

The Geopolitics of Birth

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It is likely that, for most of us, the moment we had our very first geopolitical encounter was the moment we were born. In that moment we take our first breath and thus begin our existence as an independent and interdependent human being, newly disconnected from our mothers' bodies. We are welcomed, gendered, named and by these means, we are given our place in the social networks that form family and community. While this process has begun well before birth through pre-natal screenings and preparations the birth itself remains a deeply significant moment, especially for mothers. Soon birth certificates will be issued, citizenship assigned, and our geopolitical identity thus assigned. But before we even get that far we are already encapsulated in a space of geopolitics, a space of overlapping territorial claims, of power enacted and resisted, and of multiple identities brought into being.

Geopolitics has traditionally focused on international power relations and politics, often at the macro scale. Geographers are used to speaking of nations and nationalism, states and state ideologies and the production of national territories, borders and boundaries. This paper, however, focuses on a more intimate geopolitical process in which 'big' politics that shape the legislation around maternity care, the everyday and intimate experience of giving birth, and everything in between, coalesce in the birth space: that physical space and moment in time that a woman enters as she labours. This process is geopolitical (rather than just political) because it is also fundamentally territorial. A broad range of actors involved in birth make overlapping territorial claims: from state legislators; to insurance companies; to hospital managers; obstetricians; midwives; and mothers themselves (to name but a few). Each of these actors claims territory in the birth space and exerts differing levels of control over those territories, whether those territories are the sites of birth in the hospital or the home, the bodies of mothers in labour or their unborn children. But the experience of birth, and its territoriality, is not just confined to the claims of human actors. The non- and sub-human also have a significant role to play. Also present and shaping a woman's experience at birth are the machinery and the drugs, the physical attributes of the space itself, the hormones that flood the body of both mother and child during labour. There may also be incense or music, a pool, a shower, food consumed freely (or illicitly when hospital policy forbids it). All of these things, the discursive and the material, intermingle in the spaces of birth and are party to territory-making as birthing bodies and the rooms in which women birth are reconfigured through spatial claims to power.

In this paper I begin to explore how these diverse actants, (both the human and non-human actors involved, Latour 2005) create a geopolitics of birth through the territorial claims they pursue or enable. I draw both on a feminist geopolitics literature and emerging work on new materialities, beginning the paper with a brief discussion of these literatures and how they might usefully be brought together in the analysis of birth. In the

rest of the paper I focus on some of the key actants engaged in shaping the geopolitics of birth, beginning with the most prominent discourses that order understandings of birth and enable human actors to make certain kinds of claims and take particular action in the birthing space. I draw on some initial explorations from an ethnographic study with mothers, midwives and obstetricians in Australia and New Zealand ‘Mapping Birth Spaces’. Using one of the early research interviews as illustration I explore some of the ways actants come together to act in concert: claiming territory within the birth space and linking an intimate geopolitics enacted in the space of a few exceptional hours in a woman’s life with a macro-politics of medical discourse, social values, and the regulation of citizen-subjects.

Feminist geopolitics, materiality and birth

The need to consider the moment of birth through a geopolitical lense emerges from two sources. One is the experiences of women interviewed for this research project for whom a sense of control (or lack/loss of control) over their bodies and the spaces they inhabited during birth was a significant theme. The other is the feminist literature on birth in which territoriality is central in debates about control over a mothers body and where a woman should give birth.

Much of the feminist birth literature pursues a critique of dominant medicalized modes of maternity care, and explores homebirth (or ‘free birth’ in which labour and birth unattended by midwife or obstetrician) and hospital birth as modes of opposition, often manifest in competing territorial claims over places (where a woman should give birth) and bodies (the body of the birthing mother and the body of her baby) (Davis-Floyd 2001, 2004; Fahy and Parratt 2006; Fahy and Hastie 2008; Fannin 2004; Fleuriet 2009). One of the most influential scholars who takes this binary approach is anthropologist Robbie Davis-Floyd who makes the argument that birth is a form of ritual socialisation of women, with the aim of producing a mother who “believes in science, relies on technology, recognizes her inferiority (either consciously or unconsciously), and so, at some level, accepts the principles of patriarchy” (Davis-Floyd 2004:152–153). The recognition of birth as a key moment reflecting and shaping broader social relations is an important contribution but what requires more careful consideration are the particularities of the birth practices that make such an effect possible. Davis-Floyd assumes that there is a hierarchical scale in place here, with patriarchal institutions operating at the top and individual birthing women at the bottom being acted upon in particular ways. Feminist geography and geopolitics can contribute here, providing a way to examine power relationships in action around birth, and pre and post-maternal care without being forced to think through hierarchical scale.

