that the body’s subjection and its utility became matters of political concern, with effects across a range of fields from the relations of the family to the organization of hospital space. As *subject*, the body and its biological capacities become the targets of more specific interventions by hygiene and medicine. As *utility*, the body is measured, its capacities assessed, “between the more or less utilizable, those with greater or lesser prospects for survival, death, and illness, and with more or less capacity for being usefully trained.”⁴⁶ Part of Foucault’s analysis of this new form of power he would later term “biopower” is concerned with the rise of the nascent medical profession in advising and administrating this new political concern.

In describing the emergence of contemporary forms of biopower, Michel Foucault did not explicitly analyze the attempts to govern women’s bodies, either through punishment, surveillance and discipline, or through techniques and strategies of biopolitical power. This lack of attention to the specificities of biopower’s objects and to the *specific* bodies implicated in the new forms of scientific and social control that

⁴⁵ Michel Foucault, 1976, “La politique de la santé au XVIIIe siècle,” in Michel Foucault, Blandine Barret-Kriegel, Anne Thalamy, Francois Beguin and Bruno Fortier, eds. *Les Machines à Guérir (aux origines de l’hôpital moderne)*, Paris, Institut de l’Environnement. Translated by Colin Gordon and reprinted in Michel Foucault, 1980, *Power/Knowledge*, New York: Pantheon Books, page 166.

⁴⁶ Foucault, 1980, page 172.

developed in early modern Europe is a significant lacuna in Foucault's analysis of power.⁴⁷

His analysis, however, points to the significance of measures to cultivate the health of the population via the relationship of women to their children, and by extension, to the role of regulating reproduction that such political concerns entailed. Childhood, at this time, begins to take on new significance, and the responsibility of parents toward their children's survival drew on new notions of the family as a privileged site for medical and social intervention. Women's relationships to their offspring change as well; certain obligations take shape regarding mothers' care for their children: cleanliness, breastfeeding, "attentive proximity," and so on, a kind of "saturation" of social, moral, medical, and physical efforts that envelop the child and invest in the child's survival to adulthood.⁴⁸

The interest of the state in promoting the growth of the population was largely symbolic at first: the encouragement of collective marriages and the monetary rewards given to large families were a means of promoting the population's growth, but had little direct effects on the growth of the population. Gélis writes that "it is only truly at the middle of the 18th-century that royal power concretized its will to act to preserve the life of its subjects, by ensuring in particular the education of *accoucheuses*," or birth attendants.⁴⁹ Birth became an object of scientific interest and control during the period of

⁴⁷ Ann Stoler's critique of Foucault is incisive here, as are other feminist critiques of the lack of sustained attention to gender in Foucault's analysis of modern biopower. See Stoler, 1995, *Race and the Education of Desire: Foucault's History of Sexuality and the Colonial Order of Things*. Durham: Duke University Press and Jane Sawicki, 1991. *Disciplining Foucault: Feminism, Power and Body*. New York: Routledge.

⁴⁸ Foucault, 1980, page 172

⁴⁹ Jacques Gélis, 2004, page 5.

Enlightenment in France and with this the preoccupation of doctors as well as midwives over the management of birth.

I argue that the articulation between the forms of governmental power specific to contemporary liberal societies and the attempts to regulate reproduction via midwifery remain relevant to its contemporary practice. Significant differences exist, however, between midwives' increasing integration into the French medical system over the course of the 19th and 20th centuries and the relegation of midwifery in North America to the margins of medical practice during this same period.⁵⁰ In both sites, however, midwifery is a productive lens onto transformations in health care systems and the reshaping the identities and practices around reproduction. I begin my comparison with the contemporary "re-emergence" of midwifery beginning in the late 1970s in Québec, and the simultaneous transformations to midwifery in France. In the final chapter of the dissertation, I examine the constitution of midwifery as on a global scale, examining how midwives' envision their emotional work as universal, an understanding of their practice that has certainly permitted the translation and cross-fertilization of practices across national boundaries, but that may also conceal differences between midwives.

Midwifery, then, is a lens onto social transformations. This lens reveals some aspects while no doubt obscuring others, but by concentrating on a specific field of forces, I hope to magnify what is at stake in contemporary struggles over midwifery framed in terms of reproductive self-determination and autonomy. This lens is also an opening onto questions that may lie at the heart of future feminist projects. These

chapters attempt to diagnose the relations of force that take midwifery as the target and goal of new forms of control, through the constitution of pregnancy and birth as political and politicizing acts.

Chapter Overview

Chapter One, “Law, government and territory: Midwifery and the state in France,” examines the efforts by midwives in France to develop birth center projects, both within hospitals and clinics, and as freestanding *maisons de naissance*. I focus particularly on the efforts of midwives in Montpellier to develop a *maison de naissance*, an efforts that drew partly from the birth center models in Québec and Germany. The efforts to develop birth centers began in the late 1980s in France and were motivated in part by the encouragement of the Ministry of Health to consider “experimental” projects, much like the process developed in Québec. The policies aimed at “rationalizing” maternal health care in France, however, was centered on consolidating births in larger structures ostensibly in the interest of safety.

A series of decisions by the Ministry of Health relative to the standards required for any health care establishment, however, placed conditions on the development of any new establishment. These conditions have limited the development of birth centers in France, as have debates among midwives or activists over the possibility that the development of birth centers will, as in the Québec case, eliminate the possibility of

⁵⁰ As subsequent chapters will discuss in more detail, midwives’ juridical status in France is that of medical

home birth, still legal in France and within the professional capacity of midwives. I trace how midwives' movement from the "liberal" (independent, private) sector into hospitals and clinics accompanied the shift in births from home to hospital, as well as the specialization of midwifery into new domains.

This chapter also examines how the question of parents' and women's autonomy with respect to birth is a feature not only of the conventional management of pregnancy care, which places the "existential responsibility" of birth on the individual, but also within oppositional movements to claim reproductive self-determination with respect to birth. The next three chapters examine midwives' status as both devalued and revalued labor, devalued because it is feminized, but also revalued, however marginally, for its capacity as affective labor, labor that helps women exercise reproductive self-determination (which looks different in different places). The last chapter turns to how midwives reflect on their affective labor as global and constitute their work as universal, a construction positions midwives differently in relationship to modernity, in ways that reinstate older internationalisms rather than new, unbounded forms of connection. These new claims are made possible in part by fixing some in the world of tradition while others move freely, both literally and imaginatively, about the globe.

Chapter Two, "A labor of love? Midwives and affective labor in contemporary France," more closely analyzes the conditions and forms of midwives' work in France. In 2001, midwives were on strike across France. This chapter examines how midwives' efforts to gain recognition for the professional status focused on pay increases and a

professionals.

“revalorization” of their work in light of their considerable responsibilities, both in their daily work and with respect to their juridical status as medical professionals. I draw from Hardt and Negri’s theorization of the predominance of affective labor in the global economy, as well as from critiques from feminist scholars regarding their theorization of caring labor, its material realities as well as its political possibilities.

Midwives I interviewed spoke of their work through two metaphors, the *corps morcelé* or “fragmented body” and the *usine de bébé*, literally, the “baby factory.” These metaphors recurred throughout my interviews with midwives’ concerning the pressure and transformations of their work. Midwives’ described these changes as the effect of broader changes to the health care system in France. First, the division of labor and compartmentalization of midwifery itself has increased, in part due to the vast technological and administrative functions attached to the surveillance of women’s pregnancies and births in France. Midwives described the *corps morcelé* as one effect of the splitting of the woman’s body in two discrete parts, that of the fetus and the mother. The primacy of the fetus in public health policy up to this time is reflected in the policy of transfers of infants before their births or “*in utero*” to facilities with higher levels of pediatric and neonatal care.

These policies are partly a response to the efforts of the French health care system to reduce its comparatively high rates of infant mortality and prematurity with respect to the rest of Europe. They have been challenged in recent years by efforts to establish the primacy of the mother’s experience of birth in public health policy (a development examined in greater detail in Chapter Three). Finally, Chapter Two examines the

consolidation and closures of small hospitals in France that have led to the creation of what are derisively termed *usines des bébés*, or “baby factories,” part of a territorial strategy since the 1970s (and introduced in Chapter One) made possible by the capacity for “caring at a distance” via the new technologies for monitoring births that replace midwives “body-to-body” relationship to women and redefine the content of midwives’ relational work.

In Chapter Three, “The power to act: The rights of mothers and midwives in France,” I examine the new forms of midwives’ relational work that take women’s desires for reproductive self-determination as their target. I examine the discourse around a crisis in French health care in the 1970s that led to the development and implementation of policies designed to “rationalize” maternal and infant health care. By the 1990s, these efforts at rationalization introduced new subjects into the state’s concern with the “security” of birth: health care policy was not to focus solely on the physiological aspects of birth, a tendency that had preoccupied health care planners for the previous two decades, but was to take into consideration the emotional and psychological aspects of birth, reorienting medical professionals around a new axis, that of the psychological state and affective capacities of the mother, the attachment of parents to the child, and the role of the health care system in addressing the participation of patients newly endowed with rights.

Claire Crignon-De Oliveira and Marie Gaille-Nikodimov argue that the French juridical tradition does not “accord well with the idea of the existence of rights over one’s

own body, or over a part of one's body.”⁵¹ The passage in 2002 of a law outlining a “Patient’s Bill of Rights,” however, specifically inscribes the rights of the patient to be informed and to participate in decisions impacting his or her health, as well as the right to refuse care on the grounds of the inviolability of the body. Sophie Gamelin and Martine Herzog-Evans develop this concept further in their book, *The Rights of Mothers*, a text examined more closely in this chapter.

At the same time, attempts to accord the patient a greater participation in health care have also elaborated on a discourse of “responsibilization” regarding the patient’s role in caring for his or her own health. For example, the 2004 reform in the health care system seeks to give the patient greater responsibility in order to prevent the “abuse” of the health care system by instituting a “symbolic” payment of one Euro per consultation with a doctor.⁵² This chapter examines how concepts of “responsibilization” mediate midwives’ relationships to women, and women’s relationships to their bodies. For midwives and birth activists in France, the efforts to gain greater autonomy over the body are heterogeneous and draw on both liberal notions of citizens’ rights and neoliberal notions of individual autonomy.

Chapter Four, “Regulating birth, body, self: new midwifery in Québec” examines the regulation of birth within the new midwifery in Québec. Midwifery was legalized in Québec in the late 1990s after several decades of activism. In this chapter I examine the

⁵¹ Crignon-De Oliveira and Gaille-Nikodimov, page 138.

⁵² “La contribution forfaitaire, à la charge des assurés pour les actes réalisés par des médecins, sera établie dans le but de responsabiliser l’assuré dans son comportement de soins en lui faisant supporter directement une part minimale des frais. Le montant de cette contribution sera fixé à 1 euro par acte de médecin.” *Reforme de l’assurance maladie*, Ministère de la Santé et des Solidarités, accessed November 1, 2005, http://www.sante.gouv.fr/assurance_maladie/index.htm.

discourses of responsibility in the new practice of midwifery. The efforts to transform obstetric care in the province coalesced around the “humanization” of care and in the early 1990s, the provincial health care system established “experimental” pilot projects in which midwives would practice temporarily, in order to evaluate the feasibility of their practice. These efforts were successful, and today, midwives may practice in hospitals, birth centers, as well as at home births.

My analysis focuses on the ways the “experience” of birth became an object of provincial health care policy. I draw from the work of Barbara Cruikshank on the “technologies of citizenship” to examine how women’s self-esteem and empowerment became public health concerns. Cruikshank notes that these technologies of citizenship target the power of citizens to act on their own, and are the characteristic modes of constituting citizens of democratic societies.

Midwifery in Québec, I argue, is implicated in these new technologies of citizenship. Women are expected to take responsibility for their pregnancies and births and to exercise control over their bodies and their selves. The chapter demonstrates, however, that the assumption of these new responsibilities are also experienced as burdens. The emergence of “new” midwifery in Québec formalizes the role of the midwife as “mediator” in the relationship between the birthing subject and her body. Midwifery permits the expression of a desire for a fully autonomous relationship to the body, acting on the capacities and will of the woman to cultivate her own practices of self-reflection and self-government.

Chapter Five, “Global midwifery and technologies of emotion,” examines the constitution of midwifery as a global practice through the work of international organizations like the International Confederation of Midwives, established in 1919 in Europe, and the International Alliance of Midwives, established as an online organization in 1994 in the United States. In comparing these two organizations, I examine how midwifery constitutes the “global body” as an object of midwifery knowledge. International midwifery organizing in the early part of the 20th century relied on forms of association grounded in identification with the demographic strategies of the nation, with strong links to national health and welfare policies. New forms of global connection emerging among groups of midwives draw expressly on midwives’ emotional connections with each other to foster new identities and senses of belonging.

For midwives who identify with a “global” midwifery community, globality brings with it an intimacy of feeling. Midwifery’s globalism is also institutional, where the promotion of professional midwifery in the global South is a visible element of development platforms within international institutions such as the United Nations and the World Health Organization. This chapter argues that the “global” has an emotional geography in which connections with others are deeply felt across distances. The production of “global” midwifery, however, can obscure the material differences between midwives. In international forums, midwives address only obliquely the racial and class differences among women, often by drawing on cultural tropes of modernity and tradition that afford the mobility of some while spatially and temporally fixing others.

CHAPTER ONE

Law, Government and Territory: Midwifery and the State in France

In the late 1990s, midwives in France began to propose plans for the establishment of birth centers, sites in which midwives could independently practice and provide care for women's pregnancies and births external to existing hospital protocols or even the physical structure of hospitals. As of that time, no birth centers operated legally in France.⁵³ Partly because of the encouragement of then Minister of Health Bernard Kouchner, who had expressed support for these efforts, midwives and activists began to develop projects for birth centers, some attached to hospitals, other independent of institutions.

In the summer of 2004, I interviewed a midwife in private practice about the efforts in the late 1990s to establish a birth center in Montpellier. She recounted what motivated her to develop, with three other midwives, the plan for the Montpellier *maison de naissance*, as birth centers in France were termed.⁵⁴ She had studied the status of midwifery pilot projects in Québec, had visited another project for a *maison de naissance* in Pau in the southwest of France, and had worked briefly in a German *geburthaus*.⁵⁵ The

⁵³ See Philippe Viossat and Jean-Claude Pons. 2001. "Maisons de naissance: revue de la littérature" *Journal de Gynécologie, Obstétrique et Biologie de la Reproduction*. 30: 680-687.

⁵⁴ "*Maison de naissance*" translates more precisely to "birthing home." This distinction is important in France, where midwives and activists advocating the construction of out-of-hospital sites for birth have sought trademark protection for the term *maison de naissance*, and have advocated that similar efforts proposed within hospitals and clinics be named "centres de naissance" rather than "maisons de naissance." I will use the term *maison de naissance* throughout this chapter to signal the specificity of out-of-hospital sites, and "birth center" to describe sites, both internal and external to hospitals, where midwives would be the primary caregivers.

⁵⁵ Out-of-hospital birth sites in Germany managed by midwives use this term denoting "birth place" as well as more literally, "birth home."

Montpellier *maison de naissance* was a “synthesis of German and Québécois projects.”⁵⁶

The *maison de naissance* in Montpellier was a response to “more and more women demanding a more human approach to birth, sustained by midwives and some obstetricians for whom pregnancy and birth are, above all, physiological phenomena.”⁵⁷ Financed in part by a private investor, the Montpellier birth center was ready to open in 2001.

The model and point of reference for the Montpellier *maison de naissance* project was home birth. In a brochure publicizing the Montpellier birth center, the *Association “Maison de Naissance de Montpellier”* notes that the demands for home birth today emanate from a more diverse clientele than the more “*écolo*” or “alternative” clients of the 1970s and 1980s. Various professions are represented by the parents who have chosen home birth, from farmers to members of the medical profession. The demand for home births among the midwives participating in the project steadily increased as well, from 25 women in 1999 to over 100 women in 2002.⁵⁸ The geographic extent of the midwives’ home birth practices has also grown, covering approximately 80 kilometers surrounding Montpellier. The midwives refuse almost 30% of the women who request their services by virtue of distance, either from the woman’s home to that of the midwife (who would be conducting home visits and thus driving long distances regularly), or from the woman’s home to that a hospital or clinic (in the event that a transfer was necessary during a birth). Construction of a birth center located no more than 15 minutes from a

⁵⁶ Interview by author, Montbazin, France, August 26, 2004.

⁵⁷ Association “Maison de Naissance de Montpellier.” No date. [Brochure]. *Présentation de la Maison de Naissance de Montpellier*. Montpellier: Association “Maison de Naissance de Montpellier.”

⁵⁸ Association “Maison de Naissance de Montpellier,” No date, page 3.

hospital, then, is seen as a potentially rational solution to the increasing demand for home births from women in Montpellier and surrounding regions.

In 2001, at least twelve other birth center projects were under way across France, three situated in hospitals, nine sustained by associations of parents or midwives. In articles and brochures describing these projects, their development was traced to birth centers in the United States in the 1970s and throughout Europe in the 1980s. In France, the inspiration for birth centers was also Québec, where unlike birth centers developed elsewhere, *maisons de naissance* staffed by midwives were funded in full by the public health care system. In much of the documentation of the development of birth center projects in France, the comparison between birth centers elsewhere and the developing projects in France was explicit. The model of Québec inaugurated my interest in comparing the practices of midwives in Québec and France. How was the development of *maisons de naissance* in both places articulated through the practice of midwifery?

Given that both French and Canadian health care systems are undergoing pressures to “liberalize,” how might attention to midwives’ practice shed light on these transformations? These pressures take different forms, be they the outright privatization of previously public services or the more subtle efforts to introduce market-oriented models of accounting and management into health care systems. Most significantly for my interest in *maisons de naissance* or birthing *homes*, neoliberal efforts to move health care services to the community and to the home are both *spatial* and *ideological*. The reliance on home or community-based care is not simply an attempt to reduce the costs of health care. As geographers have demonstrated, the growth of home-based care relies on

a reaffirmation of traditional gendered notions of care as women's (unpaid) work, as well as understandings of the domestic sphere as the more "natural" site for the work of social reproduction. In this context, how might efforts to construct *maisons de naissance* in France be bound up with redefinitions of the spatial and ideological nature of birth? And how might the struggles over birth centers also point to new problematics for the neoliberal state, specifically the redefinition of birth as an exercise of reproductive self-determination?

To examine the context for the development of birth center projects in France (twenty-one were in existence when I conducted fieldwork in 2004) requires explicating more clearly the territorial politics of health care in France. In this chapter, I first examine the spatial effects of efforts to "rationalize" maternal health care in France, effects that played a large part in the efforts to develop birth centers. Beginning in the 1970s, a policy of stringent minimum requirements for hospital personnel and facilities led to a series of hospital closures and the spatial reorganization of maternal health care. By the late 1990s, "regionalization" policies that classified facilities into three separate levels began to categorize pregnancies based on risk (specifically, fetal risk of prematurity). These policies were an attempt to improve France's rates of maternal and infant mortality and morbidity and further accelerated the closure of small maternity hospitals and clinics. These changes dramatically affected the conditions as well as the sites of midwives' work.

The politics of birth centers in the 1990s developed within these continuing efforts to order and spatially reorganize birth in France, yet also rested on the delegation

of responsibility to new spatial configurations of practice: regional “networks” consisting of coordinated health care establishments and interdisciplinary “teams” of medical professionals. These developments were also accompanied by the notion that women were “active” participants in their pregnancies and births, a characteristic of what Fabienne Brion terms the “neoliberal State.” Brion notes that if liberalism is the “art of risk management,” then the new mechanism of risk management for the contemporary French state is one of “the individualization as well as the communitarization of risks, transferring from the State to individuals and to ‘natural,’ ‘cultural,’ or ‘existential’ communities, the responsibility to prevent risks and protect oneself from them.”⁵⁹ Subsequent chapters in this dissertation interrogate the development of efforts within French and Québécois health care to reinvest individuals and families as “natural” communities in the management of the risks of birth. In this chapter, I examine how the development of birth center projects, particularly projects envisaged outside of hospitals or clinics, reveals the contradictions and struggles internal to these transformations.

Midwifery in France

Before addressing the expectations and goals set out by advocates of projects to construct birth centers in France, a more complete demographic picture of midwifery in France is required. The status of midwifery, indeed, even the term “midwife” resonates differently across geographical and historical contexts. In France, the work of midwives intersects, to varying degrees, with the work of nurses, social workers, doctors, caring aides and

⁵⁹ See Fabienne Brion, 2003. “Art de la gestion des risques et méthodes de sécurité dans les sociétés

others that attend to the needs of women and children.⁶⁰ Unlike in North America, where midwifery, and particularly home birth midwifery, re-emerged as a “new” profession in the last several decades, midwives in France have a relatively uninterrupted history of participation in public health care over the course of the 20th century. As Carolyn Sargent notes, “The core of the maternity system in France is midwifery.”⁶¹

Midwives in France may work in prenatal and postnatal consultation, attend births, and follow high-risk pregnancies in hospitals or in women’s homes. In contrast to the concentration of Québec midwifery practice around “normal” or “low-risk” pregnancy and birth, midwives in France, although theoretically trained to handle only “normal” pregnancies, may become specialists in diagnostic ultrasound and are involved in medical procedures and practices (abortion, fertility treatments) not typically performed by midwives in North America, as I discuss below. With doctors, midwives work in the fields of medically assisted procreation, gynecology, family planning, sexual violence units, and surgical obstetrics. Midwives are also integrated into the state’s Maternal and Infant Protection program (PMI), a form of home- and community-based social services.⁶² Thus the practice of midwifery in France is sufficiently diverse to permit midwives to specialize in particular aspects of reproductive health care that are not limited to “normal” pregnancies and births. As Sargent observed in fieldwork on

libérales avancées” *Recherches Sociologiques* 2: 109-121, page 113.

⁶⁰ Detailed histories of early modern midwifery and reproductive practice in France can be found in Jacques Gélis, Mireille Laget, and Marie-France Morel, 1978. *Entrer dans la vie: Naissances et enfances dans la France traditionnelle*. Paris: Gallimard; and Jacques Gélis, 1988. *La Sage-femme ou le medecin: une nouvelle conception de la vie*. Paris: Fayard.

⁶¹ Sargent, Carolyn. 2005. “Counseling Contraception for Malian Migrants in Paris: Global, State, and Personal Politics” *Human Organization* 64 (2): 147-156, page 150.

contraception advice given to immigrants in French hospitals, midwives' implementation of government objectives regarding family planning were "irregular, depending on the structure and policies of particular institutions and the training and motivation of personnel," and a similar diversity of midwives' practices surrounding other aspects of pregnancy and birth exists as well.⁶³

In 1945, the establishment of the *Ordre des Sages-Femmes* during the Vichy regime inaugurated the organized professional regulation of midwifery by the French state. Professional orders were to regulate the ethics and responsibilities of the medical professions, and this regulatory body, along with other professional orders governing doctors and dentists, would be given the charge of "maintaining the discipline and honor" of the profession.⁶⁴ In 1949, an official code was passed outlining in detail the duties of the midwife toward the patient and toward other medical professionals, as well as the general duties of the midwife to give care to those in need.⁶⁵ Recalling the historical regulation of midwives' practice by the Catholic Church, the 1949 code states that the "exercise of the profession of midwife is a ministry, which must not, in any case or in any way be practiced as commerce."⁶⁶ The moral character of the profession was to be upheld

⁶² François-Xavier Schweyer, September 1996, "La profession de sage-femme: autonomie au travail et corporatisme protectionniste" *Sciences Sociales et Santé* 14 (3): 67-101.

⁶³ Sargent, 2005, page 150.

⁶⁴ Ordonnance 45-0284 du 24 septembre 1945, *Relative à l'exercice et à l'organisation des professions de médecin, de chirurgien dentiste et de sage-femme*.

⁶⁵ Décret no.49-0351 of September 30, 1949. "Portant Code de Déontologie des Sages-Femmes." *Journal Officiel de la République Française*, 5 Octobre 1949, page 9955.

⁶⁶ Article 10: "L'exercice de la profession de sage-femme est un ministère; celle-ci ne doit, en aucun cas, ni d'aucune façon être pratiquée comme un commerce." Author's translation. In the second half of the 17th century, the Catholic Church in France authorized *matrones* (the term found in French sources from the 15th century onwards to describe a midwife) to perform baptisms *in utero* during a pregnant woman's labor, in the event that the infant might not survive the birth. Historians emphasize that the midwife's spiritual and moral rectitude was considered more important to the Church than her skill. These early midwives were

at all times and the law outlined activities expressly forbidden to midwives: commercialization of their practice via advertising or collaboration with a commercial enterprise and public demonstrations unless they had an “exclusively scientific or educational purpose.” Midwives, like other medical professionals, were held to professional secrecy, and most importantly, were not permitted to compromise the “complete professional independence” of their practice.⁶⁷ Midwives are thus considered medical professionals under the law, and are governed by many of the same conventions as doctors and dentists, even though their rates of pay are closer to those of nurses. The *Ordre des Sages-Femmes* is their professional governing body, and also negotiates with the Ministry of Health over the conditions of their practice.

In 2003, 16,521 midwives were registered to practice in France, and seventy-nine percent of births in France are attended by midwives.⁶⁸ By contrast, in Canada, midwives attended less than ten percent of births.⁶⁹ To practice midwifery in France, one must possess a diploma from the French State and possess either French citizenship or be a

sometimes required to take an oath swearing their adherence to the Church’s precepts and promising to uphold its teachings while attending women in labor and birth. See Jacques Gélis, Mireille Laget, and Marie-France Morel, 1978. *Entrer dans la vie: Naissances et enfances dans la France traditionnelle*. Paris: Gallimard

⁶⁷ Article 10 continues: “Sont spécialement interdits à une sage-femme: 1-Tous les procédés de réclame ou de publicité personnelle de caractère commercial, notamment les appels par la presse ou par la radiodiffusion, sauf dans des cas exceptionnels...; 2- Les manifestations spectaculaires n’ayant pas exclusivement un but scientifique ou éducatif; 3-Toute collaboration à une entreprise commerciale de soins dans laquelle la sage-femme n’aurait pas sa complète indépendance professionnelle.

⁶⁸ Ordre des Sages-Femmes. 2003. “La démographie des sages-femmes en 2003.” Accessed January 15, 2005, <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/schema2.htm>; see also Ordre des sages-femmes. Accessed November 17, 2005. <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/demo1.htm>, citing DREES, répertoire ADELI.

⁶⁹ Knox, Sarah and Miranda Hawkins. 2003. *The Midwifery Option: A Canadian Guide to the Birth Experience*. Toronto: Harper Collins, page 39.

citizen of an EU state, or Morocco or Tunisia.⁷⁰ In 1982, the government opened the practice of midwifery to men, and now 1% of practicing midwives are men.⁷¹ Fifty-one percent of midwives in France practice in public hospitals, 20% are salaried employees of private clinics, 10% are “liberal” practitioners (which means they have independent private practices), and 4% work in social services. For midwives who work in public hospitals, part-time work has become increasingly common: in 1985, 12.5% of midwives worked part-time. Twenty years later, in 1995, this number had doubled. In 2001, 35% of midwives worked part-time, most in the private sector.⁷² Some supplement their income by working in several places at once, or by working in a hospital and maintaining a private practice of childbirth preparation or post-natal rehabilitation. Most births take place in hospitals or clinics, with out-of-hospital births accounting for approximately one percent of all births on average, although in some regions this figure may be as high as 7% of all births.⁷³

The Ministry of Health determines the rate of growth of the midwifery profession, as it does all medical professions, by restricting the number of new students admitted to

⁷⁰ The requirement of French citizenship for medical professionals dates to 1935. Although these restrictions have been successively loosened (as evidenced by the inclusion of EU citizenship as well as citizenship in some of France’s former colonies), these restrictions were rooted in the conservatism and xenophobia of the 1930s. For a discussion of these positions in the creation of the L’Ordre des Medecins, see Francine Muel-Dreyfus. 2001. *Vichy and the Eternal Feminine*. Trans. Kathleen A. Johnson. Durham and London: Duke University Press, page 265-272.

⁷¹ *Loi 82-413 du 19 mai 1982* replaced *Loi 191 du 24 avril 1944* that limited the profession of midwifery to women only.

⁷² Ordre des sages-femmes. Accessed November 17, 2005. <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/demo1.htm>, citing Direction de la Recherche, des Études, de l’Évaluation et des Statistiques, Ministère de la l’Emploi et de la Solidarité (DREES), répertoire ADELI.

⁷³ The *département* of Ardèche has the highest percentage of home births in France. See the anonymously authored 2001 review, “Maisons de naissance: un état des lieux encourageant,” *Profession Sage-Femme* 79: 7-10.

midwifery schools, and the curriculum for midwives is standardized across France and includes both theory and clinical work.⁷⁴ Midwives working in public and private hospitals are salaried employees and those working as independent practitioners are reimbursed by individual “act” performed, with rates for reimbursement determined by the national government. Midwives are limited to performing certain acts and prescribing a specific number of medicines, all of which are determined by the Ministry of Health.

Over time, however, midwives’ responsibilities as medical professionals have grown. In 1948, midwives were permitted to carry and administer three medications: extracts of opium (for pain relief) and ergot (for stimulating uterine contractions) to be given as injections to a laboring mother, and a weak solution of silver nitrate, a common prophylactic solution placed in a newborn’s eyes to prevent gonorrhea and chlamydia.⁷⁵ In 1952, the list of medications approved for midwives was increased to ten, and by 1971, the list of medications had more than quadrupled to 45 different types of medication: anti-hemorrhagic agents, nervous system stimulants (analeptics), antispasmodics, antiseptics, solutions used in administering intravenous medications, laxatives, local anesthetics, heart stimulants, uterine stimulants, and anti-emetic drugs.⁷⁶ Midwives were permitted to carry materials used for resuscitation including oxygen, and to carry out

⁷⁴ After the 2001 strike, midwifery training was extended to four years, plus one year of introductory coursework in medicine. Chapter Two examines midwives’ education in greater detail.

⁷⁵ Ordonnance 45-0284 du 24 septembre 1945, *Relative à l’exercice et à l’organisation des professions de médecin, de chirurgien dentiste et de sage-femme*.

⁷⁶ See Arrêté du 4 janvier 1949, *Délivrances par les pharmaciens de certaines substances vénéneuses aux sages-femmes*, followed by Arrêté du 12 juin 1952, *Délivrances par les pharmaciens de certaines substances vénéneuses aux sages-femmes*.

tracheal intubations or umbilical injections on newborns.⁷⁷ Midwives' use of instruments, however, was restricted under a 1949 ordinance to those limited for use in "normal" deliveries, where the midwife may need to administer injections and suture tears.

By the mid-1980s, midwives were permitted to conduct ultrasounds during a woman's pregnancy and to conduct electronic monitoring during pregnancy and labor, to measure fetal blood pH, and to provide check-ups on women using intra-uterine devices as a method of contraception.⁷⁸ The use of x-ray exams and laboratory tests to determine the health of a pregnancy were not part of midwives' practice under the 1949 law outlining the limits of the profession, but a 1971 law permitted midwives to determine (and prescribe) those examinations and tests necessary for their practice. At the time, this included blood tests and pap smears for the mother, and urine and blood tests for the infant. By 1983, the scope of midwives' practice was considerably wider, expanding the diagnostic uses of blood and urine tests, as well as introducing into midwives' professional scope of practice the use of x-rays for examining the uterus and for measuring the pelvis. By 1989, midwives were permitted to test for Hepatitis B and HIV during a woman's pregnancy.⁷⁹ In 1989, midwives were permitted to administer 59 different medications and substances as part of their practice.⁸⁰

Many of the drugs that came under midwives' official pharmacopeia did so because of efforts on the ground to see current practices incorporated into the law. As

⁷⁷ Nelly Merlaton, 1996, "Evolution de la profession de sage-femme en France entre 1945 et 1995," *Mémoire pour l'obtention du diplôme d'état de sage-femme*. Lyon: École de Lyon, page 14.

⁷⁸ Décret 86-0124 du 23 janvier 1986.

⁷⁹ Merlaton, 1996, page 17.

⁸⁰ Merlaton, 1996, pages 9-10, citing Article 3 of the Arrêté du 3 octobre 1988 *Fixant la liste d'instruments que peuvent employer les sages-femmes*.

Danièle Carricaburu notes in her analysis of the introduction of epidural anesthesia in the mid-1980s, midwives' efforts to gain a measure of autonomy with respect to their clients and their practice meant that no one unanimous perspective on the expansion of pharmacological methods of pain relief existed. Rather, midwives were engaged in multiple efforts both to expand and to limit their prescriptive power.⁸¹

Midwives may belong to several professional unions but a professional body, the *Ordre des Sages-Femmes* (discussed above) negotiates the terms of midwifery practice and remuneration with the Ministry of Health (the president of whom, until quite recently, was not a midwife but an obstetrician). Midwives possess a considerable legal autonomy to make decisions regarding a woman's pregnancy and childbirth, yet in practice most pregnant women choose the services of a gynecologist and subsequently an obstetrician for their pregnancies. Even so, a midwife or midwives will, in most cases, attend their births. As a result, most women delivering in French hospitals and clinics may not have had any previous contact with the midwife attending their birth.

"Rationalizing" maternal health care: the décret Dienesch

After World War II, many midwives opened their own small maternity clinics, a practice that reduced the amount of travel time required to visit patients treated at home. These clinics also ensured that running water and electricity were available for births.⁸² In the late 1960s, however, health policy officials began to express increasing alarm at France's

⁸¹ See Daniele Carricaburu. 1986. "Les sages-femmes face à l'innovation technique" in Pierre Aïach and Didier Fassin, eds. *Les métiers de la santé: enjeux de pouvoir et quête de légitimité*. Paris: Anthropos /Economica, pages 281-308.

⁸² Merlaton, 1996, page 29.

high rates of maternal and infant mortality and morbidity, among the highest in Europe, and began to advocate for greater coordination of perinatal care. In 1970, a law was introduced to regulate and private and public hospitals, the first to closely analyze the growing public hospital sector. Noting the differences between public and private hospital services, health care officials began to advocate coordinating health care planning of facilities and services across the national territory.⁸³

Accent was placed on prenatal surveillance: the improvement of conditions of birth implied a politics of prevention, involving an increased supervision of pregnancy [and]...an increase in the number of consultations and in the number of women benefiting from these consultations.⁸⁴

After the development of a *perinatal plan* in 1970, and the publication of a proposal to create “perinatal referral centers,” the efforts to “rationalize” the system of maternal health care in France turned toward the spatial organization of care.⁸⁵ Until this time, women were free to choose a maternity hospital for their birth.⁸⁶ In the event of complications, women or infants were transferred to a service with a higher level of care. According to critics, this practice essentially permitted the “anarchic” development and maintenance of small maternity hospitals throughout France.⁸⁷ In 1972, following the

⁸³ Economic Models Limited, 1976, *The French health care system*, Chicago: American Medical Association, page 12.

⁸⁴ Wolf, 2001, page 34.

⁸⁵ See Emile Papiernik and Louis G. Keith. 1995. “The regionalization of perinatal care in France – description of a missing policy.” *European Journal of Obstetrics and Gynecology* 61: 99-103.

⁸⁶ Freedom of choice of one’s physician was codified in post-war public health law but finds antecedents in the Revolutionary notion that “a free population would be able to choose the best healers,” hence the state should only affirm the “principle of total freedom for people to choose whom they wanted to cure them.” See Olivier Faure, 2002, “Health Care Provision and Poor Relief in 19th Century Provincial France” in Ole Peter Grell, Andrew Cunningham and Robert Jütte, eds. *Health Care and Poor Relief in 19th and 19th Century Northern Europe*, Aldershot: Ashgate, page 310. Faure cites Jacques Léonard, 1978, *Les médecins de l’ouest au XIXe siècle*. Lille: Atelier Reproduction des thèses, Université de Lille III, pages 196-253.

⁸⁷ Nathalie Sapena, 1997, “Bien choisir sa maternité,” *60 millions de consommateurs*, 311: 16-19.

publication of a new requirements for health establishments known as the “*décret Dienesch*,” many of the maternity clinics run privately by midwives were required to close due to the impossibility of complying with the standards required by the decree.⁸⁸ Named after then Secretary of State to the Minister of Health Marie-Madeleine Dienesch, the new norms required private clinics to ensure the care of normal as well as “pathological” births by guaranteeing the possibility of abdominal surgery at any point during a pregnancy, as well as gynecological surgery, and to provide care for infants in the establishment itself.

The *décret* required the presence in any new private clinic of a minimum of 25 beds for a freestanding clinic, or 15 beds for a maternity clinic associated with an existing healthcare establishment.⁸⁹ Several weeks later, the new norms were extended to public hospitals as well.⁹⁰ Judith Wolf’s ethnography of a *maison de naissance* in Sarlat (in the southwest of France between the Massif Central and the region surrounding Bordeaux) that was officially condemned by the departmental health authority in 1999 and eventually forced to close in 2002 is instructive here. Wolf notes that over the course of the post-war period in France, midwives increasingly moved from independent practice into the expanding public health and social service system.⁹¹ As midwives’ private clinics disappeared, the number of midwives in independent, private practice began to decline,

⁸⁸ Merlaton, 1996, page 24.

⁸⁹ Décret 72-162 du 21 février 1972 *relatif aux normes applicables aux établissements privés d'accouchement*. Ministère de la Santé Publique et de la Sécurité Sociale. Journal Officiel de la République Française. 3 mars 1972, page 2316.

⁹⁰ Wolf, 2001, page 34.

⁹¹ Home births accounted for over half of all births in France in 1952, and less than 5% by 1968. The *maison de naissance* in Sarlat was initially established as a private clinic by a midwife, Suzanne de Béarn, until 1986, when standards for health care establishments required the presence of an obstetrician,

as more midwives began working as employees in public and private hospitals. These closures continued through the 1970s. In 1975, over half of the maternities operating in France were privately run (52% or 716 out of 1,369) but in the period between 1975 and 1985, 190 private maternities closed. Closures also affected the public sector, particularly small “rural” maternities, some with no more than 10 beds. In the decade between 1975 and 1985, 139 public maternities closed. Closures continued in both the public and private sectors throughout the 1980s, and in 1996, private maternities were in the minority, representing only 33% of total beds devoted to obstetrics.⁹² Many midwives who had practiced independently in their own small clinics or in women’s homes became salaried employees of hospitals and clinics. In 1974, thirty-six percent of all midwives practiced in public hospitals and this number increased to 45% in 1980 and again to 53% in 1985.⁹³ In 2001, 63% of midwives working in France worked in public hospitals.⁹⁴ Today, seventy-one percent of midwives are salaried employees of public or private hospitals, a spatial shift that also marks the shifting location of birth from home to hospital.⁹⁵

anesthetist, pediatrician, and midwife at all births. See Judith Wolf. 2001. *La maison de naissance de Madame de Béarn*. Paris: Denis Diderot Presse.

⁹² Baubeau, Dominique, Serge Morais, and Antoine Ruffié. July 1999. “Les Maternités de 1975-1996: un processus de restructuration sur longue période” *Études et Résultats* 21. Paris: Direction de la Recherche, des Études, de l’Évaluation et des Statistiques, Ministère de la l’Emploi et de la Solidarité, page 2.

⁹³ See Delphine Guffond, 2001, “Trente ans au cœur de la vie: Évolution de la pratique d’accompagnement des sages-femmes à travers l’évolution de la naissance de 1970 à nos jours” *Mémoire présenté en vue de l’obtention du diplôme d’État de sage-femme*. École de sages-femmes de Lyon.

⁹⁴ Ordre des sages-femmes. Accessed November 17, 2005. <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/demo1.htm>. Some midwives work as independent practitioners and obtain contract work in hospitals and clinics. The law forbids midwives working in public hospitals (and thus employees of the state) from maintaining a private practice at the same time, including part-time work in public hospitals. See Ordonnance number 82 296 du 31 mars 1982.

⁹⁵ Daniel Sicart, 2005. *Document de travail: Les Professions de la Santé* 82. Paris: Direction de la recherche, des études, de l’évaluation, et des statistiques, page 23.

Regionalization of care: “Décrets Périnatalité”

Subsequent decrees issued by the Ministry of Health continued to establish new norms for hospital and clinic births. The closure of specialized maternity hospitals begun in the 1970s continued through the 1990s. In a 1994 report issued by the Haut Comité de la Santé Publique, the authors recommended the closure of maternity hospitals with fewer than 300 births per year.⁹⁶ The plan also recommended the classification of maternity hospitals into three distinct levels differentiated by their capacity to accommodate premature births. The efforts to promote a “regionalization” of maternal and infant care were initially promoted in the early 1970s by the Ministry of Health as a means to coordinate maternity care services across the territory of France. Advocates argued that efforts to coordinate the transfer of pregnant women rather than infants after birth would result in lower rates of prematurity and fewer stillbirths and neonatal deaths. The concept of a “regionalization” policy for maternal health care was initially developed in the United States, and to varying degrees regionalization policies have been incorporated into public health programs in Canada as well as other European countries.⁹⁷

Reports calculating the number of infant deaths and injuries that could have been avoided with the proper “organization” of care fueled the sense that maternal health care in France was in “crisis.” In a 1997 report by the national insurance scheme (Caisse nationale d’assurance maladie), the total number of premature infant deaths due to the ineffective organization of care was an explicitly spatial concern; the author states that

⁹⁶ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique.

“670 premature infants die each year because they were not born in the right place,” that is, in hospitals lacking highly specialized neonatal facilities.⁹⁸ The report also states that 370 incidents of severe infant disability could have been avoided if the child had been adequately treated earlier. In the same year, the highly publicized death of a woman in 1997 at a hospital in Pithiviers resulted in the hospital’s closure, ostensibly due to the lack of adequate provision of anesthetic services and general concerns by the regional health agency about the “safety” of the establishment.⁹⁹

Analysts attribute France’s rather abysmal rates of infant and maternal mortality and morbidity compared to its European neighbors to a complex of causes: increasing numbers of premature infants (linked to growing social insecurity or “*précarité*” among the poor) combined with the historical and geographical constraints of separate hospital facilities for adults and children, where the distance between facilities complicates the situation in which both a mother and a child might need intensive medical treatment. The need to transport either the infant or the mother (or both) to more specialized hospitals inevitably runs the risk of worsening the conditions of either patient.¹⁰⁰ Other critics, however, point out that France’s increasing “medicalization” of birth is partly to blame for the dismal state of maternal and infant health: the proposal to define all pregnancies as “inherently risky” results in the costly “over-technicization” of births for some women while neglecting more crucial questions of access to prenatal care for others.

⁹⁷ See Jennifer Zeitlin, Emile Papiernik, Gérard Bréart, and The EUROPET Group. 2004. “Regionalization of perinatal care in Europe” *Seminars in Neonatology*. 9: 99-110.

⁹⁸ Nathalie Sapena, 1997, “Bien choisir sa maternité,” *60 millions de consommateurs*, 311: 16-19.

⁹⁹ Sapena, 1997, page 16.

¹⁰⁰ Sapena, 1997, page 17.

Indeed, the question of risk has preoccupied health care planners in France, where the notion of all births as potentially risky (and thus that a “normal” birth can only be defined in retrospect) is regarded as the guiding principle.¹⁰¹ In 1998, the Ministry of Health began to actively promote the reorganization of hospitals and clinics into decentralized networks, assigned to treat different categories of fetal and maternal risk. These networks were developed initially to deal with the small percentage of births that are high risk.¹⁰² In taking up the recommendations of the 1994 report, the “décrets Périnatalités” issued new “norms” for maternity care establishments and mandated the classification of hospitals and clinics by type as well as the closure of facilities with less than 300 births per year. The implementation of the new standards began a process of consolidating births into larger structures, with all establishments classified by “level”: Level I facilities handle “normal” births, including cesarean deliveries; Level II facilities must have a neonatology unit; and Level III facilities have a neonatology unit as well as a unit for intensive care of newborns.¹⁰³

This process of consolidation was an attempt to overhaul the perceived “dysfunction” of the health care system, given the fact that between 1982 and 1997 France had fallen from 4th to 12th among OECD countries in terms of rates of death for infants less than seven days old. The reorganization of structures was justified as a response to high rates of maternal and infant mortality in France relative to other parts of

¹⁰¹ See Madeleine Akrich and Bernike Pasveer. 1996. *Comment la naissance vient aux femmes*. Paris: Les Empêcheurs de Penser en Rond.

¹⁰² Tapie, Christine. April 1999. “Nos Attentes: voir respecter le choix, libre et éclairé, des parents en ce que concerne le lieu et les conditions de la naissance de leurs enfants” *Les Dossiers de l’Obstétrique* 271: 45-48, page 45.

Western and Northern Europe, which have hovered around 10 maternal deaths per 100,000 live births for the last several decades. The current rate in France is 9 maternal deaths per 100,000 live births.¹⁰⁴

In 1998, the Ministry of Health issued *décrets* that effectively mandated the closures of small maternity hospitals with less than 300 births per year.¹⁰⁵ These closures massively reorganized the nation's maternal healthcare system.¹⁰⁶ Although hospital and clinic closures had occurred regularly since the mid-1970s, the 1998 decrees accelerated this process. Between 1975 and 2001, the number of maternity hospitals decreased from 1,369 to 694, and since 1996, 120 maternity hospitals and clinics have closed, following decisions by successive governments to reduce the number of establishments in the interest, they argue, of greater safety.¹⁰⁷ In effect, the 1998 decrees mandated that all establishments with fewer than 1,500 births were newly required to have the presence 24 hours a day of an anesthesiologist, a gynecologist-obstetrician, and a pediatrician.¹⁰⁸ Unable to comply with the requirements issued for maternity clinics and hospitals, many

¹⁰³ Décret no. 98-899 and Décret no. 98-900, 1998 "Décrets Périnatalités" *Journal Officiel de la République Française*, 10 Octobre 1998, page 15343-15344.

¹⁰⁴ By comparison, Canada's ratio of maternal deaths per 100,000 live births from 1993 to 1997 was 4.4, one of the lowest in the world, see Beverly Chalmers and Shi Wu Wen. 2004. "Perinatal Care in Canada" *BMC Women's Health* 4 (Supplement 1): S28.

¹⁰⁵ Critics fear the closures of small maternity services will affect local and regional development. The hospital may be the largest employer in a small town, and as one analyst I interviewed noted, may be a factor in the attracting industries to an area. Interview by author, Paris, France, November 5, 2003.

¹⁰⁶ Madeleine Akrich, 2000. "Quelles sages-femmes pour demain?" *XXVIIIèmes assises nationales des sages-femmes: compte-rendu scientifique* Paris: Association professionnelle des sages-femmes des facultés de médecine de Paris, pages 61-64.

¹⁰⁷ No author. 9 March 2004. "Dangers sur la maternité." *L'Humanité*. Accessed November 11, 2004 <http://www.humanite.fr/journal/2004-03-09/2004-03-09-389624>.

¹⁰⁸ Laffitte, Adeline. October 1998. "Maternités: on ferme" *Alternative Santé – L'Impatient*. 249: 10-12, page 10.

closed their doors. Between 1980 and 2001, the number of locales with a maternity hospital decreased from 750 to 520.¹⁰⁹

This reorganization of maternity care was seen as a solution to the highly publicized costs of health care spending: more births in larger facilities means a more *efficient* use of state resources, but also a more efficient use of *midwives' time*. The reorganization of care also affected the ability of medical professionals to accommodate new classifications of risk. As one analyst noted,

Before the system of Level I, II, and III, doctors could do what they wanted. For many doctors, it was difficult to transfer because of professional pride. They could decide when to refer a patient and sometimes this did not turn out well...Now, the level of planning facilities is decided by a planning body and is decided on the level of the facilities, not necessarily by the level of skill of the practitioner. Doctors at Level I and Level II facilities are afraid of medico-legal consequences and tend to transfer at the slightest sign of pathology, out of fear. What is the result of this? Many doctors at lower levels lose the ability to deal with complications.¹¹⁰

These changes have shifted the geography of birth in France, albeit unevenly. In 1997, 60% of regions lacked a Level III maternity, yet in Île-de-France, which includes Paris, Level III maternities were overcrowded. According to a study conducted in 2003, women in France must on average travel 14 kilometers to give birth. For women living in urban centers, the average distance of travel between her residence and the maternity hospital is nine kilometers; for women living in rural areas, this distance increases to approximately

¹⁰⁹ INSEE report, number 903, June 2003, cited in the anonymously authored September 2003 report "Quatorze kilomètres pour accoucher," *Profession Sage-Femme*, 98: 12.

¹¹⁰ Interview by author, Paris, France, June 22, 2004

23 kilometers.¹¹¹ Some women must now travel over 60 kilometers to reach a hospital equipped for a cesarean. The highly publicized deaths of two infants whose mothers needed emergency cesarean sections but could not get to properly equipped hospital in time led to heavy criticism of the governments' policy of hospital and clinic closures.

In the wake of widespread closures, however, small maternity hospitals that can no longer provide obstetrics services for birth have been transformed into *Centres Périnataux de Proximité*, or "Perinatal Centers" that provide pre- and post-natal care, as well as family planning, childbirth education, and consultations with doctors and midwives. But as one midwife explained to me, these new "Perinatal Centers" aren't well-integrated into care after a birth, "[t]he problem is that most women don't want to spend one day at the maternity, then transfer to a perinatal center....they would prefer to go home! At least this has been the experience in Brittany. Is this actually solving any problems? I don't think so."¹¹² While the closures of small hospitals undertaken in the interest of safety, a woman active in politically mobilizing the "users" of maternal services described closures to me this way:

After the 1998 decrees, women must stay in the structure where they gave birth for two hours, but after this, they are permitted, if they want, to leave. So the women who go back to their regional perinatal centers may see midwives there, and these may be midwives they saw before their pregnancy, but these are not the midwives who were there for their births...both the midwives and the women are disappointed. They have cut off women's stories of birth, and for both the midwives and the women, it is difficult to have not shared the experience of the birth. You can transfer all the medical information in the patient's file between structures, but you cannot pass on the stories of birth.¹¹³

¹¹¹ No author, 2003 "Quatorze kilomètres pour accoucher," *Profession Sage-Femme* 98: 12.

¹¹² Interview by author, Ste Foy-les-Lyons, France. August 6, 2004.

At the same time that the Ministry of Health was mandating closures of small maternity hospitals, however, the Minister of Health was also expressing interest in the development of birth center projects.

Birth Center Projects

In 1999, a national working group (*Groupe National de Travail sur les Maisons de Naissance*) was established to explore the birth center concept in France. The group brought together members of the two national unions of midwives, the *Organisation Nationale des Syndicats de Sages-Femmes* (ONSSF) and the *Union Nationale des Syndicats des Sages-Femmes* (UNSSF), and a parents' association, *Naissance et Liberté* (Birth and Freedom). Despite the new and exacting guidelines for maternity hospitals and clinics laid out in the 1998 *décrets*, the government expressed interest in exploring the group's evaluation of the function and financing of the birth center concept in France.

As part of a process of evaluation, representatives from Germany, Switzerland and Québec presented information relative to birth centers from their respective sites, and the *Groupe National de Travail* presented a report to the new Ministry of Health, Jean-François Mattèi.¹¹⁴ Given that "home birth remains a marginalized position," the report notes, "one place thus remains to imagine and create: a *Maison de Naissance*."¹¹⁵ Birth centers represented the linking of "two currents, parents and midwives...around the same

¹¹³ Interview by author, Villeneuve, France, August 14, 2004.

¹¹⁴ When the National Working Group began its study of birth center projects, Bernard Kouchner was Minister of Health.

¹¹⁵ Groupe National de Travail sur les Maisons de Naissance. 2003. *Dossier de Synthèse des Projets de Création Maison de Naissance en France*. Lyon: Groupe National de Travail sur les Maisons de Naissance

concept.” This concept is characterized by what the working group termed *accompagnement global de la maternité*, that is, a “total” accompaniment, encompassing the “physiological process of maternity” as well as the development of “a relationship between the couple, the woman, and the baby.”¹¹⁶

The *maison de naissance* will foster a relationship between the midwife, the couple, the woman and the baby in which “each is an actor, a partner and has responsibility.” This relationship, the report avers, will affect the future “becoming” of the infant. For the stakes of birth are high: “it is in reflecting on mistreatment (familial, social, institutional), on the insufficiencies of maternal care, on the notions and the genesis of attachment and detachment (in the sense of autonomy) in relationships between a child and his/her parents, that the event of birth may be considered a primordial event.” Given the incidence of social problems (“abuse, violence, drug addiction, adolescent suicide”), does a link not exist, the report asks, between the conditions of birth and “the future of each human being?”¹¹⁷ The national working group’s proposal echoed the sentiments expressed in a 1999 “Forum Naissance” organized by the Ministry of Health. The forum brought together “users” of the health care system to air their grievances with respect to birth. One participant noted,

Women are the principal actors of their birth. By contrast, today they are most often reduced to being birthed...One proposes that they are passive, while others around them, taking them in charge, will be the actors for the extraction of their baby. This is what more and more women refuse.¹¹⁸

¹¹⁶ Groupe National, 2003, page 5.

¹¹⁷ Groupe National, 2003, page 5.

¹¹⁸ Tapie, Christine. April 1999. “Nos Attentes: voir respecter le choix, libre et éclairé, des parents en ce que concerne le lieu et les conditions de la naissance de leurs enfants” *Les Dossiers de l’Obstétrique* 271: 45-48, page 46.

In the report by the *Groupe National de Travail*, it was not only women, but couples too who refuse passivity,

More and more couples are asking questions. Their origins and their styles of life are very diverse, as are their requests. The common point is the search for a personalized accompaniment that favors coherence and will be effected by one person who will be present and all the stages of this period. They expect from this accompaniment that it will leave them the possibility of developing a certain autonomy and responsibility with respect to the pregnancy, birth, as well as health. They look for a place where they can feel heard, respected in their desire for responsibility and autonomy, accepted with their fears and their limits. They equally seek to acquire information in order to be able to participate in the choices that may present themselves.¹¹⁹

In a special issue of the midwifery journal *Les Dossiers de l'Obstétrique* devoted to *maisons de naissance*, contributors note the numerous birth centers managed by midwives in other European countries, as well as in the United States and Canada. As Chantal Georgens, the president of a European network of birth centers, *Netzwerk Europa*, writes, autonomy is the “liberty to govern oneself by one’s own laws; independence; possibility of disposing freely of oneself.”¹²⁰ For women, birth centers will provide a means for women to “to fully guide their body and their spirit in complete independence;” for fathers, the birth center will help them in their own “birth” as fathers; and for infants, the birth center will protect their rights and above all, respect the rhythm of their own birth. For midwives, a *maison de naissance* will provide a space for the exercise of their autonomy inscribed into the law. As such, the birth center is seen as a “step in advance,” promoting the “medical syncretism” of two practices (home birth and

¹¹⁹ Groupe de Travail, 2003, page 6.

¹²⁰ Georgens, Chantal. April 1999. “Pour des Maisons de Naissance autonomes” *Les Dossiers de L'Obstétrique*. 271: 41-42, page 41.

hospital birth) that have been seen as oppositional. For Georgens, the *maison de naissance* “takes the best of both, without making either disappear.”¹²¹ Care in a *maison de naissance* is personalized and perfectly adapted to the individual. No act is systematic; in a birth center, midwives must respond to the “changing needs of birthing women.” Parents will take an active role in the management of the birth center, in a spirit of collaboration rather than hierarchy, “a collegial functioning, with responsibilities clearly defined and shared.”¹²² For in the birth center, responsibility and autonomy are intertwined. Both midwives and parents must exercise their own responsibility and their own autonomy with respect to birth.

Birth centers, then, are founded on the “Respect and Recognition of the natural competence of women to have children. They favor the free choice, the autonomy, and the responsibility of parents.”¹²³ For the *maison de naissance* in Montpellier, these objectives are outlined clearly:

- to support the “global accompaniment” [“*accompagnement globale*”] of maternity (pregnancy, birth, post-partum) by a competent midwife.
- to work towards the humanization of birth in taking into account the psycho-affective and psycho-somatic factors of birth proper to each maternity.
- to favor the Respect of the Normal and the natural competence of mothers to have children.
- to favor the best relation possible between the mother and the child during pregnancy, birth, and after birth.
- to encourage the birth of the family in giving the father his place.
- to provide information on the different possibilities offered in places of birth in order to encourage the free choice of parents.

¹²¹ Georgens, 1999, page 41. Georgens suggests that French health care authorities keep open small maternities with less than 300 births per year by transforming them into autonomous *maisons de naissance*.

¹²² Georgens, 1999, page 42.

¹²³ Nadel, 1999, page 9.

- to assure consistent safety in the capacity to realize a healthy correspondence between the pregnant woman and the place of birth¹²⁴

The birth center would put in place mechanisms of responsibility for the pregnant woman seeking services: “a document of ‘*informed choice*’ will be given to pregnant women.

After understanding this, the pregnant woman will sign *a contract of consent for care in the Maison de Naissance*.”¹²⁵ The care of a midwife at the *maison de naissance*, on the basis of monthly consultations by a midwife through 32 weeks of pregnancy, followed by consultations every two weeks afterwards or more if necessary, will be accompanied by prenatal preparation courses, designed to familiarize women and couples with the exigencies of birth, and teach various psycho-corporal techniques: “sophrology,¹²⁶ prenatal singing, psychological accompaniment of couples, physiological information regarding birth, massage...”¹²⁷

The “primordial role” of the midwife is one of vigilance toward any signs of pathology, and *maison de naissance* will be the privileged site of preventive measures that extend beyond those of conventional medical care:

The time given to a consultation is sufficiently long to permit a lengthy clinical examination as well as attentive listening. The midwife must take into consideration, beyond physical signs, all the signs of need, of expectation, of the behaviors of a woman, of her socio-economic conditions, of her cultural milieu, of her personal and familial history, of her habits. She pays attention to that which revealed by speech...as well as by silence. She may thus act more easily on potential risks and prevent or reduce their emergence by a preventive attitude. The midwives of the *Maison de Naissance*, in following their patients during an entire

¹²⁴ Association “Maison de Naissance de Montpellier.” No date. [Brochure]. *Présentation de la Maison de Naissance de Montpellier*. Montpellier: Association “Maison de Naissance de Montpellier.”

