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Reinscribing the Birthing Body:

Homebirth as Ritual Performance

In this article, I examine the clinical practices engaged in by U.S. homebirth midwives and their clients from the beginning of pregnancy through to the immediate postpartum period, deconstructing them for their symbolic and ritual content. Using data collected from open-ended, semistructured interviews and intensive participant-observation, I describe the roles ritual plays in the construction, performance, and maintenance of birth at home as a transgressive rite of passage. As midwives ritually elaborate approaches to care to capitalize on their semiotic power to transmit a set of counterhegemonic values to participants, they are attempting, quite self-consciously, to peel away the fictions of medicalized birthing care. Their goal: to expose strong and capable women who “grow” and birth babies outside the regulatory and self-regulatory processes naturalized by modern, technocratic obstetrics. Homebirth practices are, thus, not simply evidence-based care strategies. They are intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces (home) and authorities (midwives and mothers). [homebirth; midwifery; ritual; childbirth]

We want mothers to reflect on their births, to be amazed at what they have accomplished, and to fall madly in love with their babies. As women in this society, we are told that something is wrong with us at every turn. We have PMS that requires medications so we're not too bitchy. We need thousands of dollars worth of technology to get our babies out alive. Our breast milk is a burden, so we're offered a substitute . . . The myth of the totally dysfunctional female body is big business! That's a lot to ask women to take in—to be made to feel totally incompetent. But then we're expected . . . to raise up new members of our society. Midwifery is about listening to all of that and saying “I don't buy it!” . . . We're overturning unfounded notions about our bodies one birth at a time.

—Lucinda, a 62-year-old “illegal” homebirth midwife, who has been catching babies for almost 40 years

In the early 1990s, symbolic and critical feminist anthropologist Robbie Davis-Floyd turned the lens of ritual analysis inward and analyzed U.S. hospital deliveries

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as heavily ritualized and socially constructed rites of passage (2004). She argued that childbirth, as it has been performed since the industrial era, is not simply “evidence-based medicine” but, rather, a reflection of a larger patriarchal and technocratic society that constructs women’s reproductive bodies as inherently faulty and in need of medical management—a perspective shared by Lucinda, the midwife cited above. Almost 20 years later, many of Davis-Floyd’s critiques of U.S. hospital birth practices as overly medicalized and unsupported by research are still relevant. What has changed is the rising tide of outspoken dissent from mothers, natural birth advocates, midwives, and a minority of physicians who are calling for the reform of overly expensive, socially alienating, potentially dangerous, and often unnecessarily interventive technologies in the birthplace. Although still a small and underresearched minority, these critics are constructing new approaches and perspectives in opposition to hegemonic obstetric paradigms (Wagner 2006).

In this article, I examine the clinical practices engaged in by U.S. homebirth midwives and their clients from the beginning of pregnancy through to the immediate postpartum period,¹ deconstructing them for both their symbolic and ritual content. I use Davis-Floyd’s (2004) now classic *Birth as an American Rite of Passage*, and her critique of technocratic birthways as ritualized attempts to communicate society’s deepest beliefs about the supremacy of technology, as a comparative model for examining the systems-challenging praxis (Singer 1995) of homebirth midwives in the United States. By refocusing our attentions from hospital to home, physicians to midwives, and patients to women, I argue that two things are made possible.

First, we can begin to see within the largely hidden world of home delivery (about 1 percent of all births in the United States), moving beyond assumptions and stereotypes, to an examination of the range of practices, skills, and values that constitute midwifery care in this contested domain.² Second, by shifting the ethnographic location from hospital to home, our sense of just what constitutes ritual, as well as the ways the latter functions to create, transmit, and challenge social meaning, can be critically reexamined. In the pages that follow, I describe the ways homebirth midwives explicitly manipulate ritual in attempt to communicate the sufficiency of nature over the supremacy of technology,³ replacing mechanistic views of the body and birth with the language of connection, celebration, power, transformation, and of mothers and babies as inseparable units. And yet, as an analysis of homebirth narrative and performance makes evident, the functions of birthing ritual expand beyond the unidirectional transmission of core social values. During homebirth as a rite of passage, midwives and mothers cocreate, appropriate, and reinterpret meaning in childbirth, intentionally employing ritual as a political tool for challenging the normativity of medicalized delivery. I argue that performance and praxis theories, when combined with classic, ritual-as-language approaches, illuminate homebirth practices as intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces (home) and authorities (midwives and mothers).