Feminist geopolitical analyses offer an alternative lens through which to consider both the immediate power dynamics within the birthing room and its links to broader social and political processes. Feminist political geographies have challenged the masculine stance of traditional geopolitical perspectives and has shifted our attention to the concerns of marginalised and minority ‘Others’ (Dowler and Sharp 2001; Hyndman 2007, 2010). With this has come a focus on the small scale and local dynamics of territoriality and political struggle, the micro-geopolitics which shape spaces of everyday life in the home,

in communities and in the workplace (Gökarkısel 2012; Dowler and Sharp 2001; Nagar et al 2002; Pain 2009; Secor 2001). Embodied experience has become an especially important area of feminist contributions to geopolitical analysis, focusing on the ways geopolitics affects, controls and constructs bodies as well as analysing how geopolitical constructs are realised through embodied action and experience (Fluri 2011; Hyndman, 2004; Koopman 2011, Smith 2009, 2011, 2012). In this paper I am inspired by this work to explore some of the ways in which a macro-scale geopolitics becomes manifest at a micro-scale in and through embodied experience. The ‘big’ geopolitics engaged with here however has little overt connection to processes of state or nation building that often inflect the work cited above (although there is significant potential to make these connections). This research is not about how, for example, the reproductive body is a conduit through which geopolitical contests over state/national territories are played out. In this paper the body itself is the territory to be constructed, claimed, fought over. The links outward, beyond the body and beyond the intimate experiences of birth, stretch towards the institutions and corporations that define both the dominant discourses and legal frameworks through which maternity care is determined. The geopolitics of birth is, thus, an intimate geopolitics – focused primarily on a mother and the life she is bringing forth, but attending also to how her experience is inextricably connected to broader political struggles.

Feminist geopolitics only partially addresses the shortcoming of the existing literature on birth. While it provides an impetus for linking analysis of the ‘macro’ to the ‘micro’, the institutional to the intimate, it does not address a strong tendency in the birth literature to enact a binary of medical vs natural, hospital vs home, obstetrican vs midwife. In this research I am exploring new materialities, in particular Actor Network Theory (ANT) as a way to sidestep such binaries, adapting an ANT method of cataloguing all the human, nonhuman and subhuman actants without assuming they are already positioned in relation to a two sided debate. ANT is influential in the growing body of work in geography on affect and assemblages, but as yet has had little presence in the feminist geopolitical literature (Williams 2011 is a notable exception). . In the birth literature likewise there has been little engagement with new materialism or ANT. One exception is the work of Madeleine Akrich and Bernike Pasveer (2004) examining the construction and reconstruction of embodied selves through the interventions of different actors, including medical professionals and the technologies they deployed. Akrich and Pasveer do not assume that the birthing woman is an already existing rational subject, but instead attend to how she is constructed as a subject in particular ways. I draw on this approach, and on Latour’s critique of ‘the social’ (Latour 2005) as a way of sidestepping the necessity of placing a woman or her experience upon an already decided terrain. Latour argues that social scientists have it wrong when we invoke pre-existing structures to explain social relationships. For him, such ‘structures’ are not pre-existing, but are created afresh through networks brought into being in particular spaces and times. In much of the birth literature there is an assumption that the dominant social structure (patriarchy) is an already existing active agent, with obstetricians acting in concert with intention of producing this obedient citizen. For Davis-Floyd the dominant structure is already in place in the maternity care system and women are forced into a position of either going along with the dominant system or engaging a deliberate and combative stance against it.

Taking inspiration from Latour I prefer to ask how what we come to call patriarchy is being enacted through the complex networks that coalesce in the birthing room. In brief this involves cataloguing the diverse actants present and examining the role each plays in the birth stories told by individual women, trying to untangle how each of the actants make certain actions possible and seeing how actants come together to shape the birth experience. In thinking through networks rather than structures there may be opportunities to see past the binaries and to formulate different kinds of engagement – collective rather than combative. In the following I begin to explore how our understandings of birth might alter if viewed with the conceptual tools provided by feminist geopolitics together with ANT. Here a feminist geopolitics provides tools for analysing the plays for control over intimate territories of the body and the birthing room, while ANT provides tools for exploring the role of all actants in the room in ways that can acknowledge the presence of the ‘macro’ actors of state authorities without having to diminish the powerful role of the ‘micro’ actors engaged in the immediate work of birthing.