¹²⁵ Nadel et al., 1999, page 24. Emphasis in original.

¹²⁶ Sophrology is a combination of breathing exercises, relaxation, and visualization techniques, similar to hypnosis. See Luc Andoin, 1998. *La Sophrologie*. Toulouse: Éditions Milan.

¹²⁷ Nadel et al. 1999, page 24.

pregnancy and birth, collect information that will give them an incisive knowledge of the particularities of each person, [knowledge] *that may facilitate the early detection of complications.*¹²⁸

Documents publicizing the Montpellier *maison de naissance* make clear, however, that midwives must also address the objectives of the French health care system with regard to birth, objectives that are addressed as *statistical goals* to be met: to “diminish maternal mortality by 30%; to lower perinatal mortality by 20%; to reduce the number of low birth-weight infants by 25%; to reduce by 50% the number of women having received little or no prenatal care.”¹²⁹

Doris Nadel, a midwife working on the Montpellier *maison de naissance* project, writes that the birth center “concept” first appeared in the United States, “in reaction to the overmedicalization of birth,” and soon after developed in Québec as an experimental project responding to the demands of women and parents.¹³⁰ The model for a *maison de naissance*, she states, must be home birth, and cites Isabelle Brabant, a midwife from Québec, “[h]ome birth is our point of reference. It must not only remain accessible, for families who choose it, but it must be, in our opinion, an integral part of the work of a midwife, a perpetual recollection of what birth is when parents appropriate it entirely.”¹³¹ Indeed, in France, the equipment and technology that would be available at the proposed birth centers is no greater than what would accompany a midwife to a home birth, a practice that is legally defined within the competency of midwives. Estimates from

¹²⁸ Nadel et al., 1999, page 25. Emphasis in original.

¹²⁹ Nadel, Doris, Françoise Servent, Chantal Georgens and Dominique Paradis. April 1999. “Dans l’Hérault aux alentours de Montpellier” *Les Dossiers de L’Obstétrique* 271: 23-25, page 23.

¹³⁰ Nadel, Doris. April 1999. “Une Maison de Naissance? Qu’est-ce que c’est?” *Les Dossiers de L’Obstétrique*. 271: 7-9, page 7.

¹³¹ Nadel, 1999, page 9.

midwives I spoke to in France put the number of midwives in private practice who currently assist home births between 15 and 40.

Home birth practice is becoming difficult, however, given the passage in 2002 of a law requiring all medical professionals in independent practice to purchase malpractice insurance.¹³² This insurance continues to become more and more expensive, and midwives who practice home births also have difficulty coordinating transfers to hospitals in the event of complications. Some midwives manage to develop amicable relationships with hospitals in order to smoothly transfer women if needed, but there is no guarantee or requirement that hospital and clinic staff welcome them. During my interviews, some home birth midwives spoke of ambiguously legal situations in which women gave birth in the midwives' office or home, and some spoke of the need for prudence in carefully spacing the number of supposedly "unplanned" births that might occur with too much regularity at the midwives' office. One midwife I interviewed owned an apartment near her office, and "rented" this space to women for home births; some *maison de naissance* projects (such as the *Cœur Familiale* in Pau) involve groups of parents who collectively manage apartments or homes in which midwives attend "home" births. Midwives attempted to hide these activities given the risk they ran of being accused (as in the case of the *maison de naissance* in Sarlat) of running a health care establishment that did not conform to the standards set out by the *décrets* relative to hospitals and clinics.

¹³² Loi numéro 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé.

Revisiting the Montpellier maison de naissance

In 2001, the birth center in Montpellier was ready to open and needed only the approval of the regional health authority. This approval, however, was refused and the birth center was sold. According to one midwife involved with the project, this work was a “show of force” because although they tried to work with the Ministry of Health, in the end, “they said that we were a cult...doctors and obstetricians were so against it, they accused us of being a cult.” Indeed, rumors of some midwives’ involvement in a conference organized by a “sect” was published in national midwifery journals.¹³³ Other midwives I interviewed discussed different reasons for the project’s ultimate failure,

No one could really say why the *maison de naissance* didn’t work, in fact, someone called another midwife involved in the project, and said, it’s not the network, it’s power. It won’t work. Maybe the fact that it was a private initiative, that it was the effort of a philanthropist, that didn’t sit well with that Regional Health Authority...The rumors that it was part of a cult didn’t help, these were rumors I know were circulating. We complained but one really can’t say why it didn’t work. Too much animosity, too many differences.¹³⁴

These differences were apparent in the interviews with other midwives who sought to develop *maisons de naissance* in structures adjoining hospitals. Birth center projects had been encouraged by Minister of Health Bernard Kouchner but he announced in 1999 that “birth centers will be annexed to hospital structures or they will not be allowed to develop.”¹³⁵ A midwife in private practice in Montpellier for twenty years conducting pre- and post-natal consultations remarked to me,

¹³³ Mignot, Sandra. 2001. “La France sur le point de rattraper son retard” *Profession Sage-Femme* 79: 4-6.

¹³⁴ Interview by author, Montpellier, France, September 11, 2004.

¹³⁵ Viosat and Pons. 2001, 681.

I am not for independent *maisons de naissance*, this scares me. It's a bit fundamentalist [*intégriste*]. Politically, we are not ready in France. I am for something like in Québec, where we evaluate the *maisons de naissance* and they are linked with a network. I am for normal birth centers in hospitals, which is not the case in France. We systematically medicalize birth. I'm for a place in the maternity hospital, where women give birth spontaneously, with freedom, but that is not a question of my power as a midwife.

She commented that the reason the birth center in Montpellier had failed was because the midwives involved “did not want to work in a network, did not want to work with doctors...if we close small maternities and propose *maisons de naissance*, it's not logical.”¹³⁶

Her comments ultimately underscore the challenge to the state's logic of rational birth that midwives and activists sought to develop in birth centers. In this sense, the attempts to gain state sanction for birth centers in France drew on liberal notions of women's autonomy and freedom in contrast to the subordinate and passive place accorded pregnant women in French health care. These “critical, truth-based counterdiscourses characterizing medicine as directive and sovereign” were also directed at the generalized notion that pregnancy is universally a “high-risk” activity.¹³⁷

The pervasiveness of discourses of risk has been well documented.¹³⁸ In much of the literature on governmentality the notion of liberalism as the “art of risk management” explores the permutations of risk informing contemporary liberal government. The emergence in the early 20th century of new forms of social management that rely on

¹³⁶ Interview by author, Montpellier, France, September 7, 2004.

¹³⁷ Weir, 1996, page 388.

¹³⁸ For a discussion of how the concept of risk, from Mary Poovey's historical analysis of the modern fact from Ulrich Beck's “risk society,” has permeated late 20th-century culture, see Kathleen Woodward. 1999. “Statistical Panic” *differences* 11 (2): 177-203.

calculations of “collective” risk have been termed “actuarial” by theorists of liberalism.¹³⁹

Pat O’Malley argues that contemporary forms of government, however, are more properly characterized by a *prudential* approach to risk, in that they target individuals rather than collectives and encourage the careful calculation of personal risk by the individual. In his analysis of risk and responsibility under neoliberalism, he argues that the collectivist notions of risk underlying actuarial technologies are inadequate for understanding the emphasis within neoliberal regimes on the responsible calculating individual.¹⁴⁰ He proposes an individualized notion of risk management:

“*prudentialism*...a technology of governance that removes the key conception of regulating individuals by collectivist risk management, and throws back upon the individual the responsibility for managing risk.”¹⁴¹

Health care is one of the primary sites in which risk-based techniques of management have been progressively individualized. O’Malley cites the developments in the realm of health care provision in which the services of the state are downsized or under-funded so as to render them less accessible or “less attractive (e.g. long waiting lists for surgery),” accompanied by a moral emphasis, particularly directed at the middle-class regarding the undesirability of dependence on the state. Such shifts may also be accompanied by an emphasis on changing individual practices or behaviors. Such

¹³⁹ See Jacques Donzelot, 1991. “Pleasure in Work” in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press, pages 251-280; also Pat O’Malley, 1996, “Risk and responsibility” in Andrew Barry, Thomas Osborne, and Nikolas Rose, Eds. *Foucault and Political Reason*. Chicago: University of Chicago Press, pages 189-207.

¹⁴⁰ The concept of “solidarité” in France is one instance of a collective approach to social risk. See Jacques Donzelot, 1991. “The mobilization of society” in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect: Studies in Governmentality*. Chicago: University of Chicago Press, pages 169-179.

¹⁴¹ O’Malley, 1996, page 197.

programs and practices emphasize the “responsible (moral) and...the rational (calculating) individual” who engages in a singular, rather than collective, practice of risk-management.¹⁴²

One of the most important aspects of this shift from welfare state to neoliberal regime rests on the redefinition of risk as an opportunity rather than a danger. Whereas the welfare state attempted to eliminate risk to the population (viewing poverty and ill health as market failures), the neoliberal *prudential* state attempts to cultivate a relationship to risk that is opportunistic and entrepreneurial, thus shifting the responsibility for anticipating and managing risk to the individual, and importantly shifting the capacity to define “which risk?” to the individual as well. The “efficiency,” O’Malley writes, of such a system relies on the assumption of responsibility for outcomes by the individual: “the success of the measures taken will be assessed in terms of the cost-benefit calculus of individuals who put their own resources and their own safety on the line.”¹⁴³

Lorna Weir emphasizes, however, that the kind of risk management governing pregnant bodies conforms to what she terms “clinical risk” rather than insurantal or actuarial risk. This form of risk “closely tied with epidemiological knowledge” acts on individual bodies (much as O’Malley’s concept of *prudentialism*) but “remains linked to a therapeutic objective and administers individuals diagnosed as pathological”¹⁴⁴ In her examination of three aspects of contemporary pregnancy management in Canada, Weir

¹⁴² O’Malley, 1996, page 199.

¹⁴³ O’Malley, 1996, page 204.

¹⁴⁴ Lorna Weir, 1996. “Recent developments in the government of pregnancy” *Economy and Society* 25 (3): 372-392, page 374.

argues that the problematic of women's freedom and autonomy in pregnancy is a key point of conjuncture between feminist critiques of liberalism's exclusions and theories of governance, a conjuncture yet to be fully explored. She examines clinical risk alongside the figure of the fetus and the problematic of women's freedom and autonomy in pregnancy. She argues focusing attention away from whether reproductive technologies constrain or liberate the body so as to open up lines of inquiry into ways that "the conduct of pregnancy is organized," and onto the creation of a field of struggle over freedom that defines liberal political rationality. For it is in the persistent practices of "discovering and substantiating unfreedom" that liberalism demonstrate its self-reflexive capacity for developing and elaborating "practices of freedom." In the context of efforts to develop birth centers in France, it becomes clear that the claims to autonomy and freedom are themselves contested by activists and by midwives.

For some activists, the debate over the *maisons de naissance* in France hinged primarily on consideration of the autonomy of parents. One woman I interviewed had given birth in a private clinic near Lyon and became involved in militating for the continuation of the clinic's services after its merger with a public hospital. She explained that the failure of the *maisons de naissance* in France until then could be traced to the resistance of doctors as well as midwives. "Maybe hospital midwives are not capable of conceiving of the practice" of home births, on which the projects of freestanding birth centers explicitly took as their model. But more importantly, she said, "the midwives

manage the birth centers themselves. They did not integrate users...the users are not at all part of the debate over the birth centers.”¹⁴⁵

As Sophie Gamelin writes, the idea of the *maison de naissance* in France remains ill-defined for just this reason. “Even if it is not deliberate, the partisans of birth centers avoid the subject of home birth, which in effect relegates this possibility to the bottom rung. Do we not risk, in defending only birth at a birth center, seeing home birth forbidden, as in Québec?”¹⁴⁶ Gamelin cites a midwife in Belgium, Jean-Claude Verduyckt, who advocates for a “*maison de naissance dite Familiale ou Parentale*,” a familial or parental birth center, managed by parents and “leaving more place to the expression of the rights of citizens. Thus, can we not perhaps imagine the development of a consciousness of individual responsibility by citizens, and a better understanding of their individual duties, rather than remaining in a spirit of assistance by professionals and institutions...?”¹⁴⁷ Struggles over the concepts of autonomy and freedom were crucial to proposals to construct *maison de naissance* in France. These struggles point not to the failure or success of “alternatives” to French medical and midwifery practice, but rather to the diverse and even contradictory techniques governing the pregnant body. Birth center projects elaborated new forms of midwives’ professional specificity related to “global accompaniment,” and projected claims to autonomy and freedom within the “natural” community of the family and the non-institutional space of the “*domicile*

¹⁴⁵ Interview by author, Villeneuve, France, October 8, 2004.

¹⁴⁶ Gamelin, Sophie. No date. [Brochure] *Maison de naissance: Une idée à définir en France...* Roumagne: Sophie Gamelin. See also www.maisondenaissance.info, accessed April 16, 2004.

¹⁴⁷ Verduyckt, Jean-Claude, cited in Sophie Gamelin. No date. [Brochure] *Maison de naissance: Une idée à définir en France...* Roumagne: Sophie Gamelin. See also www.maisondenaissance.info, accessed April 16, 2004.

déplacé,” or the “displaced home,” as one midwife I interviewed labelled the concept of the *maison de naissance*. Their “failure” however, highlights the stakes of struggles over the government of the pregnant body and the constitution of the “birthing subject.”

In the following chapters, I examine how Weir’s concept of the “polymorphism of liberal governance” is linked to the efforts of midwives and activists to redefine birth as a means to women’s autonomy.¹⁴⁸ With respect to midwifery, this requires a redefinition of one’s work as a midwife. As one midwife involved with a project to develop a *maison de naissance* near Lyon explained to me,

The projects began in earnest in the late 1980s, and Kouchner was supportive, but with each change in the Ministry of Health, things change. Mattëi was supportive on the condition that they be located in hospital structures, so that is how they are working now, although in fact there is not much happening with this project – we don’t have a lot of time, everyone is busy, and so far, we have not been able to agree on the rules for transfers, for when a women would move to a higher level of technical intervention. In Lyon, the efforts began with parents, this is unique...the idea was that parents and professionals would organize and manage a *maison de naissance*...With the statement by Mattëi regarding where [birth centers] must be located, this is not possible anymore. So now the house we chose is for the parents, but this has separated birth and parenting. We decided to keep the house for parents, for classes, for meetings with each other. But the birth center projects have stagnated...

But it’s not only that. It’s also maybe a generational difference between midwives. Because... to whom does a birth belong? I consider myself a *passeuse* [lit. “ferrywoman”] I don’t want to direct a birth...One hears more and more testimonies by women, what she wants, what she doesn’t want. In the last four or five years, a lot of associations have started. They help parents make themselves heard, but they [the Ministry of Health] are not ready.¹⁴⁹

¹⁴⁸ Weir, 1996, page 385.

¹⁴⁹ Interview by author, Lyon, France, August 15, 2004.

The debates over birth centers in France demonstrate the risks and responsibilities of birth: the responsible and active participation of all involved and the role of the midwife as *passeuse* or mediator of another's autonomy. In this chapter, I examined midwives' efforts to develop birth centers in France, focusing on how these efforts were linked to policies of rationalization. Birth center advocates also sought to claim the physiological as well as emotional aspects of pregnancy and birth as a professional specificity. While officially sanctioned *maisons de naissance* have yet to materialize on the French landscape, the debates over the concept, its form, and its importance reveal new dimensions of the practices of freedom and unfreedom that now characterize the liberal government of birth.

CHAPTER TWO

A Labor of Love? Midwives and Affective Labor in Contemporary France

In August of 2004, I visited a large private clinic in a suburb of Lyon, to meet with the head midwife to discuss recent changes to the clinic's obstetric practice. The clinic was well known in the region and across France for its openness to alternative approaches to pregnancy and birth and for the active role of midwives in shaping the obstetric services. This was part of the reason for my visit; the clinic had been cited as a place where midwives have been able to exercise considerable professional autonomy with the cooperation of physicians.

In the year before my visit, however, the clinic's status had changed. As part of a reorganization of care mandated by a regional health agency, the *Agence Régionale de l'Hospitalisation*, the clinic was initially slated for closure, and a small but vocal group of activists had formed a collective, *Bien-naître*, to protest the elimination of the clinic's services. The clinic had offered what *Bien-naître* termed a "*une médicalisation raisonnée de l'accouchement*," or a "reasoned medicalization of birth," and was regarded as one of the few clinics in France to take the desires of parents into consideration.¹⁵⁰ *Bien-naître* sought to "preserve the ethic developed at the maternity" and "give voice to parents to help them express their needs and to define their birth project."¹⁵¹ The clinic's closure was eventually delayed and in the intervening period, the clinic had been purchased by a

¹⁵⁰ Bornarel, Laure. 2004. "Bien-naître" http://www.millenaire3.com/Affichage_de_la_ressou.122+M5b72d46c7a9.0.html, accessed February 16, 2005.

¹⁵¹ Bien-naître. No date [brochure]. *Pour une naissance à visage humain*. Lyon: Bien-naître.

mutualité and combined with another facility. The merger of the two clinics transferred the clinic from private, for-profit status to private, non-profit management. Many of the obstetricians who worked at the clinic subsequently left their positions, and those who filled their places were, according to the head midwife, less willing to accommodate the “alternative” practices once encouraged at the clinic. The interview took place in a room that served as her office and the midwifery staff’s break room. We talked about these changes and other midwives in the room joined the conversation in what became a spontaneous group discussion. The door to the room swung continuously, with midwives leaving the room and returning to ask the head midwife questions or report on a woman’s progress.

Our conversation turned to the how the recent changes to the hospital had changed her work. “Before,” she said, “we gave care, now we are managers (*gestionnaires*).” Her colleague interjected,

My role, before, was to talk. That was my role, conversation. But now, if I have neglected to do something technical, to check something technical, now I am reproached. No one cares what else I do, but I don’t give her the proper amount of oxygen, I am reproached. Before, most of my job was to console, to talk. Now, they are more concerned with safety (*sécurité*) than with humanity.

Other midwives who joined the discussion echoed these thoughts. Those who spoke up expressed their dissatisfaction with the recent transformations of the clinic. Not only had their own working conditions changed, but they also felt that their clientele had changed. No longer did women travel from across the Rhône region to give birth there. The head midwife explained,

We did water births, and we had classes in prenatal singing. We had midwives who practiced haptonomy¹⁵² and other things. Women chose us because of these things. But now, these services don't exist. We are bitter, yes, a bit! Now we only get women from the neighborhood...it's a local population, from the neighborhood.

On my way to the clinic by bus, I had seen the tower blocks of apartments that dotted the surrounding area, surrounded by neighborhoods of small houses. I had purchased a newspaper and coffee at the only cafe I could find in the area, in a small and somewhat empty strip of shops at the center of a group of apartment blocks, where children rode their tricycles in circles over the cracked concrete blocks that paved the small courtyard. The clinic was in Vénissieux on the outskirts of Lyon, in a *banlieue* in which almost 50% of the residents live in publicly funded housing. Many residents are also receiving other forms of social assistance, and while the French census provides no indication of race or ethnicity, 14.4% of the inhabitants are identified by the city of Vénissieux counted as *étranger* or “foreign.”¹⁵³ The perception, however, is that the *banlieue* is the home of recent immigrants to France.

For the head midwife and her co-workers to say that the clinic now served only the “local” inhabitants implies that the clients are now women in precarious economic

¹⁵² Haptonomy is defined as the “science of human emotional (affective) relations and interactions, i.e. the science of affectivity.” While not used specifically as a form of childbirth preparation, the practice of haptonomy in pregnancy involves the development of affective relationships between the mother, her partner, and the child before its birth. According to those formally trained in haptonomy, the practice is considered unique to the individuals involved and therefore cannot be generalized (or even represented) outside this context. As far as one can gather from materials produced by the organization that promotes the “official” practice in France, haptonomy acts in part on the capacities of the child in the womb to react to touch and sound before its birth. Crucial to the practice of haptonomy in pregnancy is the recognition by parents of the child as an autonomous being. See www.haptonomy.net, accessed March 26, 2006.

¹⁵³ Ville de Vénissieux, 2005. “Les données économiques,” www.ville-venissieux.fr/eco/donnes.htm, accessed March 24, 2006.

circumstances, drawn by the proximity of the clinic rather than by the range of alternative services on which the clinic had built its reputation. The head midwife spoke of what she perceived as the mistreatment of mothers by the doctors at the hospital, “today,” she said with bitterness, “*on profite des pauvres*,” “we take advantage of the poor.” When asked to elaborate, she cited doctors who gave women little information regarding the care they received, she said “with the loi Kouchner, patients now have rights,” referring to the 2002 law that codifies the rights of patients within the French health care system.¹⁵⁴ Women could file a formal complaint if a health professional oversteps the law. But “here the patients are poor, and they do not complain...if they wanted to, they would have just cause.”¹⁵⁵

This exchange was one of thirty-eight interviews conducted with midwives in France in 2004. Over the course of the summer and fall I interviewed midwives in five public hospitals (two near Paris, one in Montpellier in the south of France, and two in Lyon in the southeast) and three clinics (two in Paris, and one in Vénissieux, a suburb of Lyon described above). They were primarily large facilities that handled 1,200 to 2,200 births a year, reflecting the consolidation and closure of small hospitals and clinics since the 1990s discussed in the previous chapter. I initially conducted interviews with the directors of midwifery schools in Montpellier, Lyon, Toulouse and Clermont-Ferrand. These interviews led to contacts with midwives working in surrounding clinics and hospitals, and through these networks I was able to spend several days in one Paris clinic

¹⁵⁴ See *Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé*, known as the “loi Kouchner” after Bernard Kouchner under whose tenure as Minister of Health the law was passed

and two large hospitals in Argenteuil and Poissy-St. Germain, both suburbs of Paris, interviewing midwives and caring aides. More than half of the approximately 16,000 midwives in France today work in public hospitals and private clinics (51% and 19% respectively); the rest work in private practice or in PMI.¹⁵⁶

My interviews focused on the contemporary forms of midwives' work in France. I asked midwives to describe the tasks they perform, and to talk about how their work had changed over time. In interviews, midwives spoke of both the difficulties of their work as well as how this work was changing. Several themes emerged around the conditions and forms of midwives' work, and the value attached to the tasks and responsibilities of midwives in the French health care system. In this chapter I examine the conditions and forms of midwives' work in more detail, examining how midwives characterize the devaluation of their work through the spatial metaphors of the *corps morcelé* (the fragmented body) and the hospital as a *usine des bébés* (literally, "baby factory"). I examine the narratives surrounding the 2001 midwives' strike to illustrate how midwives are attempting to revalorize their interpretive and analytical work by advocating more rigorous medical training and recognition of their legal responsibilities as medical professionals. I supplement material from the interviews with accounts of midwifery in the national media, health policy documents discussing the status of midwifery and its role in the health care system in France, and publications by midwives and parents' associations.

¹⁵⁵ Author's interview, Vénissieux, France, August 4, 2004.

¹⁵⁶ Sicart, Daniel. 2003. "Les professions de santé au 1er janvier 2003" *Serie Statistiques: Répertoire ADELI 52*. Paris: Direction de la recherche, des études, de l'évaluation et des statistiques, page 24.

This chapter traces the production of value within midwifery in France through the dialectical processes of revalorization and devaluation. These processes, I argue, are often contradictory and thus irreducible to each other yet are linked through representations of and distinctions between midwives' labor as caring labor and as valuable, productive labor. Within the enduringly hierarchical medical system in France, midwives' work is devalued in relation to that of physicians. While midwives and physicians may perform the very same tasks for a pregnant and birthing woman, midwives are paid less, reflecting in part the status of midwifery as a predominantly feminized form of work. Efforts to "revalorize" midwifery as a profession during the 2001 midwives' strike thus focused primarily on changes to the structure of midwifery education, on the possibility of increasing the value of their productive labor through an emphasis on midwives' professional status and technological skill.¹⁵⁷

In the next chapter, I examine the efforts in France to revalorize midwives emotional and caring work more closely. I argue that the twinned process of revalorization and devaluation also works paradoxically through the governmentalization of state power and through midwives' efforts to claim the relational aspects of their work as valuable. For while the affective qualities of midwives' labor are difficult to measure (or even immeasurable), this labor is also becoming crucial to the creation of new circuits of value around birth as an emotional experience and around the responsibility of the

¹⁵⁷ The revalorization of midwifery through appeals to its "medical" status also risks eliminating a potential point of solidarity between midwives in France and midwives trained outside of France (often in France's former colonies) who seek to practice but have difficulty gaining access to information about the profession in France. Many midwives trained elsewhere end up working for lower pay as caring aides, and are often called upon to perform the work of midwives without adequate remuneration or recognition of their skills,

family.

I draw on Michael Hardt and Antonio Negri's discussions of "immaterial labor" to highlight the tensions within contemporary midwifery practice in France.¹⁵⁸ Hardt and Negri use the concept of immaterial labor to discuss the new forms of work emerging under conditions of "postmodern globalization." They argue that these new forms of work are crucial to understanding the production of capitalist value in the new "informational economy."¹⁵⁹ The first is what they term the "communicative labor" involved in the increasing "informatization" of industrial production processes. This form of labor alters the relationship between the production and consumption of goods and is implicated in the development of new communicative and information networks.

The second form of immaterial labor is that of "interactive labor." Hardt and Negri further divide this form of labor into the "immaterial labor of analytical and symbolic tasks," that is, tasks characterized by the mastery and manipulation of symbols, and "routine symbolic tasks" or those considered menial and rote. The third form of immaterial labor is what Hardt and Negri term "labor in the bodily mode," or affective labor.¹⁶⁰ This is the labor of caring as well as the labor of producing emotion, the labor of health care workers as well as those in the entertainment industry, any work in which "the creation and manipulation of affect" is primary. While Hardt and Negri do not deny that

see Sandra Mignot, 2003. "Des sages-femmes en quête de reconnaissance" *Profession Sage-Femme* 93: 4-8.

¹⁵⁸ Hardt, Michael and Antonio Negri. 2000. *Empire*. Cambridge and London: Harvard University Press, page 293. Hardt and Negri take the concept of immaterial labor as the analysis and manipulation of symbols from Robert Reich, 1991, *The work of nations: preparing ourselves for 21st-century capitalism* New York: Knopf, page 177, cited in Hardt and Negri, 2000, page 291.

¹⁵⁹ See also Michael Hardt, 1999. "Affective labor" *boundary 2* 26 (2): 89-100.

the work of caring labor is “entirely immersed in the corporeal, the somatic,” caring labor does not itself result in the production of a good, but rather in the production of “social networks, forms of community, biopower.”¹⁶¹

In examining midwifery as a form of immaterial labor, I focus on divergent and often conflicting tendencies toward the revalorization of midwives’ analytical work and the devaluation of their caring labor. As I will discuss in this chapter, when midwives went on strike in 2001, they demanded a revalorization of their profession in terms of its *medical* status, emphasizing the complex analytical tasks and medico-legal responsibilities involved in their work. Midwives in France describe their work at the “interface” between the normal birth and the pathological birth, and yet their work in determining this limit is devalued.¹⁶² In the following chapter, I examine how the efforts to revalorize midwives’ professional and medical status simultaneously devalued other forms of midwives’ work: both the work of midwives trained outside of France and the work of midwifery as affective labor or labor without measure.¹⁶³

It is this quality of affective labor that offers the possibility, for Hardt and Negri, of new forms of social interaction and potentially radical forms of politics. New social movements emerging out of political and social struggles in the 1960s and 1970s prefigured the shift from a modern economy of discipline to a postmodern economy of

¹⁶⁰ Hardt and Negri, 2000, page 293. Hardt and Negri cite the work of Dorothy Smith, 1987. *The everyday world as problematic: a feminist sociology*. Boston: Northeastern University Press.

¹⁶¹ Hardt and Negri, 2000, page 293.

¹⁶² Galley, Fabienne. 2002. “Vers une nouvelle organisation des soins en périnatalité: place de la sage-femme.” *Journée de formation continue des sages-femmes de l’AP-HP: Avenir Professionnel de la Sage-femme* Paris: Délégation à la Formation.

flexible capitalism. These movements, they argue, were *creative forces*, and not simply *reactions* to or ideologies of already shifting modes of production. Hardt and Negri see feminist movements, youth sub-cultures, “dropping out,” and other autonomous tendencies as instances of the fracturing and dissolution of economic class as common political currency within emergent information economies.¹⁶⁴ These new social movements resisted the model of Fordist work organization and the gendered distinction between production and social reproduction, and were instances of a generalized “refusal of the disciplinary regime and...experimentation with new forms of productivity.”¹⁶⁵ The process by which capitalist production took on elements of these creative and experimental movements was therefore a process of domination and redefinition.

The transformative nature of such movements was to eliminate the strict division between what was “cultural” and what was “economic.” Capital, they argue, was only able to continue by adjustment. The shift in the 1980s toward more flexible and creative modes of capitalist production was therefore the *effect* of a struggle to “dominate a new composition that had already been produced autonomously and defined within a new relationship to nature and labor, a relationship of autonomous production.”¹⁶⁶ Under this new paradigm, capital and its relationship to labor take on new forms. This model of the historical process of new and unfolding modes of production permits Hardt and Negri to

¹⁶³ For a discussion of the impossibility of measuring the value of affect (or “value-affect”), see Antonio Negri, 1999. “Value and affect” *boundary 2* 26 (2): 77-88.

¹⁶⁴ Hardt and Negri have drawn criticism for their attempt to universalize what may be particular to European and North American working class movements and overlook the possibility that working class struggles may take different forms elsewhere. See Vinay K. Gidwani and Sharad Chari, 2004. “Geographies of work” *Environment and Planning D* 22 (4): 475-484.

¹⁶⁵ Hardt and Negri, 2000, page 274.

¹⁶⁶ Hardt and Negri, 2000, page 276.

claim that contemporary forms of productivity that resist capitalist logics today may form the common resource for a new mode of political belonging. They identify these resistant forms of labor as those in which social interaction and cooperation are “*immanent to the laboring activity itself*.”¹⁶⁷ That is, they posit caring and affective labor as the possibility for new forms of social organization. This possibility is a provocative one that corresponds to the efforts of midwives and parents’ associations in France to develop new forms of sociality around pregnancy, childbirth, and parenting, and I take up these claims in the following chapter. First, however, I examine the theories of social reproduction that inform Hardt and Negri’s theorization of immaterial labor before turning to the conditions and forms of midwives’ work.

Social reproduction and immaterial labor

Hardt and Negri’s theorization of affective labor draws on the work of feminist scholars on social reproduction. The generalization of affective labor within the economy, as what they term the “very pinnacle of the hierarchy of laboring forms” assumes the blurring of distinctions between the material production of commodities and the reproduction of capitalist social relations. Hardt and Negri note that feminist scholarship on social reproduction has long examined the invisibility of “women’s work” from theories of political economy. In classical economic texts, for example, the labor of maintaining life itself is only visible as “unproductive labor.” When Adam Smith spoke of the “annual labor of every nation,” he defined labor as that which “supplies [the nation] with all the

¹⁶⁷ Hardt and Negri, 2000, page 295, emphasis in original.

necessary conveniences of life which it annually consumes, and which consist always either in the immediate produce of that labor, or in what is purchased with that produce from other nations.”¹⁶⁸ Nations thrived in spite of the “great number of people who do no labor at all, many of whom consume the produce of ten times.”¹⁶⁹ For Smith, domestic labor was unproductive and indeed was characterized by the consumption of the produce of (productive) labor.

For Marx, however, capitalism reproduced itself not only through the unlimited circulation of capital, but also through “the production and reproduction of that means of production so indispensable to the capitalist: the laborer himself.”¹⁷⁰ Marx’s writings on political economy identified the reproduction of the laborer him or herself as crucial to capitalism. The reproduction of the body of the laborer also produces surplus-value for the capitalist,

By converting part of his capital into labor-power, the capitalist augments the value of his entire capital. He kills two birds with one stone. He profits, not only by what he receives from, but by what he gives to, the laborer. The capital given in exchange for labor-power is converted into necessaries, by the consumption of which the muscles, nerves, bones, and brains of existing laborers are reproduced, and new laborers are begotten.¹⁷¹

It is the reproduction of the working class as a class, therefore, that permits the continuing function of the productive processes of capitalism. While the historical shift from primitive accumulation to capitalist accumulation was achieved through the

¹⁶⁸ Smith, Adam. 1904. *An Inquiry into the nature and causes of the wealth of nations*. Volume 1. London: Methuen and Co.

¹⁶⁹ Smith, 1904, page 1.

¹⁷⁰ Marx, Karl. 1967. *Capital*. Volume 1. New York: International Publisher, page 572.

alienation of the laborer from the means of production, historical circumstances today force workers to commodify their labor as labor-power *prior to* capitalist production, creating a ready supply for the labor market.

As Katharyne Mitchell, Sallie Marston, and Cindi Katz point out, the “historical processes” by which laborers are produced or interpellated as workers today is not simply the alienation of workers from their means of production, as Marx described. Rather, the “dense social networks of obligations and ties” in which “individuals are constituted as laborers through numerous intersecting and often colliding processes” are also part of the historical processes by which labor is reproduced.¹⁷² This work, the work of social reproduction, has often been neglected as “non-work” either because it is unpaid, or paid at such low wages as to be considered unproductive: the work of maintaining households, sustaining social networks and caring for others within the family. Mitchell et al. note that,

Most of social reproduction throughout recorded history – that is, the work considered “outside” of production, either unwaged or paid so poorly it cannot serve to reproduce the laborer himself or herself – has been conducted by slaves and their descendants, colonial and postcolonial subjects, children, and women.¹⁷³

New forms of work that eliminate the distinction between the spheres of work and non-work are increasing, yet to chart the growth of home-based work and telecommuting only partially addresses the cultivation of new subjectivities around work. Mitchell et al. cite Jacques Donzelot’s discussion of the perpetual retraining of workers, *formation*

¹⁷¹ Marx, 1967, page 572.

¹⁷² Mitchell, Katharyne, Sallie A. Marston and Cindi Katz. 2004. “Life’s Work: An Introduction, Review and Critique” in Katharyne Mitchell, Sallie A. Marston and Cindi Katz, eds. *Life’s work: geographies of social reproduction*. Oxford: Blackwell, 1-26, page 8.

permanente, in which workers are continuously compelled to improve their skills and add value to their labor. Donzelot argues that permanent retraining schemes were developed in part to help condition workers to adjust to rapid technological changes in their work. By encouraging the active participation of workers in their own training and instilling “a feeling of autonomy in relation to work, and at work,” permanent retraining schemes reduce the burdens of compensating workers for the dislocations produced by the continual transformation of the workplace.¹⁷⁴

Indeed, it is around the question of the production of value that work on social reproduction gains important theoretical traction, for we see in contemporary capitalism the cultivation of subjectivities geared toward the production of value within the realm of activities formerly considered “non-productive.” For Marx, the question of value appeared through the “congelation of undifferentiated human labor” in the commodity’s relative form. The production of this congealed value-form in abstract or undifferentiated human labor embodied within the commodity is “interminable;” the circuit through which value is produced by the abstraction of human labor extends restlessly in new directions at all times.¹⁷⁵ In fact, it is this ceaseless movement of value into new domains that maintains the production of value, as the embodiment of the social and human character of all labor.

Marx’s theorization of value has thus been a productive resource for feminist and Marxist scholars interested in the rethinking the boundaries between the domains of

¹⁷³ Mitchell et al, 2004, page 11.

¹⁷⁴ Donzelot, Jacques. 1991. “Pleasure in work” In Graham Burchell, Colin Gordon and Peter Miller, eds. *The Foucault Effect*. Chicago: University of Chicago Press, pages 251-280.

¹⁷⁵ Marx, Karl, 1967, page 63.

production and reproduction in social, political and psychic life. Work examining the importance of unpaid domestic labor in the home, and the absence of considerations of racialized and gendered labor from theorizations of capitalist political economy has been crucial to these efforts.¹⁷⁶ Here, Gayatri Spivak's work on the incommensurable yet material links between the circuits of value production in the economic, the psychic, and the social, provides one way to open up the question of the production of value beyond commodity production and toward a consideration of the ways the circulation of power and desire produces value as well.¹⁷⁷ For Spivak, the discontinuities along the chain of value-money-capital become textually productive of new representations, of value measured as a *differential*, opening up "myriad and heterogeneous possibilities of value-coding" across disparate fields (the economic, the cultural, and the social).¹⁷⁸ Indeed, it is the "family resemblance, the structural similarity, indeed the discursive continuity" between Marx's concept of value, Foucault's concept of power and Deleuze and Guattari's use of the concept "desire" that renders indeterminate Marx's "'materialist' predication of the subject as labor-power" and brings the question of affective labor (or

¹⁷⁶ Considerable work has been done to critique the primacy of production in Marx, beginning with scholarship in the 1970s, see for instance the collection of essays in Rosemary Hennessy and Chrys Ingraham, eds. 1997. *Materialist Feminism*. New York: Routledge, particularly the 1972 essay by Mariarosa Dalla Costa and Selma James. "Women and the Subversion of the Community"; Heidi Hartmann. 1996. "The Unhappy Marriage of Marxism and Feminism: Towards a More Progressive Union" in Victor D. Lippit, Ed. *Radical Political Economy*. London: M.E. Sharpe. Reprinted from *Capital and Class*. Summer 1979: 1-33. More recent feminist engagements with political economy include Caren Kaplan and Inderpal Grewal. 1994. *Scattered Hegemonies: Postmodernity and Transnational Feminist Practice*. Minneapolis: University of Minnesota Press; and J. K. Gibson-Graham, 1996. *The End of Capitalism (As We Knew It): A Feminist Critique of Political Economy*. Cambridge, MA: Blackwell.

¹⁷⁷ Spivak, Gayatri. 1988. "Scattered Speculations on the Question of Value" *In Other Worlds: Essays in Cultural Politics*. New York and London: Routledge, pages 154-175.

¹⁷⁸ Spivak, Gayatri. 1999. *A Critique of Postcolonial Reason*. Cambridge, MA and London: Harvard University Press, page 103.

what Spivak terms “affectively necessary labor”) to the fore.¹⁷⁹

Other scholars have traced the production of value in the sphere of education, where educational reforms attempt to measure, calculate, and predict the future productive capacities of individuals, and pressure students to “invest” in their potential as future workers.¹⁸⁰ In the spheres of parenting, education, and health, individuals are expected to “work” on themselves and their children.¹⁸¹ Marxist feminist critics of the 1970s and early 1980s demonstrated that the work of social reproduction produces value for capital (by adding value through the reproduction of the laborer himself). Recent works extend this scholarship by demonstrating how the seemingly clear distinctions between the spheres of production and social reproduction are dissolved by the vagaries of global capital.¹⁸² These works, then, move from Marx’s theory of the production of value within capitalism to consider how relations of force within social formations are not external but immanent to the field of forces constituting capitalist relations of production.

¹⁷⁹ Spivak, 1988, page 162.

¹⁸⁰ See Katharyne Mitchell, 2006. “Neoliberal Governmentality in the European Union: Education, Training, and Technologies of Citizenship, *Environment and Planning D: Society and Space*. 24 (3): pages 389-407. For an examination of this work in the context of development initiatives in education, see Nina Laurie, Robert Andolina, and Sarah Radcliffe, 2004. “Indigenous Professionalization: Transnational Social Reproduction in the Andes” In Katharyne Mitchell, Sallie A. Marston and Cindi Katz, eds. *Life’s Work*. Oxford: Blackwell, pages 47-74.

¹⁸¹ Ann Anagnost’s work on parenting identifies the “child as a site both of economic and emotional investment,” that is, a site for the production of value. See Ann Anagnost, 2004. “Maternal Labor in a Transnational Circuit.” In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 139-167.

¹⁸² See Cindi Katz, 2004. *Growing Up Global: Economic Restructuring and Children’s Everyday Lives*. Minneapolis: University of Minnesota Press; Mariarosa Dalla Costa and Giovanna F. Dalla Costa, eds. 1999. *Women, development, and labor of reproduction: struggles and movements* Trenton, NJ: Africa World Press; and Sarah Franklin and Helena Ragoné, eds. 1997. *Reproducing reproduction: kinship, power, and technological innovation* Philadelphia: University of Pennsylvania Press.

Conditions of midwives' work

Midwives in France are trained to provide all the medical care for a woman with a normal pregnancy and birth. Their autonomy is guaranteed by the Public Health Code that also grants them the rights to prescribe certain medications and defines the limits of their competencies. Yet when asked to describe the conditions of their work in France today, midwives articulated a difference between what they felt their work was *worth* and what they received in terms of pay as well as recognition. In describing the conditions of their work, two spatial metaphors recurred frequently. The first is distinctly corporeal.¹⁸³

Midwives often spoke of the “fragmented” or “dismembered” body (*le corps morcelé*), using this term to describe both the fragmentation of the experience of pregnancy, birth, and motherhood for women and the fragmentation and dislocation they felt in relation to their work. Because midwives are responsible for the care of both the mother and baby after birth, some midwives attributed this “fragmentation” to the difficulties of caring first for one patient and then for two. As one midwife who worked in a public hospital in Lyon stated, “sometimes we have difficulties managing the side of the mother and that of the baby, because if the baby is not doing well, we must spend more time with it, and less time with the mother.”¹⁸⁴

More frequently, however, midwives attributed the fragmentation of the body to the changing conditions of health care in France. One midwife, who practiced home births near Montpellier, stated that when she began, she followed babies until they were

¹⁸³ For an excellent discussion of the spatiality of the body and its metaphoric uses in political theory, see Claire Rasmussen and Michael Brown, 2005. “The body politic as spatial metaphor” *Citizenship Studies* 9(5): 469-484.

six months old, but now “*tout est fractionné*,” everything is split up, divided. For her, the fragmentation of the body was a result of the commodification of birth and the “globalization” of an American health care model: “Birth has become like a market, and children must be perfect to be future consumers...we function more and more on the model of the United States.”¹⁸⁵ For others, the fragmentation and dismemberment of the body was internal to the practice of midwifery and linked to ways of thinking learned as part of midwives’ formation and education. The head of midwifery services at a Level 1 hospital with approximately 1200 births per year (a hospital designed to accommodate full-term, uncomplicated pregnancies) stated,

In school, students have not learned how to reflect, just to chew up and spit out information. This only cuts the body into pieces. Nursing care does not have this fragmentation, because nurses have a true public health mission. Midwives may think “nursing, nursing” because it’s on their schema [of study] but they never stop to ask why a woman may be crying in her room several days after her birth. This aspect of maternal psychology, of the process of becoming a mother, is a violent process. Nurses have dealt far better with these questions than midwives...Midwives must become more interested in the “becoming” of the woman, otherwise that woman who cried all day in the recovery room and whose departure was met by a “thank goodness” could very well hurt her child. Who would be responsible if that happened?¹⁸⁶

Others midwives attributed the “fragmentation” of the body to the “compartmentalization” of midwifery. One midwife working in a family planning center said that “we have separated birth and parenthood. . . we compartmentalize births, and women are surprised when they learn we will not be at their births.”¹⁸⁷ This compartmentalization, however, also reflects the divisions of labor and specializations

¹⁸⁴ Interview by author, Lyon, France, August 6, 2004.

¹⁸⁵ Interview by author, Montbazin, France, August 26, 2004.

within the profession of midwifery that have developed over the last several decades: midwives may work only in delivery rooms without ever seeing women in consultation, or work in family planning and prenatal education services but not attend a woman's birth.

This notion of the "fragmented body" vividly describes how midwives experience the divisions of labor between the administrative, the technical, and the communicative and affective domains of their work in which the parts of bodies are isolated and monitored, spatially fragmented into pressures, organs, pulses, pH levels, and temporally fragmented into prenatal, antenatal and postnatal periods. Citing Marx's concept of alienation, Emily Martin examines this metaphor of the fragmented body in her work on reproduction and alienation.¹⁸⁸ Martin attributes the objectification of the body as a machine composed of parts to the epistemological foundations of scientific medicine and the dissection of discrete phenomena implied in Foucault's analysis of the development of the *regard clinique*.¹⁸⁹ Martin asserts that viewed with respect to the wider field of social relations and discursive norms, the embodied work of reproduction can be also be experienced as alienating.¹⁹⁰

The second notion, that birth in France was increasingly taking place in large hospitals and clinics derogatorily termed *usine des bébés*, or "baby factories," extends

¹⁸⁶ Interview by author, Ste Foy-les-Lyons, France, August 7, 2004.

¹⁸⁷ Interview by author, Vénissieux, France, August 15, 2004.

¹⁸⁸ Martin, Emily. 1992. *The Woman in the Body*. Boston: Beacon Press.

¹⁸⁹ Foucault, Michel. 1994. *The Birth of the Clinic*. New York: Vintage Books.

¹⁹⁰ Martin's analysis of the possibilities for a less alienating experience of reproduction, however, entails the "self-conscious" development of new meanings and self-expressions through birth that she describes as "higher, more essentially human, more essentially cultural forms of consciousness and activity,"

this metaphor of production to midwives' concerns that care for pregnancy and birth in hospitals is increasingly routinized and therefore ill-adapted to women's individual desires. The concept of the "usine des bébés, in which children are produced as if on an assembly line metaphorically links midwives' work to the industrial production of commodities and dissociates it from the hospital's social welfare mission of solidarity. The attempts to "rationalize" health care, then, were not simply experienced as shifts in the financing and management of health care facilities, but extended to the actual experiences of work itself, in which workers' individual contributions and capacities were subsumed under protocols that both routinize and closely regulate work.

Attempts to measure the extent of changes in midwives' work have focused in part on the "technicization" of the profession, on the introduction of obstetric technologies into the practice of midwifery and on the increasing responsibilities assumed by midwives that accompany these technologies. When asked what had changed in the years since she began working as a midwife in the 1980s, one midwife (who worked in a public hospital in Lyon with over 2200 births a year) stated, "our work has become more and more technical, and more "rule-driven" (*protocolé*)." ¹⁹¹ The use of ultrasound, for example, was initially introduced in France in 1972 for the care of women whose pregnancies were considered "pathological." The diagnostic uses of ultrasound for "normal" pregnancies, however, increased dramatically in the years following its introduction. In 1983, the health care system began to limit the number of reimbursable

overlooking, I think, the constraints and burdens achieving these "higher" forms of consciousness also entail. See Martin, 1992, page 164.

¹⁹¹ Interview by author, Lyon, France, August 6, 2004.

ultrasounds in a normal pregnancy to two. Partly because of women's demands, and the heightened sense of risk and concern with safety surrounding reproduction, most women today receive three ultrasounds during the course of a normal pregnancy.¹⁹² Since the early 1980s, however, ultrasounds have exceeded their diagnostic origins. Midwives today emphasize the relational aspects of the practice, in order to reread a diagnostic technique of surveillance as a means of developing social ties between the parents and the child.¹⁹³

Midwives' roles as psychological support for women has also shifted, and the pharmacological management of pain made possible by epidural anesthesia has notably affected midwives' work in hospitals and clinics. Until the 1980s, epidural anesthesia was covered by the social security system only in cases of clear medical indication. This effectively prevented women from "choosing" epidural anesthesia unless they were willing to pay out-of-pocket for the medication. Since then, however, epidural anesthesia has become a "right" for women who desire it, and is reimbursed in total by national insurance.¹⁹⁴ Danièle Carricaburu writes that the introduction of epidural anesthesia into institutions in the mid-1980s eliminated the need for a "body to body relationship" between the midwife and the woman giving birth.¹⁹⁵ Carricaburu writes that the role of midwives prior to the introduction of the epidural as a means of pain management was

¹⁹² Schweyer, François-Xavier. 1996. "La profession de sage-femme: autonomie au travail et corporatisme protectionniste" *Sciences Sociales et Santé*, 14 (3): 67-100. See also Michèle Fellous, 1988. "La révolution échographique" *Sociologie du Travail* 30 (2): 301-322.

¹⁹³ Schweyer, 1996, page 78.

¹⁹⁴ Schweyer, 1996, page 75.

¹⁹⁵ Carricaburu, Danièle. 1986. "Les sages-femmes face à l'innovation technique" in Pierre Aiach and Didier Fassin, eds. *Les métiers de la santé: enjeux de pouvoir et quête de légitimité*. Paris: Anthropos, page 298.

linked to the work a midwife did to “mother” a woman through labor and birth.

Midwives’ workplace skills often involved physical contact: massage, handholding, and so on.

The intimate physicality of these acts involving the bodies of the mother and the midwife became less important as midwives began to rely on methods that in one midwife’s words also had the potential to “equalize” the relationship between the midwife and the birthing woman. As more and more public hospitals began to make epidural anaesthesia available to all women, midwives’ “mothering” role took on new dimensions. Women were no longer “infantilized” by the pain of labor and midwives’ caring work changed. As one midwife in Carricaburu’s study explained:

Before, they had so much pain, they didn’t listen to us, now one can explain what’s happening to them, they want to know and not only from an egotistical point of view to know when this will be over; they think much more about the baby who’s coming.¹⁹⁶

The psychological support midwives once gave to women has been replaced by “methods that [midwives] have been able to develop (yoga, sophrology, haptonomy).”¹⁹⁷ The midwives’ once primary role at births in hospitals and clinics has shifted, but these shifts are only attributable in part to the development of new techniques of surveillance and pain management. These shifts also reflect attempts by midwives to adjust to the new conditions of their work and reevaluate such technologies within broader social relations of motherhood and the family.

For one midwife I interviewed, this phenomena was, in her words, simply the

¹⁹⁶ Carricaburu, 298.

“evolution of surveillance” Yet the changes within the hospital after the generalization of the epidural (which in her hospital was given to 80% of women) were noticeable,

Sometimes women come in and there is not enough time to receive an epidural, and they are disappointed...the relations with mothers are not the same as before. Often, before the widespread use of the epidural, they were able, even midwives, to deal with the cries of their patients. Now the students are less prepared to be with women who cry. They don't know what to do. But patients have also changed...they have become more demanding. They think, especially with the epidural, that they don't have to do anything, their participation is more passive.¹⁹⁸

The extension of new means of monitoring and surveillance into hospitals and clinics over the last several decades in France also means that many midwives tend to monitor multiple women's labors at once from a centralized system rather than attend to individual women. Connected to a central monitoring system, the physical presence of the midwife with the laboring woman is not necessary for obtaining certain indicators of fetal and maternal health. The affective gestures of comforting, soothing, and reassuring a woman through labor and delivery is supplemented by the need to carefully document the progress of uterine contractions, cervical dilatation, blood pressure, and fetal heart rates throughout a labor and birth. Among many of the midwives working in hospitals and clinics, the act of “accompanying” a woman through her entire labor could not be adequately measured or quantified and is thus harder to justify.

As the previous chapter highlighted, the reorganization of hospitals into regional networks has had profound effects on the institutional landscape of health care in France. Just as hospitals are no longer permitted to operate as relatively autonomous institutions,

¹⁹⁷ Schweyer, 1996, page 75. Sophrology is a combination of breathing exercises, relaxation, and visualization techniques, similar to hypnosis. See Luc Andoin, 1998. *La Sophrologie*. Toulouse: Éditions

midwives are obligated to also work in “teams” that consist of obstetricians, anesthesiologists, and pediatricians. Oriented toward the team rather than the woman, work in a busy hospital separated midwives from the women they cared for. The metaphor of the “baby factory” extended to midwives’ sense that women’s births were “sped up” out of convenience for the team, rather than from the desires of the woman herself. Another midwife, who had a private practice but also worked at a Paris clinic, stated,

For the hospital, the techniques of birth are done for the use of the team, not for the woman. They want births to go faster, and this is not for the women. At the clinic where I work, there are 2000 births a year, and two midwives on the floor, who may care for two or three women in a twelve-hour shift. You cannot personalize things in a system like this.¹⁹⁹

This obligation to work as a team has, in another account, disturbed the “face-to-face” relationship between the midwife and the birthing woman, orienting midwives toward their colleagues (anesthetists, doctors, caring aides, pediatricians) rather than toward the patient.²⁰⁰

The effect of technological developments on the caring work of midwifery has been profound, but these transformations have not been considered wholly negative. Rather, these transformations have compelled some midwives to create new meanings and create value through new practices. One midwife stated that the introduction of epidural anesthesia meant that both the midwife and the mother could be more alert after a birth. “Birth is exhausting,” she said, “both for the mother and the midwife. . . an

Milan.

¹⁹⁸ Interview by author, Lyon, France, August 6, 2004.

¹⁹⁹ Interview by author, Paris, France, June 25, 2004.

²⁰⁰ See Fellous, 1988, page 6, cited in Schweyer, 1996, page 75.

epidural means the mother is not as tired and this also allows the midwife to feel more rested after the birth.”²⁰¹ Furthermore, the majority of midwives with independent, private practices (so-called “liberal” midwives) now sustain their practices by visiting women in their homes under the prescription of a doctor in a hospital or clinic. Much more of their work, under the practice of *hospitalization à domicile*, or home hospitalization, requires attending to women with problem pregnancies that require frequent monitoring.²⁰² Many private practice midwives, then, paradoxically attend to women with the most “pathological” pregnancies rather than to the women with “normal” pregnancies for which they are trained. Liberal midwives’ work, then, consists primarily of carrying out specific “acts” prescribed by medical staff as a kind of “independent contractor” within the health care system.

New flexible arrangements like “contract” work with doctors in hospitals and clinics are also evident in the increasing number of midwives in France who work part-time in hospitals and clinics. While such work has been touted as beneficial to women workers’ desires for flexible work schedules, part-time work also carries with it the insecurity associated with other forms of flexible work.²⁰³ In 1997, 30% of the positions held by midwives were part time and this percentage was slightly more in the private sector; regardless the percentage of midwives in part-time work has almost tripled in

²⁰¹ Interview by author, Paris, France, July 10, 2004.

²⁰² A system of home hospitalization was first initiated in Bayonne, France in 1961 to treat cancer patients. See F. Clark, 1984. *Hospital at home: the alternative to general hospital admission* London: Macmillan Publishing, cited in Rebecca Jester and Carolyn Hicks, 2003. “Using cost-effectiveness analysis to compare Hospital at Home and in-patient interventions. Part 1” *Journal of Clinical Nursing* 12 (1): 13-19.

²⁰³ See Matthew Sparke, 1994. “A prism for contemporary capitalism: temporary work as displaced labor as value” *Antipode* 26 (4): 295-322.

twenty years. The growth of part-time positions exceeded that of total positions available in hospitals and clinics, where 100 midwives working in 1997 are equivalent to only 89 full-time positions.²⁰⁴ By 2001, the percentage of part-time positions had increased to 35% of the positions available to midwives in both the public and private sector.²⁰⁵

Hospital closures have also changed the practices of hospital midwives, who see increasing numbers of pregnant and birthing women for shorter periods of time. As one midwife who worked in a large, urban hospital noted, one of the changes to the provision of midwifery in France has been the shortening of stays within the hospital by new mothers. Typically, hospital stays are now two to three days,

But before, when women stayed for five to even eight days, I would remember them and they would remember me if they came back two or three years later for another baby. I remember them and this created other bonds between us, not just those of midwife to mother. But now, we don't have time to create these bonds.²⁰⁶

The growth of part-time work, shorter working hours for midwives and shorter stays after a birth limit the ability of midwives to develop emotional relationships that endure beyond the brief period in the hospital.

While work hours and sustained contact with women may be short, the midwife's responsibility is considerable. A midwife, according to the French legal code that governs the practice of midwifery, "must never effect acts or give care nor prescribe in domains that surpass her professional competencies."²⁰⁷ And the midwife's role, as the primary

²⁰⁴ Vilain, 1999, page 2.

²⁰⁵ Ordre des sages-femmes. No date. "La démographie des sages-femmes en 2003" <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/demo1.htm>, accessed March 31, 2006.

²⁰⁶ Author's interview, July 2004.

²⁰⁷ *Décret no. 91-779 du 8 août 1991 portant code de déontologie des sages-femmes*, Article 13.

caregiver during a process defined today in France as “normal only in retrospect,” has become ever more closely tied to maintaining clinical vigilance. In the context of increasing fears about patient complaints and even lawsuits, midwives have assumed new responsibilities for producing what one midwife termed the “infallible trace” on paper of the birth itself.²⁰⁸

Midwives’ medico-legal responsibility extends to the maintenance of records that could later prove the innocence of the medical staff if accused of negligence or misconduct.²⁰⁹ Indeed, one might argue that the body-to-body relationship of which Carricaburu wrote in the mid-1980s has now become a relationship more fully mediated by texts. The controversies over medico-legal responsibility in France bring to light the way technologies particular to late 20th century pregnancy management construct the interests of the mother in opposition to that of the caregivers, a possibility that complicates Hardt and Negri’s association of caring labor with the creation of “social networks” and “forms of community.”²¹⁰

Midwives can be held fully responsible, both civilly and criminally, for any adverse outcomes during a pregnancy and birth. The perceived litigiousness of the public, as well as highly publicized court cases compensating individuals for care judged negligent, have given the “trace” of birth heightened importance. The most controversial of these cases was the “Affaire Perruche,” in which a severely handicapped adult was

²⁰⁸ Interview by author, Paris, France, July 2004.