Ritual Theory and Practice in Childbirth Research

Davis-Floyd’s (2004) interpretation of U.S. hospital birth as a heavily standardized rite of passage relies on the work of early symbolic anthropologists like

van Gennep (1960) and Turner (1969, 1974, 1977, 1979), who argued that major life transitions tend to be intensively ritualized. This ritualization, they assert, is often hidden, invisible, and normalized for members of a society in part because it emerges from its conceptual foundations—a place so ingrained in belief systems that only via the process of defamiliarization can participants come to see the deeper messages communicated through ritual transformations.

During a rite of passage—defined as a series of rituals that move individuals from one state or status to another—participants are situated in a transitional realm that is unlike the previous or coming state (Turner 1979). Turner argues that the nonordinary nature of this state facilitates a psychological opening in participants that society may capitalize on to communicate, reaffirm, and validate core values and beliefs. Birth, Davis-Floyd (2004) asserts, is such a process because it embodies the three stages of a rite of passage originally outlined by van Gennep (1960): (1) *separation* of the individual from her normal or previous social state (nonpregnant woman), (2) a period of *transition* where participants exist in a liminal space where they are not clearly one thing or another (pregnant and laboring mother-to-be), and (3) an *integration* phase where individuals are gradually reintegrated back into society replete with a new social status (mother of a new baby).

In addition, because childbirth is at least somewhat challenging for most women, it is likely to be a time when mothers are open to the guidance of others, and particularly to those considered “experts.” By exploiting the inherently transformative properties of the birth process, a society can guarantee that its basic values will be transmitted to participants. The ritualized practices characteristic of technocratic birth—the donning of the hospital gown, administration of intravenous (IV) fluids and medications, epidural anesthesia, and electronic fetal monitoring—communicate the supremacy of technology in the birthplace and a “birth-as-medical-event” perspective. The final result is a woman 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). Such a woman is likely to conform to the dictates of her culture, and this is a profoundly effective way of socializing members from the inside, making them want to conform to social norms and values.

However, as Davis-Floyd (2004) notes, humans are not automatons and, thus, the extent to which participants in the birth process actually emerge with these ideals depends on the individual involved. Care providers can capitalize on birthing processes to transmit core values to participants. However, because their interventions are, in most cases, not absolutely essential, a window exists that women may slip through, avoiding the full extent of technocratic socialization. Butler (1997) refers to this process of avoiding norms or of performing “wrong norms” as “slippage,” and notes that it provides the potential for resistance. As birthing women sidestep obstetric standards of care, they engage a performativity of “wrong norms” that challenges the hegemony and authoritative knowledge (Jordan 1993) of medicalized birthing care.

Davis-Floyd’s interpretation of hospital birth procedures as ritualized practice emerges from the semantic or semiotic schools of ritual analysis developed in the 1960s by theorists like Turner (1979) and Geertz (1973), who emphasize a ritual-as-language analogy that stresses the role of communication—or the ideas, values

and attitudes rituals embody and transmit. More recent approaches to ritual interpretation, including the performance approaches that emerged in the 1970s (Bell 1997), recast questions about the message content of ritual by asking how symbolic activities employed in rituals enable participants to appropriate, modify, or reshape cultural values and ideals (Wirtz 2007). Performance models focus on actors as active, rather than passive, as constructors of ritual and not simply as receivers of messages. Views of ritual as performative medium are based on the assumption that ritual does not simply mold participants but, rather, that participants actively create rituals and use them to modify their worlds (Kang 2006; Norget 2006).

Practice approaches, with their focus on ritualization as political praxis (Nash 2007; Paulson 2006; Robins 2006), have also expanded the scope of contemporary ritual analysis. Practice theorists cast ritual as paradigmatic engagement, or as an activity that showcases cultural patterns. In these approaches, researchers focus on processes of large-scale historical and social change and are often particularly attentive to the political dimensions of ritual, emphasizing how positions of domination and subordination are variously constituted, modified, and resisted through ritual.