Narrative: part 1

The birth discussed in this paper took place in New Zealand. It was a planned homebirth that ended with transfer to hospital when the midwives attending became concerned that second stage labour was continuing beyond the recommended time limit of two hours. It is just one story but illustrates well the potential of the approach being explored in the research. At a superficial level of analysis the experience of this woman could fall neatly into the hospital/home; natural/medical binary, however as my analysis progresses I show how a more careful consideration opens up possibilities for a different interpretation. In all the interviews, after an initial discussion about the birth, the interviewer asked, “What was the most important object in that room?”. The narratives begin with an excerpt from her response.

For me the wheelchair is a really important object in the whole story because that was really what made the transition between home and hospital complete. While I was at home it was still my space. In a way I'd kind of already given up. I mean, I didn't understand why it wasn't working, why I wasn't able to push her out. ... When I got to the hospital one of the on duty midwives came out to the van with a wheelchair and I was like, no thank you I don't need that... So I set out to walk in and then [my midwife] came and she ordered me to kneel on the wheelchair. They wheeled me into the ward like that. Totally undignified! Past the celebrating families, me having contractions in the middle of it all. They whisked me past it all and into the birthing suite and then ordered me to climb up on the bed and put my feet in the stirrups. I remember thinking, hang on - this isn't how I'm supposed to give birth.

Discourses of birth

The debate about where and how a woman should give birth revolves around a handful of core discourses. The most prominent among these, and the one that seems to have the most purchase among obstetricians, policy makers and news editors is a discourse of safety. In this discourse a birth in hospital is safest because sometimes things go wrong: a woman experiences pain beyond that which she can cope with and needs pain relief, a

baby gets stuck and needs help to get out, a uterus ruptures, a woman hemorrhages, a newborn child needs resuscitation, etc. The concern with safety is often linked with an objection to homebirth:

“The bottom line is that the only people who think homebirth is safe are homebirth advocates. Everyone who reads and analyzes the scientific literature, everyone who follows state and national statistics, and everyone who cares for newborn babies knows that homebirth increases the risk of neonatal death.”
(Tuteur 2012)

Despite the dominance of the ‘safety’ discourse in maternity care systems in Australia and the US there is also a great deal of opposition to the assertion that hospitals are safe places to give birth. The opposition points to evidence that shows that in the case of normal birth the outcomes of homebirth may even promote better health outcomes for both mother and child (RCOG 2007). These advocates point to considerable disadvantages associated with birth in hospital including the way birth suites are designed to cater to the clinical needs of obstetricians rather than to ease labour, the ‘cascade of interventions’ that comes with medicalised birth practice (Tracy and Tracy 2003; Tracy et al 2007), cesarean sections conducted without clinical indications that a c-section is necessary, and the negative health outcomes associated with major abdominal surgery (Deneux-Tharoux et al 2006; Gaskin 2012).

For those opposed to the dominant discourse around risk and safety, birth is not just a bio-physical process but a social event that brings into focus questions of social justice and equity. Here birth is considered to be a reflection of wider social issues such as the familiar questions of women’s role in the economy, in the family, and women’s power over their own bodies and sexualities (DeVries et al 2001). A burgeoning movement recognizes that it is a basic human right for a woman to determine what happens to her body and her baby during childbirth (HCLU 2010, see also Fannin 2012). How the recognition of such rights is translated into the practice of birth professionals remains a contentious point and one that homebirth activists and midwives often link to the empowerment of women in general. Midwife Ina May Gaskin for example represents birth as a pivotal moment of women’s empowerment and disempowerment:

" Giving birth can be the most empowering experience of a lifetime - an initiation into a new dimension of mind-body awareness - or it can be disempowering, by removing from new mothers any sense of inner strength or capacity" (Gaskin, 2011: 1, 2).