²⁰⁹ As Lorna Weir writes in her account of contemporary pregnancy management in Canada, the creation of texts about the fetus and the mother also function throughout pregnancy and birth to mediate the relationship between caregivers and the fetus itself. See Lorna Weir, 1996. “Recent developments in the government of pregnancy” *Economy and Society* 25 (3): 372-392.

²¹⁰ Hardt and Negri, 2000, page 293.

compensated for the negligence of the doctor and midwife responsible for his mother's care during pregnancy and birth. The case rested on the argument that if his mother had received accurate test results for fetal abnormalities, she would have aborted him. While the parents had been compensated earlier, the decision to compensate the child directly was seen as an acknowledgement that the lives of some people were not worth living. The lawsuit in essence compensated the man for the "mistake" of his birth, and the uproar surrounding the judgement in his favor compelled the French legislature to pass a law prohibiting such lawsuits in the future.²¹¹

However, similar cases in France involving children with Down's syndrome have intensified the discourse surrounding midwives "medico-legal" responsibilities. Patients increasing claims to "rights" and the mediatization of developments in reproductive medicine produce what one text referred to as an "informed, overinformed and even disinformed" citizenry.²¹² The price of insurance for midwives has also risen dramatically as a result of lawsuits against medical professionals; one account stated that the cost of insurance for midwives has tripled over the last ten years.²¹³ New social formations around birth also play a role in transforming midwives' relation to risk. As one text aimed at midwives and other health professionals stated, the "now habitual" presence of a woman's partner as a "witness" in the birthing room "may aggravate the situation at risk

²¹¹ *Article 1er A du Loi n° 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé*; See also Lynn Eaton, 2002. "France outlaws the right to sue for being born" *British Medical Journal* 324 (7330): 129.

²¹² Soutoul, Jean-Henri and Catherine Bardin-Bedu. 1993. *La responsabilité médicale et les problèmes médico-légaux de la sage-femme*. Paris: Maloine, page 15.

²¹³ Gaudin, 2001, para. 8.

for the midwife.”²¹⁴ The midwives’ obligation to produce the official record of the birth is time-consuming, and some midwives felt such demands left little time to truly exercise what they were trained to do: console women through a painful and potentially unfamiliar process.

Midwives’ increasing technical and medico-legal responsibilities have changed the conditions of their work in ways that invoke the corporeal and spatial metaphors of the *corps morcelé* and the *usine des bébés*. Both concepts invoke alienation from work, and link the devaluation of midwives’ skills to the devaluation of the women’s experiences of birth. As medical professionals, however, midwives’ efforts to revalorize their work culminated in 2001 when, for the first time in the history of the profession, midwives went on strike.

Public intimacies: midwives on strike

We understand waiting: a birth, it can be long. This movement can last for a long time, we’ll have Kouchner by forceps if necessary.²¹⁵

On vous a vus tout nus!²¹⁶

On March 20, 2001, midwives in France went on strike to demand recognition for their work. Following a strike the same month by nurse-anesthetists and head nurses, the

²¹⁴ Soutoul and Bardin-Bedu, 1993, page 16.

²¹⁵ Blanchard, Sandrine, 14 April 2001. “Le gouvernement refuse de rouvrir des négociations avec les sages-femmes” *Le Monde*, page 8. Bernard Kouchner was Minister of Health during the midwives’ strike in 2001.

strike was the first ever for midwives.²¹⁷ Unlike these other professions, however, midwives have a legally recognized medical status and a personal legal responsibility. Their demands were for a “revalorization” of their work: better wages in public hospitals and private clinics and a reevaluation of their compensation in the “liberal” sector (for midwives in independent practice who bill the government for their services).²¹⁸

Midwives working in for-profit or non-profit private hospitals, earn 15 to 45% less than midwives in the public sector do.²¹⁹ Of the 15,000 midwives actively working in France at the time of the strike, approximately 8,400 worked in public hospitals, 3,400 in private clinics (including 600 midwives working non-profit clinics), 640 in Centers of Maternal and Infant Protection, and 1,900 midwives practiced independently as liberal midwives.²²⁰

The closures of small maternity hospitals, combined with an increasing number of births per midwife and a decreasing number of obstetricians put midwives in an increasingly untenable position. As the spokesperson for the *Coordination nationales des sage-femmes* (the group representing midwives in negotiations) stated, “Everything falls back on us. We have to juggle between birthing rooms. The safety of our work is at stake. In the private [sector], midwives are paid so poorly they’re quitting their jobs.”²²¹ Their demands included a reevaluation of their status within the health care system, recognition

²¹⁶ Midwives’ protest chant directed at the police during the strike: “we’ve all seen you in the nude!” See Claudine Schalck, 11 April 2001. “Sage-femmes: l’impossible identité” *Libération*, page 6.

²¹⁷ Favereau, Eric, 22 March 2001. “Les sages-femmes en grève illimitée” *Libération*, page 20.

²¹⁸ Benkimoun, Paul, 4 April 2001. “Après deux semaines de grève, les sages-femmes poursuivent leur mouvement” *Le Monde*, page 38.

²¹⁹ Dufour, Christian, 28 May 2001. “Longue grève des sages-femmes” *Observatoire européen des relations industrielles* <http://www.eiro.eurofound.ie/2001/05/inbrief/fr0105151n.html>

²²⁰ No author, 9 April 2001. “Les augmentations qui leur sont proposées” *Le Monde*, page 9.

of their university-level studies, improved working conditions, an end to the closures of small maternity hospitals, and an increase in the number of midwives trained each year.

The relative invisibility of midwives as workers added to the exceptional nature of the strike. Midwives claimed that their invisibility in the workplace is exemplified by their persistent misrecognition by patients; midwives were often assumed to be nurses (if the midwife is a woman) or doctors (if the midwife is a man).²²² Midwives, a supporter noted, did not normally take to the streets to make demands, and so the strike garnered national and international attention.²²³ While coverage of the midwives' strike in the national press was generally sympathetic, one commentator remarked on the seeming incongruity of midwives as *workers*. Midwifery seemed an archaic practice, "lodged in an immovable position at the origin and dawn of humanity." The author continued,

When the myth abandons her millennial position to go on strike, to descend the streets, claiming professional exhaustion and demanding the revalorization and fair recognition of her status, we don't understand. How can one make demands when one occupies such a gratifying and magnificent position with "the most beautiful work in the world?"²²⁴

Susan Himmelweit suggests that the form of emotional commodification that accompanies caring work "is a deeper form of alienation than the commodification of the traditional labor power of muscle and brain. In emotional labor, an even more personal aspect of workers' identity, their emotional integrity, is sold as a constituent part of their

²²¹ Favereau, 22 March 2001, page 20.

²²² Interview by author, Lyon, France, August 6, 2004. The number of male midwives has risen in the years since the profession was opened to men in 1983. Male midwives remain only about 2% of the total number of midwives in France. At the time of the strike there were 71 men practicing as midwives in France. See Annick Vilain, May 1999. "Les sages-femmes: une profession en expansion" *Études et résultats* 17. Paris: Direction de la recherche des études de l'évaluation et des statistiques, Ministère de l'emploi et de la solidarité.

²²³ Gaudin, Emilie. 2001. "Blues Rose" *Particule* #4,

labor power.”²²⁵ The identification with one’s work as an integral part of one’s identity tends to mystify the alienating aspects of work. In France, midwives’ personal identification with their work was seen as one reason for their low level of participation in national workers’ unions before the strike.²²⁶ On the one hand, the notion of midwifery as a “labor of love” was deployed by striking midwives to further draw attention to their exploitation. The “most beautiful work in the world” was also relatively low paid, with long hours, heavy responsibilities, and emotionally exhausting.

The demands for recognition and “revalorization” of the profession were linked to transformations in midwives’ education that emphasized their proficiency in that second form of immaterial labor described by Hardt and Negri, “the immaterial labor of analytic and symbolic tasks” over the relational aspects of their work.²²⁷ As Chapter One made clear, midwives’ legal status is that of medical professionals. Yet midwives’ training and pay placed them with other professions considered “paramedical” in France: physical therapists, radiologists, and nurses. The *Coordination nationale* demanded a transformation in the criteria required for students who wish to become midwives. The length of schooling had increased steadily to four years of training, yet midwives’ degrees were considered professional degrees and offered no possibility of advancement into fields of research or advanced university study.²²⁸ At the time of the strike, almost

http://canalvilaine.free.fr/particule/article.php?id_article=61, accessed November 21, 2005, para. 3.

²²⁴ Schalck, 11 April 2001, page 6.

²²⁵ Himmelweit, Susan. 1999. “Caring Labor” *The Annals of the American Academy of Political and Social Sciences*. 561: 27-38, page 37.

²²⁶ Gaudin, 2001, para. 3.

²²⁷ Hardt and Negri, 2000, page 293.

²²⁸ Union Nationale des Syndicats de Sages-femmes Françaises, no date. *Une grève le 20 mars, pourquoi? Comment?* Paris.

one-third of midwifery schools required one year of medical school as a prerequisite to entry, putting the total number of years required to receive a midwifery degree at five (one year of medical school plus four years at a school of midwifery). One of the demands of striking midwives was to extend this requirement to all midwifery schools in France. The Ministry of Employment and Solidarity regulates the number of places allotted to midwifery schools for each year, and midwives also demanded an increase in the number of places allotted to the midwifery schools.

An initial agreement between the *Coordination* and the government was reached on April 5th, 2001, but was met with disappointment by the masses of striking midwives. In this initial agreement, pay raises were to only be given to midwives at the end of their careers in the public sector. Liberal midwives would have been permitted to practice certain procedures independently of a doctor's prescription (like fetal monitoring) as well as increase rates for other procedures for which midwives' compensation had remained the same for over a decade.²²⁹ Yet the strike continued on the grounds that midwives' demands over salary and recognition of their medical status had not been met. At the time of the strike, midwives working in the public sector at the start of their career earned about \$1,600 (8,500 francs) per month and \$2,600 (14,000 francs) per month at the end of their career, with midwives working private clinics receiving slightly less.²³⁰

Given the nature of midwives' work, however, many midwives were forced to return to work soon after the strike was called. Municipal government officials filed

²²⁹ Cabut, Sandrine & Charlotte Rotman. 7 April 2001. "Les sages-femmes ne veulent pas trop l'être" *Libération*, page 15.

²³⁰ Gaudin, 2001, para. 7.

orders of requisition with the courts to force midwives to return to public hospitals and private clinics to work.²³¹ Some clinics closed their maternity wards, sending women to public hospitals and treating emergencies only. In some locales, midwives were requisitioned within two days of calling the strike on the grounds that their absence would jeopardize public safety. Union leaders criticized the rapidity with which such orders were made and criticized municipalities for needlessly jeopardizing midwives' right to strike. But these requisitions also brought to light the contradictions of policies that closed public maternity hospitals deemed "unprofitable" on the one hand while claiming a state of emergency to force midwives in the remaining private clinics back to work.²³² Several days into the midwives' strike, rail workers also went on strike, prompting one midwife to note that "one can't block births like one blocks trains."²³³

As the strike wore on, factions within the movement led to the dissolution of the *Coordination nationale des sage-femmes* and the reformulation of a more representative body. Accused of being too "Parisian" by the masses of striking midwives, a new federation of regional representatives became the force behind negotiations and in conversations with the large unions representing other workers in the health care sector. The revision of salaries agreed upon by five of the seven national unions representing the health care sector several weeks before the strike, however, left midwives' demands for salary renegotiation at an impasse. The tone of compromise between the Minister of Health Bernard Kouchner, himself a doctor, and the group of striking midwives that

²³¹ Cabut, Sandrine. 18 April 2001. "La coordination se réorganise dans la douleur." *Libération*, page 16.

²³² Alexandre, Garcia. 9 April 2001. "De nombreuses grévistes ont dû reprendre le travail sur l'ordre des préfets ou des tribunaux." *Le Monde*, page 9.

²³³ Blanchard, 14 April 2001, page 8.

characterized the initial weeks of the strike took a less conciliatory tone. As midwives marched for the fourth time in cities across France and staged all-night vigils in front of the Ministry of Health, Kouchner declared that negotiations were at an “impasse,” and declared that midwives “did not need to content themselves with sit-ins and playing at May 68.”²³⁴

By April 27, 2001, after five weeks on strike, a delegation of midwives reached an agreement with the government.²³⁵ The salaries of midwives in the public sector would increase an average of \$218 (to \$2,100 per month) at the beginning of a midwife’s career and \$526 (to \$3,300 per month) at the end. Rates of promotion would also be reevaluated. The requirements for midwifery education would now be streamlined with that of doctors and dentists. Potential midwifery students would be required to pass a first year of medical school (with its attendant examination, the PCEM1 or *la 1^{ère} année du premier cycle des études médicales*) to be eligible for a midwifery program. This streamlining was already a requirement for several individual midwifery schools and would ostensibly raise the status of the profession. For independently practicing midwives, rates of reimbursement would increase. Midwives employed by private clinics fared less well. The state could not guarantee salary increases, which were at the discretion of their employers.

At a meeting convened by the professional order of midwives and midwives’ unions at the Ministry of Employment and Solidarity, Pierre Bourdieu addressed the

²³⁴ Bommelaer, Claire. 27 April 2001. “Les sages-femmes encore dans la rue” *Le Figaro*.

²³⁵ Blanchard, Sandrine. 28 April 2001. “Après cinq semaines de grève, les sages-femmes espèrent toujours parvenir à un accord” *Le Monde*, page 11.

arbitrary distinction made between the work of midwives and that of obstetricians. He admitted that while he knew little of their daily struggles, clearly “the work of midwives was not recognized at its true value.” Bourdieu continued,

In 99% of cases everything would go well if midwives were assimilated to obstetrician-gynecologists. But the difference between gynecologists, men for the most part, and midwives, women for the most part, exists and it is necessary to justify it at all costs. One of the instruments of legitimation, of the consecration of arbitrary limits is the system of teaching...

It is first on the terrain of education that the symbolic devaluation of midwives begins (in other words the ratification, the consecration of the inferior status of this feminine profession – if I may say feminine profession *par excellence*). Teaching today is done, as for “paramedical” professions, in professional schools by doctors sometimes still engaged in their own studies.²³⁶

Midwives’ education was thus comprised of “devalued teaching that devalues” and this devaluation continued in practice; for the same medical act, for the same procedure, midwives were paid one-third to one-fifth that of doctors. This seemed, to Bourdieu, a fundamental injustice, founded simply in the dominance of one group over another, remedied only by putting in its place “normal teaching, received in common with other medical professions.”²³⁷

Yet as some practicing midwives noted, the requirement for the PCEM1 as a prerequisite to entry into midwifery school was a step toward the further “medicalization” of their practice, and at worst, would subordinate midwifery to the professions of medicine and dentistry. Students entering midwifery school might in fact have failed to qualify for medical school, choosing midwifery by default rather than because of a

²³⁶ Bourdieu, Pierre. 6 December 2001. *Intervention*. Journée d’information: Sage-femme? Quelle autonomie professionnelle? Ministère de l’Emploi et de la Solidarité, Paris.

motivation to practice midwifery. The structure of the PCEM1 ranks students; those at the top are permitted their first choice between medicine, midwifery, and dentistry. As places fill in medical school, those students whose scores do not meet the minimum requirements for medical school may choose either dentistry or midwifery. In interviews, midwives noted that some students who cannot enter medicine see midwifery as more “medical” than dentistry, and this influences their choice.

My interviews took place three years after the strike. It’s clear that there were and still are a multiplicity of positions regarding whether midwives’ demands had been met, reflecting in part the diversity within midwifery itself. Midwives may work independently, in public hospitals, in the private sector, and in social services. For some, the strike was hardly more than a public relations success, an effective spectacle. Its most visible personality was Mireille Jospin, whose son, Lionel Jospin, was Prime Minister at the time. Mireille Jospin’s appearance on television publicly requesting her son meet midwives’ demands led some midwives I interviewed to feel their cause had “symbolically” profited from media attention.

While the strike garnered considerable coverage by the news media and resulted in a measure of public recognition, some midwives I interviewed felt the results were meager. They had “the feeling of having been heard but not understood.”²³⁸ The gains of the strike were an attempt to remedy the invisibility of midwifery by further professionalizing work that still bore with it the stigma of a mere “vocation.” The

²³⁷ Bourdieu, 2001.

²³⁸ Benkimoun, Paul. 4 April 2001. “Après deux semaines de grève, les sages-femmes poursuivent leur mouvement” *Le Monde*, page 38.

revalorization of midwifery, however, that requires all midwifery students pass the first year of medical school makes France's midwifery education system one of the longest (five years total) in Europe. Many midwives with whom I spoke expressed disappointment or anger that their claims had gone no farther than the requirement to attend a first year of medical school. To be "ranked third" after doctors and dentists seemed only to further entrench their inferiority and further model the foundations of their practice, inappropriately they felt, after that of obstetric medicine. One midwife who works in Maternal and Infant Protection (*Protection Maternelle et Infantile* or PMI) at a family planning center stated that the strike "put in place mechanisms of dialogue" and revalorized midwives' salaries but that midwives' other demands were not met,

Our demands, for improving working conditions and for letting the birth centers develop, were not heard at all. Mentalities did not change. It bothers me a bit that students now take a year of medical school. There has been an opening toward the exterior in midwives' formation, toward PMI for example, but a midwife who has not truly chosen her profession? I fear that people are not motivated...and this is profoundly passionate work. It's a difficult job; one can't do it without love. It leaves me to question...if we make better midwives this way.²³⁹

Some felt that the "revalorization" of midwifery as a medical profession was successful only in terms of the state's interest in maintaining midwives' subordination within the health care system and in controlling the costs of health care. One midwife, the head of a Level I maternity outside Lyon, stated that she was firmly against the strike. She felt that the statements by the Ministry of Health to encourage midwives to "reimagine their profession" were an attempt to move midwives out of their primary role as public hospital employees and into liberal practice where their numbers would further

dwindle. Her anxiety over the obsolescence of the profession was shared by others, for although the strike had brought midwives a measure of *material* revalorization in the form of increased salaries and a reaffirmation of medical status, the strike did not, and perhaps could not, revalorize the immeasurable aspects of their work. As a midwife stated in her evaluation of the further professionalization of midwifery in France, “In an economy of health care where the hospital is more and more managed like a business, a competent professional midwife can only ‘sell herself.’”²⁴⁰

Hardt and Negri’s theorization of the radical possibilities of affective labor, then, points to what Susanne Schultz argues is part of a “long left tradition of idealizing women’s and reproductive work as spheres free from alienation and domination.”²⁴¹ In this chapter, I examined the ways midwives articulate the devaluation of their labor through the metaphors of the *corps morcelé* and the *usine des bébés*, two spatial metaphors linked to changes in the French health care system.

²³⁹ Interview by author, Vénissieux, France, August 10, 2004.

²⁴⁰ Costa, Jane. 1993. *Identités et Professionalisme*. Mémoire présentée à l’École de Cadres Sages-Femmes, Dijon.

²⁴¹ Schultz, Susanne. 2006. “Dissolved Boundaries and ‘Affective Labor’: On the Disappearance of Reproductive Labor and Feminist Critique in *Empire*” *Capitalism, Nature, Socialism* 17 (1): 77-82.

CHAPTER THREE

The Power to Act: The Rights of Mothers and Midwives in France

This chapter examines more closely how midwives' affective labor in France is implicated in new forms of regulation, by examining how the exercise of reproductive self-determination in France, framed as a *right* by associations of health care "users," is increasingly posited as an obligation by the state. This concept of biopolitical power as governmentalizing, to which Hardt and Negri seem elsewhere attuned and in which midwifery as a particularly feminized form of labor is implicated, could be a useful corrective to their thesis on the possibilities of affective labor.

The metaphors of the fragmented body and the hospital as a site for the quasi-industrial production of infants figured prominently in midwives' descriptions, before *and* after the strike, of alienation from their work. The efforts of the 2001 strike to revalorize the profession, however, were focused on the context and terms of midwives' employment: pay and reimbursement, as well as requirements for entry into the profession. Midwives sought to bring their employment status in line with their legal status and accompanying juridical responsibilities as medical professionals.

Yet midwives I interviewed also spoke of their work in terms of its *immeasurable* qualities: as work that cannot be easily quantified and measured. The qualitative aspects of their work were for many inseparable from the "technical" skills needed to diagnose and detect complications during a pregnancy. As one midwife and family counselor wrote, technical skills cannot fully "master" all the risks associated with pregnancy and birth but must take into account "the emotions, the worries, the suffering expressed by the

pregnant woman, the future father.”²⁴² More dramatically, she warns, “technology without relationship may lead to an inhuman violence.” The pressures on pregnant women to have the perfect child, “to invest in the child without delay, to talk to her, to be Zen, to have positive thoughts, to take care of oneself, to remain beautiful and feminine,” are pressures that medical care supplements with concerns regarding the diet of the mother, the habits (tobacco use, smoking), with “obligatory” exams, and often contradictory advice: “continue to work, but rest, rest but move around a little.” In sum, the midwife’s role is one of managing the contradictions, the ambiguities and the ambivalence of pregnancy and birth: “That a pregnant woman expresses negative thoughts seems unbearable to hear. But, when we eliminate these thoughts, it’s ambivalence that we suppress and this cuts off the relationship [between the midwife and the woman].”²⁴³ For midwives, then, the relational aspect of their work takes into consideration the complexity of the birthing subject. It is the new importance accorded to the complexity, the desires, and the self-determination of the birthing woman as a *subject* of her birth that informs this chapter. Midwifery takes on a therapeutic and mediating role for the women’s own experiences, “To not take into account what she tells us, in order to adjust our actions, prevents the woman from finding in herself the reference points that will help her carry out her pregnancy.”²⁴⁴ Midwives’ “relational” work is seen as crucial to the successful outcome of a pregnancy and birth.

²⁴² Castell, Evelyne. 2004. “La maternité, aventure humaine” *Les Dossiers de l’Obstetrique*. 328: 25-27.

²⁴³ Castell, 2004, page 25.

²⁴⁴ Castell, 2004, page 26.

In this way, I examine more closely what Nikolas Rose terms the “psychologization of the mundane” that transforms childbirth into a “life event” requiring confession, introspection, and “the internal assumption of responsibility.”²⁴⁵ The emergence of pregnancy and birth as modes of reproductive self-determination, I argue, accord particular significance to the relational aspects of midwifery, a dimension of their “professional specificity” that many midwives argue was not fully recognized by the strike.²⁴⁶ Although less time is spent on the work of caring in a “body-to-body” relationship, the affective aspects of midwives’ work remain important. As the head midwife of a medium-size hospital explained to me,

They, midwives, must be interested in the future of the woman... Care is not just whether or not she had blood work done, no fever, stitches healing, and so on but also how the woman feels as a mother, what her psychological relationship to the baby is, whether or not she has family or friends to help her.²⁴⁷

The expertise of midwives must lie in both the technical realm of blood work, fever, and stitches as well as the psychological state of the woman, how she *feels* as a mother.

This chapter will focus on the importance of this *psychological* or *emotional* aspect of birth in France. Recent policies address birth as a question not only of physical safety but of “psychological security” as well. The importance attached to birth as a psychological as well as physical process, with repercussions that weigh on the individual as well as on society, animates this chapter. How do state policies and activists groups frame the question of birth as an exercise of self-determination? How is pregnancy and

²⁴⁵ Rose, Nikolas. 1999. *Governing the Soul*. London: Free Association Books, page 249.

²⁴⁶ Schweyer, François-Xavier. 1996. “La profession de sage-femme: autonomie au travail et corporatisme protectionniste” *Sciences Sociales et Santé*. 14 (3): 67-100.

²⁴⁷ Interview by author, Ste Foy-les-Lyons, France, August 2004.

birth defined as a policy concern and a stake in political struggles? And finally, how do midwives play a role in the redefinition of birth as an exercise of agency, and in new liberal political terms, as the exercise of “rights?” Recent activist efforts to clearly identify the rights and responsibilities of women as *mothers* point to specific forms of liberal transformation in French health care.

This chapter, then, examines the form of immaterial labor Hardt and Negri term “labor in the bodily mode,” not as an abstraction (as Hardt and Negri tend to do), but through the policies and political stakes raised over the uses of the pregnant and birthing body. Hardt and Negri point to the political possibilities of caring labor, but in its everyday practice, “caring labor” can also be the site for new forms of domination. Not only is caring labor gendered labor and thus subordinated on the labor market, but caring labor is also implicated in the circulation of biopolitical power and the emergence of new practices and identities acting on the body and the self. In this chapter, I examine how the “liberalization” of reproduction from the discipline of the state has also produced new forms of “counter-conduct,” evident in the way activists as well as midwives articulate new desires for birth. This argument draws productively from the work done by Foucault to elucidate the multi-form aspects of contemporary power. In the incomplete shift from forms of regimes of discipline to those of biopower, the axis of power also tends to shift from that between the subject and the sovereign to the movements of power internal to a given population.²⁴⁸ Midwives mediate this shift with respect to birth, I argue, in part because of their incorporation into emergent forms of administration that privilege the

solicitation of women's desires. These new forms of power operate on the affective capacities of the individual. Women's psychological experience of birth has been included in state policies in France and provides the ground for new political subjectivities. Most importantly, these new forms of power are not only imposed from above, via the sovereign or the law, but are also elicited through the relational aspects of affective labor itself, through the desires of the birthing subject for autonomy over her birth, and through the capacities of the individual to act.

In this way, midwives seek to revalorize their affective labor as work that acts on both the mind and on the body and crucially, as work that incorporates the wishes and desires of the birthing subject into calculations of care. These *relational* and affective aspects of midwives' work correspond to broadening of conceptions of health that encompass the redefinition of health as a means to self-realization. These broadened conceptions of health entail transformations in the administration of the body, both the body of the population, and under more recent neoliberal changes to health care policy in France, the body of the individual.

I draw from interviews conducted with midwives and activists, as well as recent policy documents discussing the state of birth in France today.²⁴⁹ I also read texts by activists, some published (either in print or online form) and some distributed to members of associations formed to participate politically in the redefinition of the "rights" of patients and in the fields of policy-making around birth. These documents are used to

²⁴⁸ For an analysis of the administration of the body in France, see Didier Fassin and Dominique Memmi, eds. 2004, *Le Gouvernement des Corps*. Paris: Éditions de l'École des Hautes Études en Sciences Sociales.

²⁴⁹ Translations of all documents and interviews are my own, unless otherwise indicated.

elucidate how activists draw on the enhanced role of the “user” to make political claims, and in fact, to claim recognition from the state of rights to participate in their own health care.

In part, this chapter extends scholarly concerns in geography on “care” to analyses of midwives’ affective or caring labor. The literature on care and caring labor is also rich and well developed in the fields of feminist theory, philosophy, sociology and economics.²⁵⁰ Yet considerable diversity remains in how the concept of “care” is defined. Caring is at once an ethical approach, a form of labor implying an emotional connection between giver and receiver, and a term synonymous with the work of social reproduction, or the work that reproduces labor and life more generally. A survey of research on care and caring labor across disciplines reveals the complexity of the term itself. In the field of health geography, scholars have recently begun to focus more attention on the spaces of care and caring labor. Much of this work seeks to expand the consideration of health care geography in the discipline beyond the dual themes of epidemiological concerns with disease distribution and policy-oriented studies on health care access.²⁵¹ Focus on “care” in health care geography has produced research exploring the emotional and

²⁵⁰The work of Carol Gilligan, Joan Tronto, Alison Jaggar, and Sara Ruddick, among others, has been particularly useful in developing feminist concepts of care. See Carol Gilligan’s *In a Different Voice: psychological theory and women’s development*, 1982, Cambridge, MA: Harvard University Press; Joan Tronto’s *Moral boundaries: a political argument for an ethic of care*, 1993, New York: Routledge; and Alison Jaggar’s article on “Feminist Ethics: problems, projects, prospects” in *Feminist Ethics*, Claudia Card, ed. 1991. Lawrence, KS: University Press of Kansas: 78-106. See also Sara Ruddick, 1989. *Maternal Thinking*. Boston: Beacon Press. Other scholars have focused on the emotional aspects of caring work. Arlie Russell Hochschild’s work on the emotional labor of service jobs requiring empathy or nurturing extends caring labor from those traditional definitions of “mother work” to jobs requiring the maintenance of emotion at the workplace (such as the work of flight attendants and bill collectors). See Arlie Russell Hochschild, 1983. *The Managed Heart: commercialization of human feeling*. Berkeley: University of California Press.

psychological aspects of health and illness, and opened the field to questions of meaning and representation as they are linked to shifts in health care priorities and policies.

Others have drawn on the notion of care to complicate the analysis of political economy with notions of “alternative economies” that do not function solely through the narrow self-interest of the rational individual. In geography, scholars like Susan Smith have argued that examining how markets actually work reveals that even market logics (often assumed to be that of the calculating, self-interested individual) are not wholly defined by an instrumental approach to exchange. Smith argues for the possibilities of considering how an “ethics of care” operates within markets and within “rational” economic calculation. Her argument that markets involve the value-laden considerations of feelings as well as of exchange points toward the possibilities of reconsidering the significance of emotions in relation to political economy.²⁵²

Other geographers advocating an “ethics of care” ask how a relational concept of justice requires the reformulation of welfare and health policies as well as scholarly research agendas. To this end, two recently themed issues of the journals *Social and Cultural Geography* and *Environment and Planning A* focus on the geographies of care and welfare, representing the breadth of recent geographical research on the subject.

Geographers working on issues of care ask how the spaces of health care and welfare are

²⁵¹ See Hester Parr’s 2003 summary of the state of medical geography with respect to new considerations of care in “Medical Geography: care and caring” *Progress in Human Geography* 27 (2): 212-221.

²⁵² Susan Smith, 2005. “States, markets and an ethic of care” *Political Geography* 24: 35-38 with commentaries by John Christman and Veronica Crossa in the same issue. In this sense, Smith’s work takes up the “alternative economies” approach developed by J-K Gibson-Graham that seeks to challenge capitalism’s hegemony in scholarly analyses of political economy. See JK Gibson-Graham, 1996, *The End of Capitalism (As We Knew It): A Feminist Critique of Political Economy*, Oxford and Cambridge, MA: Blackwell Publishers.

changing in response to neoliberal economic imperatives of cost-effectiveness as well as to political ideologies about the family, the self, and the community.²⁵³ This research has attempted to track the new sites of caring labor, noting that in many late capitalist economies, the shrinking of state sponsored welfare has devolved care for the frail, the disabled, the very old and the very young onto private institutions or individuals.

These changes have been traced within formal and informal care systems, as well as through notions of self-care that place the responsibility for health and well being on the individual person. For example, the rhetoric of welfare-to-work programs in the United States places much of the responsibility for caring from the state onto the individual welfare recipient.²⁵⁴ And finally, a crucial question informing much of the research on caring labor, both within geography and in other disciplines, relates to who performs the work of caring and how are the new configurations of care are spatialized. In this research, the new geographies of caring labor are central, as in the growth of home-based hospice care in the United States, one instance of the broader spatial shift of care toward more “individualized” sites and spaces, in this case to the domestic space of the home.²⁵⁵ Literature on care and caring labor in geography, then, has made explicit the costs of neoliberal economic policies that endow the individual with greater responsibilities for his or her own health.

²⁵³ Staeheli, Lynn A. and Michael Brown, 2003. “Guest editorial: Where has welfare gone? Introductory remarks on the geographies of care and welfare” *Environment and Planning A*, 35(5): 772.

²⁵⁴ See Jamie Peck’s examination of workfare programs in the United States, Canada and Great Britain in *Workfare States*, 2001. New York: Guilford. Peck demonstrates how the effects of welfare-to-work policies not only shift the responsibility of welfare onto the individual worker, but also provide support for the creation and maintenance of a low-wage labor market.

Rationalizing health care in France

The French health care system, although publicly funded and aimed at universal coverage, functions through the provision of social insurance, which “does not give the State the role of a dominant economic agent, but rather a role as the guarantor of the area for negotiation” between providers of social insurance, unions, and medical professionals.²⁵⁶ Recent debates over an encroaching “neoliberal” approach to health care have focused, in part, on the conjugation of “privatization” and “statization” in the health care system, that is, on the new modes of governance that structure cooperation and coordination between private (“complementary”) and public (“obligatory”) insurers, for example.²⁵⁷ Post-war transformations in the health care system in France have coalesced around two decidedly neoliberal concepts: the new subject-position of the “responsible” citizen, and the financial “rationalization” of care that brings economic calculation to bear on social welfare.

These new modes of governance, however, are not entirely recent. The notion of a “crisis” in the welfare state’s provision of health care began as early as the 1960s. It was then that policy makers began to describe the growing problem of health insurance

²⁵⁵ See England, Kim, Joan Eakin, Denise Gastaldo, and Patricia McKeever, forthcoming, “Neoliberalizing home care: Managed competition and restructuring home care in Ontario” and Michael Brown, 2003. “Hospice and the spatial paradoxes of terminal care” *Environment and Planning A* 35 (5): 833-851;

²⁵⁶ Letourmy, Alain 1995, “The economic forms of the regulation of health spending in France: negotiated waste” in Mission Interministérielle Recherche Expérimentation du Ministère des Affaires Sociales et de l’Emploi (MIRE), *Comparing Social Welfare Systems in Europe*, volume 1, Oxford Conference France-United Kingdom, Paris, MIRE, page 317. Cited in Richard Freeman, 2000. *The Politics of Health in Europe*, Manchester: Manchester University Press, page 63.

²⁵⁷ Mills, Catherine, and José Caudron. 30 June 2004. “Assurance maladie: une réforme qui conjugue privatisation et étatisation” *Libération*, page .

spending with respect to the economy's growth as a whole.²⁵⁸ The 1960s thus marked the beginning of attempts to "rationalize" health care costs, using new modes of financial accounting, and in particular the extension of cost-benefit analysis to the field of health care policy and planning.²⁵⁹ Attempts to "rationalize" the care of mothers and infants began in earnest as health policy makers turned the technologies of *rationalisation des choix budgétaires* (RCB) as a method of setting long-range goals and devising objective criteria to meet them. The RCB was an "adaptation of the PPBS [Planned Programming Budgeting System] developed in the USA by the Defense Secretary in the Kennedy administration, Robert McNamara."²⁶⁰ In 1968, Prime Minister Georges Pompidou applied these techniques to the realm of birth by commissioning a study to determine the cost to the nation of disabled children. At the time, France had one of the highest rates of rates of perinatal mortality (a combination of fetal and neonatal deaths) in Europe at 30 deaths per 1,000 births.²⁶¹ The study, entitled the Bloch-Lainé report, concluded that the cost to the nation for the care of handicapped children was 2% of gross national product.²⁶² From this report, a first *Plan du Périnatalité* was written to comprehensively develop objectives for reducing the number of preventable "accidents" at birth that were

²⁵⁸ Donzelot, 1991, page 270.

²⁵⁹ Donzelot, Jacques. 1991. "Pleasure in Work" in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect: Studies in Governmentality*, pages 251-280, see particularly the section on "The cost of life," page 276-279.

²⁶⁰ Ziller, Jacques. 2005. "Public law: a tool for modern management, not an impediment to reform" *International Review of Administrative Sciences*. 71 (2): 267-277.

²⁶¹ Cour des Comptes, 2005, page 366.

²⁶² Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 35.

leading to the deaths and disabilities of infants.²⁶³

The 1970-1976 *Plan du Périnatalité* was issued partly in response to widespread media publicity surrounding the number of infants and children in France who had sustained brain injuries at birth. Conceived as means of rationalizing birth both financially and technically, the plan made four prenatal consultations obligatory. The plan also sought to guarantee the availability of both personnel and of the equipment to care for severely distressed infants in health care establishments. The efforts to rationalize maternal and infant health care were thus marked by the development of new norms for maternity hospitals and clinics, including recommendations regarding the formation and demography of medical professionals.²⁶⁴ The plan was aimed primarily at standardizing of technology and personnel in private clinics, rather than public hospitals and resulted in the closure of numerous small private clinics.²⁶⁵ The *décret Dienesch*, issued in 1972, further targeted small obstetrical clinics for closure, many managed by midwives.²⁶⁶ By 1980, perinatal mortality in France had decreased to 13 deaths out of 1000, far below the goal of 18 set by the 1970 *Plan du Périnatalité*, and testament, according to some, of the success of efforts to “rationalize” health care.

If efforts to rationalize infant and maternal health care focused on the technical

²⁶³ Naiditch, Michel. 2000. “Quelle place pour les sages-femmes dans la nouvelle organisation des soins périnatal” *Journées d'études et de formation: XXVIIIèmes assises nationales des sages-femmes, Bruxelles, 24-26 mai 2000: compte-rendu scientifiques*. Paris: Association professionnelle des sages-femmes des facultés de médecine de Paris, page 65-78, 67.

²⁶⁴ See Haut Comité, 1994, page 35.

²⁶⁵ Cour des Comptes. 2006, *Rapport au Président de la République*, Paris: Cour des Comptes, page 366.

²⁶⁶ As discussed in Chapter One, these closures began midwives' migration from “liberal” practice to employment in the public sector. See Dominique Baubeau, Serge Morais and Antoine Ruffié. 1999. “Les

and human resource capacities of hospitals and clinics to ostensibly improve the security of birth, efforts at “responsibilization” targeted the behavior of users of the health care system. The initial post-war premise of the social security system in France rested on a generalized notion of “social risk” that granted equal and universal rights of access to care and defined equal needs for all. Yet as Jacques Donzelot notes, this concept of “social risk” began to break down in the 1970s, in the recognition of what Donzelot terms the “statutory rigidity” of the subject before the health care system. By “statutory rigidity,” Donzelot seeks to capture the indistinction with which the social security system viewed the subject of health care, as simply a being in need, “simultaneously a beneficiary and a claimant.”²⁶⁷ Beginning in the 1970s, this one-sided conception of the subject, a subject *dependent* on the health care system, is increasingly challenged by the introduction of new actors into health care policy-making: the “users” themselves. The 1968 *Bloch-Lainé* report determined that the “costs” of caring for some were greater than others, for example. Donzelot notes that efforts to differentiate and target “risky” behavior, however, began in campaigns that drew on the “the subject’s own autonomous resources” of self-control and self-realization.²⁶⁸

The development of a concept of *prevention* introduced into the French health care system for the first time the notion that patients were to be active and responsible participants in their own care. According to Luc Berlivet, early campaigns in France drew

Maternités de 1975 à 1996: un Processus de restructuration sur longue période” *DREES Études et Résultats* Number 21. Paris: Ministère de l’Emploi et de la Solidarité.

²⁶⁷ Donzelot, 1991, page 272.

²⁶⁸ Donzelot, 1991, page 272.

explicitly from notions of prevention developed in Canada and in Northern Europe.²⁶⁹

Berlivet notes that prevention developed in part as a response to the rising costs of health care and focused first on the growing importance of “chronic degenerative” diseases such as cancer and diabetes among the populace.²⁷⁰ Early prevention campaigns disseminated through the media, however, expended considerable sums to develop television and radio spots aimed at promoting healthier habits, targeting particular segments of the population (youth, pregnant women) with a range of arguments against tobacco and alcohol use.

Initial prevention campaigns in the mid-1970s under the Minister of Health Simone Veil, then, sought to overcome the disciplinary and punitive connotations of “sanitary education” present in previous disease-oriented public health efforts by substituting more “positive” campaigns aimed at “education for health.” The notion of “education for health” relied on the desires of individuals to develop a “knowledge of the body” and to exercise power to “take charge” of their health. Under Veil’s tenure as Minister of Health, commissions like the *Comité Français d’Éducation pour la Santé* (CFES), attempted to promote more *rational* behavior among the French populace. The mission of the CFES marked a rupture in the disciplinary approaches of the state’s public health apparatus.

The actions of the committee were henceforth presented as attempts to help the French find the motivation necessary to liberate themselves from at-risk practices, understood as reactions to stress brought on by the conditions of life prevalent in contemporary western societies. [These efforts] were no longer concerned at “blaming the victim,” but at creating

²⁶⁹ Berlivet, 2004, page 46.

²⁷⁰ These diseases were identified in public debates at the time as “*diseases of civilization*,” that is, as diseases reflecting the prosperity of the middle-classes in industrialized France. Berlivet, Luc. 2004. “Une biopolitique de l’éducation pour la santé” in Didier Fassin and Dominique Memmi, eds. *Le gouvernement des corps*. Paris: Éditions de l’École des Hautes Études en Sciences Sociales, pages 37-75.

and maintaining resistance to harmful influence; in place of calling to order infantile individuals forgetful of the necessities of the biosocial order, it was concerned henceforth to awaken actors, endowed with autonomy, to their potential.²⁷¹

Accompanying this new approach to the “autonomous” individual, these transformations were also accompanied by the introduction of new actors to the field of health care.

Doctors numbered far less in the CFES than in public health commissions formed during the height of social sanitation campaigns in the early post-war period. Those doctors who did participate often identified themselves as practitioners of “community health care” a notion translated from the Canadian context and one that emphasized distinction from older, more authoritarian approaches to health and medicine. In addition, demographers, sociologists, and other experts in the social sciences began to participate in the development of new motivational campaigns. Their presence was at once designed “to legitimize (epistemologically and politically) and to realize the project carried out by the prevention campaign promoters.”²⁷²

Centered on the motivations and psycho-social causes for various behaviors deemed “risky,” the new mechanisms of control introduced new modes of identity through the individuation of a previously undifferentiated population. Most importantly, Berlivet notes, unlike disciplinary regimes, the new prevention campaigns refused to define in advance the proper attitude toward one’s health. Rather, “education for health” took a different approach,

[e]ducation for health wanted, definitively, to lead people “at risk” to make subjects of themselves...affirming their individuality by compelling

²⁷¹ Berlivet, 2004, page 50-51.

²⁷² Berlivet, 2004, page 54.

them to break with imitative behaviors harmful to their health. This conception thus rests on a particular representation of this process: the idea, never truly explained and that may appear very naïve, according to which fully realizing oneself as an individual is paired with adopting a lifestyle that economizes “risky behaviors,” as dangerous for the organism as they are alienating.²⁷³

The development of prevention programs aimed at changing individual health behavior eventually began to incorporate the affective and psychological dimensions of birth as elements of health care policy.

Prevention, psychology and a new concept of security

Until the 1970s, it was primarily doctors, not midwives, who were the most vocal proponents of new birthing techniques that attempted to “responsibilize” women and permit them a more “active” role in birth. In 1951 and 1952, for example, Fernand Lamaze carried out experiments with 500 women at a maternity clinic, the *Hôpital des Metallurgistes*, located in a predominately working-class neighborhood in Paris, in order to determine the possibility of translating a method of childbirth preparation practiced widely in the Soviet Union to the French context.²⁷⁴ The generalization of Lamaze’s practice of *accouchement sans douleur* throughout France began first at the clinic, where

²⁷³ Berlivet, 2004, page 66.

²⁷⁴ Dreyfus, Michel. 1997. *Une Belle Santé: la Maternité de l’Hôpital des Métallurgistes Pierre Rouquès*. Paris: Hôpital des Métallurgistes Pierre Rouquès, page 26.

it was noted that “...no one cries. No one cries because no one suffers.”²⁷⁵ The technique promised women “mastery” over their births through physical exercises, pedagogy designed to “suppress in the future mother fear of the unknown and of pain,” and a “true psychological education” acting on women’s anxiety and fatalism regarding pregnancy and birth.²⁷⁶, that in the days birth was then disseminated across France, in part through the efforts of midwives to bring the methods used by Lamaze to the hospitals and clinics where they worked, as well as through the support of women’s associations like the *Union des femmes françaises*.²⁷⁷

By the late 1970s, however, when Lamaze’s techniques were widely disseminated across France, *accouchement sans douleur* began to draw criticism from women who saw the reliance on medical expertise regarding pain management as authoritarian. In a book commemorating the 50-year anniversary of the “Bluets” Maternity clinic at the Hôpital des Metallurgistes in Paris, the author describes the transformation toward new forms of what could be described as “responsibilized” birth. By the mid-1970s, the author writes:

[c]hildbirth preparation must equally take into account the evolution of thinking, and take charge, in a new way, the Mother-Child relationship, [and] the relationship of the couple and the relationship with medical staff: in 1975, times had changed, in comparison with the years after Liberation. In place of the “painless childbirth courses” where one held a class with pregnant women as if they were student nurses, the Hospital of Metallurgists proposes interviews on preparation where future mothers come with questions and problems and where techniques of group dynamics are used.

²⁷⁵ Lamaze, Fernand. 1952-1953. “L’accouchement sans douleur par psycho-thérapie tel qu’il se pratique en Union Soviétique est-il possible en France aujourd’hui?” Photocopied text, five pages. Cited in Dreyfus, 1997.

²⁷⁶ Dreyfus, Michel. 1997. *Une Belle Santé: la Maternité de l’Hôpital des Métallurgistes Pierre Rouquès*. Paris: Hôpital des Métallurgistes Pierre Rouquès, page 25.

²⁷⁷ Dreyfus, 1997, page 33.

Distance is equally taken on the behavioral model sustaining Pavlov's theories, felt by some as a sort of "brainwashing": one prefers now an individual accounting of the "experience" of each woman, ending thus in preparation and a more personalized and much more effective accompaniment. Several years later, one was able to scientifically demonstrate that preparation, thus understood, was highly effective in preventing prematurity. The accent is placed on the preventive and pedagogical mission of midwives who then find value in their work of preparation. Couples find themselves responsabilized with respect to the safety of the expected child.²⁷⁸

The notion that patients could become active participants in their own health care resonated with critiques of medical authority emerging from feminist movements in France during the 1970s. While critiques of authoritarianism were aimed primarily at the medical profession, they also included midwives. Midwifery journals published critiques of the authoritarian stance adopted by obstetricians *as well as midwives* vis-à-vis their female patients. Midwives, it seems, were also complicit in the standardization of birth practices in hospitals, forcing women through the "same mold" and providing them little information under the assumption that they are too "feeble" to understand information related to their pregnancies and births.²⁷⁹ The 1970s were thus marked by changes in the administration of pregnant and birthing bodies. It is in the efforts of women and activists to renovate the norms of hospitals and clinics that we see the emergence of a more complex subject who attempts to exercise autonomy over her pregnancies and births, not as "mastery" over birth but as an expression of "liberty." Commenting on a television program featuring the technique of "painless childbirth," midwife Jeannette

²⁷⁸ Dreyfus, 1997, page 54.

Bessonart writes:

...birth is not solely a history of pain. The show, the debate oriented us totally toward the following subject: how, for the “technicians” of birth, to “work” comfortably in a “labor” room, to no longer hear women “screaming.” Response: preparation with painless childbirth. In fact: to neutralize feelings and sanitize expression...[the film] above all did not say that birth is first of all a story of women, an extraordinary story, profoundly emotional, sensual, sexual, painful as well. Birth is a language, the language of the body, of a body, that of a woman who gives birth with all her being, her personality.²⁸⁰

Bessonart continued, “liberty” is possible only when women “give birth as they desire according to their own bodies, with whom they desire.”²⁸¹ In 1976, a new midwifery journal *Les Dossiers de l'Obstétrique* published the manifesto of a research collective created in Paris to consider the conditions of maternity and birth for women in the city's hospitals. While the group consisted of professionals and lay people, men as well as women, the collective was established as “*Femmes-Sages-Femmes*” (“Women-Midwives”) in order to signal their solidarity across what was perceived by some as a considerable gulf. Midwives in the collective sought to resist the widespread public perception of their practice,

Many midwives are strongly preoccupied by the “brand image” of their profession, of the prestige attached to their job. We do not think that our role is to reflect on our “prestige” but to situate ourselves in the service of health. For this we claim *the right to difference*, that is to say the right to not have the same conceptions as the official majority of midwives. We fear that, before the silence of the majority of midwives, public opinion believes that we are only preoccupied by our standing, by our “brand

²⁷⁹ No author. 1976, page 30.

²⁸⁰ Bessonart, Jeannette. 1977. “Comment on falsifie l'information ou “Les Dessous et les Devants du Petit Ecran.” *Les Dossiers de L'Obstetrique* 38: 36-42, page 37.

²⁸¹ Bessonart, 1977, page 40.

image” or by our “marriage with a doctor.”²⁸²

Midwives in the collective *Femmes-Sage-Femmes* recognized women’s desires for a more active role in their pregnancies and births, “Women, couples claim the right to the consideration of the whole body.” Yet this body was not simply the individual body, but “the body of the woman who is there before us, the body of the couple, body of their child, body-family, body-relationship, body-social life.”²⁸³ In the discussions taking place between women in the collective, the prospect of advocating for home birth led to a discussion of the “individualist attitude” that this solution may represent. Without rejecting the attempts of those seeking home birth, the collective resolved that “It seems to us more necessary to collectively pose the problem of change for the scandalous practice of births in the hospital and in the clinic, for it is there that the majority of women live their pregnancies and their births. Home birth has perhaps become, in our age, a ‘luxury’ of a minority who understood certain things and who confront these problems.”²⁸⁴ If the new orientation within French health care in the 1970s emphasized the active participation of the patient in making decisions regarding his or her health, this emphasis, at least in the words of activists from *Femme-Sage-Femme* was focused first on collective strategies.

As midwife Jeannette Bessonart wrote in 1977, “it is true that we do not have, in France, preventive medicine, we live above all in an environment where people have

²⁸² No author. 1976. “Creation du collectif ‘femmes-sages-femmes’” *Les Dossiers de l’Obstetrique* 23: 29-32.

²⁸³ No author. 1976, page 30.

²⁸⁴ No author. 1976, page 30.

been dispossessed of their knowledge of their body, or judgement of what is good or bad for them, and of the power to take charge of themselves.”²⁸⁵ By the publication of the second *Plan du Périnatalité* in 1994, the introduction and generalization of new reproductive technologies (epidural anesthesia, fetal monitoring, artificial insemination) had altered the context of the relationship between midwives, other medical professionals, and birthing women. In the intervening years, however, improvements in maternal and infant health statistics in France had improved more slowly compared to improvements in other European countries.²⁸⁶ This “stagnation” of French maternal and infant health inaugurated a new period of reflection and a reconsideration of the priorities of the previous decade. In this sense, the publication of the second *Plan du Périnatalité* in 1994 attempted to orient policies, for the first time, toward the demands of women for greater autonomy and participation in their pregnancies and births. The “psychological security” of birth became a matter of policy concern.

A new perinatal plan

In the 1994 *Plan du Périnatalité*, a committee appointed by then Minister of Health Bernard Kouchner, the *Haut Comité de la Santé Publique*, published the results of a study undertaken to examine priorities for maternal and infant health care: the organization of hospitals and other health care services in the territory and the security of birth as well as its “economic, cultural, and psychoaffective dimensions.”²⁸⁷ As in the first perinatal plan

²⁸⁵ Bessonart, 1977, page 37.

²⁸⁶ Naiditch, 2000, page 68.

²⁸⁷ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page vii.

in 1970, the 1994 plan sets out objectives and norms for the staffing and technological capacities of establishments. Focused primarily on the health and well-being of the infant, the report also recommends prioritizing the transfer of infants “*in utero*” rather than after birth. In effect, the plan’s recommendations require a reorganization of care that favors larger establishments and assumes that higher volumes of patients are more favorable to the maintenance and improvement of professionals’ skills.²⁸⁸

Most notably, however, the report also introduces the notion that the affective dimensions of birth and the active participation of patients in their own care must be part of any reform to the public health care system. An earlier report prepared for the Ministry of Health (the *rapport Papiernik*) is cited by the authors as “a remarkable document, well documented and convincing, but centered almost exclusively on the restructuring and reorganization of maternities.”²⁸⁹ The report of the *Haut Comité*, however, aims to respond to the request of Minister of Health Bernard Kouchner, by “adding to the dimension of security the psychoaffective, social, and cultural dimensions” of birth.²⁹⁰ The efforts by the medical profession and the state to revalorize the subjective experience of the mother, rather than simply the life of the child, represent a transformation in the status of birth in France. Indeed, the report begins with the

²⁸⁸ The notion that medical professionals working in establishments with fewer than 300 births per year were not “up-to-date” and therefore provided less safe care than practitioners in higher-volume facilities was one of the motivating factors in the closure of low-volume maternity hospitals. This assumption also underlies the increasing emphasis on continuing education for midwives, as well as other medical professionals.

²⁸⁹ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 2.

²⁹⁰ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 2.

question, “What is birth?” (*Qu’est-ce que la naissance?*). In France, the committee continues, birth takes place largely in specialized hospitals, under the control and responsibility of specialized medical professionals. Yet the report also notes that this definition, by itself, is insufficient. In a passage in the report examining explicating further the implications of these new dimensions, the committee writes that “birth” can no longer be reduced to the single act of “giving birth” nor can birth be reduced to a solely medical event. It is worth quoting at length:

Giving birth is preceded by nine months of expectation, the unfolding of which has an influence on giving birth itself, and followed by a period termed neonatal (arbitrarily fixed at 28 days) where the risks are not negligible, neither for the infant or for the mother.

One cannot reduce pregnancy “to the growth of one body in a body,” nor birth to the exit of the first from the second. It is also a fundamental psychological and human experience, rich with fantasies, hope and anguish. A pregnancy and a birth psychologically poorly assumed, by the mother notably, may have grave consequences leading to the mistreatment of the infant, itself a possible factor of mistreatment in the generation following. Prevention is thus a condition of the safety and of the quality of the birth. In other words, beside the sequence of events of a nature psychological and biological that go from -9 to +1 month, the birth of a human being is also a fundamentally psychological story. From before the birth itself, during, and in the days that follow it, the arrival of this new being is at the heart of an inter-individual problematic (that is attachment): that of the relationship of the mother and the child notably, with the intervention of a third person: the father.

This new axis of analysis, then, introduces a new concept of security into the report’s calculation: that of “psychological security,” in which the knowledge and acceptance of medical professionals (both gynecologists and midwives) will be crucial. The development of a clear “semiology of attachment and an epidemiology of its

difficulties” will be necessary to objectively measure and analyze this new domain of security, in which the very first experiences of the child may have an affect on his or her future health as an adolescent and an adult. “The stakes of a politics of security and of quality of birth and of infancy are thus very vast, and are not limited to the first weeks of life.”²⁹¹

This notion of the importance of the affective dimension of birth for a politics of security is taken, the report notes, from a study published by the Canadian Institute for Advanced Research.²⁹² The committee’s concerns, however, are not simply about the individual woman’s or infant’s experience of birth (although the authors advocate for the introduction of these two domains into health care policy) but also about the implications of such experiences on the health of the population at large. An emotionally or psychologically troubling experience with a first pregnancy will influence a woman’s future pregnancies, with implications for the future of the collectivity, given that “the sum of births in a given group or population represents the condition of demographic becoming of this population.”²⁹³

In this sense, the work of “education” is paramount: both for practitioners, who may not comprehend the full extent of the problem, and for politicians, focused on the

²⁹¹ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 3.

²⁹² See J. Fraser Mustard and John W. Frank, 1991, *The Determinants of Health/Les Déterminants de la Santé*, Toronto: Canadian Institute for Advanced Research/Institut Canadien de Recherche Avancée, cited in Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 5.

²⁹³ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 6.

highly sensational aspects of curative rather than preventive medicine. For users, education is even more important. The 1994 *Plan du Périnatalité* stated,

It concerns above all the public: women in effect advocate strongly that their capacities as mothers, real or potential, be recognized and valued. They want to participate in an active and autonomous way in this major event in their life. The request is very strong among women for a complete [*globale*] preparation for motherhood, that includes but is not limited to preparation for birth, and that also includes the management of their pregnancies, care given to their infant, and consideration of the psychological dimension and of the difficulties in their relationship with their child.²⁹⁴

Public health in France must include a “community health” approach, in which the “persons and groups concerned must be able to play the largest possible role in the promotion, protection, and restoration of their health.”²⁹⁵ Noting that associations of women and parents are “often aggressive” in demanding participation in their own health care, the committee advocates a more open and receptive attitude toward the populace. Women articulate their concerns over pregnancy and birth around three concepts: “appropriation, autonomy and continuity,” yet their desires for autonomy are also distinct from the professional concerns of practitioners.

With regard to the notion of continuity of care, the report’s authors state that “certain parents’ associations make themselves the active interpreters” of the requests of “liberal” midwives (midwives with private independent practices) for “*accompagnement globale*,” in which the woman receives care from one person throughout her entire pregnancy and birth. This notion, however, sits uneasily with the new orientation of the health care system around the coordination of professionals into “multidisciplinary”

²⁹⁴ Haut Comité, 1994, page xv.

teams and the spatial reorganization of care into networks. Regardless of the orientation of health care professionals, however, the report notes,

...the wish expressed is that preparation seeks to transform the passive attitude of the uninformed woman into an active attitude of conscious participation and openness to the act of pregnancy and birth. Women demand that one recognize and develop their abilities.²⁹⁶

To accomplish these objectives, the report notes, requires the collaboration of medical staff with the professions of psychiatry and psychology, and recognition of the social and emotional dimensions of birth. In addition to consideration of the affective dimensions of birth, the report strongly advocates that *all* pregnancies and births in France should be covered in total by the social security system, in part because of the problems associated with pregnancies in which women receive no prenatal care. From passivity to activity, the new approach to pregnancy and birth by medical professionals and health care policy makers should be one of receptivity to the demands of women,

The principal to keep in mind is necessity of developing a policy that favors the largest possible autonomy for pregnant and birthing women; all maternities should be capable of offering a choice from a sufficient range of solutions: from personalized accompaniment to epidural anesthesia, and for this last to favor techniques that conserve the feeling of expulsion while rendering it somewhat painless (analgesia without anesthesia).²⁹⁷

The report notes as well that the legal and civil status of the infant must be more clearly delineated. The infant must no longer be considered a “clandestine passenger” but rather a rights-bearing citizen: “from his birth, the infant must have a complete administrative

²⁹⁵ Haut Comité, 1994, page 31.