Embedded in these approaches are different definitions and applications of the term *ritual* itself. Davis-Floyd (2004:8), for example, defines a ritual as a “patterned, repetitive and symbolic enactment of cultural beliefs and values.” She focuses on the transformative elements, rhythmic repetition, stylization, and staging of ritual performance that heighten emotional impact. These characteristics, she asserts, are what make ritual so effective at achieving its primary purpose—the cognitive transformation of participants. Religion scholar Catherine Bell describes ritual as “fundamentally a way of doing things to trigger the perception that these practices are distinct and the associations they engender are special” (1992:220). Although both authors emphasize formalization and periodization as common components of ritualization, Bell is careful to note these characteristics are not intrinsic to ritual per se. Some ritualized practices are deliberately informal, she asserts, usually because the actors are attempting to distinguish themselves from a known tradition or style as a means of appropriating or redefining the hegemonic order.

In this analysis, I use an inclusive definition of ritual as patterned, repetitive, and symbolic behaviors or practices that are commonly (but necessarily) formalized and designed to communicate the special or sacred nature of an event or process—in this case, birth at home with a midwife. By interpreting the practices associated with homebirth midwifery care as part evidence-based medicine and part ritual performance, we can begin to decode the metamessages of childbirth as it unfolds on a different terrain. However, the rituals of homebirth midwifery care, I will argue, are not simply about communicating an alternate set of values. They also provide a critical platform for resisting the cultural normativity of medically managed hospital deliveries. Just what this means for individual participants, however, differs, as each mother and her midwives coconstruct the nuances of pregnancy, labor, and postpartum care in accordance with their own unique needs, beliefs, and values. Birthing ritual is nothing, therefore, if not “flexible strategy” (Bell 1992:121), calling forth both consent and resistance (Klassen 2001). As a socially performed act of differentiation, homebirths are constructed in opposition to dominant ways of giving birth, although just where the lines between consent and resistance lie are not always clear, shifting with each provider and each mother, over time and in the retellings.

Methodology

The goal of this research was to use open-ended, semistructured interviews, intensive participant-observation, and the lens of Davis-Floyd's work on U.S. hospital deliveries as a framework for examining the roles of ritual in the construction, performance, and maintenance of homebirth as a transgressive rite of passage. To explore this question, I utilized a prospective, modified grounded theory approach (Glaser and Strauss 1967) following the methodology proposed by Charmaz (2000). After receiving Institutional Review Board approval for the ethical and noncoercive treatment of participants, I interviewed a voluntary sample of home birthing mothers ($n = 50$), midwives ($n = 20$), and for comparative purposes, obstetricians ($n = 10$) in three different regions of the United States during fieldwork between 2001 and 2005. I employed a multisite ethnography approach in the Northwest (NW), Southwest (SW), and Midwest (MW) of the United States in hopes of capturing any variations in scope of practice or care giving styles influenced by the varying legal statuses of midwifery across the nation (see Table 1 for a summary of the study sample by research site).⁴ Throughout this manuscript, I refer only to the region where midwives practice or mothers live, and not to specific towns or communities, to protect the women who live in "felonious states" for whom home delivery is an act of civil disobedience.

The mothers who were interviewed for this study were largely white, middle-class, educated, employed, and married or in long-term, stable relationships, as were most of the midwives. Physicians were all trained as Obstetrician-Gynecologists and evenly split between males and females, with a range of six to 27 years of experience. About half of participants identified as politically "progressive" or "liberal," while the other half described themselves as "conservative" both religiously and politically. All of the mothers interviewed engaged in prenatal, intra- and postpartum care with midwives and began labor intending to deliver at home.

I began interviews by asking participants to explain the procedures and practices they engage(d) in during the prenatal, intrapartum and postpartum periods, encouraging them to elaborate on the rationale and clinical evidence for their favored practices. When half of the interviews were completed, in keeping with grounded theory, I transcribed and analyzed providers' and mothers' narratives to produce an initial coding system based on commonly recurring themes. Analysis of the first set of interviews indicated that midwives engage in practices not simply for their clinical significance, but also expressly for their symbolic content. In turn, many women and their partners consciously embody and advocate for the ideals their midwives attempt to communicate and reinforce for them over the course of their care. As a result, I expanded interviews to include explicit questions on: (1) how women's experiences with homebirth midwifery care influenced their views of their bodies and babies, and (2) the explicit messages midwives sought to communicate to women during the provision of care.