Finally, for some coalitions in the debate the moment of birth is also a moment that determines the shape of our future society. Postnatal depression, ongoing health problems of mother and baby, and maternal death have been linked to the kind of birth a woman has had and the medical interventions she and her infant received during the birth. In addition, it has been argued that the kind of birth a woman has is the cause of more subtle impacts on the relationship between mother and child. The role played by vital hormones released during labour (oxytocin, adrenaline, beta-endorphins) is thought to have an important influence on the success of establishing breastfeeding, the strength of child-mother attachment, the likelihood of avoiding post-natal depression and the degree of confidence a woman has in her mothering abilities (Buckley 2010; Douglas 2010; Gaskin 2010, 2011; IsHak, Kahloon and Kakhry 2010; Skrundz et al 2011). A contingent of

childbirth scholars and advocates argue that because of the important role played by these hormones, the birth experience itself will shape the levels of empathy, caring and respect between mother and child, playing an important role in shaping the character of the newborn infant as they enter the social world and grow to adulthood.

“Women’s experiences and their feelings about themselves, their babies and motherhood, translate directly into thoughts and biochemistry that lay down patterns in their baby’s developing nervous system and brain. These patterns shape, not only how we see ourselves as children, but the relationships we form as adults and how we care for others and our world... (Arms 2012)

Birth, it is claimed, is not just about the hours of labour and delivery but about the shape of our future society.

This series of competing/complementary discourses rest on a series of claims to truth, out of which there is not (and can never be) a definitive answer to what is the best, the safest, the easiest, the most empowering, way to give birth. What is interesting is that, despite the diversity of viewpoints and the multiplicity of women’s birth experiences, the terrain is remarkably polarised. On one side stands a cohort of those who advocate for a bio-medical perspective on birth, and for whom questions of justice, empowerment, spirituality, and even the practice of midwifery, are highly suspect. Aligned opposite are homebirth and natural birth advocates, who often appear to be equally suspicious of a medical environment that is seen to be often hostile and bullying, giving little credence is given to a woman’s right (or ability) to make informed decisions.

Narrative part 2

... I didn't question - I was way beyond that kind of engagement I remember when the obstetrician leaned over with her scalpel in one hand and the syringe in the other and saying, I'm just going to give you a little cut to help bub come out. I don't remember feeling afraid, or like saying 'hey no way!' - that came afterwards. But thank god just as she leaned in between my legs a big contraction came and the midwives kept her back and that was it, [the baby's] head popped out, then the rest of her with the next one and [my midwife] caught her and slapped her down onto my tummy. And there she was...

This birth story could easily be shaped to fit with a story of the battles between the bio-medical camp and the homebirth camp. Being moved from the home to the hospital reconfigured the birthing mother as a patient, and no longer entitled to decide what happened to her own body in the same way. At home her consent was constantly being sought for interventions of the midwives, whereas in hospital consent was sought by the obstetrician saying “I’m just going to give you a little cut”. Thus the narrative could be read as a story of empowered in one space, disempowered in another...

Narrative part 3

...in retrospect it was a close call.... Here I was with my feet in stirrups like some nightmare of a 1950s maternity ward, totally out of it after pushing for 4 hours, and this bloody obstetrician wanted to do that to me just because she thought she ought to do something. [The baby] was absolutely fine... It would have been completely unnecessary but there was nothing I was capable of doing at that moment to stop it or argue, and the

power of my midwives to stall her had run out I guess. Up until that time, I didn't realise it but my mum told me later, they'd been acting like a scrum - stopping the obstetrician from getting to me and interfering.