²⁹⁶ Haut Comité, 1994, page 32.

²⁹⁷ Haut Comité, 1994, page 33.

personality, and become one having rights like any other hospitalized person.”²⁹⁸ And so, the report concludes with an explanation of the “primacy of the child” in health care policy, that to provide security and facilitate the attachment of mothers and parents to their children, the state must intervene on behalf of the infant.

While the 1994 plan introduced the psychological dimension of birth into considerations of health care policy, commentators noted that the attention given to those practitioners for whom the psychological dimension of birth is considered a professional specificity is scant at best. In the over 250 page document, the work of midwives is mentioned only briefly in several pages of text, even though, as Danièle Carricaburu noted, these seemingly “forgotten” practitioners are present at over two-thirds of births in France.²⁹⁹ Carricaburu’s interviews with obstetricians following the publication of the 1994 *Plan Périnatalité* reveal the extent to which midwives’ status as “independent” practitioners who may assume full responsibility for normal pregnancies and births represents a potentially radical shift in the orientation of French health care toward pregnancy and birth. As one obstetrician derisively noted, to give midwives the full responsibility for caring for pregnant women would “encourage them to demand the Dutch model,” often held up as the ideal system of independent midwifery practice in Europe.³⁰⁰

²⁹⁸ Haut Comité, 1994, page 73.

²⁹⁹ Carricaburu, Danièle. 2005. “Entre coopération et concurrence: sages-femmes et obstétriciens face à la réforme de la périnatalité.” *Contributions aux Xème Journées Internationales de Sociologie du Travail. Atelier 5: Rationalisations productives et relations au/de travail*. Université de Rouen, 24-25 November 2005.

³⁰⁰ Carricaburu, 2005, page 31. In the Dutch system, midwives have full responsibility for “normal” pregnancies and births and obstetricians treat only “pathological” cases. For a comparison of discourses of security and the practices of midwifery and obstetrics in France and in the Netherlands, see Madeleine

The new importance given to the solicitation of women's desires regarding their births offers the possibility, for midwives, of revalorizing the affective dimension of their practice. As one midwife, working in Level III hospital remarked, "The diploma of a midwife, that's given if she can manage pathology, that's her test, not accompaniment...but the midwife finds all her meaning in a woman's passage to a mother. The epidural has banalized this passage a bit...and now women are defined as 'users,' they are actors and partners in decisions."³⁰¹ The participation of individuals in their own health care requires a new orientation toward the active and responsible patient, toward the patient who now speaks her desires for an *active* approach to her pregnancy and birth. This active approach to pregnancy, birth and parenting is evident in the associations formed in recent years to advocate for "users" of the health care system who demand that medical professionals take their desires into consideration. The proliferation of narratives describing individual's desires for birth point to the new sites of struggle over the autonomy of the body with regard to reproduction, as well as new forms of biopolitical control, that is, new forms of power that takes the very life of individuals as their target.

The government of birth

The notion of reproduction autonomy is not, of course, confined to pregnancy and birth. The French Government decriminalized contraception in 1967 and abortion in 1975,

Akrich and Bernike Pasveer. 1996. *Comment la Naissance Vient aux Femmes*. Paris: Les Empêcheurs de Penser en Rond.

³⁰¹ Interview by author, Paris, France, September 10, 2004.

ostensibly liberating reproduction from state control.³⁰² Yet as Yvonne Knibielher writes, “If the Neuwirth (1967) and Veil (1975) laws decriminalize (under certain conditions) contraception and abortion, it is inevitably to place them under medical control.”³⁰³ The “Veil law” decriminalizing abortion, passed under Simone Veil’s tenure as Minister of Health, was initially passed only as an “experiment;” abortion for “voluntary” reasons was only permanently decriminalized in 1979 and only in 1982 were abortion services reimbursed by social security. Veil explicitly avoided founding the law on the liberty of the body, but rather cited the “distress” of the woman as a condition for abortion. In effect, the passage of the law was presented by Veil as a means to *restore* the state’s authority, eroded by the admissions of both women and doctors to having received and performed abortions.³⁰⁴ Decriminalization, although removing sanctions against both medical professionals and women seeking abortions, did it make acquiring an abortion particularly easy. Women were required to stand before a committee to justify seeking an abortion, followed by an eight-day waiting period.³⁰⁵

Yet women in France are no longer *punished* as they once were for having abortions. While many of the prohibitions and restrictions that once existed around contraception, abortion, sterilization and fertility have been removed, what is *still*

³⁰² In 1976, penalties for sex reassignment were also removed. See Dominique Memmi. 2003. *Faire vivre et laisser mourir*. Paris: Editions la Découverte, page 15-16.

³⁰³ Knibielher, Yvonne. 2003. “Les femmes face aux soignants.” *Les Dossiers de l’Obstetrique* 317: 3-5, page 5.

³⁰⁴ Crignon-De Oliveira and Marie Gaille-Nikodimov. 2004. *À qui appartient le corps humain?* Paris: Les Belles Lettres, page 66-67.

³⁰⁵ As Claire Crignon-de Oliveira and Marie Gaille-Nikodimov argue, however, the open and highly publicized admissions by well-known women and their doctors that they had received or performed abortions challenged the state’s authority to prosecute women for abortion. Veil’s tactic in the political struggle was to urge the passage of a decriminalization law as a means to the restoration of the state’s

required to gain access to these practices is a conversation with a doctor. “What is this conversation about?” sociologist Dominique Memmi asks. “Almost nothing” is the reply.³⁰⁶ This “almost nothing,” however, is in fact something, and it is this “almost nothing” that make clear the narrative nature of contemporary biopolitical control. Subjects are asked to assert the desire to “control” their own “bodily destiny.”³⁰⁷

Dominique Memmi writes that this shift is evident in the language used to talk about reproduction in terms of “the subject’s control over...her own bodily destiny. Terms such as birth ‘control,’ ‘planned parenthood,’ and ‘family planning’ have become so commonplace that we have forgotten how strongly they convey the ideal of control in the area of procreation.”³⁰⁸ What was once the concern of the state, Memmi argues, has now been shifted: reproduction is intimately the concern of the *individual*, expected to take control for their own reproductive capacities.

Indeed, the locus of biopower today is focused not on national populations, but rather on the *individual*, and this biopower, paradoxically, works through notions of the subject’s “procreative self-determination.” The “biological complications” of living have become, very intimately, the responsibility of each and every one of us. We are supposed to make rational decisions to control our own lives, our own reproductive capacities, our fertility, our lack of it, and we are increasingly becoming responsible for our own deaths as well. Repeated abortions, for example, are an example of “lack of control” over one’s

authority. See Claire Crignon-De Oliveira and Marie Gaille-Nikodimov, 2004. *À qui appartient le corps humain?: Médecine, politique et droit*. Paris: Société d’édition Les Belles Lettres, page 66.

³⁰⁶ Memmi, 2003, page 648.

³⁰⁷ Memmi, 2003, page 645.

³⁰⁸ Memmi, 2003, page 652.

fertility. And the growth of euthanasia and assisted death movements all speak to the interest in exercising control over the end of our lives as well,

while the advent of procreative techniques is no doubt a sign of the growing triumph of the scientist's rational control over nature, our point here is that it is accompanied by a delegation of that rational control to the ordinary citizen. To put it more precisely, the citizen is asked to use his or her body "reasonably."³⁰⁹

Her analysis of how the contemporary French state "manages" the reproduction of its citizens is instructive. For as Memmi argues, the mechanism of control over reproduction in today is not via the disciplinary mechanisms of criminalization, but rather through the incitement to *speak* one's desires for the use of one's body.

The new demands placed on individuals in the health care system in France to reproduce narratives legitimated by the state extend midwives' roles as interlocutors to women's desires for birth. Midwives' emphasis on their relational work is thus part of broader shifts in the orientation of the French health care system toward compelling subjects to care for themselves, but most importantly toward the critical role of "government through speech" in which the active participation of the individual in his or her own care is the target of new modes of power. While Memmi's work focuses on the remaining restrictions in place to regulate abortion, fertility services, and contraceptive use, her argument for the importance of *narratives* as the locus of struggles over reproduction can be productively brought to bear on the efforts of women to exercise reproductive self-determination with regard to their births.

³⁰⁹ Memmi, 2003, page 652.

The struggle over the birthing woman's expressions of desires for her birth are reflected in the ongoing debates in France over "birth plans" or "birth contracts," methods used with eventual success in other contexts (most notably in North America and the UK). In 2002, Marie-Pierre Hospital, a midwife in private practice in Clermont-Ferrand in central France wrote of the efforts of women to develop a "projet de naissance" or birth plan. Such a plan, in the form of a "contract," proposes a relationship of cooperation between two "protagonists:" that of the parents and the hospital or clinic medical team. Hospital writes:

It's meeting, discussion, and exchange that will permit the initial breach (*fossé*) separating these two protagonists to progressively close. One is above all in a relationship, medical certainly, with ins and outs, but this relationship is before everything human. And it is on this field (*plan*) that each is going to take a little of the path in the direction of the other and that they will be able to meet each other. The caregiver who is not going to position him or herself as he or she who knows and who knows what to do and the patient who is not going to position herself in expectation, in submission to know-how but who has reflection and autonomy in the process.³¹⁰

In practice, however, medical professionals, particularly those working in public hospitals, have met such birth plans with derision.³¹¹ For many midwives and parents, however, birth plans were seen as pragmatic means of making explicit the underlying relationship between doctor and patient in French law, that of the contract. They were also means for eliciting the expression of a woman's or couple's desires for birth, part of

³¹⁰ Hospital, Marie-Pierre. 2002. "Choisir de naître autrement" *Entretiens de Bichat: Entretiens des Sages-Femmes*. Paris: Éditions Scientifique, 29-30.

³¹¹ This point underscores the contextual specificity of technologies such as the birth plan. For a discussion of the overwhelmingly negative reactions of obstetricians in France to one such "projet de naissance" on an online obstetricians' forum, *Gynelist*, as well as responses by activists, see the 2000 debate *Projet d'accouchement: Ce "contrat", qu'est-ce que vous en faites?* Retrieved July 15, 2005 from fraternet.org/naissance/docs/gynewebcontrat.htm.

what Dominique Memmi argues is an integral part of the administration of reproductive bodies in other domains.

Responsibility for the surveillance of pregnancy and birth is spatially uneven; as Memmi notes, the development of new modes of “discursive surveillance” is itself “delegated to the periphery of public service, to the representatives of those professions termed ‘liberal.’”³¹² Indeed, it is primarily in the private sector (including some clinics) in which women are most actively given greater responsibilities for their pregnancies and births, and it is with liberal midwives that women may opt out of many of the protocols governing hospital and clinic practices.³¹³ As one midwife stated in an interview, “Women in public hospitals do not ask for more ‘natural’ births...women who want this go to private clinics, they choose places based on their appearance, their rooms.”³¹⁴

The efforts to revalorize midwives’ emotional work are closely linked to the emergence in French health care of the birthing subject as an active and responsible patient. When asked to describe their women patients today, many midwives interviewed said that women were “more demanding,” and “better informed.” Recent efforts in France by activists to exercise greater autonomy over their pregnancies and births have focused more on identifying and asserting *rights* to particular kinds of care. The passage of the public health law of 2002 formalized the emergence of a new health care subject, that of the informed and active rights-bearing patient. The liberalization of French health care has thus introduced the possibility of a new form of liberal subjectivity, the rights-

³¹² Memmi, 2004, page 136.

³¹³ Gamelin-Lavois and Herzog-Evans, 2003, page 63.

³¹⁴ Interview by author, Lyon, France, August 6, 2004.

bearing patient, endowed with the responsibility of counterbalancing the abuses of medical authority.

Responsibilization and rights: creating new citizen-subjects of a “health democracy”

The law of March 4, 2002 codifies the “rights” of the patient within the French health care system.³¹⁵ Patients may choose their doctor, and they have the right to be “informed” about their health. Patients now have the right to participate in decisions concerning their own health and have access to their own medical file. They are guaranteed a right to medical privacy as well as the right to designate a person as “*personne de confiance*” or “confidante” with whom the doctor may share medical information and who may participate in decisions with regard to the patient. The patient is also granted the right to file a complaint against a doctor with a regional commission or with the professional order of doctors in order to reach an “amiable” agreement and eliminate a lawsuit and trial.³¹⁶

The three sections of the law relate to the promotion of a more transparent health care system or “health care democracy” in the words of then Minister of Health Bernard Kouchner; interventions in the quality of care and reform of the national body that accredits and evaluates health care establishments and professionals, and finally, regulations for reparations to patients injured by medical interventions.³¹⁷ While French law had established patients’ rights via laws regarding the professional secrecy of

³¹⁵ Loi n. 2002-303 du 4 mars 2002 art. 3.

³¹⁶ Costa, Solène. 2003. “Les médecins et les droits du patient” *INC Hebdo*, 1274: 1-6.

³¹⁷ Evin, Claude, Bernard Charles and Jean-Jacques Denis, 2002. “Rapport d’information” *Droits des Malades*, www.assemblee-nationale.fr/11/dossiers/droits_des_malades.asp, accessed March 5, 2004.

medical consultations and rights accorded in the domains of bioethics, medical information and medical structures, the *Loi Kouchner* codifies clearly the rights of sick persons and the rights of all in relation to the health system. The public health code guarantees the patient's rights to *access* to health care, but the 2002 law extends this rights to the *consent* of the patient, in what some fear is a move towards a "medical marketplace" where the desires of the client-patient will exceed the relationship of "mutual trust" between doctor and patient.³¹⁸

It is through this new discourse of "patients' rights," however, that new political subjectivities have emerged with regard to reproduction. In *The Rights of Mothers*, Sophie Gamelin-Lavois and Martine Herzog-Evans outline in exacting detail the laws that regulate reproductive practices in France. *The Rights of Mothers* highlights moments where the ambiguities of French civil, penal, or public health law leave no clear sense of women's obligations and thus offer the possibility of resisting attempts to enforce a securitizing micro-management of a woman's pregnancy and birth.

In an interview, one of the authors of *The Rights of Mothers*, Sophie Gamelin-Lavois, stated that "Women don't know their rights. It's only after Kouchner in 2002 that patients were discussed in terms of rights, and *The Rights of Mothers* came after this...but it's not clear that women know about their rights." According to Gamelin, "patients have rights, it should be illegal to violate them."³¹⁹ The book's focus, as the title makes clear, are the rights and responsibilities of mothers. Gamelin-Lavois and Herzog-Evans note in

³¹⁸ Hervé, Christian and M. Wolf. 1998. "Relation médecin-malade: soigner ou se protéger? La traversée de l'Atlantique par la responsabilité médicale." *Presse Médicale*, 27 (27): 1387-1389.

³¹⁹ Interview by author, Roumagne, France, August 20, 2004.

the introductory chapter that “pregnancy, whether carried to term or interrupted, produces juridical effects.”³²⁰ The authors summarize the laws governing pregnancy, including abortions undertaken by choice (deemed “voluntary”) and those prescribed medically in the event of a fetal abnormality or a risk to the life or health of the mother. In addition, Gamelin-Lavois and Herzog-Evans examine the status of miscarriage and the death of the mother.

The responsibilities of mothers require them to declare their pregnancies to health care authorities and adhere to a minimum of medical examinations. Until 2004, only a physician could perform the first examination that functions as the “declaration of pregnancy.” Midwives advocated for the possibility of performing this examination, and in 2004, were granted permission to confirm a woman’s pregnancy and establish the date of conception.³²¹ This examination must take place in the first 14 weeks of pregnancy. After the declaration, a woman’s obligations take the form of monthly certificates to be signed by a midwife (or doctor), with stickers affixed to her health care records that are then returned to the family allocation agency and to the social security system, respectively.³²² Although the law does not *require* women to receive prenatal health care, the receipt of family allocations requires the pregnant woman to undertake seven prenatal examinations. These examinations are completely covered by the social security system, and all medical examinations in the final four months of pregnancy are covered

³²⁰ Gamelin-Lavois, Sophie and Martine Herzog-Evans. 2003. *Les Droits des Mères*. Paris: L’Harmattan, page 9.

³²¹ See Loi n° 2004-806 9 August 2004 relative à la politique de santé publique, *Journal Officiel* n° 185 du 11 août 2004, page 14277.

³²² Gamelin-Lavois, Sophie and Martine Herzog-Evans. 2003. *Les Droits des Mères*. Paris: L’Harmattan, page 32.

as well. The law nowhere stipulates the content of such examinations, and the authors of *The Rights of Mothers* argue that this “silence” can in no way obligate women to undergo procedures they consider intrusive; such violations, they write, would be attacks on the integrity of the human body and are contravened by the French Civil Code.³²³

While no sanctions (under criminal law or under health and social codes) exist for women who do not receive the required prenatal examinations, the sum given to women as the family allocation after the birth will be reduced if all seven examinations are not followed. The examinations are thus considered, by Gamelin-Lavois and Herzog-Evans, as “a benefit, thus a right and not an obligation.”³²⁴ These responsibilities are enforced not by recourse to authoritarian mechanisms, but rather by virtue of “financial incitement.”³²⁵ For it is only in following the prescribed number of prenatal examinations that women may receive the benefits of social security, the protections of labor law regarding dismissal, and eventually the “family allocation” in which the state provides a sum to households with children.

Gamelin-Lavois and Herzog-Evans trace the origins of the increasingly protocol-driven nature of practices in hospitals and clinics to the growth of lawsuits aimed at medical professionals. Beginning explicitly in 1998, medical professionals attempted to develop recommendations for common practices known by all.³²⁶ These

³²³ Code Civil, article 16-3, cited in Gamelin-Lavois and Herzog-Evans, 2003, page 35.

³²⁴ Gamelin-Lavois, Sophie and Martine Herzog-Evans. 2003. *Les Droits des Mères*. Paris: L’Harmattan, page 33.

³²⁵ See Memmi, 2003, page 75-102 for a discussion of this “soft pedagogy” of financial control.

³²⁶ Gamelin-Lavois and Herzog-Evans cite the report of the Comité National d’Experts sur la Mortalité Maternelle. The committee met from 1995 to 2001 to analyze the problem of maternal mortality in France. The committee was comprised of 12 members of the medical profession: five gynecologist-obstetricians, three anesthetists, three epidemiologists, and one midwife, as well as representatives from state health care

recommendations, a set of obstetric “best practices” were to be “regularly written and published, accessible and available in all obstetric services.”³²⁷ This effort, Gamelin-Lavois and Herzog-Evans note required the coordination of health care services between hospital, clinic and private practitioners, and an attempt to rationalize practices across different domains. This coordination resulted in the promotion of the “informatization of maternities and the use of a ‘common perinatal file’” for each patient that is accessible by all caregivers.³²⁸

Gamelin-Lavois and Herzog-Evans note, however, that the informatization and rationalization of administrative tasks have also altered the substance of the care received and the practices of midwives, doctors, anesthetists, and pediatricians who are involved with pregnancies and births,

The protocols correspond as well to the notion of standardized “ready-to-birth” [“prêt-à-accoucher”]. One of the objectives is to obtain more rapid births, at a set time, permitting the optimization of labor rooms, of personnel, and the concentration of personnel on purely technical tasks, and thus to avoid the psychological accompaniment for pain and for birthing, gluttons of time and of energy.³²⁹

The Rights of Mothers seeks to “counterbalance” the prevailing climate of fear over lawsuits that have led to the “overmedicalization of maternity, and particularly of pregnancy.” As the authors state early in the book, an informed choice cannot be made without clear and accessible information. They note the recent changes in the orientation of the French health care system to consider the legal rights of patients,

and insurance agencies, professional bodies, and research institutes. See Comité National d’Experts sur la Mortalité Maternelle, 2001. *Rapport Comité National d’Experts sur la Mortalité Maternelle*. Paris: Direction Générale de la Santé, page 7.

³²⁷ Comité, 2001, page 38, cited in Gamelin-Lavois and Herzog-Evans, 2003, page 71.

³²⁸ Gamelin-Lavois and Herzog-Evans, 2003, page 71.

In field of health, it is the autonomy of the will of patients that has been considerably reinforced (the law on the rights of patients, the law on contraception and sterilization), to the point that one can signal a profound revolution in the legal relationships between mothers and medical professionals, even if resistance is still significant.³³⁰

For activists such as Gamelin-Lavois and Herzog-Evans, there is only *informed* choice, which they note has been far more profoundly explored in English-language materials.³³¹

In *The Rights of Mothers*, however, we see the emergence of a discourse, however minoritarian, around the patient that is addressed the patients' right to information, as well as to the right of *refusal* to the governmental administration of pregnancy and birth. These "counter-conducts" of the governmental state pose themselves, then, in terms that correspond to the new forms of power operating through delegated biopolitics:

...the moment where the population, broken with all the links of obedience, will have effectively the right, not in juridical terms, but in terms of essential and fundamental rights, to break all the links of obedience that it may have with the State and, to stand against it, to say henceforth: it's my law, it's the law of my demands for myself, it's the law of my nature even of the population, it's the law of my fundamental needs that must substitute itself to these rules of obedience.³³²

Unlike the rights of the patient to basic health care guaranteed by early public health law, the 2002 law stipulating the rights of the patient establish the juridical status of the informed and responsible individual within French health care. For the authors of the *Rights of Mothers*, both members of the activist group, *Alliance Francophone pour l'Accouchement Respecté*, the exercise of rights as mothers is both the possibility of

³²⁹ Gamelin-Lavois and Herzog-Evans, 2003, page 72.

³³⁰ Gamelin-Lavois and Herzog-Evans, 2003, pages 8-9.

³³¹ Gamelin-Lavois, Sophie and Martine Herzog-Evans. 2003. *Les Droits des Mères*. Paris: L'Harmattan, page 77.

agency and autonomy over one's body, as well as the assumption of new *responsibilities* that were once the purview of the state. The *Alliance Francophone pour l'Accouchement Respecté*, established in 2003, calls on parents and future parents to "ask themselves about their roles and about the consequences of their choices." These practices of self-reflection "can only responsabilize them and lead them towards more reflective forms of education...Parents and their infant must be put at the center of the system, subjects and not objects of care or accompaniment."³³³

Along with 41 other activist organizations, AFAR participated in the 2003 *États Généraux de la Naissance*, a national commission convened by the *Collège National des Gynécologues et Obstétriciens Français*, to evaluate the state of birth in France. The *États Généraux* was organized partly as a response to the "regression of perinatal health" and the inapplicability of decrees that mandate the networking of maternity hospitals and the ideal conditions of births. France's rates of maternal mortality and prematurity have increased, the organizers noted, while hospitals encounter shortages of beds and personnel. The *États Généraux*, however, would also bring together users ("pregnant women themselves," the press release announced) with professionals, representatives of the government as well as the media.³³⁴

Activist and advocacy groups concerned with the conditions of birth, pregnancy and parenting in France grouped themselves under an umbrella organization, the *Collectif Interassociatif Autour de la Naissance* (CIANE) in response to the commission's efforts

³³² Foucault, Michel. 2004. *Sécurité, territoire, population: Cours au Collège de France. 1977-1978*. Paris: Gallimard/Seuil, page 364.

³³³ AFAR, no date, "Pour un accouchement respecté..." [Brochure]. Roumagne: AFAR.

to solicit the views of “users” of the health care system.³³⁵ On the occasion of the first *États Généraux de la Naissance*, CIANE emphasized that its principal activities rested on the exercise of citizen’s *rights*: “the right of users to medical information, to informed consent and to taking into account their demands, guaranteeing a real freedom of choice regarding medical decisions that concern them personally, as well as choice of place of birth.”³³⁶ The objectives of CIANE were to promote the exchange of information, observation, communication and responsabilization.³³⁷

For activists and advocates of autonomy through birth, access to information and the responsabilization of users in the health care system have permitted the language of “rights” and the rights-bearing patient to elaborate claims against the medical profession’s exercise of authority. Recently joined to this liberal notion of patients’ rights, however, is the concept of the patient as *consumer* of the goods of the state. In 2004, the Minister of Health instituted the “symbolic payment” of one Euro for each act or consultation with a doctor previously paid in full by the national health insurance system. This “contribution...signals the shared solidarity and ‘responsibilizes’ the insured” to ostensibly avoid abusing the health care system.³³⁸ The demands by the state to responsabilize citizens introduce an economic rationale within health care; the

³³⁴ Collège National des Gynécologues et Obstétriciens Français. 20 November 2002. “Prise en charge de la naissance: situation de crise” [Press release].

³³⁵ As of April 2006, CIANE represents 100 associations in France. See CIANE’s website, ciane.info, accessed April 17, 2006.

³³⁶ CIANE. 2002. “Charte du CIANE” [Brochure] Villeneuve: CIANE.

³³⁷ CIANE, 2002. “Presentation” [Brochure] Villeneuve: CIANE.

³³⁸ “Document d’information à destination des professionnels de santé” No date. http://www.sante.gouv.fr/assurance_maladie/documentation/professionnels/remboursement.htm, accessed November 21, 2004.

regulation of one's health and one's responsibility toward the state are indexed to the growing costs of health care in France. As one activist I interviewed said,

People need to become more responsible. We are reforming our health care system because the law for SÉCU [social security] dates from 1947, and many things have changed....for one, medicine has become more technical and more costly, and people also use the system without thinking, because it's free. You know why people take too many medicines? Because it is free. This is a problem of responsibility, of responsabilization. We need to become more responsible for ourselves....because if people can be responsible, they should be, if they don't want to, that is not right. Some cannot pay, and as a collectivity, we can take care of those who are not able. But for those who don't want to pay, we need a way to responsabilize them.³³⁹

The new forms of sociality engendered by the promotion of responsabilized rights-bearing subjects require the articulation of one's desires for birth and place new constraints on subjects to articulate control over their bodies. Midwives, who continue to claim the relational aspects of their work as professional specificities are often faced with the contradictory demands of "users." On the one hand, the 1994 *Plan du Périnatalité* argued that women's *access* to epidural anesthesia, for example, must be considered a *right*.³⁴⁰ For Gamelin-Lavois and Herzog-Evans, the *Rights of Mothers* include the right to *refuse* the systematic interventions of medical professionals. The 1998 *Décrets périnatalités*, a series of organizational guidelines issued by then Minister of Health Luc Mattèi, continued the task of "rationalizing" maternal and infant health care in France by dividing hospitals and clinics into three different "levels" of care: from Level I for "normal" pregnancies to Level III for pregnancies at highest risk. The tendency, however,

³³⁹ Interview by author, Lyon, France, August 8, 2004.

³⁴⁰ Haut Comité de la Santé Publique. 1994. *La Sécurité et la qualité de la grossesse et de la naissance: pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique, page 33.

for some women to perceive Level III hospitals as the safest and for others to deplore the protocols present in Level I establishments, however, reflect the contradictory demands of individuals: “between the ‘promises’ of ‘hyper-technicity’ (‘mastery’ over conception, ‘absolute’ security, pains suppressed, ‘perfect’ infant...) and a feeling of dispossession with regard to birth (absence of choice of place and of method, personal implication, fragmentation of accompaniment, application of protocols centered on ‘risk’ and not on ‘well-being’).”³⁴¹

In either case, however, the exhortations to pregnant women in France are to “choose well” and to assume responsibility for these choices. As one commentator (old enough, she admitted, to celebrate the birthdays of her great-grandchildren) stated,

I experienced my births as a wished-for dependence. You put a human being into the world, it’s such an important act in the life of a woman, how do you assume it all by yourself? It’s not possible, even with the father of the infant. All of society must take part and give her the right to act.³⁴²

Today, this “wished-for dependence” seems anachronistic and antithetical to an *active* citizenry. Individuals are no longer granted the right to act, but actively seek to cultivate new responsibilities in the French health care system. *Maternage*, or the midwife’s role as “symbolic mother” to the birthing woman is now supplemented by the midwife’s role as interlocutor of the desires of the patient.

Dominique Memmi describes the midwife’s role as privileged interlocutor with women as a “delegated biopolitics,” in which the solicitation of the patients’ desires for

³⁴¹ CIANE, 2004, “Plate Forme de Propositions en 40 Points du Collectif Interassociatif Autour de la Naissance” Version III. [Brochure] Villeneuve: CIANE, page 7.

³⁴² Knibielher, Yvonne. 2003. “Féminisme et maternité.” *Les Dossiers de l’Obstetrique* 317: 3-5, page 17-20, 18.

their births tends to replace the exercise of authoritative and disciplinary mechanisms of control that once governed the uses of the body in France. This new mode of government, she writes, “is far from the representations of the all-powerful and centralized State” described by Michel Foucault in his analysis of the disciplinary and punitive powers of the state.³⁴³ While Foucault’s early work on “disciplines” tells us much about the rise of institutions like the army, the school, the prison, and the hospital, these concepts do not seem adequate for explaining the form of biopower that has evolved over the last few decades in the realm of reproduction.³⁴⁴ Rather, delegated biopolitics operates through what Memmi argues are discursive forms of surveillance, replacing the policing of bodies under disciplinary power with the policing of narratives.

This policing of narratives is evident in the consternation of some midwives before women who, when solicited by medical professionals, “say nothing.” In an interview at a private clinic outside Lyon, one midwife told me that since the clinic’s merger with another establishment, things had “fallen apart,”

Now we get couples from the neighborhood, but before women came from far away, from all over the region. Before about 20% of the women came from the neighborhood and they were treated no differently from the women who were professionals. Now, that has changed, and most of the women are from the neighborhood, a neighborhood that is considered “plus défavorisé,” with concerns that differ from the women who came before...

I realize now that the women who came to the clinic before were privileged. They heard about us and came because word-of-mouth spread, over 30 years of building the clinic, of really catering to what women wanted, what they asked for. Now, it’s like no one asks for anything. They just submit to whatever they’re told to do! It irritates me, because I feel

³⁴³ Memmi, 2004, page 137.

³⁴⁴ See Dominique Memmi, 2003. *Faire Vivre et Laisser Mourir: Le Gouvernement Contemporain de la Naissance et de la Mort*. Paris: La Découverte.

powerless, but by the time I see a woman, it's at her birth, and by then, it's too late to give her all the information about what she might want to do otherwise.

Indeed, the mechanism of reproductive self-determination through speech seems to “encourage, in the mass of patients, the ‘somatic culture’ proper to the middle class,” that of careful self-maintenance and self-control.³⁴⁵

Midwives’ affective labor, then, works on the desires of the birthing subject, newly endowed with rights. The inseparability of the physical and psycho-social dimensions of pregnancy and birth, which midwives claim as a professional specificity, has been integrated into the regulation of the body, to the extent that control over the use of the body is delegated by the state to the individual herself. Midwives claim this specificity as a means of revalorizing their *affective* work, work that is closely linked to notions of femininity and *maternage*. And this work is not limited to midwives’ *maternage* of pregnancies brought to term and of births. Across all domains of reproduction in France (abortion, fertility medicine, genetic testing), “it is midwives who take the lead: they announce a difficult pregnancy and accompany grief.”³⁴⁶ This “feminization” of delegated biopolitical control, “introduces mediation in the relations of force” between patients and the medical profession. A new social authority has emerged: the advisor and counsellor, open to the reasoned discourse of the informed patient. The feminization of obstetrics in France, Memmi argues, is but one more indication of the extent to which “the contestation of medical power...has not put medical hierarchy into

³⁴⁵ Memmi, 2003, page 257.

³⁴⁶ Memmi, 2003, page 258.

question,” but rather has introduced a “new ideal model for the administration of relations of domination.”³⁴⁷ The individual’s desires for autonomy, however, may exceed even these now more subtle hierarchies between midwife and woman. As Sophie Gamelin-Lavois, the author of the *Rights of Mothers* stated, many of the “desires” attributed to women in France were in reality the desires of midwives,

Midwives want birth centers, but it’s really for them, not for women. It’s what they want for themselves...it’s the same with vaginal exams. Midwives do this far too often. They say they don’t, but when you ask them, they do it. Maybe not during the prenatal exams, but during the birth, yes, they do it, when it’s really not necessary. Very few midwives go about birth preparation by teaching the couple how to do it themselves. There is a midwife in Switzerland who prepares parents for this, [asking parents], “what if I don’t make it in time?” because you know...it’s really their choice to call the midwife, when and if they want to.³⁴⁸

In the efforts to exercise full autonomy over one’s body, then, we see the experimentation with “counter-conducts” to the delegated biopolitics of governmental reason, in demands for an even greater autonomy of the body, through the exercise of a “choice” to call the midwife, “when and if they want to.” In the new delegated politics, then, the emergence of a discourse of “individualized” rights is first posed as a question of responsibility and obligation. It would be overly simplistic, however to see the relationship between government and the governed solely as that between domination and resistance. The autonomy of the individual body (through the rights of patients and the rights of mothers) is not necessarily a resistance to delegated biopolitics.³⁴⁹ The responsabilization of birthing subjects is simultaneously countered and complemented by

³⁴⁷ Memmi, 2003, page 265.

³⁴⁸ Interview by author, Roumagne, France, August 20, 2004.

the discourse of rights mobilized by birth activists in France.

In midwives' affective labor, then, we see the emergence of new modes of biopolitical control. These modes are not limited to midwives' work. They are part of a shift in modes of domination that extend across the social field, toward forms that replace medical paternalism with a more "feminized" maternalism that solicits patients' desires for self-determination. For activists, the irreducibility of reproduction to its purely biological or "medical" dimensions is affirmed by the new attention paid to women's psychological security. Indeed, the efforts to claim corporeal self-determination through appeals to rights reveal how the new forms of "care of the self...in turn return to the State."³⁵⁰ Activists seek recognition of their capacities for self-determination, appealing to "mother's rights" to guarantee the inviolability of the body, and paradoxically, to codify resistance to medical authority. That biopower is now "delegated" to the individual does not mean that all individuals are endowed equally with the power of decision-making and autonomy. Rather, as Memmi makes clear, delegated biopolitics requires the production of narratives that conform to the expectations of those interlocutors who mediate the relationship between the patient and the state. Although these interlocutors are currently on the peripheries of the public health care system (in private clinics and in "liberal" practice), the incitement to *speak* one's desires for birth and to take responsibility for one's decisions are also considered potential solutions to the "identity crisis" of French hospitals. For the hospital is now an "institution in which one

³⁴⁹ As Fassin and Memmi write, "all practice that does not conform to the injunctions of power does not necessarily express resistance," 2004, page 28.

³⁵⁰ Memmi, 2003, page 290.

demands not only the exercise of medicine, of course, but also, more and more, a mission of accompaniment and psychological support that is carried out nowhere else.”³⁵¹

For activists, the discourse of rights is deployed to counter the abuses of medical authority and marks the emergence of a *right of refusal* to the state’s intervention. Midwives’ new role, I argue, is that of the *mediator* between the exercise of women’s reproductive self-determination and the delegated control of the state over pregnancies and birth. This role requires midwives accommodate the wishes of women who are, as several midwives expressed in my interviews, becoming more and more “demanding” with respect to their pregnancies and births. The changing practices and policies surrounding midwifery and birth in France make clear that biopolitical concerns with preserving and cultivating the life of the population (a preoccupation of modern state power) now focus more closely on the life the individual. When the individual’s experience of birth becomes the target of political intervention, the “autonomy” of the birthing subject becomes a stake in political struggles.

Midwives’ affective labor today constitutes the individual woman as an active agent with respect to birth. Yet this agency in part is related to the new forms of administration over the body: increasingly, individuals are requested to make decisions that demonstrate their autonomy with regard to their health. Midwives actively seek to reframe their roles as advocates for newly empowered patients, yet in explicit contrast to North American “birth communities” that seek “to increase the collaborative marketing efforts of birth professionals, and to create pockets of activism destined to promote

³⁵¹ No author, 27 April 2001. “L’ire des sages-femmes” Editorial. *Le Monde*, page 16.

changes in birth, as well as the midwifery model of care,” activists in France counter the commodification of representation through “marketing” by promoting a “free, informed, and responsible” approach.³⁵² The discourse of the responsible patient assumes that the individual is responsible both for taking the appropriate measures to prevent illness as well as the consequences of engaging in “risky” behaviors, behaviors that include, with respect to the government of the body, the “risk” of reproduction.³⁵³

Rationalization policies, albeit oriented toward cutting costs, were eventually deemed inadequate to the task of promoting a more *active* citizenry with respect to health, for it was in concert with critiques of the purely economic forms of rationalization that policies designed to promote the development of more responsible health care subjects emerged. New claims to patients’ rights and mothers’ rights have emerged to counter protocol-driven medical practices. The claims to greater autonomy and control over birth by actors previously absent from the state’s considerations of public health implicate midwives in new ways: as interlocutors between the state and the individual requested to articulate rational desires for her pregnancy and birth. Midwives emphasize their affective labor as mediators of women’s desires as specific to their profession. Attendance by a midwife, in fact, is seen by many women as the only possible way to receive what is referred to as *accompagnement globale*, or comprehensive accompaniment, in part because they are the only practitioners in France who, although

³⁵² Yule, Cynthia and Katie Heffelfinger. 2000. “How to build a birth network” *Midwifery Today* 56, pages 10-14. Cited in Bernard Bel. Forthcoming. “Naissance d’une communauté virtuelle” *Communication Processes*, 1. London: Sage Publications. fraternet.org/naissance/docs/communautevirt.htm. Accessed March 27, 2006.

small in number, will attend births outside of hospitals and will follow women through out the entire period of their pregnancies and births.³⁵⁴

The new rights-bearing patient, endowed with the capacity to participate in health care decisions, is both a norm and a privilege in France. Most importantly, the new forms of sociality created through midwives' affective labor that ask women to express their desires for birth supplement the hierarchies of disciplinary approaches to the body with a new topography of power that incorporates the desires of the birthing subject for autonomy over her birthing body. The medical professional now requests that the individual rationally express her desires for birth, and the content of these expressions becomes the locus of struggles in the domains of law and policy.

As the next chapter on Québec will discuss, these expressions have also been framed as *choice*. Midwives in Québec have also been positioned as mediators of the relationship between women and the state. Emerging from the “ground up” within feminist and other social movements in the province, midwives in Québec have articulated their practice in relationship to women's desires for reproductive self-determination via notions of control and choice.³⁵⁵ Common to both contexts is the politicization of reproductive self-determination via the midwife, through an individualized biopolitics of desires for one's birth.

³⁵³ For a discussion of the twin notions of individual responsibility and collective participation in French public health initiatives, see Didier Fassin, ed. 1998. *Les figures urbaines de la santé publique*. Paris: Éditions La Découverte.

³⁵⁴ Estimates of the number of midwives in France who attend births outside of hospitals range from 50 to 14.

³⁵⁵ In North America, this desire is also for the decriminalization of midwifery, a practice still unregulated or illegal in eighteen states and five provinces and territories. Midwives in some states in the United States continue to face criminal persecution for “practicing medicine without a license,” see Adam Liptak, 3 April

This individualized biopolitics then supplements Foucault's concept of the population as the target and medium of biopolitics, yet reaffirms what for Foucault was the fundamentally novel character of the governmentalizing state beginning in the second half of the 18th century: "liberty itself becomes an indispensable element to governmentality itself...To not respect liberty is not only to exercise the abuse of rights in relation to the law, but above all to not know how to govern as one should."³⁵⁶ Both the exercise of one's rights before the law and the expression of one's desires for birth before a professional require the clear articulation of claims to autonomy and corporeal inviolability. These articulations, as Foucault's work and now Memmi's have demonstrated, can also be modes of control, for they take the very desires of the individual as their object. Indeed, these new forms of control are channelled in part through desires for reproductive self-determination occurring in the margins of state control in the liberal practice of midwifery, that is, by "liberal" midwives or through private clinics. This chapter, then, examines in more detail the ways in which the production of affect also produces new forms of control, as well as new subjectivities and new social relations.

To return to the work of Hardt and Negri, for whom the notion of affective labor represents a new "hegemonic" form, it is clear that in their work the revolutionary potential of affective labor remains an abstraction.³⁵⁷ Hardt and Negri laud the potentially

2006, "Prosecution of Midwife Cast Light on Home Births" *New York Times*, Retrieved April 4, 2006 from www.nytimes.com.

³⁵⁶ Foucault, 2004, *Sécurité, territoire, population*. Paris: Gallimard/Seuil, page 361.

³⁵⁷ For an incisive critique of how these abstractions reaffirm the centrality of European (philosophical) supremacy in Hardt and Negri's *Empire*, see Lisa Rofel, 2001. "Discrepant Modernities and their Discontents" *positions* 9 (3): 637-649. Rofel's critique of the "prophetic" and quasi-religious tone of

radical possibilities of affective labor through its ability to create new forms of sociality. Yet these new forms of sociality are not necessarily exempt from staging new forms of domination. Without attention to the specific power relations within new forms of caring labor, Hardt and Negri's analysis of the revolutionary potential of affective labor misses the critical point that the axis of power within biopower is no longer that of the sovereign and the subject, but is part of a movement internal to the population considered. Given Hardt and Negri's insistence on the radical, yet only evocative potential of affective labor, labor that, like midwifery is also highly feminized, the search for a power beyond sovereignty in *Empire* (and beyond the "individual" in the multitude) misses a critical (feminist) point: that the *practices* of affective labor are too wrought by the exercise of power.

Empire is apt, yet her critique of Hardt and Negri's use of *affective labor* could go one step further: how is affective labor, the labor of social reproduction, also implicated in new forms of domination, not only in the "old modernity" of labors of sex and love that relegated reproduction to the sphere of non-productive activity, but also in the "new modernities" that seek to invert this relationship by positing its primacy (as Hardt and Negri do)?

CHAPTER FOUR

Regulating Birth, Body, Self: New Midwifery in Québec

In 1998, one year before the eventual legalization of midwifery in Québec, an activist group, *Groupe MAMAN* (whose name is an acronym for *Mouvement pour l'Autonomie dans la Maternité et pour l'Accouchement Naturel* or Movement for Autonomy in Maternity and for Natural Birth), held a series of discussions with close to 100 women (and some of their partners) who had given birth with midwives in the previous five years. During this time, midwives had been given permission to practice experimentally in “pilot projects;” initiated in order to evaluate the cost and feasibility of legalizing midwifery in the province. They established the practice of midwifery in six out-of-hospital birthing centers, or *Maisons de naissance*, across the province. The discussions were held at the end of this period of experimentation, when legislation permitting midwives to practice permanently had not yet been passed. The results of the discussions held by *Groupe MAMAN* were sent to the Québec Ministry of Health and Social Services as part of the province’s efforts to evaluate the practice of midwifery with the consultation of community groups.

Women were asked to share what they would say to recommend midwifery to a friend. Some of the participants stated that:

“Midwives are neutral and open to our decisions without trying to control us.”³⁵⁸

³⁵⁸ “*Les sages-femmes sont neutres et œuvrent selon nos décisions sans essayer de nous contrôler.*” Bouffard, Mireille and Lysane Grégoire, 1998. *Bilan de l'expérience des hommes et des femmes ayant bénéficié des services des sages-femmes dans le cadre des projets-pilotes en maisons de naissance*. Montréal: Groupe MAMAN. Page 11.

“The approach is different, more humane, more ‘responsibilizing’ for the couple, the father is more involved.”³⁵⁹

“You’re not just a ‘case’!...You’re more than a uterus with a midwife.”³⁶⁰

Out of the series of discussions held by Groupe MAMAN, the members also formulated a declaration to be addressed to the Québec Ministry of Health and Social Services. They wrote, “Women whose pregnancies and birth are normal must absolutely have the free choice to give birth where and with whom they desire, including at home.”³⁶¹

Among many of the reasons for choosing to participate in the “pilot projects,” the importance of choice and of control over one’s body was paramount. These statements highlight different aspects of the place midwifery came to hold for activists and advocates. In the efforts to legalize midwifery, advocates drew on representations of the midwife as the practitioner who enabled women to *choose*, to feel confident about her choices, and to experience pregnancy and childbirth on her own terms. The term “empowerment” does not translate easily into French and Groupe MAMAN used the term in English to describe one of the dimensions of midwifery care appreciated most by women. Midwives actively encourage women “to take charge of themselves.”³⁶²

Efforts to advocate for choice in pregnancy and birth made the geography of birth a particularly significant concern: midwifery advocates in Québec sought the possibility

³⁵⁹ “*L’approche est différente, plus humaine, plus responsabilisante pour le couple, le père est plus impliqué.*” Bouffard and Grégoire, 1998, page 12.

³⁶⁰ “*On est pas juste un cas!...On est plus qu’utérus avec une sage-femme.*” Bouffard and Grégoire, 1998, page 10.

³⁶¹ “*Les femmes dont la grossesse et l’accouchement se déroulent normalement doivent absolument avoir le libre-choix d’accoucher où et avec qui elles le désirent, y compris à domicile.*” Bouffard and Grégoire, 1998, page 49.

of choosing both the practitioners and the place of labor and birth. Although midwives were restricted to practicing out-of-hospital birth centers during the pilot project, participants in the study by Groupe MAMAN were strongly in favor of permitting midwives in hospitals, if it was the choice of the client, as well as at home. As one participant in the Groupe MAMAN discussion stated, “It wouldn’t be right to prevent a woman from coming to give birth here [at the birth center] if that’s her choice. Choice is choice. We have the right to do what we want.”³⁶³ The liberal notions of free choice and autonomy are evident in these examples and in many of the ways that midwives and their advocates spoke of the benefits of legalization.

In Canada, the midwifery question emerged in the 1970s and 1980s within more generalized concerns about women’s experiences of childbirth in conventional hospital settings. What sets debates over midwifery apart from earlier efforts to reform the practices surrounding childbirth is the appeal to regulate a practice that until then had been clandestine and unregulated. Commentators heralded midwifery as a response to the “social need to re-evaluate existing obstetrical practices” and make “changes that would accommodate women’s demands around childbirth.”³⁶⁴ In Québec, some of the midwives advocating legalization had earlier home birth practices and were either formally trained in midwifery in other countries or were self-taught. Other midwives advocating legalization had received formal training outside of Canada but were not currently

³⁶² Bouffard and Grégoire, 1998, page 11.

³⁶³ Bouffard and Grégoire, 1998, page 34. “Ce ne serait pas correct d’empêcher une femme de venir accoucher ici si c’est son choix. Le choix, c’est le choix. Nous avons le droit de faire ce que nous voulons.”

³⁶⁴ Vadeboncoeur, Hélène. 2004. “Delaying Legislation: The Québec Experiment” in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving Midwifery*. Montréal: McGill-Queen’s University Press, page 91-110.

practicing. Both practicing “self-taught” midwives and midwives trained elsewhere to legally exercise their profession began to militate in earnest in the 1970s in an attempt to generalize the care offered by midwives and gain the financial support of the provincial health care system. Midwives, it was argued, could provide safe, low-cost, and more emotionally satisfying care for women whose pregnancies and births progressed normally.

Popular historical narratives of midwifery in Québec tend to narrate midwifery’s re-emergence in Québec as a progression from a clandestine and criminalized practice in the late 1960s and early 1970s to a fully legitimate profession following the passage of the Midwives Act of June 19, 1999.³⁶⁵ Representations of midwifery in Québec among supporters of the practice tend to present midwifery as a universal practice, common to women everywhere. Its absence from the Canadian health care system until quite recently is considered exceptional. Ivy Lynn Bourgeault attributes this progression to the advocacy efforts of midwives in Canada and their supporters and to the lack of substantial opposition from nurses or doctors. Midwifery advocates encountered “a relatively sympathetic government [that] viewed midwifery as a politically-correct cause and potentially cost-effective form of care.”³⁶⁶ In scholarly analyses of midwifery’s legalization in North America, midwifery’s emergence was interpreted until quite recently as indicative of the gendered division of power between doctors (primarily men) and their women patients. Yet framing midwifery as a struggle along lines of gender or as a question of professional power is only a partial explanation for midwifery’s emergence.

³⁶⁵ *Loi sur les Sages-Femmes*. 1999. L.Q.28, Ch. 24.

The narrative of progress that is often told of midwifery in Québec glosses over the contradictions and conflicts that emerged through efforts to legalize midwifery. As this chapter will demonstrate, midwifery advocates framed the practices surrounding childbirth as vital questions of reproductive autonomy and control over the uses of the body. Most importantly, this narrative of progress does not take into account considerations of the *value* invested in midwifery in the process. In this sense, the question of how midwifery emerged can be posed in another way. What sorts of problems emerged in Québec with respect to pregnancy and birth? What solutions did midwifery offer to these problems? This line of questioning permits us to examine the participation of women as activists in reforming a portion of the health care system while also considering how midwifery emerged as the appropriate solution to a host of disparate problems for the state.

The move to legalize midwifery was successful in Québec, as were similar movements across Canada during the 1990s in many provinces. In 1990, the Research Branch of the Canadian Parliament's Political and Social Affairs division published a report entitled *Midwifery: A New Status*.³⁶⁷ This report, written when efforts to legalize midwifery were underway in at least six Canadian provinces, emphasizes the new role midwives could assume in Canada: as potential "alternative[s] to medical delivery, which some see as excessively technological, interventionist, and expensive" as well as a potential means of reducing health care costs.³⁶⁸ The interests of women pursuing

³⁶⁶ Bourgeault, 1999, page 1.

³⁶⁷ Branch, Maureen. 1990. *Midwifery: A New Status*. Ottawa: Library of Parliament, Research Branch, Political and Social Affairs Division.

³⁶⁸ Branch, 1990, page 3-4.

alternatives to physician and hospital practice might coincide with those of Canadian provincial governments and hospitals interested in cutting costs. Midwifery in the province lacked regulatory oversight, protective legal status, education or training programs to ensure quality, as well as mechanisms for public payment. Their status was similar to that of other “alternative” health care providers such as chiropractors and osteopathic doctors. With fees around \$800 for prenatal to postnatal care, midwifery was considered too expensive for low-income women. The report concludes with a potential scenario: “if midwifery services were incorporated under medicare, and midwives were permitted to provide prenatal and postnatal care as well as attend low-risk births at home and in hospitals, a considerable number of health care dollars could be saved.”³⁶⁹

Ontario was the first province to fully incorporate midwifery into the health care system with the passage of the Midwifery Act in 1991. On January 1, 1994, midwives became a fully funded part of the Ontario health care system.³⁷⁰ In Alberta, legislation permitting midwifery passed in 1992 and a Midwifery Register was established to regulate licensure in July 1998.³⁷¹ In British Columbia, a midwifery advisory committee was established in 1993, and in 1994, midwifery became a self-regulating profession. Midwives in British Columbia have practiced with government funding since 1998.³⁷² In

³⁶⁹ Branch, 1990, page 25.

³⁷⁰ Hawkins, Miranda and Sarah Knox. 2003. *The Midwifery Option: A Canadian Guide to the Birth Experience*. Toronto: Harper Collins, page 47. See Ontario *Midwifery Act*, S.O. 1991, Chapter 31, <http://www.e-laws.gov.on.ca:81/ISYSquery/IRL172C.tmp/8/doc>, accessed January 31, 2006.

³⁷¹ Hawkins and Knox, 2003, page 41. See Alberta Regulation 328/94, Midwifery Regulation in the *Health Disciplines Act*, http://www.qp.gov.ab.ca/Documents/REGS/1994_328.CFM, accessed January 31, 2006.

³⁷² See Jude Cornelson and Elaine Carty. 2004. “Challenges to Midwifery Integration: Interprofessional Relationships in British Columbia” in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving Midwifery*. Montréal: McGill-Queen’s University Press, page 111-130. See also Canadian Doula Association, *History of Midwifery in Canada*, http://www.canadiandoulas.com/history_m.htm, accessed April 23, 2005.

Manitoba, the Midwifery and Consequential Amendments Act was passed in 1997, and became effective in 2000.³⁷³ In Saskatchewan, midwifery legislation was passed in 1999, but the Midwives Act has not yet come into effect, and midwifery is not funded by the provincial health care system.³⁷⁴ All total, six provinces (Alberta, British Columbia, Manitoba, Ontario, Québec, and Saskatchewan) have passed legislation permitting midwives to attend birthing women at home, in the hospital, and in birth centers, where available.³⁷⁵ This chapter examines the “success” of midwifery in Québec in the context of pressures on states with relatively generous social welfare programs, such as Canada, to reframe the provision of public health care. The contemporary emergence of midwifery in Québec demonstrates how the neoliberal “privatization” of health care relies on the production of new subjects and spaces of birth. The success of midwifery in Québec, I argue, reveals shifts in the regulation of the reproductive body and in new modes of subject formation in contemporary Canada.

Health care in Canada

Pressures on provinces to open up portions of their health care “market” to the private sector have increased steadily since the inception of medicare in 1966. Health care provision in Canada relies on a national and universal insurance system (medicare) established with the Medical Care Act of 1966 that guarantees coverage of basic health

³⁷³ Hawkins and Knox, 2003, page 43.

³⁷⁴ Hawkins and Knox, 2003, page 48-49.

³⁷⁵ Burtch, Brian. 1994. *Trials of Labour: The Re-Emergence of Midwifery*. Montréal and Kingston: McGill-Queen’s University Press.

costs to all Canadian citizens. The act was put into practice across the provinces by 1971.³⁷⁶ The health care system was founded on four principles: health care would provide comprehensive, universal coverage for all medically necessary services, coverage would be portable between provinces and the system would be publicly administered.

At its inception, responsibilities for health care funding were split evenly between the federal government and each province. Critics of the cost-sharing arrangement within provincial governments complained of the “inflexibility” of the federal funding system with regard to the development of less-costly services, which were earmarked for hospital-based services. In an effort to limit the increasing costs of health care for the federal government under the cost-sharing program led to the passage of the Federal-Provincial Fiscal Arrangements and Established Programs Financing Act (EPF) in 1977. This act introduced “block transfer” funding from the federal government, in which each province received an equal per capita portion of tax transfers to be used in funding the provincial health care system. Such a system was thought to introduce more freedom within the provinces to develop lower-cost health care alternatives, and de-link the federal portion of funding from spending within the provinces.³⁷⁷ Yet concerns about the accessibility of health care and allegations that provinces were using portions of their block transfer allocated to health care for other services eventually led to the passage of the 1984 Canada Health Act (CHA).

³⁷⁶ Charles, Catherine A. and Robin F. Badgley. 1999. “Canadian National Health Insurance: Evolution and Unresolved Policy Issues” in Francis D. Powell and Albert F. Wessen, Eds. *Health Care Systems in Transition*. Thousand Oaks and London: Sage Publications, page 115-150. For a discussion of the historical role of the federal government in the provision of provincial health care, see Mary Ruggie. 1996. *Realignments in the Welfare State: Health Policy in the United States, Britain and Canada*. New York: Columbia University Press.

The Canada Health Act reaffirmed the four tenets of public health care in Canada -- universal, publicly administered, portable and comprehensive coverage (meaning all conventional hospital and medically necessary services) -- and added a fifth requirement: services should be accessible. Provinces could be financially penalized by a reduction in their block transfer amount if they were not providing universal coverage (100% up from 95% under the original Medical Care Act).³⁷⁸ Specifically, the Canada Health Act banned hospitals from charging user fees and provinces from permitting the practice of extra billing (in which practitioners require patients to pay out-of-pocket for expenses in excess of provincial reimbursement). The Act devolved decisions on where to focus health care funding to the provinces, which are responsible for organizing the provision of care. In doing so, this shift in funding from cost sharing to block transfers in the 1970s and 1980s introduced the possibility of “experimentation” among the provinces as federal regulations prioritizing hospital-based services were loosened.

In 1986, a federal report entitled *Achieving Health for All: a Framework for Health Promotion* emphasizes the possibility of developing alternative, out-of-hospital sites for providing health care.³⁷⁹ Across Canada during the 1980s, all provinces began to experiment with deinstitutionalization. In New Brunswick, the provincial health service developed an experimental program termed “hospitals without walls” in which hospitals shared services and developed “day surgery” clinics to move patients outside of the

³⁷⁷ See Ruggie, 1996.

³⁷⁸ Charles and Badgley, 1999, page 127.

³⁷⁹ Ruggie, 1996, page 111.

institution.³⁸⁰ Other provinces, such as Ontario, began to close hospitals and encourage the provision of private care (in the home or the “community”) as a means to cultivate a competitive market that would eventually lower the costs of non-profit care.

As federal funding for health care decreases and provincial governments reduce services, the pressures to encourage market mechanisms in the public provision of health care increase. Critics of the public health care system in Canada cite the benefits of private competitive markets on cost and labor efficiency and on reducing waiting times for treatment. In some provinces, the dismantling of government involvement in the provision of care is founded in part on the promotion of the home and the community as the proper locus of health care delivery.³⁸¹ These changes lead commentators to characterize Canadian health reforms as (neo)liberal efforts to roll back the welfare state practices that defined the relationship between capital, labor, and the state for the latter half of the 20th century. Welfare states such as Canada put in place policies providing for certain services essential to the social reproduction of labor: health, education, social welfare. The shift in Canada toward neoliberal health care policies was not initially oriented toward the privatization of the system. David Coburn notes that “the public

³⁸⁰ See Sheila A. Brown and Neil Ritchie. 1992. “Collaborative Arrangements in Service Delivery: The Example of Two New Brunswick Hospitals.” In Raisa B. Deber and Gail G. Thompson, eds. *Restructuring Canada’s Health Services System: How Do We Get There from Here?* Toronto: University of Toronto Press, page 351-360. Cited in Ruggie, 1996, page 109.