My positionality as a medical anthropologist and Certified Professional Midwife facilitated unprecedented access to homebirthers and allowed for direct observation of the practices and procedures discussed in interviews and performed by participants. Because my approach included participant-observation at over 400 home deliveries in three different states, 60 hospital births in two states, and hundreds

Table 1. Summary of Research Participants: The Where, What and Whom of Home Deliveries

Research location by region of the U.S.	Legal status of state where data were collected	Number of deliveries observed	Formal interviews with mothers	Formal interviews with midwives	Formal interviews with obstetricians
Midwestern* U.S.	Felonious	120	30	6	2
Southwestern U.S.	Legal by Permit	60	0 [†]	4	0
Northwestern U.S.	Legal by Licensure	320+ [‡]	20	10	8
Totals	3	500	50	20	10
		Completed home deliveries: 440 (88%)	Multiparous women: 30 (60%)	Certified Professional Midwives: 15 (75%)	Males: 5 (50%)
		Hospital deliveries after transfer of care due to complications: 60 (12%)	Primiparous women: 20 (40%)	Traditional/Unlicensed Midwives: 5 (25%)	Females: 5 (50%)

*In order to protect midwives practicing in illegal states, I refer to research locations by region only.

†Over the course of this research, I have engaged in hundreds of informal conversations with midwives, mothers, families and physicians. These sample sizes reflect formal, audio-taped interviews only. No formal interviews were completed at the southwestern region research site.

‡Data collection is ongoing in this state.

of ante- and postnatal visits, I often had the opportunity to attend a delivery as researcher and midwifery assistant and then later, during postpartum visits, to listen to the retellings and ongoing interpretations of homebirth experiences. This methodology enabled me to both observe and engage in the construction of what Wirtz calls “telling moments” (2007:1)—a form of reflective discourse that includes both the noteworthy moments of the experiences themselves, as well as the “reflective discourses” that come later as ritual participants evaluate, critique, compare, commemorate, and celebrate their transitions to motherhood. The “processing” of homebirth stories as telling moments, combined with participant-observation, enabled me to see not only how ritual is constructed in the moment but also how subsequent narration plays a role in ongoing and dynamic meaning making.

After transcription was completed, I identified key themes from narratives and field notes and interpreted them with reference to van Gennep’s (1960) three phases of ritual: separation, transition, and integration. I then returned a summary of my findings to a volunteer sample of interviewees ($n = 32$), who discussed them in small focus groups. This process of member checking (Charmaz 2006) or reciprocal ethnography (Lawless 1992) returns findings to communities for comment and critique and, in this case, led to further elaboration and refinement of theoretical constructs initially identified during individual interviews. I have integrated participant critiques, as well as their validations of my interpretations, where possible throughout this article.

In the following sections, I walk the reader through the ritual phases of homebirth as a rite of passage, beginning with prenatal care (the separation phase), moving through to the labor and birth of the baby (the transition phases), and ending with the performance of the immediate postpartum period at home (the reintegration phase). Using Davis-Floyd’s work as a comparative model, I focus my analyses on frequently occurring elements of homebirth care,⁵ asking questions about both the text and subtext of standard practices, while endeavoring to push birthing ritual interpretations beyond those of core value identification and transmission.

Prenatal Care (the Separation Phase): Trust, Connection, and the Rejection of Strange-Making

Davis-Floyd (2004) argues that the beginning of pregnancy constitutes the separation phase of birth as a rite of passage; it begins with the mother-to-be’s gradual partitioning from her former identity as a nonpregnant woman and ends with her full acceptance and social recognition of the pregnancy. Under medicalized approaches to the prenatal period, the focus on diagnostic testing can function to extend this separation phase by producing a “tentative pregnancy” (Rothman 1987a). As women wait to find out about the health of their fetuses, they may delay attachments and the acceptance of imminent motherhood, lingering in a tenuous, “wait and see” separation phase characterized by fears of possible complications. Anna (a mother living in the NW who had her first baby in the hospital and her second at home)⁶ said of her obstetric care: “I kept waiting for the bad news. Surely one of those tests would eventually show something was wrong. . . . When I went into labor a week early and had a nice, fast birth, I was actually surprised. I wish now that I could have trusted and just enjoyed my first pregnancy.”