In the process of mapping out the territorial claims being made in this room and identifying the range of human and non-human actants and their discursive allegiances, however, what came into focus through analysis was not a woman suddenly disempowered by her transfer from home to the hospital delivery suite. Instead what became visible were the multiple, co-existing, competing and complementary claims and allegiances being enacted in that space by coalitions of actors, both human and non-human. A wheelchair facilitated the move from one territory to another. The move reconfigured the birthing woman as a patient, changing what could be decided and how decisions would be made, subtly changing the territoriality of her body in terms of who could lay claim to it and how. The building, the room, the staff, the equipment now belonged to the hospital, and made a new set of practices possible. The bed and stirrups, IV drip scales, fetal scalp electrode, measuring tape, bright lights, and the clock worked to make monitoring possible/easier, track adherence to normative standards, and support decisions to intervene (with an episiotomy). Staff and equipment both were compelled to follow or be deployed according to hospital policy. That policy was determined by the unknown and unseen lawyers and judges, committees, experts and politicians who decided upon the legal framework for maternity care and the lobby groups that helped to shape it – all of which determined the approved length of second stage labour. As the midwives carried out this directive, they facilitated a claim by the state to the body of the birthing woman, and enabled her annexation by the hospital/obstetrician. The obstetrician in turn, watching the clock with her scalpel and syringe, sought to lay claim to the birth passage, to cut a path for the emerging baby and assist a more timely delivery. At the same time, the midwives' 'scrum' held her at bay for as long as they could, maintaining a role of guardianship (Fahy and Hastie, 2008) over the birthing woman and defending her desires. That woman, her body already subject to competing claims by her carers, was also all at once subject to competing claims within her body. First, from her limbic system, flooding the body with labour hormones and ruled by what Gaskin (2011, 37-41) speaks of as "the inner primate": a trance state rather than a "logical, thinking state" (37), encapsulated here in the reference to being "way beyond" engagement. At the same time her ego, her rational and conscious self, remained present watching the birth unfold. Both inside and outside the body was the child being born, whose tipped head helped to slow everything down and who then emerged blue and protesting, ready to make a still ongoing claim to her mothers body and being. Present also was medical equipment on standby, pharmaceutical companies in absentia, family and friends with their own perspectives, expectations and emotions.

Conclusions

It is compelling to read birth as a space subject to polarised views of natural vs medical, midwifery vs obstetrics, women's rights vs obstetricians' convenience. Davis-Floyd's picture of a normative medicalized maternity system designed to socialise women (and their babies) to become obedient bio-medical subjects allows recognition of disturbing and disempowering birth experiences as the consequence of unjust (and often abusive)

treatment of women in maternity wards. However, these perspectives also leave little room to maneuver. In the discourses that dominate debates around birth there are currently few resources available for thinking about or engaging with birth other than through literatures already polarized by the natural vs. medical binary.

Through one short empirical example in this paper I have begun to articulate what may be an alternative vocabulary through which to understand and represent the experience of birthing women: one which does not discount the political and relations of domination or abuse, but which also allows us to attend to the multiplicity of actants and experiences shaping any given birth. Looking for the intimate geopolitics of birth it becomes possible to see the litany of overlapping territorial claims that come into play in the birth space, competing for control over the birthing body (or bits of it) and the birthing work that it is doing. In the birth space those competing claims come to the fore as decisions are made and actions taken, leading to what can be minor disputes ('wheelchair? stirrups? no way!'), skirmishes (blocking access for the obstetrician), annexation ('I'm just going to give you a little cut'), and sometimes all out warfare. Using ANT methodologies it becomes possible to see how these claims can be made by coalitions of actants who are human (mother, baby, obstetrician, midwife), non-human (wheelchair, clock, scalpel) and sub-human (hormones). Many people, things, ideas, ideologies, values, bodies, the more-than and other-than human, gather around birth and shape a woman's experience. From the competing claims within from hormones, drugs, the 'rational' or 'instinctive' mind and the as-yet-unborn child, to the competing claims from carers and the tools and technologies they enroll, birth unfolds through an assemblage of actants. It is an assemblage that gathers through war and conflict, through territorial disputes and competing truth claims, through affection, love and the work of caring. As long as the intimate geopolitics of birth are conducted as combative claims to territory a woman's birth experience is likely to be determined by which competing coalition carries the voice of authority and which territorial claim wins. If it is possible to take seriously, however, the multiple actors that are not only present, but *necessarily* assemble for birth, perhaps a more collective engagement may take shape in the birth space. The work begun in this paper also has the potential to contribute to new directions in both geopolitics literature and ANT. Work in ANT has tended to avoid politics, but in this research the tracking of networks is highlighting intricate interconnections that prove the old adage 'the personal is political'. The networks of actors that shape women's birth experiences stretch from the sub-human flows of oxytocin, through the intimacies of a woman's relationship with her newborn child, her family and carers, to the context setting power of dominant discourses, legal and policy frameworks, and the ideological bent of 'big politics' of the day. For the woman giving birth there is no escaping the competing relationships of power and the ways in which her birthing body is thus rendered in multiple and overlapping territories, whether actors representing competing interests are present at the birth or not. For feminist geopolitics this research is demonstrating the potential of ANT methods to attend to the often fleeting and minute relationships and multiplicity of actors that effect a geopolitics, creating politically inflected territorial claims even in the most intimate moments of life.

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