³⁸¹ Williams, A. Paul, Raisa Deber, Pat Baranek, and Alina Gildiner. 2001. “From Medicare to Home Care: Globalization, State Retrenchment, and the Profitization of Canada’s Health Care System” in Pat Armstrong, Hugh Armstrong, and David Coburn, eds. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*, Oxford and New York: Oxford University Press, pages 7-30. For an extended discussion of the effects of reform on Canadian health care see Pat Armstrong and Hugh Armstrong, 2003. *Wasting Away: The Undermining of Canadian Health Care*. Oxford: Oxford University Press and Kim England, Joan Eakin, Denise Gastaldo, and Patricia McKeever, forthcoming. “Neoliberalizing home care: Managed competition and restructuring home care in Ontario.” In Kim

popularity of medicare meant that at least the first impulse was to try to make medicare more co-ordinated, effective and efficient rather than simply to privatize it.”³⁸² The transformations in health care under conditions of neoliberal economic reform in Canada are socio-spatial shifts, entailing a shift to market ideologies and transformations in the spaces of health care.

However, privatization has not resulted in the wholesale retrenchment of the state from health provision. Rather it has entailed a *transformation* in the state’s role. Mary Ruggie sees the “ambiguous intersection” between private and public with regard to health care as an indication that “the state has adopted certain market-based processes.”³⁸³ The efforts to encourage health care markets in sectors that were once publicly funded have led commentators to characterize the recent transformations in Canadian health care as the “profitization” of the public system, rather than its “privatization.” Provincial governments have begun to form public-private partnerships in order to manage public institutions like hospitals (as well as roads and schools). Other services considered “nonessential” have been “de-listed” from public funding. The corporatization of the public system combined with the development of private markets for certain “nonessential” services are part of the recent reforms to the Canadian health care system that reconfigure the relationship between citizens, capital and the state.

England and Kevin Ward, eds. *Neo-liberalization: Networks, States, Peoples*. Malden, MA and Oxford: Blackwell.

³⁸² Coburn, David. 2001. “Health, Health Care and Neo-Liberalism” in Pat Armstrong, Hugh Armstrong, and David Coburn, eds. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*, Oxford and New York: Oxford University Press, pages 45-65.

³⁸³ Ruggie, 1996, page 187.

Pressures to commodify health care services in Canada are rarely directed at the system of medicare as a whole. Rather, critics argue that the system is “hollowed-out” from within, as provincial budget cuts strain the public system. The fiscal crisis engendered by reductions of federal funding to provincial health care services since the late 1970s provided the public rationale for the closure of hospitals and the reduction of services. Closures and reductions in services increase waiting times and put pressures on providers that further bolster rhetorical claims to the efficiency of the market. A spatial shift in the geography of health care has occurred as well, with provincial governments transferring the responsibility for services to municipalities and new regional configurations emerging from the efforts to coordinate health care over a territory.³⁸⁴ Such neoliberal economic tendencies seek to reorient social welfare programs around a market-based logic of competitive individualism and attenuate the role of the state in the direct provision of social programs.

Reflecting on the period of deinstitutionalization and experimentation accompanying health care reforms in Canada, Mary Ruggie notes that “Québec has advanced the farthest in alternative health care delivery.” She cites the development of locally based health care centers (*Centres Locaux de Services Communautaires* or CLSCs), run by boards made up of community members.³⁸⁵ It is in the CLSC system that

³⁸⁴ See Pat Armstrong, Hugh Armstrong, and David Coburn, eds. 2001. *Unhealthy Times: Political Economy Perspectives on Health and Care in Canada*. Oxford and New York: Oxford University Press;

³⁸⁵ Ruggie, 1996, page 111. Ruggie cites Michael Rachlis and Carol Kushner. 1989. *Second Opinion: What's Wrong with Canada's Health Care System and How to Fix It*. Toronto: Harper & Collins Publishers Ltd.; see also André-Pierre Contandrioploulos, Claudine Laurier, and Louise-Hélène Trottier. 1986, “Toward an Improved Work Organization in the Health Services Sector: From Administrative Rationalization to Professional Rationality,” In Robert G. Evans and Greg L. Stoddart, eds. *Medicare at*

the province's period of experimentation with midwifery "pilot projects" takes place. Overall, federal spending in Québec on social programs such as healthcare has dropped steadily during the 1980s and 1990s, from 32% of Québec's spending on social programs in 1984 to 22% in 2005.³⁸⁶ In the health care system, private expenditure has steadily increased since the 1980s. A 1999 report published by the Québec Ministry of Health and Social Services examined the growth of the private sector in health care.³⁸⁷ The report, commissioned by the Ministry of Health and Social Services under Jean Rochon notes that the private provision of health care in the province had increased to over 30% of total health care spending, up from 25% in 1989.³⁸⁸ Citing the increasing cuts in federal funding transfers to the province and the growing criticism of the shortfalls of the system, the report asks whether this increased share of total health care expenditure is indeed evidence of a "privatization" of the system. Tellingly, the report cites the absence of a private insurance market for services covered by the public system as one of the safeguards preventing the development of a parallel private system.

Yet in 2005, this very safeguard was overturned by a Canadian Supreme Court decision. The Court struck down the prohibition in Québec on the development of a private insurance market for services already covered by the public system.³⁸⁹ This decision introduces the notion that the patient's exposure to potential *risk* introduced by

Maturity: Achievements, Lessons, and Challenges. Calgary: The University of Calgary Press, page 287-324.

³⁸⁶ Ministère de la Santé et des Services sociaux. 2000. *Funding: Current Situation and Outlook Québec*: Ministère de la Santé et des Services sociaux.

³⁸⁷ *La Complémentarité du Secteur Privé dans la Poursuite des Objectifs Fondamentaux du Système Public de Santé au Québec (Rapport Arpin)*. 1999. Québec: Gouvernement du Québec, Ministère de la Santé et des Services Sociaux.

³⁸⁸ *La Complémentarité*, 1999, page 11.

waiting times violates the right to life and personal inviolability protected under the Canadian Charter of Rights and Freedoms, a foundational constitutional document. Notably in the recent Supreme Court decision, the notion of “liberty” is extended to the economic right of *freedom of contract*, an idea that until now has not been drawn from the rights outlined in the Canadian Charter.

Ivy Lynn Bourgeault notes that although changes to Canadian health care over the last decade have been overwhelmingly framed as negative (the *closure* of hospitals, the *lack* of providers, the *decreases* in federal funding and the ensuing *cutbacks* to provincial systems), “one recent health care initiative has been heralded as most progressive and long overdue. This is the integration of midwifery into the Canadian health care system.”³⁹⁰ Research on neoliberal pressures in relation to the legalization of midwifery has quite understandably focused on the public funding of midwifery as a matter of *policy* concern (i.e. whether or not midwifery as a legal practice will also be covered by the provincial health insurance scheme).³⁹¹ Yet little work on midwifery to date has examined the *practices* of midwifery in light of neoliberal forms of governance in Canadian health care. How does one explain the *productive* nature of midwifery’s emergence as a new practice in the health care system in Québec, and across Canada?

³⁸⁹ *Chaoulli v. Québec (Attorney General)*. 2005 S.C.C. 35.

³⁹⁰ Bourgeault, Ivy Lynn. 1999. “Delivering Midwifery: The Integration of Midwifery into the Canadian Health Care System.” *The Canadian Women’s Health Network* 3 (2), <http://www.cwhn.ca/network-reseau/2-3/midwifery.html>. Accessed January 21, 2004.

³⁹¹ See Susan James and Ivy Bourgeault. 2004. “To Fund or Not to Fund: The Alberta Decision” and Anne Rochon Ford and Vicki Van Wagner. 2004. “Access to Midwifery: Reflections on the Ontario Equity Committee Experience,” both in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving Midwifery*. Montréal: McGill-Queen’s University Press.

Wendy Larner notes that the tendency to see neoliberalism as a “top down impositional discourse” is reflected in the paucity of scholarship on how neoliberal forms of governance produce “acting subjects.” Research on neoliberalism focused solely on shifting economic policies is unable to grapple with the “the complex appeal of concepts such as ‘freedom’, ‘empowerment,’ and ‘choice.’”³⁹² Larner points to work that approaches neoliberalism as a form of governance as a potential counterpoint to studies of the shrinking welfare state. Neoliberalism as a form of governance implies that all forms of human conduct (economically productive as well as socially reproductive) as potential objects of rational economic calculation. In this way, neo-liberalism as a rationality of government seeks to transform all forms of conduct (rational and irrational, or productive and reproductive) into sources of value. As Colin Gordon writes, a neoliberal conception of the subject sees human abilities as “quasi-machines for the production of value.”³⁹³ Investing in one’s own human capital requires maximizing one’s satisfactions as one would maximize economic profit. The entrepreneurial subject of neoliberalism seeks to perpetually improve upon his or herself, to invest in his or herself, to have positive experiences that build on and improve self-esteem. The self becomes the perpetual ground for improvement.

Underlying this examination of the political economy of midwifery in Québec is the premise that state policies engendering market-oriented approaches to the regulation, funding or delivery of health care are simultaneous to efforts to shape human conduct in

³⁹² Larner, Wendy. 2003. “Neoliberalism?” *Environment and Planning D: Society and Space* 21 (5): 509-512.

³⁹³ Gordon, Colin. 1991. “Governmental rationality: an introduction” in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect*. Chicago: University of Chicago Press, 1-51, page 44.

new ways. The policies transforming Canadian health care are not simply structural shifts in the state's provision of a service. Rather, they inform all levels of the processes of economic production and social reproduction. While these policies may seem to operate at the level of official discourse, they are also constitutive of new spaces and new subjectivities. In this way, the efforts to "privatize" Canadian health care have emerged contemporaneously with transformations in social roles. This chapter will explore how these transformations have created new spaces and new subjects within Canadian health care for the "practices of freedom" that are simultaneously the targets and goals of governmental intervention.

These processes of subject formation are operative across disparate social fields, particularly programs that seek to shape human behavior.³⁹⁴ The efforts to encourage the participation of individuals in the maintenance of their own health are part of this shift in responsibility for the *care of the self*.³⁹⁵ Yet the state by no means disappears in such a formulation. Rather, the state's role becomes one of encouraging and facilitating the creativity of the individual to develop novel means of accomplishing the work of self-improvement. The tendency of states is to share the responsibility of crisis management by "'offering' individuals and collectivities active involvement in action to resolve the

³⁹⁴ In the realm of health care, "social marketing" campaigns emerged in the 1970s in Canada, involving "the application of marketing technologies developed in the commercial sector to the solution of social problems where the bottom line is behaviour change." Alan Andreasen, quoted in "Social Marketing" *Health Canada*, http://www.hc_sc.gc.ca/ahc-asc/activit/marketsoc/index_e.html, accessed January 19, 2006. See also Alan R. Andreasen, 1995. *Marketing social change: changing behavior to promote health, social development, and the environment*. San Francisco: Jossey-Bass. These campaigns began as efforts to discourage "unhealthy" behaviors: smoking, drinking and drug use, and later were extended to the promotion of "positive" behaviors: physical activity, diabetes awareness, healthy eating, positive self-image and so on. In 1987, the government initiated a "strategic alliance" with the private sector to distribute anti-drug messages on school supplies to youth.

kind of issues hitherto held to be the responsibility of authorized governmental agencies.”³⁹⁶ The interest among Canadian provinces to develop deinstitutionalized sites for the promotion of self-care is part of a generalized shift to modes of control that attempt to facilitate and encourage the individual’s capacities for self-government. The transformation of pregnancy and childbirth into political questions of control and autonomy are cast in new light. The success of midwifery in Québec reveals much about how contemporary transformations in health care produce new subjects as well as new spaces of governance.

A study conducted in the mid-1990s in Québec on the cost-effectiveness of the practice demonstrated that midwifery was in fact no less costly than conventional medical care.³⁹⁷ However, the investigators calculated the *cost-effectiveness* of midwifery care, measured partly in clinical terms: rates of cesarean, 3rd and 4th degree perineal tears and the need for neonatal ventilation for more than five minutes. Cost-effectiveness was also evaluated using four measures related to the “individualization” of care: “quality of prenatal care, feeling of control over delivery, quality of care during delivery, and self-confidence in caring for the baby.”³⁹⁸ In these terms, midwifery in birth centers was deemed more cost-effective than physician care in hospitals. The authors conclude, “the

³⁹⁵ Michel Foucault’s three volumes on the care of the self develop different uses of the notion, but point to the varying modes self-occupation and self-reflection have taken as tasks of human endeavor.

³⁹⁶ Burchell, Graham. 1996 “Liberal government and the techniques of the self” in Andrew Barry, Thomas Osborne, and Nikolas Rose, Eds. *Foucault and Political Reason*. Chicago: University of Chicago Press, 19-36, page 29.

³⁹⁷ Reinharz, Daniel, Régis Blais, William D. Fraser and Andre-Pierre Contandriopoulos. 2000. “Cost-Effectiveness of Midwifery Services vs. Medical Services in Québec” *Canadian Journal of Public Health* 91 (1): I12-I15.

³⁹⁸ Reinharz et al. 2000, page I12.

midwife option seems to be advantageous from a subjective client perspective.”³⁹⁹ The significance of this “subjective client perspective,” I argue, is crucial to the emergence of midwifery in Québec. Midwifery in Québec, and elsewhere in North America, elicits a new way of relating to one’s self, of fashioning one’s own conduct. For this reason, midwifery represents a new way of governing the self.

Midwifery in Québec: a new problematic

To return once again to the question animating this chapter, what problems did midwifery emerge to solve? The problems, it seems, were in part the dissatisfaction of women with regard to their experiences of pregnancy and childbirth. This dissatisfaction had been expressed early in the 1970s as a desire for the “humanization” of maternal health care. And in the wealth of scholarly research midwives and their advocates marshaled to their cause, women’s emotional and psychological experiences of birth were linked to their physical health. These ideas were nothing new; early criticisms of hospital birthing practices by doctors such as Grantly Dick-Read in the United Kingdom and Frederic Leboyer in France attempted to provide scientific evidence that women’s emotional states could affect their physical health.⁴⁰⁰ Yet the emphasis among early advocates of midwifery in Québec focused on the importance of women’s choice and autonomy in birth, notions that arguably neither Dick-Read nor Leboyer made the focus of their critiques of conventional hospital birth.

³⁹⁹ Reinharz et al. 2000, page 115.

⁴⁰⁰ Dick-Read, Grantly. 2004. *Childbirth Without Fear*, London: Pinter & Martin Ltd; Frederick Leboyer. 1975. *Birth Without Violence*. New York: Alfred A. Knopf.

The efforts to establish midwifery in Québec were not smooth. It was not a question of merely implementing a policy recommendation. Struggles took place between and within physician organizations, midwives' associations, and groups of women who advocated as community members for midwifery. Yet the problems posed by hospital birth were, over time, framed as perceived social problems. Midwifery emerged first with the context of early debate over the "humanization" of birth. In Québec, efforts by the provincial government to consider the humanization of birth as a focus of maternal health care policy were initiated early in the 1970s. The publication of two reports, in 1973 and 1974, by the Ministry of Social Affairs addressed the reorganization of obstetrical services and the Ministry's role in pregnancy and birth in the province.⁴⁰¹ Part of the efforts to transform obstetric care focused on hospitals; some hospitals developed birthing rooms designed to promote women's comfort while giving birth. Early attempts to promote the practice of midwifery appeared with the formation of the *Association des sages-femmes* in 1975, whose goal was the legal recognition of midwives in the province. Two years later, in 1977, the *Collectif de Saint-Léandre* in Matane, Québec, sent a letter to the Council on the Status of Women and to the Ministry of Social Affairs, demanding the "respect of women's choices" and the "rehabilitation" of the midwife.⁴⁰²

⁴⁰¹ Le Comité, 1989, page 59

⁴⁰² Yet the interest in midwifery for the provincial government also extended to questions of population. At the same time that discussions on the humanization of birth were taking place in cities throughout Québec, the provincial government was considering the potential benefits of midwifery from another register. In 1979, the Council on Social Affairs and the Family published a report entitled *Naître au Québec*, discussing the potential contribution of the humanization of birth to Québec's "problem" of depopulation, "the humanization of care during childbirth was seen...as a measure susceptible to increase the birth rate." Le Comité, 1989, page 60.

In 1980, the first midwives association in the province was established, *Association des sages-femmes du Québec* (ASFQ). The association grouped together midwives who were trained formally, either outside of Canada or in the few programs in the province that prepared nurses for international relief work or work in the remote areas of Canada. Such programs had existed during the 1960s and 1970s but were not designed to train health care professionals to attend births among urban women in Southern Québec. In eleven regional meetings held across the province that same year, over 10,000 participants had gathered to discuss the “humanization” of birth. These meetings, sponsored by the Québec Public Health Association, were entitled “*Accoucher ou se faire accoucher*,” or “To Give Birth or To Be Delivered,” and were later considered a “milestone event” in the efforts to shift the practices surrounding childbirth in the province.⁴⁰³

But midwifery was not seen as an obvious solution to the new social problems of women’s dissatisfaction with conventional hospital birth. In 1980, the Québec Ministry of Education conducted an analysis of the “midwifery function” and published a report detailing the work of six consultation groups gathering over sixty people interested in investigating midwifery. From the report, the Ministry of Education formed a committee, composed of members of the Ministry for Social Affairs, Office of Professions of Québec, Council on the Status of Women, and the Secretary of State for the Condition of Women, as well as a nurse trained in obstetric health.⁴⁰⁴ This committee was given the

⁴⁰³ Le Comité, 1989, page 59; see also Hélène Vadeboncoeur, 2004, page 92.

⁴⁰⁴ Boilard, Huguette, Diane Gagnon, and Monique Séguin. 1982. *Rapport de la Mission en Californie sur les Sages-Femmes*. Ministère de l’Éducation: Québec, page 2.

responsibility of ascertaining the potential utility of midwifery in Québec. In 1981 and 1982, two exploratory visits were undertaken to evaluate the practice of midwifery in Europe and in the United States.

The first “mission,” to California, had four objectives: 1) to gain a better sense of midwives legal status (to “understand the situation of midwives regarding the legislative context defining their professional practice”); 2) to compare the diverse sites of midwifery practice (hospital, home, and birth center); 3) to evaluate midwifery training; and finally, 4) to examine midwives’ relationships to other medical professionals (nurses, obstetricians).⁴⁰⁵ The recommendations to the committee were clearly in favor of permitting the midwives in Québec who already possessed formal midwifery training to begin practicing in the province. The report recommends that midwives living in the province who have previously received formal training be utilized before training other midwives, and “in consequence, it would be better to first develop a clinical field, and then a midwifery training school.”⁴⁰⁶ The emphasis of the committee on the capacities of midwives who had already received training refers to the midwives living in Québec who received their formal training elsewhere, primarily in Europe.

The mission to Finland and England in March of 1982 produced different recommendations. The report emphasized that the role of midwives in both Finland and England had been superseded on one side by nursing and on the other by obstetrics.⁴⁰⁷

⁴⁰⁵ Boilard et al., 1982, page 3.

⁴⁰⁶ Boilard et al., 1982, page 31.

⁴⁰⁷ Courchesne, Marie-Christine, Diane Gagnon, and Lucie Mignon. 1982. *Rapport de la Mission Européenne sur les Sages-Femmes*. Ministère de l’Éducation: Québec. Marie-Christine Courchesne also authored the 1980 report published by the Ministry of Education on the role of the midwife, *Inventaire des*

The report's authors recommended that in order to ensure the midwife's "professional expertise," midwives' labor must be protected from the *morcellement* or parceling out of the tasks of midwifery to others. While both missions came to separate conclusions regarding the path legalization could take, one of the reports clearly stated the stakes of the debate over midwifery: "the legalization of the status of midwives is more and more perceived in Québec as one of the means to favor the humanization of care in childbirth and to give more control back to women over their maternity"⁴⁰⁸ This report signaled the emerging coherence of a project to "rehabilitate" the midwife in the province.

In 1986, a group of practicing midwives formed their own organization in the province, *l'Alliance Québécoise des sages-femmes praticiennes*. In total, the two midwifery groups had approximately 200 members, of which approximately 20 to 30 from the *l'Alliance* were actively practicing midwifery, primarily in women's homes. At the same time, a collective of "consumer groups" formed to advocate for changes to the practices surrounding childbirth. *Naissance-Renaissance* began pressuring the government to develop midwifery pilot projects outside the hospital and develop sites where "giving birth can be less bureaucratic and the family can be present."⁴⁰⁹ The *Alliance Québécoise des sages-femmes praticiennes* and *Naissance-Renaissance* worked closely together and the *Alliance* established a set of standard for midwifery practice and

tâches et opérations de l' "Intervenante en santé-obstétrique" (sage-femme). Ministère de l'Éducation: Québec.

⁴⁰⁸ Boilard, Huguette, Diane Gagnon, and Monique Séguin. 1982. *Rapport de la Mission en Californie sur les Sages-Femmes*. Ministère de l'Éducation: Québec, page 1.

⁴⁰⁹ Branch, 1990, page 21, see also Marie-Claude Martel, 1998 April, "Où Accoucher," *The Canadian Nurse*, page 37.

established an apprenticeship program for aspiring midwives.⁴¹⁰ They also began to agitate for the development of “pilot projects” in Québec.

Midwives were practicing in the province of Québec during the 1980s, even though the practice of obstetrics was expressly prohibited to anyone other than a physician. Midwifery itself had never been explicitly declared illegal, however, and physicians were permitted to engage the assistance of a midwife, although with potentially adverse consequences.⁴¹¹ In 1989, a physician had been suspended from hospital practice for six months after permitting a midwife to deliver a child at a Montréal hospital, but the physician was immediately hired by another institution eager to develop a “midwifery pilot project.”⁴¹² Some hospitals were interested in promoting midwifery experimentally, just as some physicians were open to the possibility of collaborating with midwives in the hospital.

Yet the opposition of physicians’ organizations to the legalization of midwifery was strongly stated by representatives of two professional medical organizations in Québec. The president of the Québec Corporation of Physicians, Dr. Augustin Roy, asked in an interview in 1989, “Why not legalize prostitution? There are a lot more people asking for the legalization of prostitution than the legalization of midwives?”⁴¹³ By linking the legalization of midwifery to that of prostitution, Roy links two practices related to the uses of the body. The comparison between midwifery and prostitution

⁴¹⁰ See Vadeboncoeur, 2004.

⁴¹¹ Vadeboncoeur, 2004, page 92.

⁴¹² See Kate Dunn, 1989, April 15. “Midwives: Operating on Law’s Edge,” *The Gazette (Montréal)*, and Michèle Ouimet, 1989, May 13, “Ces sages-femmes dont on parle tant,” *La Presse*, cited in Branch, 1990, page 20.

attempts to equate women's sexual and reproductive labor by denigrating both. By linking the midwife with the prostitute, Roy also links the private market activity of midwifery (as a "choice") to that of marketized sexual labor.

Physician opposition also focused on the question of midwives' skill and expertise. The president of the Québec Federation of General Practitioners stated that to allow midwives to attend births was comparable to "letting an apprentice pilot take charge of a Boeing 747 loaded with passengers."⁴¹⁴ Yet the Report notes that the provincial government had issued several recommendations in support of the practice of midwifery. The "Rochon Commission" or the Commission of Inquiry into Health and Social Services issued a 1988 recommendation that midwifery be legalized, as did the Advisory Council on Social Affairs in the same year.⁴¹⁵

In 1989, the provincial Task Force on Midwifery (*Le Comité de travail sur la pratique des sages-femmes au Québec*) came to a similar conclusion regarding the possibility of legalizing midwifery. The committee was established in 1986 by the Minister of Health and Social Services, Thérèse Lavoie-Roux, to compile the practices of midwifery currently existing in the province and elsewhere and "provide to the Minister of Health and Social Services the information necessary to make decisions regarding the

⁴¹³ Branch, 1990, page 21, citing Ingrid Peritz, 1989, May 10, "Québec Wants Midwives Law by June" *The Gazette (Montréal)*.

⁴¹⁴ Picard, André. 1989, May 11. "Québec Doctors Denounce Proposed Midwifery Law" *Globe and Mail (Toronto)*, cited in Branch, 1990, pages 21-22.

⁴¹⁵ In fact, midwives had been practicing in far northern parts of the province during this time under the supervision of physicians. An early midwifery program was established in 1986 in Puvirnituk.

practice of midwifery in Québec.”⁴¹⁶ The committee was comprised of 15 members, including officials from the Ministry of Health and Social Services, a midwife in private practice in Montréal, and two midwives practicing in provincial health care centers (one in Povirnitug in northern Québec), one gynecologist-obstetrician, and a representative from the activist group *Naissance-Renaissance*. The goals of the committee were to assemble “information” related to the practice of midwifery, and to define the “problems” that midwifery proposed to solve.

These problems were varied, given Québec’s relatively positive statistics on maternal and infant mortality among other Canadian provinces and in comparison with other highly industrialized economies. In analyses of infant mortality data for 1985, Québec and Alberta had the lowest rates of infant mortality among all Canadian provinces, 7.82 and 8.0 percent respectively compared with 8.7 in Ontario and 10.8 in Newfoundland. In effect, the only statistic related to infant health in which Québec ranked lower than other heavily-industrialized economies was in the percentage of low-birthweight babies: 6.4% in Québec compared with percentages below 6% for the Canada as a whole, and for most Western European nations.⁴¹⁷ The report stated that efforts to prevent low-birthweight and premature babies should continue.

However, in contrast to the favorable reduction of infant mortality in Québec since the mid-1970s, the frequency of some obstetrical interventions had increased. Vacuum extractions in 1981 were a total of 0.6% of all births and increased to 4.5% in

⁴¹⁶ Le Comité de travail sur la pratique des sages-femmes au Québec, 1989, *La Pratique des Sages-Femmes: Étude d’un moyen pour atteindre les objectifs en périnatalité*. Québec: Ministère de la Santé et des Services Sociaux.

⁴¹⁷ Le Comité, 1989, page 5-7

1986, while at the same time, the use of forceps decreased (from 23.1 % in 1981 to 14.8% in 1986). During the same period, the percentage of Cesarean births increased from 16.4% to 19.0%, a relatively high percentage in comparison with the Netherlands (5.6% in 1983) and Sweden (10.3% in 1980), for example.⁴¹⁸ But the long-term negative effects of obstetrical interventions, the report notes, are not always easy to quantify, and the authors cite the routine application of obstetrical interventions as an unacceptable, though widespread, practice. The authors also cite the work of British sociologist Ann Oakley, who links post-natal depression with the overuse of technological interventions that contribute to women's sense of a lack of control over their bodies and to their dissatisfaction with the experience of giving birth.⁴¹⁹

The report makes clear that the strongest “evidence” for the promotion of midwifery is not the failure of the Québec health care system to produce healthy infants; rather, the emphasis is on the failure of the medical system to consider women's *experiences* of birth. The essentially incalculable experience of birth is linked to the emotional health and well-being of the mother,

for the woman in labor, the guarantee of control over the event, the possibility of influencing certain decisions and the feeling of taking part in the team increase her self-esteem and leads her to have a more positive experience.⁴²⁰

The authors highlight data collected from sites in the United States and Europe in which midwives play a part in administering health care to women, noting the benefits to reducing prematurity, infant and maternal mortality and morbidity, and to decreasing the

⁴¹⁸ Le Comité, 1989, page 14-15.

rate of obstetric interventions. Midwives and their advocates claimed that doctors focus excessively on “physical security and neglect the aspect of psychological security.”⁴²¹ The claim is just as strongly argued that midwifery can improve women’s self-esteem and sense of satisfaction by experiencing a more humane birth. The report proposes that increasing attention be given to measures of women’s wellbeing by the province’s health officials. But how did psychological security, self-esteem and satisfaction become a priority for government?

Responsibility and new technologies of citizenship

In Barbara Cruikshank’s work on the making of democratic citizens, she argues that the promotion of “self-esteem” is part of the myriad “technologies of citizenship” that engender citizen-subjects in contemporary liberal democracies. Echoing Simone de Beauvoir’s assertion regarding gendered subjectivities, Cruikshank writes that citizens are not born but made.⁴²² The active production of subjects into citizens in a democracy cannot be accomplished with force; rather, democratic governance proceeds through the exercise of biopolitical power that acts on the subject’s desires and capacities for exercising her free will.

⁴¹⁹ Le Comité, 1989, page 115-16. See Ann Oakley, 1984, *The captured womb: a history of the medical care of pregnant women*. Oxford and New York: Blackwell.

⁴²⁰ Le Comité, 1989, page 16.

⁴²¹ Laurin, Renée. 1993, April 15. “Le point sur la maison de naissance.” *Le Droit*, page 19. The author cites Hélène Vadeboncoeur, a researcher on maternity and author of a book on avoiding a cesarean birth entitled *Une Autre Césarienne? Non merci!*, 1989, Montréal: Editions Québec/Amérique.

Cruikshank's work focuses on poverty reform movements, self-help programs, and the discourses of "empowerment" that characterize policy on "the poor" as historically constituted subjects in the United States. Following work on what Michel Foucault termed the "governmentalizing of the state," Cruikshank argues that contemporary technologies of government targeted at improving the self-esteem of the poor "work upon and through the capacities of citizens to act on their own."⁴²³ Democratic citizenship is not *a priori* to democracy, but is the effect of techniques of governance that take the self-empowerment of subjects as their object. Contrary to theorists of "social control" who see people's perceived *lack* of resistance as evidence of coercion and thinly concealed repression, Cruikshank emphasizes the ways in which power can be "simultaneously voluntary and coercive." Her underlying assumption, following Foucault, is that power in every relationship, even those we may consider the least coercive. If all domains of life are marked by persistent struggles over power, then even relationships that are not considered conflictual are relationships of power. In this sense, "one's desire could be both one's own and a product of power."⁴²⁴ Cruikshank examines the contemporary self-esteem movement, tracing its conception and emergence as a potential solution to social and political problems. She argues that the technologies of the self that operate in self-esteem movements are far more significant for thinking about politics than critics have recognized. The notion that individuals should attempt to

⁴²² Barbara Cruikshank. *The Will to Empower*, Cornell University Press, 1999: page 3.

⁴²³ Cruikshank, 1999, page 4.

⁴²⁴ Cruikshank, 1999, page 33. See also Nikolas Rose, 1999. *Governing the Soul: The Shaping of the Private Self*. 2nd edition. London and New York: Free Association Books.

improve themselves through measured self-reflection is one of the ways in which government operates to manage its own crises of governability.

Such technologies are not instances of the depoliticization of power relationships. Rather, these technologies are evidence of attempts by liberal governments to build on the capacities and subjectivities of citizens, “the logic of empowerment targets the capacities of the ‘powerless,’ measures and seeks to maximize their actions, motivations, interests, and economic and political involvements.”⁴²⁵ In focusing on the discourse of self-esteem that permeates both popular American culture and poverty reform programs, Cruikshank argues that such technologies are not instances of a politicization or depoliticization of the self. Rather, they take the private self and reconstitute it as a new site of politics. Self-esteem is no longer an individual matter, rather, self-esteem has become a “social relationship and a political obligation.”⁴²⁶ The obligation to feel good about oneself and to seek out ways to know oneself better is much more deeply inscribed into our ways of thinking about ourselves than we have imagined.

The significance of self-esteem discourse in Cruikshank’s analysis is its capacity to cultivate practices of self-reflection and self-government on the part of individual citizens. Cruikshank reads self-esteem discourse as a technology of citizenship that produces subjects capable of governing themselves in a democratic society. Cruikshank argues that the techniques of self-esteem are “literary.” Individuals tell stories of their passage from disempowerment to empowerment and in doing so they narrate themselves as active subjects, in control of their selves and their futures. Through these narratives,

⁴²⁵ Cruikshank, 1999, page 69.

individuals actively construct a self upon which to act. The narrative techniques of self-construction are political practices because they impinge on what it means to be a citizen, where citizens are construed as individuals with a sense of responsibility toward themselves and to others. Cruikshank writes:

One must accept the responsibility to subject one's self, to establish voluntarily a relationship between one's self and a tutelary power (such as a therapist or social worker) and a technique of power (in a social program or parenting class). Building self-esteem is a technology of citizenship and self-government for evaluating and acting upon ourselves so that the police, the guards, and the doctors do not have to. Consent in this case does not mean that there is no exercise of power; by isolating a self to act upon, to appreciate and to esteem, we avail ourselves of a terrain of action; we exercise power upon ourselves.⁴²⁷

Democracies cannot force citizens to act against their own will but must find ways to cultivate democratic principles in subjects. The goal of democratic governance, Cruikshank argues, is to “govern people by getting them to govern themselves.”⁴²⁸ The target of democratic governance is the subject's will to modify her behavior to achieve certain goals, to produce oneself as a responsible citizen, a mother, a worker, and so on. The production of politically active citizens takes place in myriad small ways, and Cruikshank focuses on the micro-scale techniques and strategies for producing a citizen whose own will to power is directed at herself.

In Québec, the humanization of birth is proposed as a solution to a crisis of governability, in which some women were not only exercising their reproductive

⁴²⁶ Cruikshank, 1999, page 88.

⁴²⁷ Cruikshank, 1999, page 91.

⁴²⁸ Cruikshank, 1999, page 39.

autonomy by giving birth outside the hospital, but also decrying hospital births as deeply disempowering. The problem midwifery proposes to solve is that of women's lack of control over their pregnancies and birth. Midwives propose to elaborate new techniques of self-government for pregnancy and birth in which the health of the subject is constituted through psychological as well as physical experience. The efforts by the provincial government to rationally determine the course of integrating midwifery into the health care system is directly linked to demonstrating midwifery's potential for increasing the capacities of women to manage their own emotional states and actively make decisions about their births.

This potential also begins to emerge in the policies adopted by the medical profession as a whole. The interest in opening lines of communication between doctors and patients is expressed in a 1987 statement by the Canadian Medical Association supporting the "growing participation of patients in decision-making relative to the process of birth."⁴²⁹ The Association expresses its support for sharing information with women about choices they may make regarding the surveillance of their pregnancies and births and any potential interventions. The report, however, does not say that women are given full decision-making capabilities, but rather that doctors should share any "necessary information" and inform women of their "available choices," a qualified autonomy that leaves room for the doctor's authority in determining what is indeed necessary information and available choice. But this value on communication between doctors and women may have another added benefit; communication contributes to the

maintenance of trust and may even decrease the likelihood that women will engage in legal action against a doctor perceived (wrongly, it is assumed) of negligence.

In 1989, the Minister of Health and Social Services, Thérèse Lavoie-Roux announced that she would permit the practice of midwifery in selected hospitals for evaluation. As the law stood, the College of Physicians governed the practice of midwifery, yet was not willing to regulate the practice. After an initial unsuccessful attempt to persuade the College of Physicians to change this provision within the Medical Act, Lavoie-Roux placed a law before the legislative assembly to permit the legalization of midwifery against the opposition of professional physicians' organizations.⁴³⁰

In 1990, midwives were given the authority to begin a period of experimentation in a series of "pilot-projects" designed to evaluate midwifery. Bill 4 established the provision of midwifery in pilot-projects to evaluate the "appropriateness" of legalizing midwifery and the means of integration into the health care system.⁴³¹ Institutions were invited to propose locations for these pilot-projects to the Ministry of Health for evaluation. As the efforts to implement midwifery pilot projects continued it became apparent that no hospitals would be participating in the experiment. Although the legislation on midwifery had not restricted the practice to out-of-hospital centers,

⁴²⁹ Le Comité, 1989 page 16. See Association Médicale Canadienne, 1987, *Obstétrique 87, Un rapport de l'Association médicale canadienne sur les soins obstétricaux au Canada.*

⁴³⁰ Branch, 1990, page 21.

⁴³¹ Vadeboncoeur, 2004, page 93. See Québec Loi 4, *Loi sur la pratique sage-femme dans le cadre de projets-pilotes.*

attempts by hospital administrations to develop midwifery pilot-projects within the hospital were routinely rejected by the hospital physicians.⁴³²

The official provision of midwifery care in Québec was implemented in 1993 through pilot programs in six CLSCs and one maternity hospital.⁴³³ These pilot programs were designed to provide an evaluation period for midwifery in the province, in which midwives were “assessed as being qualified, but not licensed, to practice at recognized sites for a limited time.”⁴³⁴ The key provincial health care objectives in the early 1990s were to reduce the number of premature births, teen pregnancies, low-birthweight babies, and the rates of obstetrical interventions. The community-based health care established in local health care centers (CLSCs) was deemed crucial to achieving these objects. The “experimental program” to establish midwifery services was linked to these objectives, affording a potentially lower-cost alternative than conventional hospital care with doctors.

Initially, a committee of fifteen midwives was chosen by the provincial government of Québec to determine who would practice under the pilot projects.⁴³⁵ This early group of “accredited” midwives then chose the means by which other midwives could qualify to participate in the pilot project. The Ministry of Health attempted unsuccessfully to negotiate the establishment of pilot projects in hospitals. The Québec Association of Gynecologists and Obstetricians urged all doctors, residents and medical

⁴³² Girous, Stéphane. 1993, May 28. “Sages-femmes au Centre hospitalier de Maria: Les médecins disent non au projet pilote.” *Le Soleil*, page B1.

⁴³³ See Blais and Joubert, 2000.

⁴³⁴ See Canadian Doula Association, *History of Midwifery in Canada*, http://www.canadiandoulas.com/history_m.htm, accessed April 23, 2005.

⁴³⁵ No author. 1993, September 18. “Maison des naissances de Gatineau” *Le Droit*, page 13.

students in Québec to oppose the practice of midwifery. In a letter written by the president of the Association, Dr. Robert J. Gauthier, he states that physicians “must oppose and not collaborate in any way with any project stemming from the Law on the practice of midwives in pilot projects.”⁴³⁶ Faced with continuing physician opposition at the level of professional physician associations as well as the refusal of individual doctors to collaborate with midwives, the midwifery pilot projects were located entirely under the administration of CLSCs. The CLSCs negotiated agreements with neighboring hospitals in the event of a transfer.

The midwifery pilot projects lasted five years, from 1993 to 1998.⁴³⁷ Midwives were given an extension to practice until the evaluation of the pilot projects was completed and legislation was passed. Midwifery care in the province was formally legalized in 1999 with the passage of Law 28, *Loi sur les Sages-Femmes*.⁴³⁸ In Québec, the “distinct route” taken by midwifery was that of experimentation, evaluation, and consultation with community groups on the part of the provincial government.

In the same year midwifery was legalized, the Minister of Health and Social Services, Marc-Yvan Côté, submitted a reform of the health and social services system to the Québec legislature. On the first page of the report, Côté expresses the desire to make the health and social services system more “citizen-oriented” and continues,

The policies and measures that follow have but one goal: to redirect the system towards objectives rather than means, with the focus on the needs,

⁴³⁶ Chouinard, Louise. 1993, September 13. “La saga se poursuit dans le dossier des sages-femmes.” *Le Droit*, page 15.

⁴³⁷ *La Périnatalité Québécoise Depuis Vingt Ans*. 2000. Montréal: L’Association pour la Santé Publique du Québec.

⁴³⁸ *Loi sur les Sages-Femmes*. 1999. L.Q.28, Ch. 24.

problems and expectations of the individual, in the hope of offering services that can be adapted to these needs with flexibility and rapidity; in short, a system centred on the individual.⁴³⁹

The citizen possesses “excessive expectations” that the reform of the health care system will attempt to attenuate, “the solutions proposed require either that taxpayers *demand less* from the health and social services system or that the government invest more in it.”

⁴⁴⁰ Increasing government spending on health care is deemed impossible and the implication is clear. In order for citizens to demand less from the system, the citizen must take on new responsibilities. As the report proposes, the citizen must become the *focus* of health care reform, in the active roles of *consumer, decision-maker, and payer*.

Midwifery, as a new practice within the provincial health care system, promises to cultivate a similarly active role for women in the provision of health care.

In February of 2003, one hospital in the province reached an agreement with midwives working at a CLSC in Montréal at Lac St. Louis to allow midwives to accompany women who wish to give birth in the hospital. Since then, one other hospital has negotiated with a nearby CLSC to lease space in the hospital for the practice of midwifery. And in June of 2005, the provincial government adopted a resolution regarding the criteria and conditions of practice for home births. The final implementation of this resolution, however, requires the negotiation of insurance coverage for midwives who assist at home births.

⁴³⁹ *A Reform Centred on the Citizen* [hereafter *Reform*]. 1990. Québec: Ministère de la Santé et Services Sociaux. Also issued in French as *Une Réforme Axée sur le Citoyen*.

⁴⁴⁰ *Reform*, 1990, page 10, my emphasis.

At this point I want to return to some of the reasons women gave for seeking midwifery care from the beginning of this chapter. It's clear that midwives and their advocates in Québec seek to de-instrumentalize women's relationship to reproduction ("*I am not just a uterus; I am not just a case*"), while at the same time, midwifery instills new demands on the reproductive subject (reflected in the notion that "*midwives' approach is more "responsibilizing..."*").

This "responsibilizing" approach is deemed to give the woman more freedom and more control over her own body. But this "responsibilization" is not without its own burdens. The responsibilities that the woman must bear are clearly articulated in the array of promotional and informational materials midwives authored to publicize their practice. The expectations for women interested in midwifery care are explicitly stated in the documents given to women interested in birth center care. As a woman seeking midwifery care, your responsibilities are:

- to be well-informed and take into consideration all the available options as well as your own feelings before making the decision to give birth with a midwife at the *Maison de naissance*.
- to eat well, to sufficiently rest and exercise, and to generally take good care of yourself during your pregnancy.
- to prepare yourself as well as possible for the realities of labor, of birth and of life with a new baby.
- to inform your midwife of your expectations regarding your care and services that you will receive from her and from the *Maison de naissance*.
- to inform your midwife of all health problems and any other situation that could affect your pregnancy and your birth.
- to respect appointment times of your prenatal visits and to make known as soon as possible if you must miss a visit.

- to arrange your return home after your stay at the *Maison de naissance* within 8 to 12 hours [after the birth] and to arrange any help needed at home during the first week.⁴⁴¹

Midwives expect women to regulate their bodies (to eat well, to rest), to make rational decisions regarding care (to prepare yourself, to be well-informed), and to speak the truth of one's self to the midwife (to inform the midwife of your expectations, to inform her of any health problems or other situation that may affect pregnancy and birth).

Midwifery in Québec thus represents a successful attempt to shift the responsibility for reproduction onto the individual woman, to “individualize” pregnancy and birth. As one midwife I interviewed explained,

We are the only group [of midwives] in Canada who did not choose *choice* as a fundamental principle. This may be a tool, but it's not an end in itself! The midwife is not there so that the woman can make an informed choice. If this is the case, it [midwifery] becomes a recipe to follow. This desolidarizes...it instrumentalizes her decisions...We have shared decision-making, this is what we do and it's more appropriate to the alliance of being with a woman....I am not an option, a “health care provider” and midwifery is not an offer, an option...I explain that there will be more certainty with a choice that *she* must make, but then she becomes the only one responsible – but how can you do that to a mother? We need a new strategy.⁴⁴²

Although midwifery-attended births represent only a small fraction of the total births in the province, the shifts to “privatize” and individualize birth are simultaneous to transformations in the spaces and subjects of debate over public health care that place the responsibility for health maintenance on the individual. Responsible reproduction, in this

⁴⁴¹ Maison de naissance Côte-des-Neiges. 2004. *Présentation des Services* [Pamphlet]. Montréal, QC: Author.

⁴⁴² Interview by author, Montréal, Canada, December 7, 2004.

new manifestation, becomes a social obligation. These efforts, however, were not implemented solely through “top-down” policies emanating from the state, but rather through the aspirations and desires of individuals who are continually compelled to make decisions about their health and who actively seek to shape the terms of those decisions. By doing so, they attempt to exercise control over their own bodies. These ideas are part of the new midwifery in Québec. The “philosophy” officially adopted by the *Ordre des Sages-Femmes du Québec* on March 29, 2002 states,

Midwives encourage women to make choices as to the care and the services she receives and how they are administered. They understand decisions to be the result of a process in which responsibilities are shared between the women, her family (however it is defined by the women) and health professionals. They recognize that the final decision belongs to the woman.

Midwives respect the right of women to choose their health professional and the place of birth, in agreement with the norms of practice of the Order of Midwives of Québec. Midwives are ready to assist women in the place of birth of their choice, including the home.⁴⁴³

Midwives encourage women to make choices, to rationally deliberate on their own care, and to assume a greater responsibility for their pregnancies and births. In short, midwives are to support women’s desires for reproductive self-determination. Yet as the work of Dominique Memmi makes clear, in no society anywhere has a woman been granted “the

⁴⁴³ Regroupement les Sages-Femmes du Québec (RSFQ). 1997. *Philosophie de la pratique sage-femme* [Pamphlet], adopté par le Bureau de l’OSFQ le 29 mars 2002. “Les sages-femmes encouragent les femmes à faire des choix quant aux soins et services qu’elles reçoivent et à la manière dont ceux-ci sont prodigués. Elles conçoivent les décisions comme résultant d’un processus où les responsabilités sont partagées entre la femme, sa famille (telle que définie par la femme) et les professionnelles et les professionnels de la santé. Elles reconnaissent que la décision finale appartient à la femme. / Les sages-femmes respectent le droit des femmes de choisir leur professionnelle et leur professionnel de la santé et le lieu de l’accouchement, en accord avec les normes de pratique de l’Ordre des sages-femmes du Québec. Les sages-femmes sont prêtes

right to do what she wants to her body against any public intervention.”⁴⁴⁴ The political struggles of women for “rights” to their bodies, in fact, have not resulted in the granting of an unlimited liberty regarding the use of the body. Rather, reproductive “rights” are more accurately interpreted as “mere social possibilities, and are strictly regulated” as such.⁴⁴⁵

Memmi writes that in the case of women’s reproductive self-determination, “the request [is] made to social actors to subscribe solely to narratives that can be legitimated by the state.”⁴⁴⁶ In the case of midwifery in Québec, these narratives are the result of claims and counter-claims that seek to constitute women as free. These narratives are also those of the responsible client, actively engaged in a practice of reproductive self-determination and self-control. As one participant in the Groupe MAMAN discussion stated, “My midwife led me to have confidence in myself. I feel safe, I feel in control.”⁴⁴⁷ This request for control, I argue, requires a reconfiguration of the relationship between the body and the self, in which the midwife is the privileged mediator. For it is through the midwife’s solicitation of a narrative about what kind of birth one wants that women come to see themselves as actively participating as *subjects* in their own pregnancies and births.

In an effort to manage this relationship between the body and the self, midwives expect responsibilities on the part of the mother that must be individually assumed. Yet

à assister les femmes dans le lieu d’accouchement de leur choix, incluant le domicile.” See also www.osfq.org/ordre/index_mission.html, accessed March 3, 2006.

⁴⁴⁴ Memmi, Dominique. 2002. “Public-Private Opposition and Biopolitics: A Response to Judit Sándor” *Social Research* 69 (1): 143-147, page 145.

⁴⁴⁵ Memmi, 2002, page 145.

⁴⁴⁶ Memmi, 2003, page 645.

these demands are often felt as burdens. As one woman participating in the Groupe MAMAN discussions presented earlier in this chapter stated,

Not being rushed means having the time to get to know one another, to develop trust, and to have my questions answered. I always feel heard. This does, however, come at the price of added responsibility. Tests and procedures that were simply taken for granted in my doctor's care require decisions with the midwife. While I appreciate the information, and am amazed at not having heard much of it before, I occasionally find myself secretly wondering if the empowerment of informed choice is truly preferable to letting someone else make decisions for me. Why do I always have to be the grown-up? But deep down, I know it is.⁴⁴⁸

While many scholars have noted the ways in which neoliberal regimes enact a kind of “de-gendering” that assumes the ideal citizen-type is an “unattached and unbiased” subject, the “new” midwifery in Québec compels women to invest intimately and personally, “deep down,” in the project of staking claims for reproductive self-determination.⁴⁴⁹ These investments are reflected in other areas of reproduction. From the development of birth plans outlining what procedures are desired (or not) during one's birth to the increasing responsibility placed on individuals to undergo genetic testing for fetal abnormalities, *all* are examples of the way in which the presentation of choices raises questions of self-determination and autonomy.

Midwifery activism in Québec deploys liberal notions of choice in an attempt to counter claims to the risk of midwife-attended hospital birth. Yet the freedoms engendered by choice are also experienced as potential risks. As a participant in the study

⁴⁴⁷ Bouffard and Grégoire, 1998, page 19.

⁴⁴⁸ *The Midwifery Option*, 2003, page 95.

⁴⁴⁹ See Banu Gökariksel and Katharyne Mitchell. 2005. “Veiling, secularism, and the neoliberal subject: national narratives and supranational desires in Turkey and France.” *Global Networks* 5 (2): 147-165.

conducted by Groupe MAMAN in 1998 stated, “In the beginning [of labor], it feels unsafe to be free to move and take the positions I want.”⁴⁵⁰ The role of the midwife is to help women recalculate her own relationship to risk, and recalibrate the relationship between feeling safe and doing what one wants. The midwife thus helps individuals negotiate their own personal forms of risk management, as part of what Pat O’Malley emphasizes is the “prudentializing” of technologies of power. O’Malley writes that prudential risk-management techniques are increasingly at work in the political programs of welfare states, turning forms of “socialized actuarialism into privatized actuarialism (prudentialism).” O’Malley cites these changes as multi-dimensional. They involve, he writes:

the retraction of socialized risk-based techniques from managing the risks confronting the populace; their progressive replacement through the extension of privatized risk-based techniques, and the articulation of this process with the strategic deployment of sovereign remedies and disciplinary interventions that facilitate, underline and enforce moves towards government through individual responsibility.⁴⁵¹

Midwifery in Québec must conform by law to stringent rules regarding the scope of practice and competency. Their practice is restricted to “normal” birth. This limits midwives to caring for pregnancies that are continuously measured in relation to predetermined norms (no twins, no breech births, deliveries between 37 and 42 weeks of gestation only, delivery within 24 hours of the rupture of membranes, the baby must not weigh over 10 pounds, etc.). Yet the desires of some women to remain within these

⁴⁵⁰ Bouffard and Grégoire, 1998, page 22. “Au début, c’est insécurisant d’être libre d’agir et de prendre les positions qu’on veut.”

protocols in order to continue with midwifery care may result in the disciplining of one's own behavior. One woman who had received midwifery care stated, "I stopped eating at the end of my pregnancy because I was too afraid that my baby would be too big and exceed the authorized weight to be born at the birthing center."⁴⁵² With the freedom from externally imposed controls that midwifery offers, we see a corresponding increase in the exercise of self-discipline. Another participant offered that "My principal stress was to not fit within the rules."⁴⁵³ These transformations in the regulation of reproduction that place the onus of decision-making on the individual oblige women to make decisions that were once the province of the state. The appearance of liberal forms of agency in pregnancy and birth thus transforms the relationship between birth, body, and self in new ways. Midwifery emerges as a privileged mediator of this new relationship.

Colin Gordon writes that contemporary liberalism engenders new relations of rule. A neoliberal conception of the relationship between the state and the individual is one in which "the state presents itself as the referee in an ongoing transaction in which one partner strives to enhance the value of his or her life, while another endeavors to economize on the cost of that life."⁴⁵⁴ Midwifery intervenes in this transaction to cultivate pregnancy and birth as sites of emotional investment and psychological security. Yet midwifery is not simply the imposition, "top-down," of a new form of regulation by the

⁴⁵¹ O'Malley, Pat. 1996. "Risk and Responsibility" in Andrew Barry, Thomas Osborne, and Nikolas Rose, Eds. *Foucault and Political Reason*. Chicago: University of Chicago Press, pages 189-207.

⁴⁵² Bouffard and Grégoire. 1998. page 21. "Moi, j'ai arrêté de manger à la fin de ma grossesse car j'ai eu trop peur que mon bébé soit trop gros et dépasse le poids autorisé pour naître à la maison de naissance."

⁴⁵³ Bouffard and Grégoire. 1998. page 21. "Mon principal stress était de ne pas cadrer dans les règles."

⁴⁵⁴ Gordon, Colin. 1991. "Governmental rationality: an introduction" in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault Effect*. Chicago: University of Chicago Press, 1-51, page 45.

state, for activists and advocates of the practice had lobbied for nearly two decades to achieve the legal recognition of the practice.

This process was by no means smooth, for it also entailed significant internal debate about the qualifications of a midwife, whether or not to legalize midwifery, how best to integrate diverse practices into a profession, and where and how midwives should practice. All these are crucial questions of midwives' identity and the spatiality of their practice. The emergence of midwifery in Québec was also characterized by a period of experimentation and evaluation, constituting midwifery as an appropriate response to crises in the rational government of reproduction. Most significantly, midwifery's emergence in Québec was marked by activists' appeal to the state for recognition as well as the active solicitation by provincial health care authorities of citizens' input, revealing the ways states enlist the participation of citizens in the development of new forms of self-government. In this chapter, I examined how midwifery activism and the emergence of midwifery as a professional practice in Québec circumscribe practices of reproductive self-determination. These practices are made manifest in part through the regulation of the uses of the body that emerge within midwifery and alternative childbirth activists' strategies and discourses around birth.⁴⁵⁵

⁴⁵⁵ For an examination of the strategies alternative birth advocates employed in their efforts to legalize midwifery in the United States, see Katherine Beckett and Bruce Hoffman, 2005. "Challenging Medicine: Law, Resistance and the Cultural Politics of Childbirth." *Law and Society Review* 39 (1): 125-170.

CHAPTER FIVE

Global Midwifery and Technologies of Emotion

The world has become a global village. With this freedom to share information comes the ability to travel and relocate. When midwives move from one country to another, they should, with equivalent education and credentials, be able to practice their profession wherever they live.⁴⁵⁶

Global culture...is an aspiration, a fantasy, a desire as well as a marketplace and systems of flows and exchanges. Global subjects are constituted through the promise of a transcendent mobility, allowing them to move freely across time and space, joining the transnational flows of other objects (images, information, products).⁴⁵⁷

Midwifery activism in North America envisions scales of political action in addition to the state and the province. Midwives are actively engaged in cultivating new forms of sociality, in part through appeals to the “global” nature of midwifery. In this chapter, I examine the invocations of global midwifery emerging out of activist networks in North America. In North America and Europe, the privatization and rationalization of public services has engendered new links between political activists. These connections have arguably become globalized as activists relate local struggles and national shifts in health care policy to macro-scale economic transformations. Free trade agreements, the movement of skilled labor across national boundaries, and the increasing emphasis within social welfare systems in North America and Europe on cost and labor efficiency have

⁴⁵⁶ Verber, Christine Hindle. 1995. “International Credentialing of Midwives” [Electronic version]. *Midwifery Today* 2, <http://www.midwiferytoday.com/articles/intercred.asp>, accessed March 13, 2006.

⁴⁵⁷ Stacey, Jackie. 2000. “The Global Within: Consuming Nature, Embodying Health.” In Sara Franklin, Celia Lury & Jackie Stacey, eds. *Global Nature, Global Culture*. London: Sage, pages 97-145; 141.

the potential to draw health care activists into conversation with each other. Attention to the transnational linkages forming between activists, or what Jamie Peck and Adam Tickell argue is the formation of the “partial globalization of networks of resistance,” is important in part for understanding the broader implications of neoliberal globalization.⁴⁵⁸ By examining the emergence of online organizations such as the International Alliance of Midwives (IAM), we can see how “new forms of translocal political solidarity” work out in practice.⁴⁵⁹

New “global” networks of midwives rely, in large part, on communication technologies like the Internet to facilitate sharing information and comparing political strategies. But these networks are also performed through moments of “intermittent bodily copresence” that bring midwives together in international forums.⁴⁶⁰ In international forums, midwifery’s globality is posited on an embodied experience that seeks to move midwives to think and feel beyond the confines of national professional boundaries toward more global visions of midwifery care. International professional organizations of midwives in Europe have existed since the early 20th century, but new organizations have emerged in the last several decades to form part of a self-styled “global grassroots movement” of midwives and “natural” childbirth advocates.⁴⁶¹ Activists in the United States envision midwifery as a “global” social movement, and

⁴⁵⁸ Peck, Jamie and Adam Tickell, 2002. “Neoliberalizing Space.” *Antipode* 34 (3), 380-404, page 399.

⁴⁵⁹ Peck and Tickell, 2002, page 399.

⁴⁶⁰ Urry, John, 2004. “Connections” *Environment and Planning D: Society and Space*. 22 (2): 27-37.

⁴⁶¹ Goer, Henci. 2004. “Humanizing Birth: A Global Grassroots Movement.” *Birth* 31 (4): 308-314. Goer examined the formation, goals, and political strategies of 24 grassroots birth-activist groups who address “the failure of conventional obstetric management to provide safe, effective humane care; the failure of government and medical professionals to meet the needs of low-income women; or both,” page 311. Goer surveyed groups by email in Australia, Brazil, Canada, Costa Rica (representing the Caribbean and Central

draw political inspiration from midwives elsewhere. While technologies like the Internet have facilitated communication between midwives and opened possibilities for imagining political communities oriented toward new spheres of work and practice, globality also does symbolic work. As the first quote above illustrates, gestures toward the global posit the midwife as a mobile and cosmopolitan figure.

The diversity, however, of midwives' practices and the material circumstances under which they work points to the necessity of paying close attention to the discourses and practices of homogenization and differentiation that inform the political projects of "global" scale-making and knowledge production. While activist midwives in North America draw on a discourse of "global" midwife-sisterhood to legitimate their aims, such a "global" political project is not entirely new; older internationalisms exist. In the following section, I examine one such organization, the International Confederation of Midwives (ICM), in part because the ICM serves as the primary international midwifery organization, and also because new organizations have emerged as self-identified "alternatives" to the ICM.