In addition, during the prenatal–separation phase, Davis-Floyd (2004, after Abrahams 1973) argues that many physicians engage, perhaps unconsciously, in “strange-making,” or the process of making the commonplace strange by juxtaposing it with the unfamiliar. Complex medical terminologies that label and sometimes judge the everyday, embodied experiences of pregnancy (as with “false labor,” “irritable” uterus, or “incompetent” cervix) contribute to strange-making and enhance the sense of separation Davis-Floyd argues is inherent in the prenatal period. Through the process of strange-making, withholding (or perhaps not having time to share) vital information about the birth process, and by relying on alienating “OB talk” as several mothers referred to it, doctors function as powerful ritual elders and elite knowledge bearers who will take responsibility for monitoring and eventually delivering the baby. Marshall, an obstetrician practicing in the MW, embraced this positionality in saying: “I am all for women asking questions, but what they have to remember is that I have 20 years of experience and a frame of reference they can never have having one or two babies.” Mothers who engage in mainstream obstetric care may internalize some of the messages communicated during prenatal visits and begin to perceive themselves as having little or nothing to add to the process. As a result, some may complete the separation phase feeling vulnerable and beholden to their doctors, or to the institution that provides them with a healthy child (Davis-Floyd 2004; Gamble and Creedy 2009; Rothman 1987b).

Midwives describe the desire to peel away these fictions of medicalized prenatal care, exposing strong and capable women who “grow” and birth babies outside the regulatory and self-regulatory processes naturalized by modern, technocratic obstetrics. Echoing the voices of midwives, feminist scholars have also worked to deconstruct “natural facts” of the pregnant and birthing body. As MacDonald describes: “Women’s bodies have been scientifically constructed as essentially faulty; their reproductive bodies as potentially dangerous to babies; childbirth as so fraught with danger as to be unthinkable without biomedical surveillance and intervention” (2007:95). Drawing on concepts like Foucault’s (1977) notion of “biopower,” feminist theories of the body have helped to expose scientific facts as power-laden, cultural constructs that emerge from disciplinary power/knowledge regimes located within social institutions like hospitals and prisons (Kaufman and Morgan 2005). What does it mean then, when midwives and mothers perform prenatal care within the home and away from the gaze of technocratic obstetrics? As families and midwives engage in the practices of pregnancy monitoring at home, they challenge the authority of more medicalized approaches, create new meanings around prenatal testing, and claim the home as a powerful political symbol and gendered space (Spain 1992).

The midwives who participated in this study openly reject the messages of danger, uncertainty, fear, “tentative pregnancy,” doctor-as-ultimate-authority, strange-making, and even, to some extent, the separation they believe are communicated by the rituals of medicalized prenatal care. Instead, they focus on encouraging connections with the baby and empowering the mother to “trust her body” through knowledge sharing; this begins at the first prenatal visit. Once a woman has interviewed the midwives working in her area and made her selection, in-home prenatal visits begin following the same schedule as obstetric appointments—every four weeks from 10 to 28 weeks of pregnancy, every two weeks until 36 weeks, and then

every week until delivery—although the appointments are typically much longer, lasting between one and one-and-one-half hours each. When midwives arrive at the home for a prenatal visit, the first 15 to 20 minutes are generally spent “checking in,” or talking about how the mother is doing with her diet, exercise level, and any emotional changes that have occurred since the last visit. These informal discussions usually happen over a cup of tea or other snack and are used by midwives to set the tone for a friendly and egalitarian care provider–client relationship. As Victoria (a midwife in the MW who has attended hundreds of deliveries “under the radar”) explained: “Accepting food or drink offered by a client in her home is a way of shifting the power back to women. By sharing food in the mother’s space, we can decrease the barriers that often exist between a pregnant woman and her doctor.”

Once the midwife and mother have “settled into the space they create together,” midwives conduct many of the same diagnostic procedures as physicians, including the urine screen, blood pressure and weight checks, fetal heart tone evaluation, palpation of the mother’s belly for fetal positioning and growth assessment, blood testing, and measurement of fundal height—tasks that, together, take about 20 minutes to complete. Family members are commonly called on to participate in these procedures; older children might help to hold the equipment for listening to fetal heart tones, and mothers and partners often palpate along with the midwife to get a sense of how the baby is positioned. The remainder of each visit is spent making sure women and their families understand the tests, procedures, and physiological–emotional changes of pregnancy they are likely to encounter in the coming weeks.