Early midwifery internationalism

Love of the Mother-country is innate in the hearts of us all, but true understanding of the love of one's own country is accompanied by the deepest respect for the countries of others...By your singleness of purpose and by the eagerness which you have all shown to come together, you evince a deep feeling of unity, and I rejoice to think it is not only a feeling of professional solidarity, which brings you together, but a feeling of unity amongst women, passing beyond and above all frontiers...Looking upon

and South America), France, Hungary, Israel, Mexico, the Netherlands, Poland, South Africa, the United Kingdom, Uruguay, and the United States.

you now, I cannot but be moved by the thought that I am in fact in the presence of those who are the good harvesters of humanity, those who reap the harvest of life, directing it from the first moment towards health and happiness.

--- former French Minister of Employment and Hygiene
Justin Godard to the 8th International Midwives' Congress,
1939.⁴⁶²

The ICM currently functions as an umbrella organization for 85 national midwives' associations in 75 countries, advocating for midwifery in its work with international organizations and national governments to promote maternal, child, and family health. Headquartered at The Hague, the ICM is the sole official midwifery organization working with the United Nations and the World Health Organization to promote midwifery worldwide. A midwife and an obstetrician established the IMU at a Flemish scientific congress in 1919. The organization promoted the development of an internationalist agenda for professional midwifery, and like many of the health and welfare organizations formed in Europe during the inter-war years, organized professional and scientific institutions on an international, rather than national, scale.⁴⁶³ Initially established as the International Midwives' Union (IMU), the organization represented associations of midwives in eighteen European nation-states, as well as representatives from Europe's colonies in India and North Africa.

The IMU held international congresses until the beginning of World War II. Its initial efforts were focused on promoting midwifery among European states and examining the conditions of midwives' work. In a 1997 essay on "European Midwifery in

⁴⁶² An account of Godard's speech was published in the *Mitteilungen des Internationalen Hebammenverbandes/ Communications of the International Midwives' Union/ Annales de l'Association Internationale D'Accoucheuses*, 1939. Gent-VIII (10): pages 52-53.

the Inter-War Years,” Anne Thompson relates the early history of the International Midwives’ Union.⁴⁶⁴ She notes that around 800 people participated in the Berlin congress of 1936, boosted in no small part by Germany’s pro-natalist policies and the fact that the Nazi Minister of Health’s mother was a midwife.⁴⁶⁵ Germany’s pro-natalist policies were echoed by other European states’ efforts to encourage the most “fit” women to bear children.

European midwives, Thompson argues, closely aligned themselves with state efforts to increase birth rates as a matter of professional survival. In a summary of a speech delivered at the 1936 Berlin Congress by the German Minister of the Interior, the IMU journal notes,

Problems of population and depopulation were vital questions for all the civilised world and must sooner or later be solved by governments or by the people themselves. The collaboration of the midwife in her connection with the family was of capital importance in the matter. The German government is convinced that the life of a country, its intellectual and cultural value, depends on a satisfactory birth-rate.⁴⁶⁶

Midwives and others working in maternal and child health “put their objections to birth limitation in a moral framework, and strongly resisted neo-Malthusianism” as an attempt to limit population growth.⁴⁶⁷ Neo-Malthusianism was viewed as a threat to midwives’

⁴⁶³ Weindling, Paul. 1995. *International health organisations and movements, 1918-1939*. Cambridge: Cambridge University Press.

⁴⁶⁴ Thompson, Anne. 1997. “Establishing the Scope of Practice: organizing European midwifery in the inter-war years 1919-1938.” In Hilary Marland and Anne Marie Rafferty, eds., *Midwives, society and childbirth: debates and controversies in the modern period*. London: Routledge, pages 14-37.

⁴⁶⁵ Thompson, 1997.

⁴⁶⁶ The early journals of the IMU were first published in four languages: French, German, English and Dutch. Translation into Dutch was dropped by 1934. See *Communications of the International Midwives’ Union/Mitteilungen der Internationalen Vereinigung der Hebammenverbaende/Annales de L’Association Internationale D’Unions Accoucheuses*, 1937. Ghent-XII (9), page 29.

⁴⁶⁷ Neo-Malthusianism held that population growth would outstrip the abilities of the environment to support human life, with the implication that population growth should be limited.

livelihood as well as to the strength and productive wealth of a nation.⁴⁶⁸ Working at the nexus of the “birth-nation link,” midwives’ were implicated in the new forms of biopolitical power expressed through pro-natalist and eugenic concerns that took the health and well-being of the populace as their targets.⁴⁶⁹ These concerns were not simply expressed within the boundaries of the nation-state, but informed states’ (and midwives’) internationalist agendas.

Thompson argues that midwives capitalized on state concerns over maternal and child welfare to further their professional aims; “midwifery’s political strength lay in its potential as an agent for the pro-natalist movement.”⁴⁷⁰ Midwives’ pro-natalist stance was also an attempt to distance midwifery from its historical association with abortion. The increasing prevalence with which IMU conferences addressed the question of midwives’ “social” work outside the purview of childbirth and the period immediately following birth indicates midwives’ imbrication with emerging state policies that sought to regulate the social reproduction of a modern citizenry.⁴⁷¹

Another common concern among midwives of the IMU was the growth of hospitals and the increasing acceptance and ability of both middle- and working-class

⁴⁶⁸ Thompson, 1997, page 17.

⁴⁶⁹ Agamben, Giorgio. 1998. *Homo Sacer: Sovereign Power and Bare Life*. Stanford: Stanford University Press, page 131. Giorgio Agamben examines the loosening of the birth-nation link in the aftermath of the First World War. Ultimately the link between birth and nation, founded by the inauguration of national citizenship as a function of one’s birth within a territory, of “bare natural life – which is to say, the pure fact of birth – that appears here [in the Declaration of 1789] as the source and bearer of rights,” is irreparably broken by the constitution of refugees as “stateless people,” (1998, page 127). The early efforts of midwives to organize internationally around the connection between birth and nation point to the potential for forms of political alliance that do not rely on the sovereign state model as well as the eventual “globalization” of biopolitical control.

⁴⁷⁰ Thompson, 1997, page 31, citing Françoise Thébaud, 1986. *Quand Nos Grand-Mères Donnaient la Vie: la Maternité en France dans l’Entre-Deux-Guerres*, Lyons: Presses Universitaires de Lyon.

⁴⁷¹ Donzelot, Jacques. 1979. *The Policing of Families*. New York: Random House.

women to use them. Hospitals were perceived as an additional pressure on midwives' work; midwives viewed the home as a preferable site for birth on moral as well as health grounds. Midwives, Thompson notes, aligned their work more closely with the maintenance of institutions such as the family and the community rather than the hospital. The impact of economic depression and the growth of insurance schemes offering working-class women access to hospitals were recognized as serious threats to the viability of midwifery as a profession if it was not officially recognized by the state.⁴⁷²

The concerns of the organization also mirrored the pro-natalist and racialized nationalist sentiments circulating in Europe at the time.⁴⁷³ The IMU's congress agendas point to the world-political scope of pro-natalist and neo-Malthusian policies beyond the boundaries of European nation-states. Studies of colonial midwifery explore how early professional midwifery's interest in promoting pro-natalism and racial nationalism were articulated, sometimes contradictorily, in the attempts to create professional midwifery in Europe's colonies and elsewhere.⁴⁷⁴ Population policies in Europe were often intimately tied to fears of racial degeneration and colonial tensions over the reproduction of racialized bodies in both Europe and the colonies.

During World War II, the organization was inactive, but was re-established as the

⁴⁷² Thompson, 1997, page 26.

⁴⁷³ See Maria Sophia Quine, 1996. *Population politics in twentieth-century Europe: fascist dictatorships and liberal democracies*. London & New York: Routledge.

⁴⁷⁴ For engagements with the colonial practice of midwifery, see Lynn M. Thomas, 2003. *Politics of the Womb*. Berkeley: University of California Press; Harriet Deacon, 1998. "Midwives and Medical Men in the Cape Colony Before 1860," *The Journal of African History* 39 (2): 271-292; and Carol Summers, 1991. "Intimate Colonialism: The Imperial Production of Reproduction in Uganda," 1907-1925, *Signs* 16 (4), 787-807.

International Confederation of Midwives in 1954.⁴⁷⁵ Headquartered at the Royal College of Midwives in London, the organization was involved in facilitating exchanges in which midwives could apply first through their national organizations to work elsewhere. By the 1960s, the ICM was working with the International Federation of Gynecology and Obstetrics (FIGO), primarily on projects related to family planning, breastfeeding and maternal and infant health in the developing world. In documents outlining the organization's work on development projects, it is clear that the "midwife," although never explicitly defined, is a formally trained professional. Indeed, part of the work of the ICM and FIGO during the 1970s was to train "traditional birth attendants" or "TBAs" in developing countries. Training TBAs was seen as a temporary fix to rural and poor women's lack of access to "trained" personnel.⁴⁷⁶

A report from a 1979 FIGO workshop with the ICM states that the knowledge of TBAs in their local communities "greatly enhance their value and use" for getting information to women about "family planning, breast feeding, and oral treatment of gastro-enteritis. TBAs also have an important function as a link between the professional services and the community, passing on to the latter information on health care and on the various services that are available." The report's authors also note that while "many TBAs are intelligent, many are also illiterate." Their training should be "for short periods, preferably on the spot, and task-oriented. Technologies should be simple, appropriate, and inexpensive. Traditional practices that are not harmful should be accepted." Although

⁴⁷⁵ "Seventy five years of international collaboration: a birthday for midwives. "1994. *Women's International Network [WIN] News* 20, page 19.

⁴⁷⁶ FIGO workshop report on *Innovative Approaches to Maternal and Perinatal Care as part of Primary Health Care* from Tokyo, 22-24 October 1979, pages 5-6.

TBAs are seen as essential, “in the longer term we must seek to replace them with more fully trained medical workers, whether midwives or nurses.”⁴⁷⁷

These programs have been widely criticized, yet the efforts to “modernize” birthing practices in the global South continue to implicate the ICM in development projects. As Joy Phumaphi, the Assistant Director-General of Family and Community Health at the WHO stated in her address to the 2005 ICM Congress in Brisbane, “...the global community agrees that we all take responsibility with a shared vision and a common goal ...if we all play our roles, we will all realize self-actualization...No longer should we speak about TBAs vs. skilled attendants. TBAs should be replaced over time with skilled attendants.”⁴⁷⁸ These definitions are important, for as naming practices they later play a role in the emergence of “alternative” organizations that seek to redefine midwifery in more inclusive terms.

In 1985, the ICM made no distinction regarding *who* was considered a midwife; the definition by default referred to midwives who were trained and regulated by their governments. This absence of definition was the source of controversy, however, as self-taught or apprentice-trained midwives in North America began to advocate for regulation of what was previously an unregulated and clandestine practice. In the wake of the ICM’s reluctance and even refusal (in the 1987 case of a midwives’ organization in Québec), to permit the membership of organizations composed primarily of midwives without formal nursing or midwifery training, the ICM constitution was adjusted to

⁴⁷⁷ Figo workshop report, 1979, page 5.

⁴⁷⁸ Phumaphi, Joyce. Speech to the International Congress of Midwives, Brisbane Australia, July 25, 2005.

account for the practices of “community” midwives.⁴⁷⁹ The ICM constitution currently states that any association of midwives interested in joining the confederation “shall consist primarily of midwives recognised by their government as being competent to practice midwifery.”⁴⁸⁰ In the event that midwifery is *not* recognized by national, state or provincial governments, the ICM “Guidelines for Application for Membership” requires that member associations describe “how midwives are recognized by employers / communities as midwives.”⁴⁸¹

In part because of the political struggles over the once restrictive criteria for membership in the ICM, the organization serves as the counterpoint to my examination of an online organization, the International Alliance of Midwives (IAM). In the case of the IAM, I examine the set of political possibilities that emerge from framing the organization in deliberately non-institutional terms. While the International Confederation of Midwives (ICM) requires midwifery associations to apply for membership in the organization (through a national midwifery association or formal work/community recognition), the International Alliance of Midwives (IAM) is open to individual midwives and “all those with a midwife heart” regardless of membership in any formal organization.⁴⁸² This definition exemplifies what I argue is one of the compelling ways in which midwives in North America envision global connection with other midwives. Not only are individual midwives as well as their supporters encouraged

⁴⁷⁹ Meeting notes from the “Conseil de la Confederation Internationale des Sage-Femmes,” August 18-20, 1987, The Hague, page 2.

⁴⁸⁰ International Confederation of Midwives [ICM]. 2006. “Guidelines for Application of Membership.” [Brochure]. The Hague: Author.

⁴⁸¹ ICM, 2006.

⁴⁸² Tritten, Jan. 1999. “Editorial: Global Alliance of Midwives” [Electronic version]. *Midwifery Today* 46.

to join, but membership is also represented as an emotional commitment to the work of midwifery.

In this chapter, I examine the political possibilities of midwifery's emotional attachments to "feeling global."⁴⁸³ This chapter approaches "globality" as a response to the problem of thinking about geographical and historical specificity in the context of appeals to "global midwifery."⁴⁸⁴ By appealing to the global nature of midwifery, activists are able to position specific practices as universal, a move that occludes how contemporary midwifery emerges specific geographies and histories of professionalization, commodification, development initiatives, the legacies of colonialism, and economic transformation. As highlighted in the previous chapter, studies of midwifery have only recently begun to move beyond analyses of gendered labor and professional power to explain contemporary midwifery politics.⁴⁸⁵

In addition, histories of midwifery rarely challenge the primacy of nation-state boundaries. As my discussion of the ICM makes clear, however, midwives have been engaged in constituting formal supra-national alliances since the early part of the 20th

<http://www.midwiferytoday.com/articles/globalalliance.asp>, accessed February 10, 2005, para. 5.

⁴⁸³ Robbins, Bruce. 1999. *Feeling Global: Internationalism in Distress*. New York and London: New York University Press.

⁴⁸⁴ See Chauncey Colwell, 1997. "Deleuze and Foucault: Series, Event, Genealogy" *Theory and Event* 1(2): 28 pars. [Electronic version]. Colwell's clear reading of genealogy in the works of Foucault and Deleuze through the concepts of series and event points out that "genealogy functions by decomposing the particular series along which events have been organized in order to create a different series for those events," para. 2. In this way, genealogies are not attempts to rewrite histories or unearth hidden truths but rather to put events into new series, that is, to "make the problem problematic, to make it a real problem once again, a problem we no longer know the answer to but for which we are compelled to find solutions," para. 26. I attempt to problematize midwives' emotional appeal to a new form of global sociality.

⁴⁸⁵ See Raymond DeVries, Cecilia Benoit, Edwin R. Van Teijlingen and Sirpa Werde, eds. 2001. *Birth by Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*. New York and London: Routledge; Ivy L. Bourgeault, Cecilia Benoit and Robbie Davis-Floyd, eds. 2004. *Reconceiving Midwifery*. Montréal: McGill-Queen's University Press.

century. These efforts have continued as many midwives from North America travel around the globe, either as practitioners or trainees seeking opportunities to practice in places where birth is less “medicalized,” as part of religious missions or with non-governmental organizations. Others travel as “entrepreneurs” of birth, seeking to establish private clinics or establish networks with midwives in other places. In addition to travel for training or practice, midwifery activists in North America look to other places for political strategies. The comparative method has served midwives in North America well; Brigitte Jordan’s ethnographic study, *Birth in Four Cultures*, is widely cited by activists in the English-speaking context as an important text.⁴⁸⁶

My initial interests in midwifery in France and Québec were motivated by examining how comparative ethnographies, like Jordan’s, are mobilized in practice. Midwives in France cite the development of birthing centers in Québec as the inspiration for the attempt to develop birth centers in France that I discussed in more detail in Chapter One. The links between midwives in both places are complicated. Some midwives practicing today in Québec were originally trained in France; some of the members of a committee selected by the Québec Ministry of Health to assist in the evaluation of proposals for midwifery education in Québec are directors of midwifery schools in France. My initial impetus for comparing midwifery in France and Québec focused on these ties, these entanglements, connections, networks and links that brought midwives as activists together across national political boundaries.

During fieldwork in 2004, the question of how these links are imagined and

⁴⁸⁶ Jordan, Brigitte. 1978. *Birth in Four Cultures*. Montreal: Eden Press.

materialized developed in ways that at first seemed unproductive. When I asked midwives in France, during fieldwork in 2004, whether they had connections or ties to midwives in other places (and specifically Québec), many answered “no.” Their reaction to the notion of comparing practices in France and Québec depended in part on their comfort with out-of-hospital birth (as practiced in Québec) in general and their familiarity with the situation in Québec in particular. Some seemed wary of the new midwifery in Québec or even willing to dismiss differences between the two systems as simply cultural difference. Others thought that ties between midwives were closer between midwives in France and the Netherlands or the UK, given their proximity.

Some, however, were enthusiastic about the possibility of out-of-hospital practice and the potential for using Québec as a model for French out-of-hospital birth centers. For those midwives in France who responded that they envisioned their practices in connection with others, the accent, however, was not on the “formal” political work that transnational linkages could support, but rather on the emotional ties they felt with midwives in other places. I anticipated that midwives would respond with clear rationales for why transnational networks were important (for changing policy, for developing political strategies), but instead received responses that pointed to the affective weight of connection with distant others. In part because health care and legal systems vary across space and have different historical trajectories, one of the primary ways it seemed midwives were able to connect with each other was through appeals to the emotional character of their work, and to the imagined emotional connections with other midwives. As one midwife who works in Paris and who, after ten years of hospital practice, began to

attend home births stated,

[knowing other midwives] gives me a lot of strength and a sense of community...in my practice, I am very alone and it is a rather solitary place to be. I receive emails now and then...it helps me feel a bit more surrounded by others [*entourée*]. One is a midwife in order to find a response to life, and this links midwives to each other...[It is] a practice that reveals one's inner life. It's true that being with women throughout their pregnancies and births...it's hard and it demands a lot of effort. But almost at the unconscious, there is a lot of joy, a lot of emotion... there is an atmosphere of community, of welcoming, of working with life.⁴⁸⁷

Work could be isolating, particularly for midwives who had independent home-birth practices and whose colleagues in hospitals and clinics may not be supportive of their work. Identification with other midwives around the globe may provide a supportive network of fellow practitioners. The ease with which midwives travel and communicate with each other makes possible the representation of midwifery as global and facilitates the formation of global networks. It is the invocation of midwifery's globality as a register of "feeling," however, that persistently animates these connections. It became clear that emotional and affective ties between midwives, even ties that were *imagined* with unseen others, were transmuted quite readily into political imaginations of what might be possible in one's own context, or rather that these two realms were not separate for many practitioners. In this sense, this chapter grapples with the notion of midwifery's "emotional" globality by bringing literature in geography and elsewhere on emotion into conversation with the representations and performances of globality by midwifery activists. New online organizations like the International Alliance of Midwives and the online presence of its founding entity, the magazine *Midwifery Today*, constitute

midwives and their skills as global. They also enact moments of “intermittent bodily copresence” in which midwives meet in person through conferences to share information and experiences. In this chapter, I examine how the representation and the performance of midwifery as “global” enacts hierarchies of cultural exchange that attempt to catalog cultural difference. Cataloging cultural difference becomes a means to “feeling global,” yet these feelings also map a *telos of modernity*, from “tradition” to “technique,” across nations and bodies. Modernity, then, becomes a way to both spatialize and temporalize distant “others.”

As midwives establish connections across national boundaries through organizations like the IAM and the ICM, their political activism mobilizes representations of midwifery’s globalism. But how is this “globalism” itself produced? What makes this invocation of globality possible? Technologies like the Internet, as well as the ease of travel for some midwives, enable some midwifery professionals in North America to become highly mobile. How does this mobility facilitate new forms of activism that rely on invocations of midwifery’s globality? What kinds of geographies and subjects are imagined by invocations of a “global” midwifery movement?

Few studies have investigated the flows of bodies, products, and information implied by the globalization of midwifery politics. A notable exception is the work of Sheryl Nestel, who examines the implications of cross-border movements of midwives’ labor and of birthing women to access midwifery services. Her critical analysis of what she terms “midwifery tourism” demonstrates the salience of analyzing how midwives

⁴⁸⁷ Author’s interview, June 2004.

construct their practices as universal, obscuring the material histories and geographies of their production. Nestel's work on the legalization of midwifery in Ontario, Canada highlights the racialized politics of granting legal rights to midwives in the province in the 1990s in two ways. First, she argues that the Ontario midwifery movement, in its struggles over the professionalization of midwifery, was able to achieve its political goals at the expense of immigrant and aboriginal midwives of color. In doing so, the movement unwittingly reproduced relations of domination and subordination in the process of legalization, as "immigrant midwives of color who possess considerable professional skills, competencies, and credentials...found themselves largely excluded from access to the newly legalized midwifery profession."⁴⁸⁸

Nestel notes that these discriminatory licensing practices have extended to other professions, particularly in health care, where a large number of women of color occupy low-paying positions.⁴⁸⁹ Yet these relations of domination and subordination operating in contemporary Canada are reproduced, Nestel argues, within representations of midwifery as a "traditional" practice that posits an ahistorical and evenly distributed "women's" knowledge and experience. On a national landscape, midwifery's political project disenfranchised midwives of color. In its refusal to acknowledge race and racism within the process of legalization, midwifery in its contemporary form in Ontario was complicit with racist structures of colonial domination and oppression that exist within and outside the modern Canadian nation-state.

⁴⁸⁸ Nestel, Sheryl. 2000. "Delivering subjects: Race, space and the emergence of legalized midwifery in Ontario." *Canadian Journal of Law and Society* 15 (2), 187-215, page 188.

⁴⁸⁹ Nestel, 2000, page 189.

Second, Nestel's work examines the need for laboring bodies within midwifery training and education that engender what she terms "midwifery tourism" operating between Canada and the Mexico/U.S. border. In order to receive the certification of the North American Registry of Midwives (NARM), the examination widely accepted by U.S. and Canadian regulatory agencies, midwifery students must attend a minimum of 40 births. Because midwives in North America have difficulty finding an adequate number of births in a short period of time to fulfill the NARM criteria, they rely on attending the births of Mexican women who cross the border to give birth in the U.S. This practice, Nestel argues, implicates midwifery in cross-border encounters that mirror the influx of transnational capital into the border zones of northern Mexico. Indeed, in the United States and Canada, midwifery schools send their students to international rotations in Jamaica, St. Lucia, the Philippines, Samoa, Tanzania, Vanuatu, and Mexico, where midwives may have easier access to birthing bodies.

Nestel's work refuses the ahistoricization of midwifery in favor of historically detailing its emergence within post-industrial societies, recognizing the possibility for new forms of domination as well as resistance. By pointing to midwifery's benevolent complicity with global capital, Nestel cautions against the uncritical celebration of a feminist political project that utilizes the "resources" of birthing bodies in the South to further the professional development of women in the North. As her work makes clear, the power relations between midwives and birthing women are often neglected in much

of the sociological and anthropological literature on midwifery.⁴⁹⁰ In this sense, examining how midwives constitute their practices as “global” is a crucial task.

Communication technologies have made possible the constitution of “globality” through new activist networks and the exchange of information by activists across national boundaries.⁴⁹¹ Geographers and other scholars have examined the effect of communication technologies on the growth of new information and knowledge economies that change the relationships between the production and consumption of goods and services.⁴⁹² Increasingly, attention is being paid to communication technologies as sites of political and social exchange.⁴⁹³ One of the ways geographers examine communication technologies like the Internet are through the potentially transformative possibilities of new communications technologies on the relationships between health care professionals and patients are.⁴⁹⁴ Recent geographic research on communication technologies emphasizes the mutual incorporation of online and “off-

⁴⁹⁰ Nestel, 2000, see also Tess Coslett, 1994. *Women Writing Childbirth: Modern Discourses of Motherhood*. New York: Manchester University Press.

⁴⁹¹ Keck, Margaret E. and Kathryn Sikkink, 1998. *Activists beyond Borders*. Ithaca: Cornell University Press; Saskia Sassen, 2002. “Towards a Sociology of Information Technology.” *Current Sociology* 50 (3): 365-88. Martha McCaughey and Michael D. Ayers, eds. 2003. *Cyberactivism: online activism in theory and practice*. New York: Routledge.

⁴⁹² Castells, Manuel, 2001. *The Internet Galaxy: Reflections on the Internet, Business and Society*; Robert M. Kitchin, 1998. “Towards geographies of cyberspace.” *Progress in Human Geography* 22 (3): 385-406. For early work in this field, see Castells, Manuel, ed. 1985. *High technology, space, and society*. Beverly Hills: Sage Publications.

⁴⁹³ See Beth E. Kolko, ed. 2003. *Virtual publics: policy and community in an electronic age*. New York: Columbia University Press; Wilma de Jong, Martin Shaw, and Neil Stammers, eds. 2005. *Global activism, global media* London & Ann Arbor, MI: Pluto Press.

⁴⁹⁴ Parr, Hester, 2002. “New body-geographies: the embodied spaces of health and medical information on the Internet.” *Environment and Planning D: Society and Space* 20 (1): 73-95.

line” identities and indeed challenges the assumption of a clearly delineated virtual and “real” world.⁴⁹⁵

The new forms of sociality enabled by communication technologies like the Internet are not solely disembodied, in part because “users” are never fully virtual. Globality is also performed in moments of “intermittent bodily copresence” that challenge the usefulness of stark distinctions between embodied and virtual spaces. In her examination of democratic politics within contemporary “technoculture,” Jodi Dean argues that the Web should not be defined merely as a tool for communication or as a disembodied virtual reality. This would be to deny the embodied nature of interaction with the technology or to instrumentalize the Web as a “medium” for communication, put to use as a predetermined “materialization of particular ideologies, beliefs and aspirations.”⁴⁹⁶ Rather, Dean argues, the Web should be theorized as a “zero institution” where “is an empty signifier that itself has no determinate meaning but that signifies the presence of meaning.”⁴⁹⁷ Dean borrows the concept of “zero institution” from Claude Levi-Strauss via Slavoj Zizek. Levi-Strauss used the term to denote how members of a group were able to conceive of themselves as members of *one* group, even through their conceptions of the group as a whole may be contradictory or even antagonistic to each other. Zizek extends this concept to that of the nation, and asks,

⁴⁹⁵ Valentine, Gill and Sarah L. Holloway, 2002. “Cyberkids? Exploring Children’s Identities and Social Networks in On-line and Off-line Worlds” *Annals of the Association of American Geographers*, 92 (2): 302-319; Sarah L. Holloway and Gill Valentine, 2001. “ ‘It’s only as stupid as you are’: children’s and adults’ negotiation of ICT competence at home and at school.” *Social and Cultural Geography* 2 (1): 25-42.

⁴⁹⁶ Dean, Jodi. 2002. *Publicity’s Secret: how technoculture capitalizes on democracy*. Ithaca: Cornell University Press, page 166.

Is, then, this zero-institution not ideology at its purest, i.e. the direct embodiment of the ideological function of providing a neutral all-encompassing space in which social antagonism is obliterated, in which all members of society can recognize themselves? And is the struggle for hegemony not precisely the struggle for how will this zero-institution be overdetermined, colored by some particular signification? To provide a concrete example: is not the modern notion of nation such a zero-institution that emerged with the dissolution of social links grounded in direct family or traditional symbolic matrixes, i.e. when, with the onslaught of modernization, social institutions were less and less grounded in naturalized tradition and more and more experienced as a matter of “contract.”⁴⁹⁸

Dean argues that the Web “enables myriad conflicting constituencies to understand themselves as part of the same global structure.”⁴⁹⁹ The Internet is a site of contestation and identification; “a global space in which many can recognize themselves as connected to others, as linked to things that matter.”⁵⁰⁰ These links, however, are not evenly distributed across the globe. The significance of the Internet for global midwifery activism for my argument, then, is its ability to be represented as solidarity across difference and distance as that “neutral all-encompassing space” in which visions of the global seem to effortlessly circulate.

In the following section, I demonstrate how midwives employ communication technologies like the Internet to circulate their visions of “global.” I examine an online network, the International Alliance of Midwives (IAM) that illustrates how global midwifery is produced. By invoking the globe as site of emotional attachment,

⁴⁹⁷ Dean, 2002, page 167. See also Slavoj Zizek, 1999. “The Matrix, or the Two Sides of Perversion,” <http://www.lacan.com/zizek-matrix.htm>, accessed March 21, 2006.

⁴⁹⁸ Zizek, 1999.

⁴⁹⁹ Dean, 2002, 167.

⁵⁰⁰ Dean, 2002, 168.

midwifery activists engage in a repetition of “seemingly unbounded global visions of belonging.”⁵⁰¹ As Matthew Sparke makes clear, these “global visions of belonging” encompass “rights to move and belong in societies all over the planet as well as the rights to amass and control belongings globally.”⁵⁰² For midwives, visions of cosmopolitan citizenship are forged not only through the interactions made possible by the Internet, but also through emotional attachments of “belonging” to the vision of globality itself.

The increasing sophistication with which midwives network and forge political alliances poses compelling questions about the relationship between midwifery and technology. Midwives in North America, as I argued in the previous chapter, have emerged as practitioners of a self-styled “low-tech, high-touch” approach to pregnancy and childbirth, often actively resisting the increasing use of new medical technologies during pregnancy and birth. While much of this resistance relies on deeply essentialized notions of women’s reproductive capacities as “natural,” midwifery activists also draw productively from feminist theoretical critiques of women’s relationship to technology to identify and resist the potentially alienating effects of technological mediation on some women’s experiences of pregnancy and birth.

The opposition of “nature” and “technology” which continues to frame much of midwifery activism structures its critique of obstetric practices using the very terms such critiques might seek to undo - a point that much of the early critical work on reproduction

⁵⁰¹ Sparke, Matthew, 2006. “A neoliberal nexus: Economy, security, and the biopolitics of citizenship on the border.” *Political Geography* 25 (2): 151-180, page 156; see also Matthew Sparke, 2005. *In the space of theory: Postfoundational geographies of the nation-state*. Minneapolis: University of Minnesota Press.

⁵⁰² Sparke, 2006, 156.

and technology did not address.⁵⁰³ This opposition, implied in the use of the term “natural birth,” obfuscates any engagement with technology itself; such binaries can obscure more than they reveal. In all aspects of reproduction, reliance on technological innovations to address the uncertainties of fertility, pregnancy, childbirth, and menopause have increased dramatically over the course of the 20th century.⁵⁰⁴ Midwives in North America, particularly home birth midwives, have tended to decry the increasing medicalization of reproduction as deeply disempowering. Yet at the same time, contemporary midwifery in North America has arguably benefited from the development of technologies used to define particular births as “normal” (and therefore within the purview of midwifery care), however unstable such normative designations of risk may ultimately be.

As Sara Wickham, writing in 1998 in the journal *Midwifery Today*, stated,

We must be careful before damning all technology, for there are technologies that have been immensely helpful to midwives. Pagers and cell phones allow us to leave our homes while on call. Even telephones themselves have made a dramatic difference to midwives and birthing women...It is now far easier for us to contact each other, discuss problems and gain support, even when practising in rural areas.

The other technology that has brought midwives together is the Internet. This morning I have talked with midwives in the United States, New Zealand, and Sweden, all from a small city in England and for the price of a local phone call. Nowadays, we hear of developments in other countries almost as fast as they happen. I can send a request for information to a

⁵⁰³ Annandale, Ellen and Judith Clark. 1996. “What is gender? Feminist theory and the sociology of human reproduction.” *Sociology of Health and Illness* 18 (1): 17-44.

⁵⁰⁴ See Jael Silliman, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez, 2004. *Undivided Rights: Women Of Color Organize For Reproductive Justice*. Cambridge, MA: South End Press; Paula A. Treichler, Lisa Cartwright, and Constance Penley, eds. 1998. *The Visible Woman: Imaging Technologies, Gender, and Science*. New York: New York University Press; Faye D. Ginsburg and Rayna Rapp, eds. 1995. *Conceiving the New World Order: The Global Politics of Reproduction*. Berkeley: University of California Press; and Judy Wajcman, 1991. *Feminism Confronts Technology*. Cambridge: Polity Press.

midwife list and hear back from colleagues around the world, each with her own philosophy, experience, and knowledge to add to my own. Midwifery is truly becoming a global community, a development that can only be positive for birthing women.⁵⁰⁵

Wickham underscores how communication technologies have permitted midwives to practice and to communicate with other midwives. For midwives who have private, home birth practices, technologies like the Internet provide a sense of community. Yet technology is more than simply the technologies of travel and communication that make possible new kinds of connection. Although these have profoundly shifted the terrain of midwives' politics, these material transformations only tell a partial story of how transnational activist networks emerge. Technology, in a more Foucauldian sense, names the diverse practices that cohere to produce a logical whole.⁵⁰⁶ Techniques and practices of self-reflection in ancient Greek thought, to take up Foucault's example, cohered to produce through an assemblage of practices the coherent totality of the self that modern philosophy tended to assume as a given. Technology, in this sense, implies "not machines or mechanical applications, but the problem of choosing the most appropriate means for achieving ends or goals."⁵⁰⁷ While technologies of mass travel and mass communication have altered the ways activists organize, the forms of transnational activism taking place among midwives also rely on diverse

⁵⁰⁵ Wickham, Sara. Autumn 1998. "Widening the Circle" *Midwifery Today*, 47: 49.

⁵⁰⁶ Foucault, Michel, 1980. *The History of Sexuality. Volume 1: An Introduction*. Translated by Robert Hurley. New York: Vintage Books; see also Michel Foucault, 2005. *The Hermeneutics of the Subject: Lectures at the Collège de France, 1981-1982*. Translated by Graham Burchell. New York: Palgrave Macmillan.

⁵⁰⁷ Collier, Stephen J. and Aihwa Ong. 2005. "Global Assemblages, Anthropological Problems." In Aihwa Ong and Stephen J. Collier, eds. *Global Assemblages: Technology, Politics and Ethics as Anthropological Problems*. Oxford: Blackwell, pages 3-21, 8.

technologies of representation that constitute the “global” as a site of emotional attachment and subjective identification.

Global Midwifery

In this section, I examine the formation of another midwifery organization engaged in constituting the “global” as a site of attachment and identification. The International Alliance of Midwives (IAM) was established in 1999 as an online forum linked to the popular midwifery magazine, *Midwifery Today*, published in Eugene, Oregon. In this section, I examine the IAM as an instance of efforts in the U.S. to establish an alternative to state-focused internationalism among midwives. One of the most widely read “lay” or “direct-entry” midwifery publications in North America, *Midwifery Today* seeks to “return midwifery care to its rightful position in the family; to make midwifery care the norm throughout the world; and to redefine midwifery as a vital partnership with women.”⁵⁰⁸ The magazine has encouraged activism on the Internet since it went online in 1994 and hosts numerous online discussion threads, aimed at both midwives as well as pregnant women. The website offers ways to financially support midwives under prosecution for practicing without a license as well as discussion forums that provide help for women seeking midwives who will attend home births in states where such services are illegal or difficult to obtain.

The magazine’s extensive website hosts discussion groups and an online store of both products and services, “The Birth Market,” where subscribers in North America may

⁵⁰⁸ *Midwifery Today*, Autumn 2005. “Our Mission” 75, 4.

connect to “Find a Midwife Today.com” or “Find a Doula Today.com.” Visitors can also shop for natural health products, advertise their birth art, or find a HypnoBirthing® professional, for example, whose techniques for natural childbirth education involve self-hypnosis, deep breathing and visualization.⁵⁰⁹ The proliferation of goods and services associated with pregnancy and childbirth in the Birth Market reflects the ambiguous commodification of contemporary reproduction, given that in North America many women’s desires for reproductive autonomy are articulated through the language of consumer choice.⁵¹⁰ This “commodification” of reproduction also extends to the strategies for professionalizing midwifery in the United State. In many states, midwifery is still an unregulated or illegal and clandestine practice. As part of professionalization strategies to gain public and legal support for “direct-entry” midwifery, midwives in North America, and in the United States in particular, actively pursue strategies of marketing, branding, quality control, and standardization in order to promote their practice.⁵¹¹

Lay or direct-entry midwives acquire their midwifery skills through self-directed study, apprenticeships or non-nursing educational programs. They often practice outside hospitals, in birth centers or in women’s homes. The professionalization of direct-entry

⁵⁰⁹ HypnoBirthing®, February 21, 2005. *Natural Childbirth - HypnoBirthing®*. <http://www.hypnobirthing.com/>, accessed September 15, 2005.

⁵¹⁰ Clarke, Alison J. 2004. “Maternity and Materiality.” In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 55-71; Pamela Klassen, 2004. “Mothers between God and Mammon: Feminist Interpretations of Childbirth.” In Janelle Taylor, Linda Layne and Danielle Wozniak (eds.), *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 249-268.

⁵¹¹ Davis-Floyd, Robbie. 2004. “Consuming Childbirth: The Qualified Commodification of Midwifery Care.” In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 211-248.

midwifery has been the subject of intense debate among practicing midwives, who, like the professional counselors examined by Liz Bondi in the UK, also cite their relationships to their clients as voluntary and non-hierarchical. The professionalization of practices of “alternative” medicine and therapy reveals the extent to which professionalization itself relies on technologies of self-regulation and control, actively pursued by practitioners and not simply externally imposed.⁵¹²

The IAM, however, places no restrictions on its membership, and does not require that members possess professional midwifery credentials or affiliate with a professional midwifery organization. I have followed the development of the online network since 2001, and I draw from online texts describing the formation of the Alliance available on the organization’s website to highlight how midwives affiliated with the Alliance conceive of their practice in “global” terms.⁵¹³ In a 1999 editorial inaugurating the new “online community,” editor Jan Tritten writes that the new “Global Alliance of Midwives” (later to become the International Alliance of Midwives or IAM) will be an alternative network to the largest international organization then in existence, the International Confederation of Midwives. The International Confederation of Midwives (ICM), she writes, “represents the Western model well, having grown out of the British tradition of midwifery.”⁵¹⁴ Tritten writes that the International Alliance of Midwives will be an alternative to the ICM,

⁵¹² See Liz Bondi. 2004. “‘A double-edged sword’? The professionalization of counselling in the United Kingdom.” *Health and Place* 10 (4): 319-328 and Marcus A. Doel and Jeremy Segrott, 2004.

“Materializing complementary and alternative medicine: aromatherapy, chiropractic, and Chinese herbal medicine in the UK.” *Geoforum* 25 (6): 727-738.

⁵¹³ <http://www.midwiferytoday.com/international/>, accessed February 10, 2005.

⁵¹⁴ Tritten, 1999, para. 1; see also *International Midwifery is Alive!* (n.d.) Retrieved March 20, 2005 from

The needs of midwives globally are too great and too varied, however, to be represented by just one organization. Midwives need to regularly share their insights, inspiration and work. The encouragement we receive from each other is germane to spreading the midwifery model. As well, ICM's requirement that only organizations can become members does not acknowledge and support individual midwives. Many countries cannot belong because their midwifery does not fit the restrictive ICM Western definition of a midwife.⁵¹⁵

The establishment of the IAM sought to link direct-entry midwives in North America, many of whom were struggling to achieve legal recognition for their practices in the U.S., with informally trained birth attendants and midwives in developing countries who were often the target of WHO and development initiatives, and who may have been excluded from membership in existing national associations of (formally-trained) midwives, and thus from the ICM.

These initiatives were supported by the ICM to provide “skilled” birth attendants for women in the global South, yet were later criticized for their lack of sensitivity to the particular local cultural contexts of pregnancy and childbirth practices. Tritten continues,

Our definition of a midwife must include the traditional midwives who are so insensitively and derogatorily called TBAs [traditional birth attendants]. We must honor and learn from all our colleagues. Think how fertile an organization could be if it is inclusive. Our information exchanges could only get richer as we present good midwifery research side by side with the thousand-year-old traditions many of the world's midwives still use.⁵¹⁶

Thus, the IAM aims to create a network for midwives trained informally or through apprenticeships that were long excluded from the professional midwifery organizations affiliated with the ICM in both the global North and the global South. The global online

<http://www.midwiferytoday.com/international/>

⁵¹⁵ Tritten, 1999, para.2

community envisaged is cosmopolitan, entrepreneurial, and borderless. The informal organization of the IAM, however, still partially mirrors the nation-based structure of the ICM: midwives are encouraged to represent their respective countries, and although they are not required to hold any institutional affiliation, they are identified with their nations of residence.

The sites and networks of midwifery activism have shifted to include “global” networks of midwives and activists. Established between individuals, however, these connections are facilitated in part by technological developments in communication and travel. These connections are not simply free-floating networks, but have an emotional and material geography as well. This geography, I argue, congeals identities along lines of modernity and tradition: of “good midwifery research” (where “good” research meets rigorous and objective scientific criteria) and the ahistorical “thousand-year-old traditions” of the world’s midwives. This geography of modernity and tradition implies a command of technologies unevenly distributed between midwives in the North and South that is further effaced by the appeal to midwifery’s *globalism*.

These geographies cross local and nation-state boundaries and employ new strategies and tactics to pressure policy changes formulated through online discussion lists, websites, and chat rooms. These new political geographies of reproduction raise the possibility of new linkages or solidarities between activists. Yet they also enact the performance of what Jackie Stacey refers to as a global “panfemininity” in which specific

⁵¹⁶ Tritten, 1999, para. 5.

material differences between women/midwives are effaced.⁵¹⁷ Unlike older forms of international connection that rely on institutionalized forms of community (professional associations bound by the territory of the nation-state) these new forms of activism rely on conceptions of the universality of midwifery, and more importantly, on understandings of bodies that are global. The danger is that by defining commonality through a universal midwifery and a singular “global” body, criteria particular to a specific set of practices and bodies become the criteria for inclusion or exclusion in commonality. Embodied experience, while unique, is seen to be universal, yet the body is no more a stable signifier of commonality than that of “woman” itself.

The presumed naturalness of women’s maternity provides the foundation for a shared intimacy between women, an intimacy that is employed to promote the unity of the global. As Jackie Stacey’s notes, global “panfemininity” links self-identity and consumption through the decontextualization and recontextualization of nature itself. Through analyzing natural skin care products and self-health literature, Stacey argues that “nature is one of the key ways the global gets inside us.”⁵¹⁸ Through consuming “natural” products or envisioning more “natural” states of being, nature is at once “denaturalized and renaturalized” for consumption; nature’s mutability is made possible by its commodification.⁵¹⁹ Most importantly, Stacey argues, it is through the body that these conversions and transformations (de-naturalizing nature, re-naturalizing nature) take place. Stacey writes:

⁵¹⁷ Stacey, 2000, page 105.

⁵¹⁸ Stacey, 2000, page 113.

⁵¹⁹ Stacey, 2000, page 140.

Globalising cultures effect their appeal to the universal not only through the breadth of their reach, but also through the depth of their permeation. Within the process of globalising cultures, our bodies are now both inextricable from our global environment, and are themselves microcosmic environments indicative of our general physical, emotional, and spiritual well-being. Systematised, yet flexible, boundaried, yet open, confected, yet natural, our bodies connect us to ourselves, to each other and to the global order.⁵²⁰

While communicative and mechanical technologies facilitate global exchanges, Stacey's work makes clear that "globality" is also experienced in the body as a "feeling." The global is deeply felt within us when we incorporate otherness into our bodies. Globality, in this sense, is as much a "feeling" as it is a mode of consumption or cosmopolitan intellectual engagement. For global midwifery activists, this "feeling" is intimately linked to the care one gives to pregnant and birthing women, whose bodily experiences of pregnancy and labor are at once deeply personal and "naturalized" as universal. The birthing body is represented as a universal "body-in-common." Yet this body-in-common, understood as a natural birthing body, relies on an ahistorical and unproblematic notion of nature against which medicine and medical technology imposes its negative and negating will.

By linking the twinned nature/body against technology, *nature*, and by equivalence, *the body*, become uncomplicated and wrenched from their material context. As Helena Michie and Naomi Cahn note in their discussion of natural childbirth rhetoric in North America, this formulation "obscures the cultural work that the term 'nature'

⁵²⁰ Stacey, 2000, page 142.

itself does in the discourse on natural childbirth.”⁵²¹ The ahistorical body thus grounds the reference to midwifery’s globalism. While cultural practices may differ, the body remains the same. This grounding of the discourse of natural childbirth rhetoric in an ahistorical, yet “global,” body enacts several erasures: one is the body’s singularity, its particularity. In this forum, the body is universalized: the commonality between midwives and indeed between women worldwide is their experience of childbirth. The second erasure is the material differences between birthing women and between midwives.

Sara Franklin, Celia Lurey and Jackie Stacey argue in their work, *Global Nature/Global Culture*, that the global is at once a process, an imaginary, and a representation.⁵²² Globality is as much a performative effect of practices as it is an ideal toward which such practices aspire. The constitutive moments of globality reconfigure nature and culture across domains as varied as consumption, biology, technology, and health. Being “global” implies openness to diversity. Invocations of “world” cultures, as in “world” music or “world” cinema, however, invariably imply the “world” of an exotic other to the western subject. To be global is to be open to another, yet this openness requires the other’s difference. Being “global” thus involves reaffirming one’s self by the consumption, or “taking in” of the other, the stranger.⁵²³ Consumption of difference is thus constitutive of a global self-identity; feeling intimate with another is in part made

⁵²¹ Michie, Helena and Naomi Cahn. 1996. “Unnatural Births: Cesarean Sections in the Discourse of the Natural Childbirth Movement.” In Carolyn Sargent and Caroline Brettell, eds. *Gender and Health: An International Perspective*. Upper Saddle River, N.J.: Prentice Hall, pages 44-56, 59.

⁵²² Franklin, Sara, Celia Lury & Jackie Stacey, eds. 2000. *Global Nature, Global Culture*. London: Sage.

⁵²³ Ahmed, Sara. 2000. *Strange Encounters: Embodied Others in Post-Coloniality*. London and New York: Routledge, cited in Stacey, 2000, page 104.

possible through the twinned processes of commodification and consumption.

The International Alliance of Midwives invokes the shared global wisdom of women and midwives to draw activists together beyond seemingly bounded spheres of political action (the nation, the community). These invocations of midwifery's globality are constitutive of new geographies of reproductive politics, but also demonstrate how "globality" is a productive resource for political work. As such, the global is performative, through the iteration and reiteration across web sites, list serves, in magazines, books, and journals devoted to "international" or "global" midwifery, and in international forum. These invocations are not simply rhetorical, but are performed wherever midwives convene internationally.

Traditions vs. techniques: performing the global

Between 2003 and 2005, I attended four international midwifery conferences, two sponsored by the International Confederation of Midwives and two by the magazine *Midwifery Today*. I attended a regional ICM meeting of midwives from the Americas in April 2004 in Trinidad, and the triennial congress of the ICM in Brisbane, Australia in July 2005, its 27th international congress. The two conferences sponsored by *Midwifery Today* were held in Paris, France in November 2003 and in Philadelphia in March 2004. The conferences ranged in size from approximately fifty participants at the Paris conference to over 1800 participants at the conference in Brisbane.

The first conference I attended was held in Paris, France, in November 2003.

According to the organizers, the conference had far fewer attendees than conferences sponsored by the International Confederation of Midwives (ICM), but nevertheless the conference organizers announced that this conference was truly “global.” Midwives were in attendance from many nations of Western and Eastern Europe (Spain, the UK, Norway, Sweden, Germany, France, Italy, Switzerland, Latvia, Romania, and Poland), as well as Russia, Israel, the US, Canada, Mexico, Haiti, and Japan.

The conference featured well-known figures in the natural childbirth lecture circuit, and was advertised as a place where midwives from around the world could share and learn from each other. The conference was an attempt to create new sites of sociality between women that “draw on but extend local forms in transnational translations.”⁵²⁴ A midwife attending the conference who I interviewed remarked:

When you start your work as a midwife, you focus first on your practice, your local community....but as you grow, you start to connect with others, in your country, and then with midwives in other countries...you start to expand outwards, to other midwives, to the globe.⁵²⁵

The tenor of the conference was informal and sessions often ended in hand-holding, singing, and sharing photos and stories or reenactments of birth that for me recalled Sara Ahmed’s definition of “globality as a performative effect.” In her discussion of online networks of “global nomads,” Ahmed writes that “globality works as a form of attachment” to others who are seen as global, or “worldly humans.” Rather than relinquishing attachments, “one becomes attached to the form of globality itself.”

⁵²⁴ Tsing, Anna, 2000. “The Global Situation.” *Cultural Anthropology* 15, 327-360, 7.

⁵²⁵ Author’s interview, November 2003.

Globality, Ahmed writes, is “what would move one to tears.”⁵²⁶ And indeed, tears were shed as midwives spoke of ecstatic “natural” births, of their attendance at stillbirths, and of the loss of “traditional midwifery” from what they termed “birth cultures” around the world, cultures invariably located in the global South.

The emotional tenor of the conference was remarkable to me. What should one make of such outpourings of emotion? How might these outpourings of emotion be linked to midwifery’s “global” feeling? Recently, geographers have begun to re-assert the significance of emotional attachments to our experiences of space, arguing that emotions, while present in all social interactions, have been neglected by scholarly analysis.⁵²⁷ The recent focus on emotional geographies reiterates the phenomenological notion that “place must be *felt* to make sense.”⁵²⁸ Much of the recent work on emotional geographies focuses on the corporeal and the social aspects of emotion. However, I examine the way emotional attachments produce a “global” geography that situates bodies differently in relation to modernity.⁵²⁹ The dynamic and spatial quality of emotions means that they do not reside deep within places or subjects; rather, “meaningful senses of space emerge

⁵²⁶ Ahmed, 2000, page 20.

⁵²⁷ Davidson, Joyce, Liz Bondi and Mick Smith. 2005. *Emotional Geographies*. Aldershot: Ashgate; Joyce Davidson and Liz Bondi, 2004. “Spatialising affect; affecting space: an introduction” *Gender, Place and Culture* 11 (3): 373-374; Thrift, Nigel. 2004. “Intensities of Feeling: Towards a Spatial Politics of Affect” *Geografiska Annaler* 86B (1): 55-76.

⁵²⁸ Davidson, Joyce and Christine Milligan. 2004. “Embodying Emotion Sensing Space: Introducing Emotional Geographies.” *Social and Cultural Geography* 5 (4): 523-532, page 524.

⁵²⁹ For an examination of emotional geographies focused on the corporeal aspects of emotion, see Marion Collis, “‘Mourning the Loss’ or ‘No Regrets’: Exploring Women’s Emotional Responses to Hysterectomy,” pages 3-21 and Mark Paterson, “Affecting Touch: Towards a ‘Felt’ Phenomenology of Therapeutic Touch,” pages 161-175, both in Joyce Davidson, Liz Bondi, and Mick Smith, eds. 2005. *Emotional Geographies*. Aldershot: Ashgate. Research that focuses on the “social” aspects of emotion includes Rani Kawale, 2004. “Inequalities of the heart: the performance of emotion work by lesbian and bisexual women in London, England.” *Social and Cultural Geography* 5 (4): 565-581; see also Ruth Panelli, Jo Little, and Anna Kraack, 2004. “A Community Issue? Rural Women’s Feelings of Safety and

only via movements *between* people and places.”⁵³⁰ This sense of movement between people and places, I argue, is crucial to how geographies of globality materialize in specific places.

In this way, emotions are not productive of solely psychic or sensory geographies, but work to produce political geographies as well. Much of the work in geography on emotion seems to take emotions as ontologically given. This given-ness of emotions reduces emotions to disembodied objects of study.⁵³¹ In part, the turn toward emotions in the geographical literature is an attempt to infuse social and political relationships with new ethical potential. Yet in other literatures, emotions are understood as productive of difference. In sum, emotions as the focus of study provoke questions about the normative claims that adhere to them.

As work on immaterial and affective labor reminds us, emotions are not ontologically distinct from the bodies around which they circulate, and are also bound up with the production of value. Anthropologist Ann Anagnost’s reading of the links between the production of economic and affective value illustrates the possibility of thinking the production of emotional and economic value in tandem. Anagnost analyzes the transnational circulation of adoptive children from Asia to North America within an economy of what she terms “maternal labor,” signaling the production of value through both economic and emotional investment in the adopted child. Drawing on Gayatri Spivak’s work on the productive discontinuities between theories of the production of

Fear in New Zealand.” *Gender, Place and Culture* 11 (3): 445-467.

⁵³⁰ Davidson and Milligan, 2004, page 524.

⁵³¹ This is what Nigel Thrift identifies as “the problem of decontextualization” in much of the sociological work on emotion in the past, Thrift, 2004, page 60.

value through the circulation of capital, power, and desire, Anagnost analyzes the emotional attachments to the adopted child in order to “evoke the complex interconnections between differently privileged bodies in a global circuit.”⁵³² Her analysis points out the possibilities for examining how emotions work to occlude conditions of production and consumption but without reducing the objects consumed to mere things. Rather, what differentiates Anagnost’s work from analyses of “commodification” is her attention to the “embodied human capital” that circulates as emotional labor as well as through the material bodies of children and their adoptive parents.

The value of Anagnost’s work, I argue, is in its refusal to hold “immaterial” or emotional labor apart from the international circuits of capital that create economic value, without reducing the production of emotional value to the realm of the capital economy. She highlights how the exchange of bodies and capital is facilitated by in part by communication technologies and the ease with which adoptive parents can travel. Following her then, I argue that midwives also constitute themselves as global subjects through the circulation of bodies in space and through emotional attachments to the forms of globality itself.

Ahmed also theorizes this circulation of bodies in space in her analysis of an online network of self-identified “Global Nomads” through what she terms a “global

⁵³² Anagnost, Ann. 2004. “Maternal Labor in a Transnational Circuit.” In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 139-167, 161; see also Gayatri Chakravorty Spivak, 1996. “Scattered Speculations on the Question of Value.” In Donna Landry and Gerald MacLean, eds. *The Spivak Reader*. New York and London: Routledge, pages 109-140; see also Gayatri Chakravorty Spivak, 1999. *A Critique of Postcolonial Reason*. Cambridge, MA and London: Harvard University Press, pages 99-111.

body...produced by the movement of some bodies through the fixing of others, an economy concealed by the discourse of feeling-in-common.”⁵³³ Ahmed’s work extends Freud’s economic logic of psychic life to the social circulation of feeling, where the economic is a “relationship of difference and displacement without positive value.”⁵³⁴ Like the unconscious, emotions are without value in themselves, they “lack positive residence” in a particular body. Rather, emotions acquire value through their circulation, distribution, “coherence” and “adherence” onto bodies. Affect is produced as an *effect* of the circulation of emotions; this circulation of emotions between people marks emotions as deeply social, and not simply psychic.

Ahmed’s contribution to theories of emotional economy is her attention to the ways emotions circulate economically. The emotions that “attach” individuals to particular forms of community are the effect, Ahmed argues, of feelings that circulate between bodies and of bodies that circulate within space. Ahmed makes clear that the privilege of circulation is not granted to all. To be constituted as a “global citizen” requires those who are “too attached to the particular, the ones who do not (or perhaps even cannot) move away from home” to remain fixed in place.⁵³⁵ In the production of the global as a site of cosmopolitan community, the bodies of some circulate while others remain fixed. This circulation of bodies to which emotions are attached produces the effect of a community for the cosmopolitan global subject.

⁵³³ Ahmed, 2005, page 19.

⁵³⁴ Ahmed, Sara, 2004. *The Cultural Politics of Emotion*. New York: Routledge, page 120.

⁵³⁵ Ahmed, Sara. 2001. “Communities that Feel: Intensities, Difference and Attachment.” In Anu Koivunen and Susanna Paasonen, eds. Conference proceedings for *affective encounters: rethinking embodiment in feminist media studies*, Turku, Finland: University of Turku, School of Art, Literature, and Music, Media Studies, <http://www.utu.fi/hum/mediatutkimus/affective/proceedings.pdf>, accessed August 15, 2005, page

Ahmed writes that emotions are one of the ways in which “the bodies of others ‘surface’ in relation to other others [as ‘global’], a surfacing which produces the very effect of communities, that we can describe as ‘felt’ as well as imagined and mediated.”⁵³⁶ In critiquing the assumption that emotions are private and interior, or move from the outside in, Ahmed’s work points to the ways that emotions are *spatial*: emotions circulate between bodies across space. The politicization of pregnancy and childbirth among midwifery activists rests on representations of a “global body” invested with emotion.

At the 2003 IAM conference in Paris, the emotional tenor of the sessions produced an intimacy that was seemingly interior (“felt” as personal) but was also held in common. Yet the global body that each participant at the conference was asked to “feel” and that moved the participants many times, to tears, is also produced through “the movement of some bodies through the fixing of others, an economy concealed by the discourse of feeling-in-common.”⁵³⁷ Invocations of the “global” in midwifery activist discourse rely on openness to the diversity of midwives’ practices, yet this identity as “global” also implies the mobility of some and the fixing of others.

This relationship of movement and fixing is perhaps best illustrated by an example. One of the sessions at the conference was entitled “Tricks of the Trade.” This session was designed to be an open forum for exchanging stories of midwives’ work and the skills they rely on to manage difficult situations. An organizer, a midwife from the

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⁵³⁶ Ahmed, 2000, page 21.

⁵³⁷ Ahmed, 2001, page 19.

United States, solicited volunteers to share their “tricks” with the audience. As the session opened, the organizer turned to the two midwives in attendance from Haiti, asking them to share, in her words, the “traditional” methods they used to resolve problems that might arise before, during and after a birth: a breech baby, a prolonged labor, nervous mothers, problems with breastfeeding and so on.

They responded that they did not know any traditional methods. The rest of the audience seemed awkwardly disappointed, registering a kind of “imagined nostalgia” in Arjun Appadurai’s terms, for “experiences of loss that never took place.”⁵³⁸ And in the course of a two-hour discussion and demonstration of “Tricks of the Trade,” two midwives from Russia were also asked about “traditional” methods, but interestingly, when other midwives (from Denmark, the Netherlands, Spain, Italy) were asked to share their “tricks,” the question was framed differently. Midwives from these places were asked about “techniques that worked.” The choice of language seems instructive. In calling upon Haitian and Russian midwives to share “tradition” while midwives from Western Europe and North America were asked to share “techniques,” the implications for who was situated as the bearer of traditional knowledge and who held modern, scientific knowledge was clear. Who was fixed and who was mobile? In the international forum of a “global midwifery” conference, this mapping of the telos of modernity extends along national lines of difference from First World (Denmark, the Netherlands, Spain, and the United States) to Second World (Russia) to Third World (Haiti).

In part, this mapping elides the colonial histories of midwifery, where European

authorities actively attempted to cultivate a modern midwifery elite among women in the colonies, drawn from and often in opposition to “traditional” midwives.⁵³⁹ The specific geographic and historical circumstances of knowledge transmission through the education and training of professional midwives inform the continuing struggle (in the global South and the global North) over who speaks as a “true” midwife (and not a “TBA”). Effaced in the emotional appeals to global midwifery are the specific histories of midwifery as a deeply contested practice, reworked within a politics of representation for strategic and situated ends. The “mapping” of technique and tradition, I argue, congeals around a “universal” body that occludes the materiality of the practices of midwifery. The mapping of tradition and technique obscures the colonial encounter that produces difference through such histories; instantiations of cultural difference through “technique” and “tradition” reveal the ways global imaginaries express a will to encyclopedic knowledge gathering about the world.⁵⁴⁰

I interviewed one of the two Haitian midwives from the “Tricks of the Trade” session later in the day and asked her about her training. She responded that both she and her colleague were educated as nurses and taught at a school for professional midwives in Port-au-Prince. And it was only in passing that her colleague, who had trained as a nurse

⁵³⁸ Arjun Appadurai. 1996. *Modernity at Large: Cultural Dimensions of Globalization*. Minneapolis: University of Minnesota Press, 77.

⁵³⁹ Bell, Heather. 1998. “Midwifery Training and Female Circumcision in the Inter-War Anglo-Egyptian Sudan,” *The Journal of African History* 39 (2), 293-312; Kate Frieson, 2000. “Sentimental Education: Les Sages Femmes and Colonial Cambodia.” *Journal of Colonialism and Colonial History* 1 (1), http://muse.jhu.edu/journals/journal_of_colonialism_and_colonial_history, accessed March 3, 2005; Jane Turrittin, 2002. “Colonial Midwives and Modernizing Childbirth in French West Africa.” In Jean Allman, Susan Geiger, and Nakanyike Musisi, eds. *Women in African Colonial Histories*. Bloomington and Indianapolis: Indiana University Press, pages 71-91.

in Haiti and as a midwife in Switzerland, told me that the self-taught or “traditional” midwives practicing in rural Haiti refused to share their practices with her. How can this refusal be read? One potential reading is as resistance to the commodification of knowledge that operates within both the professionalized forms of midwifery and in international forums.

Yet the “traditional” midwife’s refusal to share is rarely heard within the arena of international cooperation and exchange that characterizes the grassroots yet global midwifery project and that elicits tradition from specific subjects. Not hearing this refusal effaces an important analysis of the relations between midwives subsumed under calls for global midwifery, an analysis of the conditions of work that many midwives face, of the distinctions between definitions of a “midwife” that are inherently political, and of the production of knowledge about midwifery. In subsequent conferences, these performances were repeated, as midwives spoke of the emotional aspects of their work and of midwifery as a “powerful worldwide sisterhood to which we all belong.”⁵⁴¹ However, what became clear from the mapping of midwives along a trajectory of “tradition” to “technique” is that the vision of midwifery as a “global” practice relies on the notion that some bodies move while other bodies are fixed in place.

Following Anna Tsing’s trajectory for thinking about globalization critically as a “site of contestation,” “global” midwifery politics is a site where visions of the global rely on mapping bodies from fixed tradition to mobile technique. These mappings only

⁵⁴⁰ Edward Said’s work on Orientalism painstakingly demonstrates the epistemological will to power implicit in practices of classification and cataloging, see Edward Said, 1979. *Orientalism*. New York: Vintage Books.

⁵⁴¹ Delivered by Caroline Weaver in her presidential address to the 2005 ICM Conference in Brisbane.

tangentially address the material conditions of global capital, uneven development, and the legacies of earlier colonial globalisms that underwrite the very possibility of thinking globality itself. Tsing cites the marketing of “culture” by social movements as one shift in the process of world-making named “globalization.” Globalization, understood as “projects of imagining and making globality,” also becomes a matter of discursive construction and material interconnection.⁵⁴² She argues that our examinations of “globalization” must be attuned to the singularity of different globalities and the claims made by appeals to the global. Contemporary midwifery produces specific geographies of modernity and tradition that resist framing their practices in reference to the nation-state form but efface the contested nature of globality in the process. Recent histories of North American midwifery demonstrate how the continuing legacies of slavery, colonialism and immigration produce and sustain midwifery as both a “traditional” and a “modern” practice.⁵⁴³ So too must histories of midwifery as global movement be attentive to “the mutual but not similar or equivalent predicaments that globalization produces for women in the United States and in non-U.S. locations.”⁵⁴⁴

The emergence of new “grassroots global” networks of activists has the potential to reconfigure international organizations, whose policies of inclusion and exclusion have been challenged from both within and without. Yet alternatives to institutionalized forms

⁵⁴² Tsing, 2000, page 328.

⁵⁴³ Fraser, Gertrude Jacinta, 1998. *African American midwifery in the South: dialogues of birth, race, and memory* Cambridge, MA: Harvard University Press; Diane C. Vecchio, 2006. *Merchants, midwives, and laboring women: Italian migrants in urban America*. Urbana: University of Illinois Press, 2006.

⁵⁴⁴ Joseph, Miranda, Priti Ramamurthy and Alys Eve Weinbaum. 2005. “Towards a New Feminist Internationalism.” In Elizabeth Lapovsky Kennedy and Agatha Beins, eds., *Women’s Studies for the Future: foundations, interrogations, politics*. New Brunswick, N.J.: Rutgers University Press, pages 207-228, 210.

of international connection also rely on other forms of connection, wherein the “global” is a “specific accomplishment” achieved in part by access to new forms of communication technology. The global is “situated, specific and materially constructed in the practices which make each specificity.”⁵⁴⁵ One key component of these practices are the affective connections between activists in which the “global” is a site of emotional attachment, intimacy, and common feeling. This intimacy is made possible in part by fixing some in the world of tradition while others move freely, both literally and imaginatively, about the globe.

This chapter connects work on the production of the global with the geographies of emotion, a link articulated in part by the development of new communication technologies that shrink the perceived distance between bodies. Attempts to link emotions and affects to new forms of politics are evident in recent work on social movements and globality; Michael Hardt and Antonio Negri see the “social networks, forms of community, biopower” that emotional labor produces as “the potential for a kind of spontaneous and elementary communism.”⁵⁴⁶ One key component of these practices are the affective connections between activists in which the “global” is imagined as the conjuncture of different temporalities across space – temporalities that are sutured by emotional attachment, intimacy, and common feeling. As Tiziana Terranova writes, the network of the Internet “offers the potential for a political experimentation, where the overall dynamics of a capillary communication milieu can be used productively as a kind

⁵⁴⁵ Law, John. 2004. “And if the global were small and incoherent? Method, complexity, and the baroque.” *Environment and Planning D: Society and Space* 22 (2): 13-26, 24.

⁵⁴⁶ Hardt, Michael, and Antonio Negri. 2000. *Empire*. Cambridge, MA & London: Harvard University Press, page 293-294.

of common ground.”⁵⁴⁷ Terranova argues that “this political mode cannot but start with affects – that is with intensities, variations of bodily powers that are expressed as fear and empathy, revulsion and attraction, sadness and joy.”⁵⁴⁸

Midwifery activists draw from both new technologies of communication and invocations of global culture to create the emotional ties of a global community. These emotional ties encourage midwives to “feel” global, not simply through consumption but through imagining a relationship to a global “body-in-common.” The “global body” is not simply represented and mediated by technology, but is *actively felt* through the fixing of some bodies while affording the mobility of others.

Midwives’ emotional attachments are in part mediated by communication technologies, but are also enacted in moments of “bodily copresence” that reiterate midwifery’s globality. In doing so, invocations of midwifery as a “global” project map onto the unequal exchanges of global capitalism, itself structured on colonial relations of domination and oppression. Emotional claims to “global midwifery” tend to position midwives differently in relationship to modernity, in ways that reinstate older internationalisms rather than new, unbounded forms of connection. Representations of midwives of color in North American midwifery activist circles often rely on troubling assumptions of midwives as the bearers of already commodified cultural knowledge even as the impulse behind these invocations is deeply informed by a liberal feminist project of equivalence between midwives and women across the globe. The implications for a more

⁵⁴⁷ Terranova, Tiziana. 2004. *Network Culture: Politics for the Information Age*. London & Ann Arbor, MI: Pluto Press, page 156.

⁵⁴⁸ Terranova, 2004, pages 156-157.

affirmative politics of globality requires recognition of how technology and emotions can both articulate and foreclose geographies of material difference, differences that are made visible when we examine more closely the performance of globality itself.

CONCLUSION

The emotional attachments generated by reference to “global” midwifery in the last chapter point to the possibilities of developing new social networks and new forms of community among midwives. These emotional attachments, however, may also obscure how new forms of sociality produce exclusion and limit the possibilities for thinking and acting otherwise. Throughout my dissertation, the discourses circulating within the practice of midwifery (of the “global,” of “responsibility,” of “autonomy”) have been analyzed in terms of their *productive* capacities for generating new spaces, new practices and new identities.

The politics surrounding the discourses of midwifery in Québec and France, and its “global” incarnation in international forums, have coalesced around the affective and emotional components of midwives’ work, whether in the formation of community with each other, or in the efforts in the daily practice of midwifery to care for women’s pregnancies and births. That midwives have claimed the emotional aspect of pregnancy and birth as a professional specificity is significant, I argue, because of the ways these “life events” have been reinvested with new purpose.

Historians in France note that the fatalism that once surrounded birth is long gone.⁵⁴⁹ The “givenness” of birth is questioned, in part because of the means available to control pregnancies effectively (or to avoid procreation altogether). Passive acceptance with respect to pregnancy and birth is no longer acceptable. In France, the politics and

practices surrounding birth have been framed by activists as rights-based claims to bodily autonomy. Claire Crignon-De Oliveira and Marie Gaille-Nikodimov argue that the terms of debates over the uses of the body in France are often over-caricatured between two poles: that of the “French” communitarian and Statist vision of the body versus the “Anglo-Saxon” liberal and individualist vision. They link the widely conceived notion that these two “poles” are oppositional to the ways in which medicine was understood to construct the body. Historical analyses of the emergence of medicine and particularly anatomical medicine in the early 1700s represent medical knowledge as invasive, dispassionate, and often mechanical, and understanding they argue is inadequate, given the ways even the Cartesian model of the body (often itself caricatured as mind vs. body) ignores the eagerness with which the body was opened up in the 17th century, its inner workings thought to reveal the mysteries of the universe.⁵⁵⁰

Crignon-De Oliveira and Gaille-Nikodimov argue that diverse visions of the body exist in France; they first examine those developed in the work of John Locke and considered characteristically “Anglo-Saxon.” For Locke, property is anything to which human labor has been applied, anything which through transformation by humans can be appropriated for human use. The body is an inalienable sphere and “is the condition of access to liberty as natural law...[and] a sphere of independence in which the State does not intervene”⁵⁵¹ This Lockean notion of the body as property is drawn from Locke’s 2nd *Treatise on Civil Government* (“On Property”) from 1690, and represents for the authors

⁵⁴⁹ Gélis, Jacques, Mireille Laget, and Marie-France Morel, 1978. *Entrer dans la vie: Naissances et enfances dans la France traditionnelle*. Paris: Gallimard

⁵⁵⁰ Crignon-De Oliveira and Gaille-Nikodimov, page 84.

the broad terms within which debates over the body as property in France are still waged.

Crignon-De Oliveira and Gaille-Nikodimov cite the following passage, the *Second*

Treatise, Chapter Five, Section 27:

Though the earth, and all inferior creatures, be common to all men, yet every man has a property in his own person: this no body has any right to but himself. The labour of his body, and the work of his hands, we may say, are properly his. Whatsoever then he removes out of the state that nature hath provided, and left it in, he hath mixed his labour with, and joined to it something that is his own, and thereby makes it his property. It being by him removed from the common state nature hath placed it in, it hath by this labour something annexed to it, that excludes the common right of other men: for this labour being the unquestionable property of the labourer, no man but he can have a right to what that is once joined to, at least where there is enough, and as good, left in common for others.

Locke writes that man is the master of himself, “proprietor of his own person,”

From all which it is evident, that though the things of nature are given in common, yet man, by being master of himself, and proprietor of his own person, and the actions or labour of it, had still in himself the great foundation of property; and that, which made up the great part of what he applied to the support or comfort of his being, when invention and arts had improved the conveniences of life, was perfectly his own, and did not belong in common to others.⁵⁵²

Crignon-De Oliveira and Gaille-Nikodimov argue that a communitarian vision of the body continues to inform the texts of French law relative to the body, informed more by Rousseau’s notion that “one’s life is a conditional gift from the state,” rather than Lockean visions of the body as a form of property.⁵⁵³ More recently, however, Crignon-De Oliveira and Gaille-Nikodimov interpret the codification of patients’ rights and the

⁵⁵¹ Crignon-De Oliveira and Gaille-Nikodimov, page 73.

⁵⁵² Locke, John. 1980. *Second Treatise of Government* (1690). In C.B. McPherson, ed. Indianapolis and Cambridge: Hackett Publishing Company.

inviolable nature of the body in French law to a more Kantian ethics of the body. They attribute the notion of human dignity in French law to Kant's concept of the view the body as inviolable; the "inalienability" of the body was clarified in the July 29, 1994 legislation on the "respect for the human body."⁵⁵⁴ Kant's *Lectures on Ethics* elaborate on the notion that the person is not independent from the body. The primary ethical relationship, then, is one's duty towards one's self, a duty of "self-esteem."⁵⁵⁵

The duties to practice restraint towards oneself, to take care of oneself "are justified by the relationship that exists between liberty, life and the body."⁵⁵⁶ In France this relationship is evident in the laws passed to protect the rights of patients; the "free, express, and informed" consent of the individual is required before submitting one's body to another's actions.⁵⁵⁷ Activists in France have drawn on this new configuration of liberty, the self, and the body to challenge the sovereignty of medicine and to claim that these *rights* also apply to women's bodies in pregnancy and birth. In Canada, as in the U.S., much of the debate over the uses of the body with respect to reproduction has been framed in terms of abortion. In Canada, abortion is also seen as a "body right" but one that is "undergirded" by medical entitlement.⁵⁵⁸ As Julia O'Connor, Ann Orloff and Sheila Shaver note, if rights are defined as a medical entitlement, they cannot be exercised by

⁵⁵³ They cite the example in France of prisoners, who are encouraged to give blood as part of their duty to the nation. See Crignon-De Oliveira and Gaille-Nikodimov, 2004, page 94.

⁵⁵⁴ Loi numéro 94-653 du 29 juillet 1994, relative au respect du corps humain, *Journal Officiel* 175, page 11056.

⁵⁵⁵ Crignon-De Oliveira, Claire and Marie Gaille-Nikodimov. 2004. *À qui appartient le corps humain? Médecine, politique, et droit*. Paris: Les Belles Lettres, page 110.

⁵⁵⁶ Crignon-De Oliveira and Gaille-Nikodimov, page 110.

⁵⁵⁷ Crignon-De Oliveira and Gaille-Nikodimov, page 113.

the woman individually. They are rights “exercised in and through” the medical profession, in which the “terms of the decision are not her own.”⁵⁵⁹

These diverse visions of the body underlie the debates analyzed throughout my dissertation over women’s reproductive self-determination. Chapter One examines women’s claims to reproductive self-determination in the context of efforts to construct birthing centers in France, modeled after those in Québec as well as in other European countries. These efforts failed, in part because of the state’s overwhelming concern with the “physical security” of the infant in the maternal health care system, but they were also the sites of struggles between midwives and women over the autonomy of each with respect to pregnancy and birth. In France, these efforts continue. In Strasbourg, an obstetrician, Israël Nisand, has developed what he terms an *espace naissance* in a public hospital, staffed by midwives but with access to neonatal intensive care in the adjoining Level III service. The *espace naissance* has been promoted as a more “homelike” space in the hospital, the first of its kind in a public hospital in France.⁵⁶⁰

Chapter Two examined the devaluation and the efforts to revalorize midwives’ emotional work in France. Efforts to “rationalize” birth made midwives’ relational work more difficult and led them to characterize their work, as well as women’s experiences of maternal health care, as increasingly fragmented. At the same time, the emerging emphasis on the rights of patients and on women’s experiences of birth has introduced

⁵⁵⁸ O’Connor, Julia S., Ann Shola Orloff and Sheila Shaver. 1999. *States, Markets, Families: Gender, Liberalism and Social Policy in Australia, Canada, Great Britain and the United States*. Cambridge: Cambridge University Press.

⁵⁵⁹ O’Connor et al., 1999, page 173.

the concept of “psychological security” into public health concerns in France, a concept I examined in detail in Chapter Three.

In Québec, women make claims to bodily sovereignty by assuming the shared responsibility with midwives for their pregnancies and births. The incorporation of citizen participation into the health care system in Québec has facilitated this process and birthing centers developed within the system of local community health centers, or CLSCs. Chapter Four examined the notion of “responsibility” in the new midwifery in Québec, experienced, albeit paradoxically, by some women as a *responsibility to be autonomous* with respect to their pregnancies and births. Shifts in the administration of birth have implicated midwives as mediators in women’s relationships to their bodies, and in the case of Québec, conditioned their “re-emergence” into the provincial health care system.

Finally, in Chapter Five, I examined midwives’ affective labor in a different register than that between the midwife and the women, the couple, and the infant. Midwives’ efforts to form more global communities with other midwives have relied in part on communication technologies, but also on technologies of feeling that accomplish the intimacy of social networks through the shared imagination of midwifery as a “global” practice. The tendency to universalize midwives’ experiences, however, may obscure differences between midwives.

⁵⁶⁰ CHU Strasbourg, 2004. “Un tout nouvel espace naissance” <http://web.reseau-chu.org/articleview.do?id=490&mode=2>, accessed May 16, 2005.

In conclusion, I argue that rethinking the state's relationship to the body requires reconsidering how state power does not operate solely as a repression of subjects' desires, but flows productively through the processes of subject formation and through the subjects' desires themselves. In this way, I demonstrated throughout the dissertation how the new forms of administration surrounding contemporary birth in Québec and France make evident the disaggregation of state power onto individuals and the efforts to endow individuals with the responsibilities for managing their own reproduction. In the practices of midwifery in both places, for example, the concept of birth as a "project" and a "plan" has developed, in part, to address the uncertainties of birth but also to prepare the self in advance for new responsibilities.

Comparative work on the specific geographies of these processes in Québec and France can counter the tendency to essentialize or too easily universalize the processes of "neoliberal globalization." Contemporary debates in geography over the "self-defining" subject of neoliberalism must be able to account for the emergence of forms of bodily regulation that emerge from the desiring subject herself, and must be able to examine processes of political economy with finer attention to how processes work out in daily practices. I synthesize concerns over the increasing reliance on market-based rationales within health care systems with the new forms of governance that take individual desires for reproductive self-determination as their object. I explore neoliberalism as a contingent and often contradictory "social process," taking the creation of new gendered identities and discourses surrounding birth into closer consideration.

The central claim of my dissertation is that contemporary struggles over midwifery (its emergence in North America, its renovations in France) represent a new relationship between women and their bodies, in which the midwife is an interlocutor in women's relationship to the state. Midwifery, I argue, is a lens onto broader transformations in the political economy of health care as well as the practices surrounding the uses of the body, in part because of the state's deep concern for the reproductive lives of its citizens. Women in Canada and France have engaged in struggles for reproductive self-determination, manifest in liberal claims to responsibility and rights with respect to pregnancy and birth. In both places, the midwife is a privileged interlocutor of the relationships between the birthing subject, her body, and the state. Comparing the ways in which neo-liberalisms vary across space (and co-exist with liberal forms of self-fashioning as in the citizen-mother bearing rights) can make more intelligible why the practices and sites of childbirth, as well as the identities of "birthing subjects," have become the locus of such powerful political claims.

BIBLIOGRAPHY

- “Creation du collectif ‘femmes-sages-femmes.’” 1976. *Les Dossiers de l’Obstétrique* 23: 29-32.
- “Dangers sur la maternité.” 9 March 2004. *L’Humanité*. Retrieved November 11, 2004 from <http://www.humanite.fr/journal/2004-03-09/2004-03-09-389624>.
- “Document d’information à destination des professionnels de santé” No date. Retrieved November 21, 2004 from http://www.sante.gouv.fr/assurance_maladie/documentation/professionnels/remboisement.htm.
- “L’ire des sages-femmes” Editorial. 27 April 2001. *Le Monde*, page 16.
- “Les augmentations qui leur sont proposées.” 9 April 2001. *Le Monde*, page 9.
- “Maison des naissances de Gatineau.” 18 September 1993. *Le Droit*, page 13.
- “Maisons de naissance: un état des lieux encourageant.” 2001. *Profession Sage-Femme* 79: 7-10.
- “Seventy five years of international collaboration: a birthday for midwives.” 1994. *Women’s International Network [WIN] News* 20, page 19.
- A reform centred on the citizen/Une réforme axée sur le citoyen*. 1990. Québec: Ministère de la Santé et Services Sociaux.
- Abel Sally and Robin. A. Kearns. 1991. “Birth places: A geographical perspective on planned home birth in New Zealand,” *Social Science & Medicine*, 33 (7): 825-834.
- Abu-Lughod, Lila, ed. 1998. *Remaking women: Feminism and modernity in the Middle East*. Princeton: Princeton University Press.
- AFAR. No date.” Pour un accouchement respecté...” [Brochure]. Roumagne: AFAR.
- Agamben, Giorgio. 1998. *Homo sacer: Sovereign power and bare life*. Stanford: Stanford University Press.
- Ahmed, Sara, 2004. *The cultural politics of emotion*. New York: Routledge.
- Ahmed, Sara. 2001. “Communities that feel: Intensities, difference and attachment.” In

- Anu Koivunen and Susanna Paasonen, eds. Conference proceedings for *affective encounters: rethinking embodiment in feminist media studies*, Turku, Finland: University of Turku, School of Art, Literature, and Music, Media Studies. Retrieved August 15, 2005 from <http://www.utu.fi/hum/mediatutkimus/affective/proceedings.pdf>.
- Ahmed, Sara. 2000. *Strange encounters: Embodied others in post-coloniality*. London and New York: Routledge.
- Ahmed, Sara. 1998. *Differences that matter: Feminist theory and postmodernism*. Cambridge: Cambridge University Press.
- Ahmed, Sara, Jane Kilby, Celia Lury, Maureen McNeil, and Beverley Skeggs, eds. 2000. *Transformations: Thinking through feminism*. London: Routledge.
- Ahmed, Sara and Jackie Stacey, eds. 2001. *Thinking through the skin*. London: Routledge.
- Akrich, Madeleine and Bernike Pasveer. 1996. *Comment la naissance vient aux femmes*. Paris: Les Empêcheurs de Penser en Rond.
- Akrich, Madeleine. 2000. "Quelles sages-femmes pour demain?" *XXVIIIèmes assises nationales des sages-femmes: Compte-rendu scientifique*. Paris: Association professionnelle des sages-femmes des facultés de médecine de Paris, pages 61-64.
- Alberta Regulation 328/94, Midwifery Regulation in the Health Disciplines Act. Retrieved January 31, 2006 from http://www.qp.gov.ab.ca/Documents/REGS/1994_328.CFM.
- Albury, Rebecca M. 1999. *The politics of reproduction: Beyond the slogans*. St. Leonards, NSW: Allen & Unwin.
- Alexander, M. Jacqui and Chandra Talpade Mohanty, eds. 1997. *Feminist genealogies, colonial legacies, democratic futures*. New York: Routledge.
- Alexandre, Garcia. 9 April 2001. "De nombreuses grévistes ont dû reprendre le travail sur l'ordre des préfets ou des tribunaux." *Le Monde*, page 9.
- Allman, Jean, Susan Geiger, and Nakanyike Musisi, eds. 2002. *Women in African colonial histories*. Bloomington: Indiana University Press.
- Althusser, Louis. 1971. *Lenin and philosophy*. London: New Left Books.

- Anagnost, Ann. 2004. "Maternal labor in a transnational circuit." In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 139-167.
- Anagnost, Ann. 2004. "The corporeal politics of quality (*suzhi*)" *Public Culture* 16 (2): 189-208.
- Andoin, Luc. 1998. *La sophrologie*. Toulouse: Éditions Milan.
- Andreasen, Alan R. 1995. *Marketing social change: changing behavior to promote health, social development, and the environment*. San Francisco: Jossey-Bass.
- Andreasen, Alan, no date. "Social marketing." Health Canada. Retrieved January 19, 2006 from http://www.hc_sc.gc.ca/ahc-asc/activit/marketsoc/index_e.html.
- Annandale, Ellen and Judith Clark. 1996. "What is gender? Feminist theory and the sociology of human reproduction." *Sociology of Health and Illness*. 18 (1): 17-44.
- Armstrong, Pat and Hugh Armstrong, 2002. *Wasting away: The undermining of Canadian health care*. Oxford: Oxford University Press.
- Armstrong, Pat, Hugh Armstrong, and David Coburn, eds. 2001. *Unhealthy times: Political economy perspectives on health and care in Canada*. Oxford: Oxford University Press.
- Arrêté du 4 janvier 1949, *Délivrances par les pharmaciens de certaines substances vénéneuses aux sages-femmes*.
- Arrêté du 12 juin 1952, *Délivrances par les pharmaciens de certaines substances vénéneuses aux sages-femmes*.
- Arrêté du 3 octobre 1988, *Fixant la liste d'instruments que peuvent employer les sages-femmes*.
- Article 1er A du loi numéro 2002-303 du 4 mars 2002, *Relative aux droits des malades et à la qualité du système de santé*.
- Association "Maison de Naissance de Montpellier." No date. [Brochure]. *Présentation de la maison de naissance de Montpellier*. Montpellier: Association Maison de Naissance de Montpellier.
- Association Médicale Canadienne. 1987. *Obstétrique '87: Un rapport de l'association médicale canadienne sur les soins obstétricaux au Canada*. Ottawa.

- Bakker, Isabella and Stephen Gill, ed. 2003. *Power, production and social reproduction*. New York: Palgrave Macmillan.
- Balsamo, Anne. 1996. *Technologies of the gendered body*. Durham: Duke University Press.
- Bannerji, Himani. 2000. *The dark side of the nation: Essays on multiculturalism, nationalism and gender*. Toronto: Canadian Scholars' Press Inc.
- Barnes, Trevor, and James S. Duncan, eds. 1992. *Writing worlds: Discourse, text, and metaphor in the representation of landscape*. London: Routledge.
- Barry, Andrew, Thomas Osborne, and Nikolas Rose, eds. 1996. *Foucault and political reason*. Chicago: University of Chicago Press.
- Bashford, Alison. 2004. *Imperial hygiene: A critical history of colonialism, nationalism and public health*. Basingstoke: Palgrave MacMillan.
- Baubeau, Dominique, Serge Morais, and Antoine Ruffié. July 1999. "Les maternités de 1975-1996: Un processus de restructuration sur longue période" *Études et Résultats* 21. Paris: Direction de la Recherche, des Études, de l'Évaluation et des Statistiques, Ministère de la l'Emploi et de la Solidarité.
- Beckett, Katherine and Bruce Hoffman, 2005. "Challenging medicine: Law, resistance and the cultural politics of childbirth." *Law and Society Review* 39 (1): 125-170.
- Bel, Bernard. Forthcoming. "Naissance d'une communauté virtuelle." *Communication processes*, 1. London: Sage Publications. Retrieved March 27, 2006 from Fraternet.org/naissance//docs/communautevirt.htm.
- Béland, François. 1999. "Preventive and primary care access systems: CLSCs as neighborhood and social service centers in Québec." in Francis D. Powell and Albert F. Wessen, eds. *Health care systems in transition: An international perspective*. Thousand Oaks and London: Sage, pages 173-198.
- Bell, David and Gill Valentine, eds. 1995. *Mapping desire*. London: Routledge.
- Bell, David, Jon Binnie, Julia Cream, and Gill Valentine. 1994. "All hyped up and no place to go" *Gender, Place, and Culture* 1 (1): 31-47.
- Bell, Heather. 1998. "Midwifery training and female circumcision in the inter-war Anglo-Egyptian Sudan." *The Journal of African History* 39 (2), 293-312.

- Benkimoun, Paul, 4 April 2001. "Après deux semaines de grève, les sages-femmes poursuivent leur mouvement" *Le Monde*, page 38.
- Benoit, Cecilia. 1991. *Midwives in passage: The modernisation of maternity care*. St. John's, Newfoundland: Institute of Social and Economic Research.
- Berg, Allison. 2002. *Mothering the race: women's narratives of reproduction, 1890-1930*. Urbana: University of Illinois Press.
- Berlant, Lauren and Michael Warner. 2002. "Sex in public" *Publics and counterpublics*. New York: Zone Books.
- Berlivet, Luc. 2004. "Une biopolitique de l'éducation pour la santé" in Didier Fassin and Dominique Memmi, eds. *Le gouvernement des corps*. Paris: Éditions de l'École des Hautes Études en Sciences Sociales, pages 37-75.
- Bessonart, Jeannette. 1977. "Comment on falsifie l'information ou 'les dessous et les devants du petit écran.'" *Les Dossiers de L'Obstétrique* 38: 36-42.
- Bhavnani, Kum-Kum, ed. 2001. *Feminism and "race"* Oxford; New York: Oxford University Press.
- Bien-naître. No date [brochure]. *Pour une naissance à visage humain*. Lyon: Bien-naître.
- Blanchard, Sandrine, 14 April 2001. "Le gouvernement refuse de rouvrir des négociations avec les sages-femmes" *Le Monde*, page 8.
- Blanchard, Sandrine. 28 April 2001. "Après cinq semaines de grève, les sages-femmes espèrent toujours parvenir à un accord" *Le Monde*, page 11.
- Boilard, Huguette, Diane Gagnon, and Monique Séguin. 1982. *Rapport de la mission en Californie sur les sages-femmes*. Ministère de l'Éducation: Québec.
- Bommelaer, Claire. 27 April 2001. "Les sages-femmes encore dans la rue" *Le Figaro*.
- Bondi, Liz. 1992. "Gender symbols and urban landscapes." *Progress in Human Geography* 16: 157-170.
- Bondi, Liz. 2004. "'A double-edged sword'? The professionalization of counselling in the United Kingdom." *Health and Place* 10 (4): 319-328.
- Bornarel, Laure. 2004. "Bien-naître." Retrieved February 16, 2005 from http://www.millenaire3.com/Affichage_de_la_ressou.122+M5b72d46c7a9.0.html

- Borst, Charlotte G. 1995. *Catching babies: The professionalization of childbirth, 1870-1920*. Cambridge, MA: Harvard University Press.
- Bouffard, Mireille and Lysane Grégoire, 1998. *Bilan de l'expérience des hommes et des femmes ayant bénéficié des services des sages-femmes dans le cadre des projets-pilotes en maisons de naissance*. Montréal: Groupe MAMAN.
- Bourdieu, Pierre. 6 December 2001. "Intervention." *Journée d'information: Sage-femme? Quelle autonomie professionnelle?* Ministère de l'Emploi et de la Solidarité, Paris.
- Bourdieu, Pierre. 1977. "Cultural reproduction and social reproduction." In Jerome Karabel and A. H. Halsey, ed. *Power and ideology in education*. New York: Oxford University Press.
- Bourgeault, Ivy Lynn, Cecilia Benoit and Robbie Davis-Floyd, eds. 2004. *Reconceiving midwifery*. Montréal: McGill-Queen's University Press.
- Bourgeault, Ivy Lynn. 1999. "Delivering midwifery: The integration of midwifery into the Canadian health care system." *The Canadian Women's Health Network* 3 (2). Retrieved January 21, 2004 from <http://www.cwhn.ca/network-reseau/2-3/midwifery.html>.
- Bower, Lisa C. 1991. "Mother" in law: Conceptions of mother and the maternal in feminism and feminist legal theory. *differences* 3, 20-38.
- Branch, Maureen. 1990. *Midwifery: A new status*. Ottawa: Library of Parliament, Research Branch, Political and Social Affairs Division.
- Brion, Fabienne. 2003. "Art de la gestion des risques et méthodes de sécurité dans les sociétés libérales avancées" *Recherches Sociologiques* 2: 109-121.
- Brodwin, Paul E., ed. 2000. *Biotechnology and culture*. Bloomington, IN: Indiana University Press.
- Bronfen, Elisabeth and Misha Kavka, eds. 2001. *Feminist consequences: Theory for the new century*. New York: Columbia University Press.
- Brown, Michael and Lynn A. Staeheli. 2003. "'Are we there yet?' Feminist political geographies." *Gender, Place and Culture* 10 (3): 247-255.
- Brown, Michael. 2003. "Hospice and the spatial paradoxes of terminal care." *Environment and Planning A* 35 (5): 833-851.

- Brown, Sheila A. and Neil Ritchie. 1992. "Collaborative arrangements in service delivery: The example of two New Brunswick hospitals." In Raisa B. Deber and Gail G. Thompson, eds. *Restructuring Canada's health services system: How do we get there from here?* Toronto: University of Toronto Press, pages 351-360.
- Brown, Wendy. 1995. *States of injury*. Princeton, NJ: Princeton University Press.
- Buchan James. 2002. "Global nursing shortages." *British Medical Journal*, 324:751-752.
- Bunch, Charlotte. 1997. "Not for lesbians only" (1975) in Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Burchell, Graham. 1996. "Liberal government and the techniques of the self" in Andrew Barry, Thomas Osborne, and Nikolas Rose, eds. *Foucault and political reason*. Chicago: University of Chicago Press, 19-36.
- Burtch, Brian. 1994. *Trials of labour: The re-emergence of midwifery*. Montréal and Kingston: McGill-Queen's University Press.
- Butler, Judith. 1990. *Gender trouble*. New York: Routledge.
- Butler, Judith. 1993. *Bodies that matter*. New York: Routledge.
- Butler, Judith. 1994. "Sexual traffic" *differences: A Journal of Feminist Cultural Studies*. 6(2-3): 62-100.
- Butler, Judith. 1997. *Excitable speech: A politics of the performative*. New York: Routledge.
- Cabut, Sandrine and Charlotte Rotman. 7 April 2001. "Les sages-femmes ne veulent pas trop l'être" *Libération*, page 15.
- Cabut, Sandrine. 18 April 2001. "La coordination se réorganise dans la douleur." *Libération*, page 16.
- Caffentzis, C. George. 1999 "On the notion of a crisis of social reproduction: a theoretical review." In Mariarosa Dalla Costa and Giovanna F. Dalla Costa, eds. *Women, development and labor of reproduction*. Trenton, NJ: Africa World Press, pages 153-187.
- Camiscioli, Elisa. 2001. "Producing citizens, reproducing the 'French race': Immigration, demography, and pronatalism in early twentieth-century France." *Gender & History* 13 (3): 593-621.

- Canadian Doula Association, no date. *History of midwifery in Canada*. Retrieved April 23, 2005 from http://www.canadiandoulas.com/history_m.htm.
- Carricaburu, Danièle. 1986. "Les sages-femmes face à l'innovation technique" in Pierre Aiach and Didier Fassin, eds. *Les métiers de la santé: enjeux de pouvoir et quête de légitimité*. Paris: Anthropos /Economica, pages 281-308.
- Carricaburu, Danièle. 2005. "Entre coopération et concurrence: sages-femmes et obstétriciens face à la réforme de la périnatalité." *Contributions aux Xème Journées Internationales de Sociologie du Travail. Atelier 5: Rationalisations productives et relations au/de travail*. Université de Rouen, 24-25 November 2005.
- Castell, Evelyne. 2004. "La maternité, aventure humaine." *Les Dossiers de l'Obstetrique*. 328: 25-27.
- Castells, Manuel, 2001. *The Internet galaxy: Reflections on the Internet, business and society*. Oxford;New York: Oxford University Press.
- Castells, Manuel. 1997. *The power of identity*. Oxford: Blackwell.
- Castells, Manuel, ed. 1985. *High technology, space, and society*. Beverly Hills: Sage Publications.
- Centre International de Recherche et de Développement de l'Haptonomie. No date. "Haptonomie." Retrieved March 26, 2006 from <http://www.haptonomy.net>.
- Chalmers, Beverly and Shi Wu Wen. 2004. "Perinatal care in Canada" *BMC Women's Health* 4 (Supplement 1): S28.
- Chaoulli v. Québec (Attorney General)*. 2005. S.C.C. 35.
- Charles, Catherine A. and Robin F. Badgley. 1999. "Canadian national health insurance: Evolution and unresolved policy issues" in Francis D. Powell and Albert F. Wessen, eds. *Health care systems in transition: An international perspective*. Thousand Oaks and London: Sage, pages 115-150.
- Chen, Kuan-Hsing. 1991. "Post-Marxism: between/beyond critical postmodernism and cultural studies." *Media, Culture, and Society* 13 (1): 35-51.
- Chouinard, Louise. 13 September 1993. "La saga se poursuit dans le dossier des sages-femmes." *Le Droit*, page 15.

- CHU Strasbourg. 2004. "Un tout nouvel espace naissance." Retrieved May 16, 2005 from <http://web.reseau-chu.org/articleview.do?id=490&mode=2>.
- Church, John, Duncan Saunders, Margaret Wanke, Raymond Pong, Carol Spooner and Marlene Dorgan. 2002. "Citizen participation in health decision-making: Past experience and future prospects." *Journal of Public Health Policy* 23 (1): 12-32.
- CIANE. 2002. "Charte du CIANE" [Brochure] Villeneuve: CIANE.
- CIANE, 2002. "Presentation" [Brochure] Villeneuve: CIANE.
- CIANE, 2004. "Plate Forme de Propositions en 40 Points du Collectif Interassociatif Autour de la Naissance" Version III. [Brochure] Villeneuve: CIANE, page 7.
- Clarke, Adele E. 1998. *Disciplining reproduction: Modernity, American life sciences, and "the problems of sex."* Berkeley: University of California Press.
- Clarke, Alison J. 2004. "Maternity and materiality." In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 55-71.
- Clarke, Freda. 1984. *Hospital at home: the alternative to general hospital admission*. London: Macmillan Publishing.
- Clough, Patricia. 2003. "Affect and control: Rethinking the body 'beyond sex and gender.'" *Feminist Theory* 4(3): 359-364.
- Clough, Patricia. 2000. *Autoaffection: Unconscious thought in the Age of Teletechnology*. Minneapolis: University of Minnesota Press.
- Coburn, David. 2001. "Health, health care and neo-liberalism" in Pat Armstrong, Hugh Armstrong, and David Coburn, eds. *Unhealthy times: Political economy perspectives on health and care in Canada*, Oxford and New York: Oxford University Press, pages 45-65.
- Cody, Lisa Forman. 2005. *Birthing the nation: Sex, science and the conception of Eighteenth-Century Britons*. Oxford: Oxford University Press.
- Collège National des Gynécologues et Obstétriciens Français. 20 November 2002. "Prise en charge de la naissance: situation de crise" [Press release].
- Collier, Stephen J. and Aihwa Ong. 2005. "Global Assemblages, Anthropological Problems." In Aihwa Ong and Stephen J. Collier, eds. *Global Assemblages*:

Technology, Politics and Ethics as Anthropological Problems. Oxford: Blackwell, pages 3-21.

- Collins, Patricia Hill. 1990. *Black feminist thought*. New York: Routledge.
- Collis, Marion. 2005. "'Mourning the loss' or 'no regrets': Exploring women's emotional responses to hysterectomy." In Joyce Davidson, Liz Bondi, and Mick Smith, eds. *Emotional geographies*. Aldershot: Ashgate, pages 3-21.
- Colwell, Chauncey. 1997. "Deleuze and Foucault: Series, event, genealogy" *Theory and event* 1 (2): 28 paras. Retrieved December 6, 2005 from http://muse.jhu.edu.journals.theory_and_event/v001/1.2colwell.html.
- Comité National d'Experts sur la Mortalité Maternelle, 2001. *Rapport comité national d'experts sur la mortalité maternelle*. Paris: Direction Générale de la Santé.
- Contandrioploulos, André-Pierre, Claudine Laurier, and Louise-Hélène Trottier. 1986. "Toward an improved work organization in the health services sector: From administrative rationalization to professional rationality," In Robert G. Evans and Greg L. Stoddart, eds. *Medicare at maturity: Achievements, lessons, and challenges*. Calgary: The University of Calgary Press, pages 287-324.
- Cornelson, Jude and Elaine Carty. 2004. "Challenges to midwifery integration: Interprofessional relationships in British Columbia" in Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving midwifery*. Montréal: McGill-Queen's University Press, page 111-130.
- Cosgrove, Denis and Peter Jackson. 1987. "New directions in cultural geography." *Area* 19: 95-101.
- Cosgrove, Denis. 1983. "Towards a radical cultural geography." *Antipode* 15: 1-11.
- Coslett, Tess. 1994. *Women writing childbirth: Modern discourses of motherhood*. New York: Manchester University Press.
- Costa, Jane. 1993. *Identités et professionnalisme*. Mémoire présentée à l'École de Cadres Sages-Femmes, Dijon.
- Costa, Solène. 2003. "Les médecins et les droits du patient" *INC Hebdo*, 1274: 1-6.
- Cour des Comptes. 2006. *Rapport au Président de la République*, Paris: Cour des Comptes.

- Courchesne, Marie-Christine, Diane Gagnon, and Lucie Mignon. 1982. *Rapport de la mission européenne sur les sages-femmes*. Ministère de l'Éducation: Québec.
- Cova, Anne. 2000. *Au service de l'Église, de la patrie et de la famille: Femmes catholiques et maternité sous la III^e République*. Paris: L'Harmattan.
- Cova, Anne. 1997. *Maternité et droits des femmes en France (XIX^e – XX^e siècles)*. Paris: Anthropos.
- Crignon-De Oliveira, Claire and Marie Gaille-Nikodimov. 2004. *À qui appartient le corps humain?: Médecine, politique et droit* Paris: Les Belles Lettres.
- Cruikshank, Barbara. 1999. *The will to empower*. Ithaca: Cornell University Press.
- Dalby, Simon. 1994. "Gender and critical geopolitics: Reading security discourse in the new world disorder" *Environment and Planning D: Society and Space*. 12: 595-612.
- Dalla Costa, Mariarosa and Giovanna F. Dalla Costa, eds. 1999. *Women, development, and labor of reproduction: struggles and movements*. Trenton, NJ: Africa World Press.
- Dalla Costa, Mariarosa and Selma James. 1997. "Women and the subversion of the community" (1972) in Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Davidson, Joyce and Liz Bondi, 2004. "Spatialising affect; affecting space: an introduction." *Gender, Place and Culture* 11 (3): 373-374.
- Davidson, Joyce and Christine Milligan. 2004. "Embodying emotion sensing space: Introducing emotional geographies." *Social and Cultural Geography* 5 (4): 523-532.
- Davidson, Joyce, Liz Bondi and Mick Smith, eds. 2005. *Emotional geographies*. Aldershot: Ashgate.
- Davis-Floyd, Robbie and Carolyn F. Sargent, eds. 1997. *Childbirth and authoritative knowledge*. Berkeley: University of California Press.
- Davis-Floyd, Robbie. 2004. "Consuming childbirth: The qualified commodification of midwifery care." In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 211-248.

- De Beauvoir, Simone. 1993. *The second sex*. New York: Alfred Knopf.
- Deacon, Harriet. 1998. "Midwives and medical men in the Cape Colony before 1860," *The Journal of African History* 39 (2): 271-292.
- Dean, Jodi. 2002. *Publicity's secret: How technoculture capitalizes on democracy*. Ithaca: Cornell University Press.
- Dean, Mitchell. 1999. *Governmentality: Power and rule in modern society*. Thousand Oaks and London: Sage.
- Décret no. 72-162 du 21 février 1972 *Relatif aux normes applicables aux établissements privés d'accouchement*. Ministère de la Santé Publique et de la Sécurité Sociale. Journal Officiel de la République Française. 3 mars 1972, page 2316.
- Décret no. 86-0124 du 23 janvier 1986.
- Décret no. 91-779 du 8 août 1991 *Portant code de déontologie des sages-femmes*, Article 13.
- Décret nos. 98-899 and 98-900, 1998 "Décrets périnatalités" *Journal Officiel de la République Française*, 10 Octobre 1998, page 15343-15344.
- Décret no. 49-0351 of September 30, 1949. "Portant code de déontologie des sages-femmes." *Journal Officiel de la République Française*, 5 Octobre 1949, page 9955.
- Defert, Daniel. 1991. "'Popular life' and insurance technology." In Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault effect* Chicago: University of Chicago Press, 211-234.
- DeKoven, Marianne. 2001. *Feminist locations: global and local, theory and practice*. New Brunswick, NJ: Rutgers University Press.
- Deleuze, Gilles. 1992. "Postscript on the societies of control." *October* 59: 3-7.
- Derrida, Jacques. 1972. *La dissemination*. Paris: Éditions du Seuil.
- Deutsche, Rosalyn. 1991. "Boys town" *Environment and Planning D: Society and Space*. 9 (1): 5-30.
- DeVries, Raymond, Cecilia Benoit, Edwin R. Van Teijlingen and Sirpa Werde, eds. 2001. *Birth by design: pregnancy, maternity care, and midwifery in North America and Europe*. New York and London: Routledge.

- Dick-Read, Grantly. 2004. *Childbirth without fear*, London: Pinter & Martin Ltd.
- Dietz, Mary G. 1985. "Citizenship with a feminist face: The problem of maternal thinking." In Joan Landes, ed. *Feminism, the public and the private*. New York: Oxford University Press.
- Dietz, Mary G. 1987. "Context is all: Feminism and theories of citizenship." In Anne Phillips, ed. *Feminism and politics*. New York: Oxford University Press.
- Doel, Marcus A. and Jeremy Segrott. 2004. "Materializing complementary and alternative medicine: aromatherapy, chiropractic, and Chinese herbal medicine in the UK." *Geoforum* 25 (6): 727-738.
- Domosh, Mona. 1998. "Geography and gender: Home again?" *Progress in Human Geography*. 22 (2): 276-282.
- Donzelot, Jacques. 1979. *The policing of families*. New York: Pantheon Books.
- Donzelot, Jacques. 1991. "Pleasure in work." In Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault effect: Studies in governmentality*. Chicago: University of Chicago Press, pages 251-280.
- Donzelot, Jacques. 1991. "The mobilization of society." In Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault effect: Studies in governmentality*. Chicago: University of Chicago Press, pages 169-179.
- Dorian, Georges and André Guionnet. 2003. *La sécurité sociale*. Paris: Presses Universitaires de France.
- Dreyfus, Michel. 1997. *Une belle santé: La Maternité de l'Hôpital des Métallurgistes Pierre Rouquès*. Paris: Hôpital des Métallurgistes Pierre Rouquès.
- Dufour, Christian, 28 May 2001. "Longue grève des sages-femmes" *Observatoire Européen des Relations Industrielles*. Retrieved March 13, 2006 from <http://www.eiro.eurofound.ie/2001/05/inbrief/fr0105151n.html>.
- Duncan, James and David Ley, eds. 1993. *Place/culture/representation*. London: Routledge.
- Duncan, James. 1980. "The superorganic in American cultural geography." *Annals of the Association of American Geographers* 70: 181-98.

- Dunn, Kate. 15 April 1989. "Midwives: Operating on law's edge." *The Gazette (Montréal)*.
- Eaton, Lynn. 2002. "France outlaws the right to sue for being born." *British Medical Journal* 324 (7330): 129.
- Economic Models Ltd. 1976. *The French health care system*, Chicago: American Medical Association.
- Ehrenreich, Barbara and Arlie Russell Hochschild, eds. 2003. *Global woman: nannies, maids, and sex workers in the new economy*. New York: Metropolitan Books.
- Elden, Stuart. 2001. "The constitution of the normal: Monsters and masturbation at the Collège de France" *boundary 2* 28 (1): 91-105.
- Elias, Norbert. 1998. *On civilization, power and knowledge: Selected writings*. Stephen Mennell and Johan Goudsblom, eds. Chicago: University of Chicago Press.
- Elias, Norbert. 1991. *The society of individuals*. Michael Schröter, ed. Edmund Jephcott, trans. Oxford: Blackwell.
- England, Kim, Joan Eakin, Denise Gastaldo, and Patricia McKeever. Forthcoming. "Neoliberalizing home care: Managed competition and restructuring home care in Ontario." In Kim England and Kevin Ward, eds. *Neo-liberalization: Networks, states, peoples*. Malden, MA and Oxford: Blackwell.
- England, Kim. 2003. "Towards a feminist political geography?" *Political Geography* 22: 611-616.
- Ettinger, Bracha Lichtenberg. 1992. "Matrix and metamorphosis." *differences* 4, 176-209.
- Evin, Claude, Bernard Charles and Jean-Jacques Denis. 2002. "Rapport d'information." *Droits des malades*. Retrieved March 5, 2004 from www.assemblee-nationale.fr/11/dossiers/droits_des_malades.asp.
- Fadiman, Anne. 1998. *The spirit catches you and you fall down: A Hmong child, her American doctors, and the collision of two cultures*. New York: Farrar, Strauss, and Giroux.
- Fagan, Patrick. 1999. "The modern western family: trends and implications from the United States." In Anthony J. Mastroeni, ed. *Is a culture of life still possible in the United States?* South Bend, IN: St. Augustine's Press.

- Fahmy, Khaled. 1998. "Women, medicine, and power in nineteenth-century Egypt." In Lila Abu-Lughod, ed. *Remaking women: Feminism and modernity in the Middle East*. Princeton, NJ: Princeton University Press.
- Fannin, Maria. 2003. "Domesticating birth in the hospital: 'Family-centered' birth and the emergence of 'homelike' birthing rooms." *Antipode* 35(3): 513-535.
- Fanon, Frantz. 1991. *White skin, black masks*. Charles Lam Markmann, trans. New York: Grove.
- Fassin, Dider, ed. 1998. *Les figures urbaines de la santé publique: Enquête sur des expériences locales*. Paris: Éditions La Découverte.
- Fassin, Didier and Dominique Memmi, eds. 2004. *Le gouvernement des corps*. Paris: Éditions de l'École des Hautes Études en Sciences Sociales.
- Faure, Olivier. 2002. "Health care provision and poor relief in 19th century provincial France." In Ole Peter Grell, Andrew Cunningham and Robert Jütte, eds. *Health care and poor relief in 18th and 19th century northern Europe*, Aldershot: Ashgate.
- Favereau, Eric, 22 March 2001. "Les sages-femmes en grève illimitée" *Libération*, page 20.
- Featherstone, Mike, ed. 1990. *Global culture: nationalism, globalization and modernity*. London: Sage Publications.
- Fellous, Michèle. 1988. "La révolution échographique" *Sociologie du Travail* 30 (2): 301-322.
- Felski, Rita. 1995. *The gender of modernity*. Cambridge, MA: Harvard University Press.
- Fesenstein, Matthew. 1998. "Contemporary liberalism." In Adam Lent, ed. *New political thought*. London: Lawrence and Wishart.
- Flanagan, Mary and Austin Booth, eds. *Reload: Rethinking women + cyberculture*. Cambridge: The MIT Press.
- Ford, Anne Rochon and Vicki Van Wagner. 2004. "Access to midwifery: Reflections on the Ontario Equity Committee experience." In Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving midwifery*. Montréal: McGill-Queen's University Press, 244-262.

- Foucault, Michel. 1973. *The birth of the clinic: An archaeology of medical perception*. A. M. Sheridan Smith, trans. New York: Vintage.
- Foucault, Michel. 1980. *History of sexuality, volume one: An introduction*. New York: Vintage Books.
- Foucault, Michel. 1980. *History of sexuality, volume three: The care of the self*. New York: Vintage Books.
- Foucault, Michel. 1980. *History of sexuality, volume two: The use of pleasure*. New York: Vintage Books.
- Foucault, Michel. 1980. *Power/Knowledge*. Pantheon Books: New York.
- Foucault, Michel. 1991. "Politics and the study of discourse." In Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault effect*. Chicago: University of Chicago Press.
- Foucault, Michel. 1994. *The birth of the clinic*. New York: Vintage Books.
- Foucault, Michel. 1995. *Discipline and punish*. New York: Vintage Books.
- Foucault, Michel. 2003. *Society must be defended: Lectures at the Collège de France, 1975-76*. New York: Picador.
- Foucault, Michel. 2004. *Sécurité, territoire, population: Cours au Collège de France, 1977-1978*. Paris: Gallimard/Seuil.
- Foucault, Michel. 2005. *The hermeneutics of the subject: Lectures at the Collège de France, 1981-1982*. Graham Burchell, Trans. New York: Palgrave Macmillan.
- Franklin, Sara, Celia Lury and Jackie Stacey, eds. 2000. *Global nature, global culture*. London: Sage.
- Franklin, Sarah, Celia Lury, and Jackie Stacey, eds. 1991. *Off-centre: feminism and cultural studies*. London: Harper Collins Academic.
- Franklin, Sarah and Susan McKinnon, eds. 2001. *Relative values: Reconfiguring kinship studies*. Durham: Duke University Press.
- Franklin, Sarah and Helena Ragoné, eds. 1997. *Reproducing reproduction: Kinship, power, and technological innovation*. Philadelphia: University of Pennsylvania Press.

- Fraser, Gertrude Jacinta, 1998. *African American midwifery in the South: Dialogues of birth, race, and memory*. Cambridge, MA: Harvard University Press.
- Freeman, Richard. 2000. *The politics of health in Europe*. Manchester: Manchester University Press.
- Friedman, Lester D., ed. 2004. *Cultural sutures: Medicine and media*. Durham: Duke University Press.
- Frieson, Kate. 2000. "Sentimental education: Les sages femmes and colonial Cambodia." *Journal of Colonialism and Colonial History* 1 (1). Retrieved March 3, 2005 from http://muse.jhu.edu/journals/journal_of_colonialism_and_colonial_history.
- Galley, Fabienne. 2002. "Vers une nouvelle organisation des soins en périnatalité: Place de la sage-femme." *Journée de formation continue des sages-femmes de l'AP-HP: Avenir professionnel de la sage-femme* Paris: Délégation à la Formation.
- Gamelin, Sophie. No date. [Brochure]. *Maison de naissance: Une idée à définir en France*. Roumagne: Sophie Gamelin.
- Gamelin-Lavois, Sophie and Martine Herzog-Evans. 2003. *Les droits des mères*. Paris: L'Harmattan.
- Gaudin, Emilie. 2001. "Blues Rose" *Particule* #4. Retrieved November 21, 2005 from http://canalvilaine.free.fr/particule/article.php3?id_article=61.
- Gélis, Jacques, Mireille Laget, and Marie-France Morel, 1978. *Entrer dans la vie: Naissances et enfances dans la France traditionnelle*. Paris: Gallimard.
- Gélis, Jacques. 1988. *La sage-femme ou le medecin: Une nouvelle conception de la vie*. Paris: Fayard.
- Gélis, Jacques. 2004. "Former des accoucheuses au XVIIIe siècle" *La "machine" de Madame Du Coudray*. Bonsecours: Édition Point de vues, pages 5-8.
- Georgens, Chantal. April 1999. "Pour des maisons de naissance autonomes" *Les Dossiers de L'Obstétrique*. 271: 41-42.
- Gesler, Wilbert M. 1991. *The cultural geography of health care*. Pittsburgh: University of Pittsburgh Press.
- Gibson-Graham, J. K. 1996. *The end of capitalism (as we knew it): A feminist critique of political economy*. Cambridge, MA: Blackwell.

- Gidwani, Vinay K. and Sharad Chari, 2004. "Geographies of work" *Environment and Planning D: Society and Space* 22 (4): 475-484.
- Gilligan, Carol. 1982. *In a different voice: Psychological theory and women's development*. Cambridge, MA: Harvard University Press.
- Ginsburg, Faye and Rayna Rapp. 1991. "The politics of reproduction" *Annual Review of Anthropology*. 20: 311-343.
- Ginsburg, Faye and Rayna Rapp, eds. 1995. *Conceiving the new world order: The global politics of reproduction*. Berkeley: University of California Press.
- Girous, Stéphane. 28 May 1993. "Sages-femmes au Centre Hospitalier de Maria: Les médecins disent non au project pilote." *Le Soleil*, page B1.
- Glenn, Evelyn Nakano, Grace Chang, and Linda Rennie Forcey, eds. 1994. *Mothering: Ideology, experience, and agency*. New York: Routledge.
- Goer, Henci. 2004. "Humanizing birth: A global grassroots movement." *Birth* 31 (4): 308-314.
- Gökariksel, Banu and Katharyne Mitchell. 2005. "Veiling, secularism, and the neoliberal subject: national narratives and supranational desires in Turkey and France" *Global Networks* 5 (2): 147-165.
- Gordon, Colin. 1991. "Governmental rationality: an introduction" in Graham Burchell, Colin Gordon, and Peter Miller, eds. *The Foucault effect*. Chicago: University of Chicago Press, pages 1-51.
- Goslinga-Roy, Gillian M. 2000. "Body boundaries, fiction of the female self: An ethnographic perspective on power, feminism, and the reproductive technologies." In Paul E. Brodwin, ed. *Biotechnology and culture*. Bloomington, IN: Indiana University Press.
- Grayson, Deborah. 2000. "Mediating intimacy: Black surrogate mothers and the law." In Paul E. Brodwin, ed. *Biotechnology and culture*. Bloomington, IN: Indiana University Press.
- Green, Mary Jean. 2001. *Women and narrative identity: Rewriting the Québec national text*. Montréal: McGill-Queen's University Press.
- Grewal, Inderpal and Caren Kaplan, eds. 1994. *Scattered hegemonies: Postmodernity and transnational feminist practices*. Minneapolis: University of Minnesota Press.