Although many, if not all, of the clinical tests offered during the prenatal period at home are the same as those used in more technocratic approaches, the layers of signification that surround their application are often quite different and intentionally modified by midwives in their efforts to produce alternate meanings. Jordan (1993:83) says of the ritual objects, instruments, and equipment deemed necessary for the culturally appropriate management of pregnancy: “To the extent that their use and operation are restricted,” they provide “support for some participants’ claims to special status via providing an occasion for the display of their expertise in operating the required technology.” The use of prenatal artifacts—equipment for taking blood pressure or for urinalysis, for example—are thus, embedded in the larger power/knowledge matrices of midwifery–obstetric practices. The context, artifacts, and symbolic actions associated with prenatal care function to stack or layer meanings for participants by providing a text and subtext that are simultaneously both literal and metaphorical (Kirmayer 2004; Rothman 1978).

During midwifery care, the artifacts of the prenatal period are used to evaluate fetal and maternal well-being, as well as to facilitate connection and to provide the opportunity for power/knowledge sharing. Eleanor (a mother living in the NW) said of her prenatal care with midwives: “I loved that we all [referring to husband and three-year-old daughter] got to take part in the prenatal care. I really understood what was going on, and I liked that feeling. It made me feel strong and smart and capable. It also really bonded me to the baby and to everyone involved in my prenatal care.” As midwives attempt to normalize and demystify prenatal care procedures for families as a way of rejecting strange-making and creating a sense of shared power, they call into question van Genneep and Turner’s tripartite division of

ritual, and particularly, whether separation is necessarily inherent in the first phase of birth as a rite of passage (Davis-Floyd 2004). Similarly, feminist, ritual theorists have argued that themes of *connection*, and not separation, more often characterize women's major life transitions (see Bynum 1991; Klassen 2001), and this seems especially true of midwives' and mothers' prenatal care narratives.

In addition, van Genneep's notion of the "pivoting sacred"—his sense that the sacred is not a stable or absolute category, but a more relational one—speaks to the fluidity of in-home prenatal monitoring as ritual performance (Klassen 2001). In the technocratic model of prenatal care, the sacred lies with the physician and his or her ability to manipulate "high-tech" testing (David-Floyd 2004). Although not always successful, midwives attempt, quite self-consciously, to shift the sacred back to mothers. The sacred pivots where the power flows (Klassen 2001), and mothers tended to describe the flow of power at home in opposition to clinic- or hospital-based prenatal care. In the latter, power was seen as flowing to and through doctors and their specialized technologies, whereas in homebirth care, power was more commonly described as flowing to and through mothers and their midwives.

The fact that prenatal care is performed in the woman's home, away from the gaze of obstetric surveillance, is itself significant and an explicit negotiation of power. As Klassen (2001:89) describes it: "women seek to subvert the 'hegemonic order' of birthing customs in the United States," by claiming the home as a "place of safety and well-being, which in turn designates their bodies as such." The location of prenatal care, thus, reterritorializes the home, rejecting certain claims about it—like the "home is too low-tech for adequate prenatal monitoring" claimed by James, an obstetrician in this study—while creating new assertions and realities within it. "Low-tech, low-stress, individualized, in-home prenatal care produces better health outcomes for mothers and babies" (Laurel, a NW midwife). As Maria (a woman living in the MW who gave birth to her first baby at home) explained: "Having prenatal care in our home was a good warm up for birth. It helped us to get comfortable with the fact that the combination of my body's intuition and the midwives' care was sufficient for the prenatal period in the same way that it would be for the delivery. I am sure that that is what helped me to feel so safe staying at home [for the birth]."

Through the rituals of in-home pregnancy monitoring, knowledge sharing, and affirmation, midwives claim mothers as the ultimate authorities on their bodies and babies and, in the process, replace notions about the supremacy of technology with the sufficiency of nature. Repeated restylizations of the strong, capable, healthy pregnant body in the home communicate connection, safety, and well-being. These reconstructed "natural facts," while equally socially embedded relative to more medicalized perspectives, are seen by midwives as essential components of the foundation needed for "trusting birth outside the hospital" once labor begins. As a MW mother named Lisa challenged: "I hope no doctors or midwives are running around thinking all we want is a live baby and mother. *How* our prenatal care unfolds and *how* we feel about it does matter." An enormous body of evidence documenting the benefits of holistic, socially supportive and prevention-oriented approaches to prenatal care support this mother's claim (Hamilton and Lobel 2008; Hazard et al. 2009; Hodnett et al. 2007; Zachariah 2009).

Labor Care (Part 1 of the Transition Phase): “Mothering the Mother,” Fetal Monitoring, and “Keeping Things on Track”

From a ritual perspective, labor—the stage of the birthing process where the uterus contracts regularly and the cervix dilates—is a time of important symbolic and physiological opening. The stress, joy, anxiety, and pain associated with labor effectively facilitate the breakdown of everyday categories, often producing an altered reality and a “psychological opening” (Davis-Floyd 2004:39) to the messages communicated through birth practices. The symbols of a typical, medically managed labor (IV, electronic fetal monitor, etc.) dominate the birthing space and, as many have argued (Oakley 1984; Davis-Floyd 2004; Mitford 1992; Rothman 1987b), function to transfer the focus from mothers to machines. As Elaine (a mother living in the MW who had her first baby in the hospital and the next two at home) explained: “During my hospital birth, I was so over the focus on that damned monitor. Everyone kept staring at it saying, ‘here comes another contraction’ and I was like, ‘no shit!’ Sometimes you wonder if anyone remembers there’s a real, live person connected to the strip of paper they’re so obsessed with.”

In opposition to more medicalized approaches to labor management, the explicit purpose of homebirth midwifery care during this phase is to initiate women into their new roles as mothers by modeling caregiving and supportive behaviors. One of the first home births I attended was for Ruby, a woman whose labor had come on hard and strong with little warning. When we arrived, she was pleading with her husband to take her to the hospital for an epidural. The midwife turned down the lights, wrapped her arms around the mother, and, rubbing her back, encouraged slow swaying and deep breathing. “You can do this. You are safe. These contractions are bringing your baby down. Just breathe . . . breathe. . . You can do this. You’ll be holding your baby soon. You are safe.” Ruby gradually relaxed into the contractions (what midwives call “surrendering to the pain”), and, melting into the midwife, began breathing with increasing ease through the contractions. The wide-eyed husband and tearful sister eventually replaced the midwife, taking turns in the support role, freeing up our hands for set-up, charting, and monitoring of mother and baby.

This form of one-on-one, intensive physical and emotional support during labor is described by midwives as a central component of the midwifery model of care, and all but the fastest home deliveries involve some combination of massage, warm water immersion (called the “midwives’ epidural” for its ability to reduce pain), counterpressure, position changes, visualization, and verbal reassurance throughout the labor. Midwives also commonly use “birth mantras” or repetitive, formulaic sayings, like those above, spoken quietly to help soothe women through contractions—“don’t fight it,” “let your body do it,” “open,” “let it be strong,” and “you’re safe, just surrender.” In addition, the use of aromatherapy, candlelight, and calming music allow midwives to capitalize on ritualized sensory manipulation to help women cope with contractions, while simultaneously defining the laboring space as sacred, special, or out of the ordinary. To help promote and solidify a support network for mothers that will ideally extend through the postpartum period, midwives intentionally pull partners and other “birth guests” into the intimacy of the labor space by encouraging them to assist with comfort measures and verbal

reassurance. Midwives believe that labor and birth participants will be transformed by the experience, and, for family members and friends, this may translate into a deep and lasting commitment to the mother, her partner, and the new baby. As Miriam (a MW midwife) explained, “Women do not forget how you treat them in labor. Even years later, they will remember. Love is what gets the baby in. Love is what will get the baby out. We try to get the family involved with the support so she will remember that, and bond with them, and feel loved, and move forward to parent from that place of connection.”