- Griffin, Gabriele and Rosi Braidotti, eds. 2002. *Thinking differently: A reader in European women's studies*. London: Zed Books.
- Grossberg, Larry. 1996. "History, politics, and postmodernism: Stuart Hall and cultural studies." In David Morley and Kuan-Hsing Chen, eds. *Stuart Hall: Critical dialogues in cultural studies*. London: Routledge. Reprinted from *Journal of Communication Inquiry*. 1986. 10 (2): 61-77.
- Grosz, Elizabeth. 1992. "Bodies-Cities" In Beatriz Colomina, ed. *Sexuality and space*. New York: Princeton Architectural Press.
- Grosz, Elizabeth. 1994. *Volatile bodies: Toward a corporeal feminism*. Bloomington: Indiana University Press.
- Grosz, Elizabeth. 1995. *Space, time, and perversion: Essays on the politics of bodies*. New York: Routledge.
- Groupe National de Travail sur les Maisons de Naissance. 2003. *Dossier de synthèse des projets de création maison de naissance en France*. Lyon: Groupe National de Travail sur les Maisons de Naissance.
- Guffond, Delphine. 2001. "Trente ans au cœur de la vie: Évolution de la pratique d'accompagnement des sages-femmes à travers l'évolution de la naissance de 1970 à nos jours." *Mémoire présenté en vue de l'obtention du diplôme d'État de sage-femme*. École de sages-femmes de Lyon.
- Guha, Supriya. 1998. "From *dais* to doctors: The medicalisation of childbirth in colonial India." In Lakshmi Lingam, ed. *Understanding women's health issues: A reader*. New Delhi: Kali for Women.
- Hall, Stuart. 1986. "On postmodernism and articulation." *Journal of Communication Inquiry* 10 (2): 45-60.
- Hall, Stuart. 1986. "The problem of ideology: Marxism without guarantees." *Journal of Communication Inquiry* 10 (2): 28-44.
- Hall, Stuart. 1988. "The toad in the garden: Thatcherism amongst the theorists." In Cary Nelson and Larry Grossberg, eds. *Marxism and the interpretation of culture*. Urbana: University of Illinois Press.
- Haraway, Donna. 1991. *Simians, cyborgs, and women: The reinvention of nature*. London: Free Association.

- Haraway, Donna. 1997. *Modest-Witness@Second-Millennium.FemaleMan-Meets-OncoMouse: Feminism and technoscience*. New York: Routledge.
- Harding, Sandra. 1991. *Whose science? Whose knowledge? Thinking from women's lives*. Ithaca: Cornell University Press.
- Hardt, Michael and Antonio Negri. 2001. *Empire*. Cambridge, MA: Harvard University Press.
- Hardt, Michael. 1999. "Affective labor" *boundary 2* 26 (2): 89-100.
- Harris, Mike. 1998. "The new Right." In Adam Lent, ed. *New political thought*. London: Lawrence and Wishart.
- Hartmann, Heidi. 1996. "The unhappy marriage of Marxism and feminism: Towards a more progressive union." In Victor D. Lippit, ed. *Radical political economy*. London: M.E. Sharpe. Reprinted from *Capital and Class*. Summer 1979: 1-33.
- Hartsock, Nancy. 1998. *The feminist standpoint revisited and other essays*. Boulder, CO: Westview Press.
- Harvey, David. 1989a. *The condition of postmodernity*. Cambridge, MA: Blackwell.
- Harvey, David. 1989b. *The urban experience*. Baltimore, MD: Johns Hopkins Press.
- Harvey, David. 1998. "The body as an accumulation strategy." *Environment and Planning D: Society and Space*. 16 (4): 401-421.
- Harvey, David. 1999. *The limits to capital*. 2nd ed. Verso: London.
- Harvey, David. 2000. *Spaces of hope*. Berkeley: University of California Press.
- Haug, Frigga. 1997. "The Hoechst Chemical Company and boredom with the economy" (1982). In Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Haut Comité de la Santé Publique. 1994. *La sécurité et la qualité de la grossesse et de la naissance: Pour un nouveau plan périnatalité*. Rennes: Éditions École Nationale de la Santé Publique.
- Hawkins, Miranda and Sarah Knox. 2003. *The midwifery option: A Canadian guide to the birth experience*. Toronto: Harper Collins.

- Helén, Ilpo. 2004. "Technics over life: Risk, ethics, and the existential condition in high-tech antenatal care." *Economy and Society* 33 (1): 28-51.
- Held, Virginia, ed. 1995. *Justice and care: Essential readings in feminist ethics*. Boulder, CO: Westview Press.
- Hennessy, Rosemary and Chrys Ingraham, eds. 1997. *Materialist feminism*. New York: Routledge.
- Hennessy, Rosemary and Rajeswari Mohan. 1997. "The construction of woman in three popular texts of empire: Toward a critique of materialist feminism" (1989). In Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Hertzman, Clyde. 2000. "Social change, market forces and health." *Social Science and Medicine* 51 (7): 1007-1008.
- Hervé, Christian and Manuel Wolf. 1998. "Relation médecin-malade: Soigner ou se protéger? La traversée de l'Atlantique par la responsabilité médicale." *Presse Médicale* 27 (27): 1387-1389.
- Himmelweit, Susan. 1999. "Caring labor" *The Annals of the American Academy of Political and Social Sciences*. 561: 27-38.
- Hochschild, Arlie R. 1997. *The time bind: When work becomes home and home becomes work*. New York: Metropolitan Books.
- Hochschild, Arlie R. 2000. "Global care chains and emotional surplus value." In Will Hutton and Anthony Giddens, eds. *Global capitalism*. New York: New Press.
- Hochschild, Arlie Russell. 1983. *The managed heart: Commercialization of human feeling*. Berkeley: University of California Press.
- Holloway, Sarah L. and Gill Valentine, 2001. "'It's only as stupid as you are': Children's and adults' negotiation of ICT competence at home and at school." *Social and Cultural Geography* 2 (1): 25-42.
- Homans, Hilary, ed. 1985. *The sexual politics of reproduction*. Brookfield, VT: Gower.
- Hoogvelt, Ankie. 1997. *Globalization and the post colonial world*. Baltimore: The Johns Hopkins University Press.
- Hospital, Marie-Pierre. 2002. "Choisir de naître autrement" *Entretiens de Bichat: Entretiens des sages-femmes*. Paris: Éditions Scientifique, pages 29-30.

- Hsu, Clarissa Wen-Ling. 2000. *Cutting cords and crossing categories: Midwifery, governmentality and the haunting of embodied experience in Saint Lucia*. Unpublished doctoral dissertation, University of Washington.
- Hudemann-Simon, Calixte. 1995. *L'état et la santé: La politique de santé publique ou "police médicale" dans les quatre départements rhénans, 1794-1814*. Sigmaringen: Jan Thorbecke Verlag Sigmaringen.
- Hutton, Will and Anthony Giddens, eds. 2000. *Global capitalism*. New York: New Press.
- Hyndman, Jennifer. 2001. "Towards a feminist geopolitics" *Canadian Geographer* 45 (2): 210-222.
- HypnoBirthing Institute. 21 February 2005. *Natural Childbirth - HypnoBirthing®*. Retrieved September 15, 2005 from <http://www.hypnobirthing.com/>.
- Innovative approaches to maternal and perinatal care as part of primary health care: FIGO workshop report from Tokyo. 22-24 October 1979.*
- International Confederation of Midwives. 2006. *Guidelines for application of membership*. [Brochure]. The Hague: International Confederation of Midwives.
- International Confederation of Midwives. 18-20 August 1987. Meeting notes of the *Conseil de la Confédération Internationale des Sage-Femmes*. The Hague, page 2.
- International Midwifery Is Alive!* No date. Retrieved February 10, 2005 from <http://www.midwiferytoday.com/international/>.
- Jaggar, Alison. 1991. "Feminist ethics: Problems, projects, prospects." In Claudia Card, ed. *Feminist ethics*. Lawrence, KS: University Press of Kansas, pages 78-106.
- James, Selma. 1997. "Introduction to *The power of women and the subversion of the community*" (1972). In Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- James, Susan and Ivy Bourgeault. 2004. "To fund or not to fund: The Alberta decision." In Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving midwifery*. Montréal: McGill-Queen's University Press, pages 131-149.

- Jeffery, Patricia, Roger Jeffery, and Andrew Lyon. 1985. *Contaminating states and women's status: Midwifery, childbearing and the state in rural North India*. New Delhi: Indian Social Institute.
- Jeffery, Patricia, Roger Jeffery, and Andrew Lyon. 1989. *Labour pains and labour power*. London: Zed Books.
- Jester, Rebecca and Carolyn Hicks, 2003. "Using cost-effectiveness analysis to compare Hospital at Home and in-patient interventions. Part 1" *Journal of Clinical Nursing* 12 (1): 13-19.
- Jetter, Alexis, Annelise Orleck, and Diana Taylor, eds. 1997. *The politics of motherhood: Activist voices from Left to Right*. Hanover, NH: Dartmouth College.
- Johnson, Nuala. 1995. "Cast in stone: Monuments, geography, and nationalism" *Environment and Planning D: Society and Space* 13(1): 51-65.
- Jong, Wilma de, Martin Shaw, and Neil Stammers, eds. 2005. *Global activism, global media*. London & Ann Arbor, MI: Pluto Press.
- Jordan, Brigitte. 1978. *Birth in Four Cultures*. Montreal: Eden Press.
- Joseph, Gloria. 1997. "The incompatible ménage à trois: Marxism, feminism, and racism" (1981). In Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Joseph, Miranda, Priti Ramamurthy and Alys Eve Weinbaum. 2005. "Towards a new feminist internationalism." In Elizabeth Lapovsky Kennedy and Agatha Beins, eds. *Women's studies for the future: Foundations, interrogations, politics*. New Brunswick, N.J.: Rutgers University Press, pages 207-228.
- Kaplan, Caren and Inderpal Grewal. 1994. *Scattered hegemonies: Postmodernity and transnational feminist practice*. Minneapolis: University of Minnesota Press.
- Kaplan, Caren, Norma Alarcón, and Mino Moallem, eds. 1999. *Between woman and nation: Nationalisms, transnational feminisms, and the state*. Durham: Duke University Press.
- Katz, Cindi. 2001. "Vagabond capitalism and the necessity of social reproduction." *Antipode* 33(4):708-27.
- Katz, Cindi. 2004. *Growing up global: Economic restructuring and children's everyday lives*. Minneapolis: University of Minnesota Press.

- Kawale, Rani. 2004. "Inequalities of the heart: The performance of emotion work by lesbian and bisexual women in London, England." *Social and Cultural Geography* 5 (4): 565-581.
- Kearns, Robin A. and J. Ross Barnett. 1999. "To boldly go? Place, metaphor and the marketing of Auckland's Starship Hospital." *Environment and Planning D: Society and Space* 17: 201-226.
- Keck, Margaret E. and Kathryn Sikkink, 1998. *Activists beyond borders*. Ithaca: Cornell University Press.
- Keller, Evelyn Fox. 1995. *Refiguring life: Metaphors in twentieth-century biology*. New York: Columbia University Press.
- Kitchin, Robert M. 1998. "Towards geographies of cyberspace." *Progress in Human Geography* 22 (3): 385-406.
- Klassen, Pamela. 2004. "Mothers between God and Mammon: Feminist interpretations of childbirth." In Janelle Taylor, Linda Layne and Danielle Wozniak, eds. *Consuming Motherhood*. New Brunswick, N.J. and London: Rutgers University Press, pages 249-268.
- Klaus, Alisa. 1993. *Every child a lion: The origins of maternal and infant health policy in the United States and France, 1890-1920*. Ithaca: Cornell University Press.
- Knibielher, Yvonne. 2003a. "Féminisme et maternité." *Les Dossiers de l'Obstétrique* 317: 17-20.
- Knibielher, Yvonne. 2003b. "Les femmes face aux soignants." *Les Dossiers de l'Obstétrique* 317: 3-5.
- Kofman, Eleanore and Linda Peake. 1990. "Into the 1990s: A gendered agenda for political geography" *Political Geography* 9: 313-336.
- Kolko Beth E., ed. 2003. *Virtual publics: Policy and community in an electronic age*. New York: Columbia University Press.
- Koven, Seth and Sonya Michel. 1993. *Mothers of a new world: maternalist politics and the origins of welfare states*. New York: Routledge.
- La complémentarité du secteur privé dans la poursuite des objectifs fondamentaux du système public de santé au Québec (Rapport Arpin)*. 1999. Québec: Gouvernement du Québec, Ministère de la Santé et des Services Sociaux.

- La périnatalité Québécoise depuis vingt ans*. 2000. Montréal: L'Association pour la Santé Publique du Québec.
- Lachronique, Jean-François. 1988. "Socialism, equity, and cost containment in health: The French experience" in *Health care systems: Moral conflicts in European and American public policy*. Dordrecht and Boston: Kluwer Academic Publishers.
- Laclau, Ernesto. 1979. *Politics and ideology in Marxist theory*. London: Verso.
- Laclau, Ernesto and Chantal Mouffe. 1985. *Hegemony and socialist strategy*. London: Verso.
- Laffitte, Adeline. October 1998. "Maternités: On ferme" *Alternative santé – L'impatient*. 249: 10-12.
- Laqueur, Thomas. 2000. "'From generation to generation': Imagining connectedness in the age of reproductive technologies." In Paul E. Brodwin, ed. *Biotechnology and culture*. Bloomington, IN: Indiana University Press.
- Larner, Wendy. 2000. "Neo-liberalism: Policy, ideology, governmentality" *Studies in Political Economy* 63: 5-25.
- Larner, Wendy. 2003. "Neoliberalism?" *Environment and Planning D: Society and Space* 21 (5): 509-512.
- Larrain, Jorge. 1996. "Stuart Hall and the Marxist concept of ideology." In David Morley and Kuan-Hsing Chen, eds. *Stuart Hall: Critical dialogues in cultural studies*. London: Routledge. Reprinted from *Theory, Culture, and Society*. 1991. 10: 1-28.
- Laurie, Nina, Robert Andolina, and Sarah Radcliffe. 2004. "Indigenous professionalization: Transnational social reproduction in the Andes." In Katharyne Mitchell, Sallie A. Marston and Cindi Katz, eds. *Life's Work*. Oxford: Blackwell, pages 47-74.
- Laurin, Renée. 15 April 1993. "Le point sur la maison de naissance." *Le Droit*, page 19.
- Vadeboncoeur, Hélène. 1989. *Une autre césarienne? Non merci!* Montréal: Editions Québec/Amérique.
- Law, John. 2004. "And if the global were small and incoherent? Method, complexity, and the baroque." *Environment and Planning D: Society and Space* 22 (2): 13-26.
- Lazzarato, Maurizio. 1996. "Immaterial labor." In Paolo Virno and Michael Hardt, eds. *Radical thought in Italy*. Minneapolis: University of Minnesota Press, pages 133-47.

- Le Comité de travail sur la pratique des sages-femmes au Québec. 1989. *La Pratique des Sages-Femmes: Étude d'un moyen pour atteindre les objectifs en périnatalité*. Québec: Ministère de la Santé et des Services Sociaux.
- Leboyer, Frederick. 1975. *Birth without violence*. New York: Alfred A. Knopf.
- Léonard, Jacques. 1978, *Les médecins de l'ouest au XIXe siècle*. Lille: Atelier Reproduction des thèses, Université de Lille III, pages 196-253.
- Letourmy, Alain 1995, "The economic forms of the regulation of health spending in France: Negotiated waste." In *Comparing Social Welfare Systems in Europe, volume 1, Oxford Conference France-United Kingdom*. Paris: Mission Interministérielle Recherche Expérimentation du Ministère des Affaires Sociales et de l' Emploi (MIRE).
- Letourmy, Alain. 2000. "Les politiques de santé en Europe: Une vue d'ensemble" *Sociologie du Travail* 42: 13-30.
- Liptak, Adam. 3 April 2006. "Prosecution of Midwife Cast Light on Home Births." *New York Times*. Retrieved April 4, 2006 from www.nytimes.com.
- Lister, Ruth. 1997. *Citizenship: Feminist perspectives*. New York: New York University Press.
- Litt, Jacquelyn S. 2000. *Medicalized motherhood*. New Brunswick, NJ: Rutgers University Press.
- Locke, John. 1980. *Second treatise of government* (1690). In C.B. McPherson, ed. Indianapolis and Cambridge: Hackett Publishing Company.
- Loi numéro 2002-303 du 4 mars 2002 relative aux droits des malades et à la qualité du système de santé. *Journal Officiel*.
- Loi numéro 2004-806 9 August 2004 relative à la politique de santé publique, *Journal Officiel* n° 185 du 11 août 2004, page 14277.
- Loi numéro 94-653 du 29 juillet 1994, relative au respect du corps humain, *Journal Officiel* 175, page 11056.
- Loi sur les Sages-Femmes*. 1999. L.Q.28, Ch. 24.
- Long, Claudia R. and Mary Ann Curry. 1998. "Living in two worlds: Native American women and prenatal care." *Health Care for Women International* 19: 205-215.

- Longhurst, Robyn. 2001. *Bodies: Exploring fluid boundaries*. London: Routledge.
- Maioni, Antonia. August 1994. "Divergent pasts, converging futures? The politics of health care reform in Canada and the United States." *Canadian-American Public Policy*. Occasional paper no. 18.
- Maison de naissance Côte-des-Neiges. 2004. *Présentation des services* [Pamphlet]. Montréal: Maison de naissance Côte-des-Neiges.
- Marchessault, Janine and Kim Sawchuk, eds. 2000. *Wild science: Reading feminism, medicine and the media*. London: Routledge.
- Marland, Hilary, ed. *The art of midwifery: Early modern midwives in Europe*. London: Routledge.
- Marland, Hilary and Anne Marie Rafferty, eds. 1997. *Midwives, society, and childbirth: Debates and controversies in the modern period*. London: Routledge.
- Marston, Sallie. "The social construction of scale" *Progress in Human Geography*. 24 (2): 219-242.
- Martel, Marie-Claude. April 1988. "Où accoucher." *The Canadian Nurse* 84 (4): 34-7.
- Martin, Emily. 1992. *The woman in the body*. Boston: Beacon Press.
- Marx, Karl. 1967. *Capital*. Volume 1. New York: International Publishers.
- Marx, Karl. 1967. *Capital*. Volume 2. New York: International Publishers.
- Massey, Doreen. 1984. *Spatial divisions of labour*. London: Macmillan.
- Massey, Doreen. 1991. "Flexible sexism" *Environment and Planning D: Society and Space*. 9 (1): 31-57.
- Massey, Doreen. 1994. *Space, place, and gender*. University of Minnesota Press: Minneapolis.
- Mayer, Tamar, ed. 2000. *Gendered ironies of nationalism: Sexing the nation*. London: Routledge.
- McAfee, Noëlle. 2000. *Habermas, Kristeva, and Citizenship*. Ithaca: Cornell University Press.

- McCaughey, Martha and Michael D. Ayers, eds. 2003. *Cyberactivism: Online activism in theory and practice*. New York: Routledge.
- McDowell, Linda. 1986. "Beyond patriarchy: A class-based explanation of women's subordination." *Antipode* 18: 311-321.
- McDowell, Linda. 1991. "Life without father and Ford: the gender order of post-Fordism." *Transactions, Institute of British Geographers* 16(4): 400-419.
- McDowell, Linda. 1999. *Gender, identity and place*. Minneapolis: University of Minnesota Press.
- McGregor, S. 2001. "Neoliberalisation and health care" *International Journal of Consumer Studies* 25: 82-89.
- McLaren, Angus. 1978. *Birth control in nineteenth-century England*. New York: Holmes & Meier.
- McTavish, Lianne. 2005. *Childbirth and the display of authority in early modern France*. Aldershot: Ashgate.
- Memmi, Dominique. 2002. "Public-private opposition and biopolitics: A response to Judit Sándor" *Social Research* 69 (1): 143-147.
- Memmi, Dominique. 2003. "Governing through speech: The new state administration of bodies" *Social Research* 70 (2): 645-659.
- Memmi, Dominique. 2003. *Faire vivre et laisser mourir: Le gouvernement contemporain de la naissance et de la mort*. Paris: La Découverte.
- Merlaton, Nelly. 1996. "Evolution de la profession de sage-femme en France entre 1945 et 1995." *Mémoire pour l'obtention du diplôme d'état de sage-femme*. Lyon: École de Lyon.
- Meyer, Cheryl L. 1997. *The wandering uterus: Politics and the reproductive rights of women*. New York: New York University Press.
- Michie, Helena and Naomi Cahn. 1996. "Unnatural births: Cesarean sections in the discourse of the natural childbirth movement." In Carolyn Sargent and Caroline Brettell, eds. *Gender and health: An international perspective*. Upper Saddle River, N.J.: Prentice Hall, pages 44-56.
- Midwifery Today*, Autumn 2005. "Our mission" 75, 4.

- Mignot, Sandra. 2001. "La France sur le point de rattraper son retard" *Profession Sage-Femme* 79: 4-6.
- Mignot, Sandra. 2003. "Des sages-femmes en quête de reconnaissance" *Profession Sage-Femme* 93: 4-8.
- Miller, Aaron A. 1910. "Obstetrics and modern gynecology" *The American Journal of Obstetrics and the Diseases of Women and Children*. 62 (5): 745-756.
- Mills, Catherine, and José Caudron. 30 June 2004. "Assurance maladie: Une réforme qui conjugue privatisation et étatisation" *Libération*.
- Ministère de la Santé et des Services sociaux. 2000. *Funding: Current situation and outlook* Québec: Ministère de la Santé et des Services sociaux.
- Mitchell, Juliet. 1971. *Women's estate*. New York: Pantheon.
- Mitchell, Katharyne, Sallie A. Marston and Cindi Katz. 2004. "Life's work: An introduction, review and critique." In Katharyne Mitchell, Sallie A. Marston and Cindi Katz, eds. *Life's work: Geographies of social reproduction*. Oxford: Blackwell, pages 1-26.
- Mitchell, Katharyne. 2006. "Neoliberal governmentality in the European Union: Education, training, and technologies of citizenship." *Environment and Planning D: Society and Space*. 24 (3): pages 389-407.
- Mitteilungen des Internationalen Hebammenverbandes/ Communications of the International Midwives' Union/Annales de l'Association Internationale D'Accoucheuses*. 1939. Gent-VIII (10): pages 52-53.
- Mitter, Swasti. 1997. "Women working worldwide" (1986). In Rosemary Hennessy and Chrys Ingraham, eds. *Materialist feminism*. New York: Routledge.
- Mohanty, Chandra Talpade, Ann Russo, and Lourdes Torres, eds. 1991. *Third world women and the politics of feminism*. Bloomington: Indiana University Press.
- Mohanty, Chandra Talpade. 1991. "Introduction: Cartographies of struggle, Third World women and the politics of feminism." In Chandra Talpade Mohanty, Ann Russo, & Lourdes Torres, eds. *Third World women and the politics of feminism*. Bloomington: Indiana University Press, pages 51-80.
- Monk, Janice and Susan Hanson. 1982. "On not excluding half of the human in human geography." *The Professional Geographer* 34: 11-23.

- Montag, Warren. 1995. "'The soul is the prison of the body': Althusser and Foucault, 1970-1975" *Yale French Studies* 88: 53-77.
- Morley, David and Kuan-Hsing Chen, eds. 1996. *Stuart Hall: Critical dialogues in cultural studies*. London: Routledge.
- Mouffe, Chantal. 1997. "Feminism, citizenship, and radical democratic politics." Reprinted in Diana Tietjens Meyers, ed. *Feminist social thought: A reader*. New York: Routledge.
- Muel-Dreyfus, Francine. 2001. *Vichy and the eternal feminine*. Kathleen A. Johnson, trans. Durham and London: Duke University Press.
- Murard, Lion and Patrick Zylberman. 1996. *L'hygiène dans la République: La santé publique en France, ou l'utopie contrariée (1870-1918)*. Paris: Fayard.
- Mustard, J. Fraser and John W. Frank. 1991. *The determinants of health/Les déterminants de la santé*. Toronto: Canadian Institute for Advanced Research/Institut Canadien de Recherche Avancée.
- Nadel, Doris, Françoise Servent, Chantal Georgens and Dominique Paradis. April 1999. "Dans l'Hérault aux alentours de Montpellier" *Les Dossiers de L'Obstétrique* 271: 23-25.
- Nadel, Doris. April 1999. "Une maison de naissance? Qu'est-ce que c'est?" *Les Dossiers de L'Obstétrique*. 271: 7-9.
- Naiditch, Michel. 2000. "Quelle place pour les sages-femmes dans la nouvelle organisation des soins périnatal" *Journées d'études et de formation: XXVIIIèmes assises nationales des sages-femmes, Bruxelles, 24-26 mai 2000: compte-rendu scientifiques*. Paris: Association professionnelle des sages-femmes des facultés de médecine de Paris, pages 65-78.
- Nash, Catherine. 1996. "Reclaiming vision: looking at landscape and the body." *Gender, Place and Culture*. 3(2): 149-169.
- Negri, Antonio. 1999. "Value and affect" *boundary 2* 26 (2): 77-88.
- Nestel, Sheryl. 2000. "Delivering subjects: Race, space and the emergence of legalized midwifery in Ontario." *Canadian Journal of Law and Society* 15 (2): 187-215.
- No author, 2003 "Quatorze kilomètres pour accoucher." *Profession Sage-Femme* 98: 12.

- Novas, Carlos and Nikolas Rose. 2000. "Genetic risk and the birth of the somatic individual." *Economy and Society* 29 (4): 485-513.
- O'Brien, Mary. 1981. *The politics of reproduction*. Boston: Routledge.
- O'Connor, Julia S., Ann Shola Orloff and Sheila Shaver. 1999. *States, markets, families: Gender, liberalism and social policy in Australia, Canada, Great Britain and the United States*. Cambridge: Cambridge University Press.
- O'Malley, Pat. 1996. "Risk and responsibility." In Andrew Barry, Thomas Osborne, and Nikolas Rose, eds. *Foucault and political reason*. Chicago: University of Chicago Press, pages 189-207.
- Ó'Tuathail, Gearóid. 1995. "Political geography I: Theorizing history, gender, and world order amidst crises of global governance" *Progress in Human Geography* 19(2): 260-272.
- Oakley, Ann. 1984. *The captured womb: a history of the medical care of pregnant women*. Oxford and New York: Blackwell.
- Oakley, Ann. 1993. *Essays on women, medicine and health*. Edinburgh: Edinburgh University Press.
- Ong, Aihwa. 1995. "Making the Biopolitical Subject: Cambodian Immigrants, Refugee Medicine and Cultural Citizenship in California." *Social Science and Medicine* 40 (9): 1243-1257.
- Ontario *Midwifery Act*, S.O. 1991, Chapter 31. Retrieved January 31, 2006 from <http://www.e-laws.gov.on.ca:81/ISYSquery/IRL172C.tmp/8/doc>.
- Ordonnance 45-0284 du 24 septembre 1945, *Relative à l'exercice et à l'organisation des professions de médecin, de chirurgien dentiste et de sage-femme*.
- Ordonnance number 82 296 du 31 mars 1982.
- Ordre des sages-femmes de Québec. No date. "*Mission, vision, valeurs*." Retrieved March 3, 2006 from www.osfq.org/ordre/index_mission.html.
- Ordre des Sages-Femmes. 2003. "La démographie des sages-femmes en 2003: France - répartition des sages-femmes inscrites au tableau." Retrieved January 15, 2005 from <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/schema2.htm>.

- Ordre des sages-femmes. No date. "La démographie des sages-femmes en 2003."
Retrieved November 17, 2005 from <http://www.ordre-sages-femmes.fr/actualites/dossiers/demographie/demographie%202003/demo1.htm>.
- Organisation for Economic Co-operation and Development. 1995a. "Internal markets in the making: Health systems in Canada, Iceland and the United Kingdom" *Health Policy Studies* 6.
- Organisation for Economic Co-operation and Development. 1995b. "New directions in health care policy" *Health Policy Studies* 7.
- Osborne, Thomas. 1996. "Security and vitality: drains, liberalism, and power in the nineteenth century." In Andrew Barry, Thomas Osborne, and Nikolas Rose, eds. *Foucault and political reason*. Chicago: University of Chicago Press, pages 99-121.
- Ouimet, Michèle. 13 May 1989. "Ces sages-femmes dont on parle tant." *La Presse*.
- Panelli, Ruth, Jo Little, and Anna Kraack. 2004. "A community issue? Rural women's feelings of safety and fear in New Zealand." *Gender, Place and Culture* 11 (3): 445-467.
- Papiernik, Emile and Louis G. Keith. 1995. "The regionalization of perinatal care in France – description of a missing policy." *European Journal of Obstetrics and Gynecology* 61: 99-103.
- Parker, Andrew, Mary Russo, Doris Summer, and Patricia Yaeger. 1992. *Nationalisms and Sexualities*. New York: Routledge.
- Parr, Hester, 2002. "New body-geographies: the embodied spaces of health and medical information on the Internet." *Environment and Planning D: Society and Space* 20 (1): 73-95.
- Parr, Hester. 2003. "Medical geography: care and caring" *Progress in Human Geography* 27 (2): 212-221.
- Pateman, Carole. 1988. *The sexual contract*. Stanford: Stanford University Press.
- Paterson, Mark. 2005. "Affecting touch: Towards a 'felt' phenomenology of therapeutic touch." In Joyce Davidson, Liz Bondi, and Mick Smith, eds. *Emotional Geographies*. Aldershot: Ashgate, pages 161-175.
- Patrick, Donna. 2003. *Language, politics and social interaction in an Inuit community*. Berlin: Mouton de Gruyter.

- Peck, Jamie and Adam Tickell. 2002. "Neoliberalizing space" *Antipode* 34 (3): 380-404.
- Peck, Jamie. 2001. *Workfare states*. New York: Guilford.
- Pederson, Susan. 1993. *Family, dependence and the origins of the welfare state: Britain and France, 1914-1945*. Cambridge: Cambridge University Press.
- Peritz, Ingrid. 10 May 1989. "Québec Wants Midwives Law by June" *The Gazette (Montréal)*.
- Petchetsky, Rosalind. 1985. *Abortion and woman's choice: The state, sexuality and reproductive freedom*. New York: Longman.
- Petersen, Alan and Robin Bunton, eds. 1997. *Foucault, health and medicine* London, New York: Routledge.
- Phumaphi, Joyce. 25 July 2005. Speech to the International Congress of Midwives, Brisbane, Australia.
- Picard, André. 11 May 1989. "Québec Doctors Denounce Proposed Midwifery Law" *Globe and Mail (Toronto)*.
- Pineault, R., P.A. Lamarche, F. Champagne, A. P. Contandriopoulos, and J.L. Denis. 1993. "The reform of the Québec health care system: Potential for innovation?" *Journal of Public Health Policy* 14(2): 198-219.
- Pitt, Susan. 1997. "Midwifery and medicine: Gendered knowledge in the practice of delivery." In Hilary Marland and Anne Marie Rafferty, eds. *Midwives, society and childbirth*. London and New York: Routledge.
- Plato. 1957. *Plato's theory of knowledge (The Theatetus and the Sophist of Plato)*. Francis M. Cornford, trans. Indianapolis: The Bobbs-Merrill Company, Inc.
- Pollack, Jack Harrison. 1953. "The case for natural childbirth." *Cosmopolitan* 135: 38-43.
- Polzer, Jessica, Shawna Mercer and Vivek Goel. 2002. "Blood is thicker than water: genetic testing as citizenship through familial obligation and the management of risk." *Critical Public Health* 12 (2): 153-168.
- Powell, Francis D. and Albert F. Wessen, eds. *Health care systems in transition: An international perspective*. Thousand Oaks, Sage Publications.

- “Projet d’accouchement: Ce ‘contrat’, qu’est-ce que vous en faites?” 2000. Retrieved July 15, 2005 from fraternet.org/naissance/docs/gynewebcontrat.htm.
- Québec, Loi 4, *Loi sur la pratique sage-femme dans le cadre de projets-pilotes*.
- Quine, Maria Sophia. 1996. *Population politics in twentieth-century Europe: fascist dictatorships and liberal democracies*. London and New York: Routledge.
- Quinton, Anthony. 1995. “Conservatism.” In Robert E. Goodin and Philip Pettit, eds. *A companion to contemporary political philosophy*. Oxford: Blackwell.
- Rachlis, Michael and Carol Kushner. 1989. *Second opinion: What’s wrong with Canada’s health care system and how to fix it*. Toronto: Harper & Collins Publishers Ltd.
- Radcliffe, Sarah. 1996. “Gendered nations: Nostalgia, development and territory in Ecuador.” *Gender, Place and Culture*. 3 (1): 5-22.
- Ram, Kalpana and Margaret Jolly, eds. 1998. *Maternities and modernities*. Cambridge: Cambridge University Press.
- Rasmussen, Claire and Michael Brown, 2005. “The body politic as spatial metaphor” *Citizenship Studies* 9(5): 469-484.
- Razack, Sherene. 2000. “From the ‘clean snows of Petawawa’: The violence of Canadian peacekeepers in Somalia” *Cultural Anthropology* 15 (1): 127-164.
- Razack, Sherene. 1998. *Looking white people in the eye*. Toronto: University of Toronto Press.
- Razack, Sherene, ed. 2002. *Race, space and the law: Unmapping a white settler society*. Toronto: Between the Lines.
- Reforme de l’assurance maladie*. No date. Ministère de la Santé et des Solidarités, Retrieved November 1, 2005 from http://www.sante.gouv.fr/assurance_maladie/index.htm.
- Regroupement les Sages-Femmes du Québec (RSFQ). 1997. *Philosophie de la pratique sage-femme* [Pamphlet]. Montréal: Regroupement les Sages-Femmes du Québec (RSFQ).
- Reich, Robert. 1991. *The work of nations: Preparing ourselves for 21st-century capitalism*. New York: Knopf.

- Reinharz, Daniel, Régis Blais, William D. Fraser and Andre-Pierre Contandriopoulos. 2000. "Cost-effectiveness of midwifery services vs. medical services in Québec" *Canadian Journal of Public Health* 91 (1): 112-115.
- Robbins, Bruce. 1999. *Feeling Global: Internationalism in Distress*. New York and London: New York University Press.
- Roberts, Dorothy E. 1998. "The future of reproductive choice for poor women and women of color." In Rose Weitz, ed. *The politics of women's bodies*. New York, Oxford: Oxford University Press.
- Rofel, Lisa. 2001. "Discrepant modernities and their discontents." *positions* 9 (3): 637-649.
- Ronel, Avital. 2005. *The test drive*. Urbana, IL: University of Illinois Press.
- Rose, Gillian. 1993. *Feminism and geography* Minneapolis: University of Minnesota Press.
- Rose, Nikolas. 1999. *Governing the soul*. London: Free Association Books.
- Ruddick, Sara. 1989. *Maternal thinking*. Boston: Beacon Press.
- Ruggie, Mary. 1996. *Realignments in the welfare state: Health policy in the United States, Britain and Canada*. New York: Columbia University Press.
- Said, Edward. 1979. *Orientalism*. New York: Vintage Books.
- Sapena, Nathalie. 1997. "Bien choisir sa maternité." *60 millions de consommateurs* 311: 16-19.
- Sargent, Carolyn F. and Caroline B. Brettell. 1996. *Gender and health: An international perspective*. Upper Saddle River, N.J.: Prentice Hall.
- Sargent, Carolyn. 2005. "Counseling contraception for Malian migrants in Paris: Global, state, and personal politics." *Human Organization* 64 (2): 147-156.
- Sassen, Saskia. 2002. "Towards a sociology of information technology." *Current Sociology* 50 (3): 365-88.
- Sassen, Saskia. 2003. "Counter-geographies of globalization: Feminization of survival." In Kriemild Saunders, ed. *Feminist post-development thought: Rethinking modernity, postcolonialism, and representation*. London and New York: Zed Books.

- Satzewich, Vic, ed. 1992. *Deconstructing a nation: Immigration, multiculturalism, and racism in '90s Canada*. Halifax: Fernwood Publishing.
- Sawicki, Jane. 1991. *Disciplining Foucault: Feminism, power and body*. New York: Routledge.
- Schalck, Claudine. 11 April 2001. "Sage-femmes: l'impossible identité." *Libération*, page 6.
- Schatzki, Theodore R. and Wolfgang Natter, eds. 1996. *The social and political body*. New York: Guilford Press.
- Schultz, Susanne. 2006. "Dissolved boundaries and 'affective labor': On the disappearance of reproductive labor and feminist critique in *Empire*" *Capitalism, Nature, Socialism* 17 (1): 77-82.
- Schweyer, François-Xavier. 1996. "La profession de sage-femme: autonomie au travail et corporatisme protectionniste" *Sciences Sociales et Santé*, 14 (3): 67-101.
- Scott, Colin H. 2001. *Aboriginal autonomy and development in northern Québec and Labrador*. Vancouver: UBC Press.
- Scott, Joan W. 1988. "Deconstructing equality-versus-difference: Or, the uses of poststructuralist theory for feminism." *Feminist Studies* 14 (1): 33-50.
- Shilling, Chris. 2005. *The body in culture, technology and society*. London: Sage Publications.
- Sicart, Daniel. 2003. "Les professions de santé au 1er janvier 2003" *Serie Statistiques: Répertoire ADELI* 52. Paris: Direction de la recherche, des études, de l'évaluation et des statistiques.
- Sicart, Daniel. 2005. *Document de travail: Les Professions de la santé* 82. Paris: Direction de la recherche, des études, de l'évaluation, et des statistiques.
- Silliman, Jael, Marlene Gerber Fried, Loretta Ross, and Elena R. Gutiérrez. 2004. *Undivided rights: Women of color organize for reproductive justice*. Cambridge, MA: South End Press.
- Smith, Adam. 1904. *An inquiry into the nature and causes of the wealth of nations*. Volume 1. London: Methuen and Co.

- Smith, Dorothy. 1987. *The everyday world as problematic: A feminist sociology*. Boston: Northeastern University Press.
- Smith, Susan. 2005. "States, markets and an ethic of care." *Political Geography* 24: 35-38.
- Smith-Windsor, Jaimie. "The cyborg mother." *Radical Philosophy* 129 (2005): 33-40.
- Soutoul, Jean-Henri and Catherine Bardin-Bedu. 1993. *La responsabilité médicale et les problèmes médico-légaux de la sage-femme*. Paris: Maloine.
- Sparke, Matthew. 1994. "A prism for contemporary capitalism: temporary work as displaced labor as value" *Antipode* 26 (4): 295-322.
- Sparke, Matthew. 1996. "Negotiating national action: free trade, constitutional debate and the gendered geopolitics of Canada" *Political Geography* 15 (6/7): 615-639.
- Sparke, Matthew. 2005. *In the space of theory: Postfoundational geographies of the nation-state*. Minneapolis: University of Minnesota Press.
- Sparke, Matthew. 2006. "A neoliberal nexus: Economy, security, and the biopolitics of citizenship on the border." *Political Geography* 25 (2): 151-180.
- Sparks, Colin. 1996. "Stuart Hall, cultural studies and Marxism." In David Morley and Kuan-Hsing Chen, eds. *Stuart Hall: Critical dialogues in cultural studies*. London: Routledge.
- Spivak, Gayatri C. 1988a. "Can the subaltern speak?" In Cary Nelson and Larry Grossberg, eds. *Marxism and the interpretation of culture*. Urbana: Univ. of Illinois.
- Spivak, Gayatri C. 1988b. *In Other Worlds: Essays in Cultural Politics*. New York: Routledge.
- Spivak, Gayatri C. 1991. "French Feminism in an International Frame" in Mary Eagleton, ed. *Feminist Literary Criticism*. London & New York: Longman.
- Spivak, Gayatri C. 1993. *Outside in the Teaching Machine*. New York: Routledge.
- Spivak, Gayatri C. 1996. "Scattered speculations on the question of value." In Donna Landry and Gerald MacLean, eds. *The Spivak reader*. New York and London: Routledge, pages 109-140.

- Spivak, Gayatri C. 1999. *A critique of postcolonial reason*. Cambridge, MA and London: Harvard University Press.
- Stacey, Jackie. 2000. "The global within: Consuming nature, embodying health." In Sara Franklin, Celia Lury & Jackie Stacey, eds. *Global nature, global culture*. London: Sage, pages 97-145.
- Stacey, Judith. 1998. "The right family values." In Clarence Y. H. Lo and Michael Swartz, eds. *Social policy and the conservative agenda*. Oxford: Blackwell.
- Staeheli, Lynn A. and Michael Brown, 2003. "Guest editorial: Where has welfare gone? Introductory remarks on the geographies of care and welfare." *Environment and Planning A*, 35(5): 772.
- Staeheli, Lynn. 2001. "Of possibilities, probabilities, and political geography" *Space and Polity* 5(23): 177-189.
- Steinberg, Ronnie J. and Deborah M. Figart, eds. January 1999. *Emotional labor in the service economy*. Special issue of the Annals of the American Academy of Political and Social Science Volume 561. Thousand Oaks: Sage Publications.
- Stoler, Ann. 1995. *Race and the education of desire: Foucault's History of Sexuality and the colonial order of things*. Durham: Duke University Press.
- Stout, Madeleine Dion and Gregory D. Kipling. 1998. *Aboriginal women in Canada: Strategic research directions for policy development*. Ottawa: Status of Women Canada.
- Strong-Boag, Veronica, Sherrill Grace, Avigail Eisenberg, and Joan Anderson, ed. 1998. *Painting the maple: Essays on race, gender, and the construction of Canada*. Vancouver: UBC Press.
- Summers, Carol. 1991. "Intimate colonialism: The imperial production of reproduction in Uganda, 1907-1925," *Signs* 16, 787-807.
- Tapie, Christine. April 1999. "Nos attentes: Voir respecter le choix, libre et éclairé, des parents en ce que concerne le lieu et les conditions de la naissance de leurs enfants" *Les Dossiers de l'Obstétrique* 271: 45-48.
- Terranova, Tiziana. 2004. *Network culture: Politics for the information age*. London and Ann Arbor, MI: Pluto Press.
- Thébaud, Françoise. 1986. *Quand nos grand-mères donnaient la vie: La maternité en France dans l'entre-deux-guerres*. Lyons: Presses Universitaires de Lyon.

- Thomas, Lynn M. 2003. *Politics of the womb: Women, reproduction, and the state in Kenya*. Berkeley: University of California Press.
- Thompson, Anne. 1997. "Establishing the scope of practice: Organizing European midwifery in the inter-war years 1919-1938." In Hilary Marland and Anne Marie Rafferty, eds. *Midwives, society and childbirth: Debates and controversies in the modern period*. London: Routledge, pages 14-37.
- Thrift, Nigel. 2004. "Intensities of feeling: Towards a spatial politics of affect" *Geografiska Annaler* 86B (1): 55-76.
- Treichler, Paula A., Lisa Cartwright, and Constance Penley, eds. 1998. *The visible woman: Imaging technologies, gender, and science*. New York: New York University Press.
- Tritten, Jan. 1999. "Editorial: Global alliance of midwives." *Midwifery Today* 46. Retrieved February 10, 2005 from <http://www.midwiferytoday.com/articles/globalalliance.asp>.
- Tronto, Joan. 1993. *Moral boundaries: A political argument for an ethic of care*. New York: Routledge.
- Tsing, Anna. 2000. "The global situation." *Cultural Anthropology*. 15 (3): 327-360.
- Turner, Bryan S. 1992. *Regulating bodies: Essays in medical sociology*. London: Routledge.
- Turriffin, Jane. 2002. "Colonial midwives and modernizing childbirth in French West Africa." In Jean Allman, Susan Geiger, and Nakanyike Musisi, eds. *Women in African colonial histories*. Bloomington and Indianapolis: Indiana University Press, pages 71-91.
- Union Nationale des Syndicats de Sages-femmes Françaises. No date. [Brochure] *Une grève le 20 mars, pourquoi? Comment?* Paris: Union Nationale des Syndicats de Sages-femmes Françaises.
- Urry, John, 2004. "Connections" *Environment and Planning D: Society and Space*. 22 (2): 27-37.
- Vadeboncoeur, Hélène. 2004. "Delaying legislation: The Québec experiment." In Ivy Lynn Bourgeault, Cecilia Benoit, and Robbie Davis-Floyd, eds. *Reconceiving midwifery*. Montréal: McGill-Queen's University Press, pages 91-110.

- Valentine, Gill and Sarah L. Holloway, 2002. "Cyberkids? Exploring Children's Identities and Social Networks in On-line and Off-line Worlds" *Annals of the Association of American Geographers*, 92 (2): 302-319.
- Vecchio, Diane C. 2006. *Merchants, midwives, and laboring women: Italian migrants in urban America*. Urbana: University of Illinois Press.
- Verber, Christine Hindle. 1995. "International credentialing of midwives." *Midwifery Today* 2. Retrieved March 13, 2006 from <http://www.midwiferytoday.com/articles/intercred.asp>.
- Vilain, Annick. May 1999. "Les sages-femmes: Une profession en expansion" *Études et résultats* 17. Paris: Direction de la recherche des études de l'évaluation et des statistiques, Ministère de l'emploi et de la solidarité.
- Ville de Vénissieux. 2005. "Les données économiques." Retrieved March 24, 2006 www.ville-venissieux.fr/eco/donnes.htm.
- Viossat, Philippe and Jean-Claude Pons. 2001. "Maisons de naissance: Revue de la littérature." *Journal de Gynécologie, Obstétrique et Biologie de la Reproduction*. 30: 680-687.
- Wajcman, Judy. 2004. *Technofeminism*. Cambridge: Polity Press.
- Wajcman, Judy. 1991. *Feminism confronts technology*. Cambridge: Polity Press.
- Walker, Michelle Boulous. 1998. *Philosophy and the maternal body: Reading silence*. London: Routledge.
- Ward, Anna, Jeanne Gregory and Nira Yuval-Davis. 1992. *Women and citizenship in Europe: Borders, rights and duties*. Stoke-on-Trent: Trentham Books and EFSF.
- Weinbaum, Alys. 1994. "Marx, Irigaray, and the politics of reproduction." In Emanuela Bianchi, ed. *Is feminist philosophy philosophy?* Evanston, IL: Northwestern University Press. Reprinted from *differences: A Journal of Feminist Cultural Studies* 6 (1): 98-128.
- Weindling, Paul, ed. 1995. *International health organisations and movements, 1918-1939*. Cambridge: Cambridge University Press.
- Weir, Lorna. 1996. "Recent developments in the government of pregnancy" *Economy and Society* 25 (3): 372-392.
- Wickham, Sara. Autumn 1998. "Widening the circle." *Midwifery Today* 47: 49.

- Williams, A. Paul, Raisa Deber, Pat Baranek, and Alina Gildiner. 2001. "From Medicare to home care: Globalization, state retrenchment, and the profitization of Canada's health care system." In Pat Armstrong, Hugh Armstrong, and David Coburn, eds. *Unhealthy times: Political economy perspectives on health and care in Canada*. Oxford and New York: Oxford University Press, pages 7-30.
- Wilson, Philip K. ed. 1996. *The medicalization of obstetrics: Personnel, practice and instruments*. New York and London: Garland Publishing.
- Wolf, Judith. 2001. *La maison de naissance de Madame de Béarn*. Paris: Denis Diderot Presse.
- Woodward, Kathleen. 1999. "Statistical panic" *differences* 11 (2): 177-203.
- Yeo-E. J. 1999. "The creation of 'motherhood' and women's responses in Britain and France, 1750-1914." *Women's History Review* 8 (2): 201-218.
- Young, Iris M. 1990a. *Throwing like a girl and other essays in feminist philosophy and social theory*. Bloomington and Indianapolis: Indiana University Press.
- Young, Iris M. 1990b. *Justice and the politics of difference* Princeton: Princeton University Press.
- Yule, Cynthia and Katie Heffelfinger. 2000. "How to build a birth network." *Midwifery Today* 56: 10-14.
- Yuval-Davis, Nira. 1996. "Women and the biological reproduction of 'the nation'" *Women's Studies International Forum* 1-2: 17-24.
- Yuval-Davis, Nira. 1997. *Gender and nation*. London and Thousand Oaks, CA: Sage Publications.
- Zeitlin, Jennifer, Emile Papiernik, Gérard Bréart, and The EUROPET Group. 2004. "Regionalization of perinatal care in Europe." *Seminars in Neonatology*. 9: 99-110.
- Ziller, Jacques. 2005. "Public law: A tool for modern management, not an impediment to reform." *International Review of Administrative Sciences*. 71 (2): 267-277.
- Zizek, Slavoj. 1999. "The Matrix, or the two sides of perversion." Retrieved March 21, 2006 from <http://www.lacan.com/zizek-matrix.htm>.

CURRICULUM VITAE

MARIA FANNIN

EDUCATION

University of Washington, Ph.D. in Geography, July 2006.
Title: Midwifery as Mediation: Birthing Subjects and the Politics of Self-Determination. (Chair: Kim England).

University of Washington, M.A. Geography, March 2002.
Thesis: Birth as a spatial process: Themes of control, safety, the natural and the family in 'homelike' birthing rooms. (Co-Chairs: Michael Brown and Kim England)

University of Kentucky, B.A. Geography and B.A. French, Magna Cum Laude, May 1998

AWARDS AND FELLOWSHIPS

Arch C. Gerlach Dissertation Fellowship, Department of Geography, University of Washington, 2005.

Edward L. Ullman Award for Outstanding Doctoral Work, 2005.

National Science Foundation Graduate Fellowship, 1999-2004.

Antipode Graduate Student Scholarship, 2004.

International Council of Canadian Studies Graduate Student Scholarship, 2004.

Foreign Language and Area Studies Fellowship, Canadian Studies, Department of Education, Summer 2002.

Foreign Language and Area Studies Fellowship, Middle East Studies, Department of Education, Summer 2002, declined.

Edward L. Ullman Award for Outstanding Master's Work, 2001.

Phi Beta Kappa, 1998.

Zembrod Award for Outstanding Graduating Senior, Department of French, 1998.

Academic Excellence Scholarship, Autumn 1997-Spring 1998.

Oswald Undergraduate Research and Creativity Award, 1997.

Paper submitted: "Urban Territories: Boundaries in the Lexington Landscape"

William A. Withington Award in Human and Cultural Geography, 1997.

Aix-en-Provence Scholarship for Travel and Study, 1997.

Chancellor's Scholarship, University of Kentucky, Autumn 1993 to Spring 1997.

RESEARCH GRANTS

Labor Studies Research Grant, University of Washington, 2005.

Sigma Xi Grant-in-Aid of Research, University of Washington, 2004.

Chester Fritz Grant for International Study and Exchange, Graduate School, University of Washington, Autumn 2004.

Howard Martin Grant for Graduate Research, Department of Geography, University of Washington, 2004.

PUBLICATIONS (* indicates refereed articles)

"Transnational Midwifery Activism in Québec and France" *Antipode* 37 (1): 165-170. January 2005. Report of research conducted with funding from an Antipode Graduate Student Scholarship.

* "Domesticated Space and Disciplined Bodies: Tracing the Emergence of 'Homelike' Birthing Rooms" in *Life's Work*. Cindi Katz, Sallie Marston, and Katharyne Mitchell (eds). London: Blackwell, 2004. 96-118

* "Domesticated Space and Disciplined Bodies: Tracing the Emergence of 'Homelike' Birthing Rooms" *Antipode* 35 (3): 513-535. July 2003.

"The Battle in Seattle: A Response from Local Geographers in the Midst of the WTO Ministerial Meetings" With Sarah Fort, Jeanine Marley, Joe Miller and Sarah Wright. *Antipode* 32 (3): 215-221. July 2000.

Submitted Articles

“‘Global’ midwifery activism: from nation-state to virtual space” Submitted to *ACME*, August 2005.

CONFERENCE PAPERS

“Choose wisely: midwifery politics and reproductive self-determination.” Presentation at the Association of American Geographers Annual meeting, Chicago, March 2006.

“Reproductive Risk Management: Biopolitics and Professional Midwifery.” Presentation at the 1st Annual University of Washington Graduate Symposium for the Humanities, April 2005.

“‘Global’ Midwifery Activism: From Nation-State to Virtual Space.” Presentation at the Association of American Geographers Annual meeting, Denver, April 2005.

“Geographies of National Reproduction: Midwifery Legalization and Inuit Activism in Québec.” Presentation at “Québec in Question: Multidisciplinary Explorations of Contemporary Québec Society” sponsored by the Canadian Studies Center, University of Washington, March 2005.

“Autonomy Reconsidered: Unassisted Birthing and Radical Reproductive Politics.” Presentation at the Association of American Geographers Annual meeting, Philadelphia, March 2004.

“At Home in the Hospital: New Domestic Spaces and the Neoliberalization of Birth” Presentation at the Canadian Association of Geographers Annual meeting, Victoria, B.C. May 2003.

“The Birth of the Nation: Contemporary Midwifery and the Reproduction of the (Trans)National Subject” Presentation at the University of Washington American Studies Colloquium, May 2003.

“Reconceiving Citizenship and the Politics of Reproduction: The Legalization of Midwifery in Quebec, Canada.” Presentation at the Association of American Geographers Annual meeting, New Orleans, March 2003.

“Metaphors of Home and the Pregnant Body: A Case Study of Hospital Birth Centers in Seattle, Washington.” Presentation at the Association of American Geographers Annual meeting, Los Angeles, March 2002.

“Spaces of Childbirth: A Case Study in Seattle, Washington.” Presentation at the Association of American Geographers Annual meeting, New York, March 2001.

INVITED PRESENTATIONS

“Rationalizing Reproduction: Health Care Efficiency and Midwifery Labor in Contemporary France.” Presentation at the Harry Bridges Labor Center Conference on Caring Labor, University of Washington 2005.

“Citizen-mothers and midwives: the politics of birth in contemporary France.” Presentation at Department of Geography Colloquium, McGill University, Montréal, Canada, November 26, 2004.

RESEARCH EXPERIENCE

Research Assistant to Katharyne Mitchell, Simpson Professor in the Public Humanities. Winter-Spring 2006. Assisted Professor Mitchell with the interdisciplinary research project, Reclaiming Childhood.

Research Assistant to Katharyne Mitchell, Department of Geography. Winter-Spring 2003. Assisted with archival research for Professor Mitchell’s project on comparative citizenship education in France and the United States.

Research Assistant to Katherine Beckett, Department of Sociology. Summer-Autumn 2001. Assisted with extensive historical research on the history of midwifery since 1850 (first issue of JAMA) and the recent legislative decisions legalizing midwifery in the United States.

TEACHING EXPERIENCE

Instructor, *Integrated Writing Program Link with Geography 277: Geography of Cities*, Spring 2005, Winter 2003

Instructor, *Integrated Writing Program Link with Geography 280: Health and Health Care Geographies*, Winter 2005.

Instructor, *Geography 200: Cultural Geography*, Summer 2003.

Instructor, *Integrated Writing Program Link with Geography 245: Population Diversity*, Spring 2003.

Instructor, *Integrated Writing Program Link with Geography 100: Introduction to Human Geography*, Autumn 2002.

Teaching Assistant, *Geography 123: Introduction to Globalization*, Professor Matthew Sparke, Winter 2002.

Teaching Assistant, *Geography 100: Introduction to Human Geography*, Instructor: Mark Purcell, Autumn 2000, Autumn 2001, Spring 2002.

Reader, *Geography/International Studies 344: Migration in the Global Economy*, Professor Katharyne Mitchell, Autumn 2002.

Reader, *Geography 378: Social Control in the City*, Professor Steve Herbert, Autumn 2001.

SERVICE

Organizer of a special session on "Preparing for Graduate School," Association of American Geographers Annual meeting, Chicago, March 2006.

Presenter, Home Seminar on Finding Research Funding, Department of Geography, University of Washington, November 2005.

Assistant Instructor, TA Conference on Teaching and Learning, University of Washington, September 2005.

Co-organizer, "Québec in Question: Multidisciplinary Explorations of Contemporary Québec Society" sponsored by the Canadian Studies Center, University of Washington, March 2005.

Member, Transnational Studies Project, University of Washington, 2003. In 2003, the Transnational Studies Project organized a speaker series on the theme of "Literacies of Transnational Migration" with funding from the Walter Chapin Simpson Center for the Humanities at the University of Washington.

Chair of special session on Philosophy and Geography, "Urban Planning, Globalization, and Phenomenological Spaces," at the American Philosophy Association, Pacific meeting, Seattle, March 2002.

Organizer and chair of special session on Medical Geography and the Body, Association of American Geographers Annual meeting, New York, 2001.

Co-organizer and moderator, Urban Sustainability Workshop. University of Washington. May 2001. The workshop initiated a conversation between University administrators, Seattle city, King County officials and environmental activists to coordinate environmentally sustainable planning for the University and the region.

Co-coordinator, Department of Geography Colloquium Series, 2000-2001. The coordinators organize the invitation and hosting of scholars from the University of Washington and other universities to a weekly series of lectures in the Geography department.

LANGUAGE SKILLS

Advanced Proficiency in French. Five years of university-level study from 1993 to 1998. Completed Summer Intensive French Language Course in 2002 at McGill University, Montreal, Canada.

Beginning proficiency in German. One year of University-level study.

REFERENCES

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