In addition to the focus on comfort measures, homebirth midwives encourage uninhibited movement, upright postures, position changes and maternal vocalizations (called “birthsongs”)⁷ as key strategies for speeding labor, protecting the safety of the baby, and for dissipating or coping with the intense energy of contractions—practices that, again, are strongly supported by research (Bodner-Alder et al. 2003; Downe 2004; Gupta and Hofmeyr 2004; Lawrence et al. 2009). These labor “tricks of the trade” are often formalized for particular midwives, as they help mothers to perform routines comprised of repetitive position changes (e.g., left side lying, hands-and-knees, right side lying, repeat), stylized vocalizations (deep moaning or grunting, short panting breaths, etc.) and timed movements in and out of the tub or shower (e.g., rest in the bath for 20 minutes, walk for 20 minutes, repeat). As an assistant, I learned very quickly which routines were encouraged by each midwife, and now my assistants know my favorite mantras and support strategies. By helping the mother to establish rituals of active self-comfort, midwives are better able to “manage the intensity of an unmedicated labor,” while mothers report feeling like they are “doing something, rather than just lying there passively waiting for contractions to happen.” When these coping strategies are successful, they contribute to a sense of personal power and agency for the labor participants.

In addition to helping to create and support the sacred space around laboring women, midwives also monitor the physical well-being of mother and fetus throughout the labor. Fetal heart tones are evaluated every half-hour in active labor and then every 15 minutes during transition—the most intense part of labor just before the pushing stage commences—for the purposes of charting, but also as a way of reassuring mothers that they and their babies are safe, their bodies capable. Midwives use portable, hand-held dopplers to listen to heart tones during and between contractions, and because dopplers do not require the mother to sit or lie in any particular position (as continuous electronic fetal monitors do), women can remain spontaneously mobile and active during labor. Miriam summed up her role in labor this way: “I am there for comfort and for monitoring. I am the guardian of normal birth. My calm presence is a reminder that she is safe and strong. She has everything she needs inside herself to birth her baby.”

Sensory manipulations in the form of “high-touch, instead of high-tech” comfort measures, mantras, and dim lighting, along with upright postures, fetal monitoring, and the encouragement of movement throughout labor are argued to have positive physiological effects on mother and baby. However, they are also understood by midwives to have the potential for profound psychosocial and emotional consequences that stem from the meanings ascribed to them. The physiological processes of labor transport women into an inherently liminal space—called “laborland” by mothers and midwives in this study—that carries its own affectivity. During labor,

midwives can capitalize on this affectivity to transmit transgressive values about pregnant and birthing bodies, socializing participants into accepting the powerful and life-giving properties of the female body and the unity of mother and baby. Homebirth narratives suggest that women tend to emerge feeling that they and their immediate support network labored the child into the world, and not the institution or obstetrician as Davis-Floyd (2004) has argued for technologically assisted labors in the hospital. Where hospital births transmit the message that experts, institutions, and technologies produce babies, the homebirth rituals around continuous labor support and fetal monitoring intentionally communicate the belief that women, in conjunction with their support networks, reproduce babies.

Spontaneous, Upright Delivery (Part 2 of the Transition Phase): An Inversion of the Doctor-Up, Mother-Down Hierarchy

Once the cervix is completely dilated, and spontaneous pushing begins, midwives encourage women to “tune into their instincts” and to “do what feels right to them.” Although I never heard a midwife tell a woman what position to assume for the pushing stage unless progress was uncommonly slow, many homebirth midwives provide birth stools and discuss the benefits of upright postures prenatally. Many women do, in fact, assume these positions as the pushing stage unfolds, suggesting that they have successfully internalized expectations for how birth at home should be performed.

Midwives encourage women to find their own rhythm as they push, offering continuous, verbal support, and often pushing along with them as part of the “communal push.” Most also diligently avoid directed, ten-count breath holding, pushing techniques used in many hospitals (sometimes called “purple pushing” for the tendency to rupture small capillaries in the face). Lucy (a NW midwife) explained that the tendency to have mothers push in a reclined position in coached, ten-count intervals “makes pushing unnecessarily difficult because it doesn’t work with the mother’s own natural body rhythms and mechanics. Telling a woman when to push and for how long overrides her inner voice and the voices of all the women who have come before her who intuitively knew how to give birth.” Deliberately constructing the pushing stage at home as less formalized and more mother-led allows midwives to further distinguish themselves from medicalized providers.

Once the head is visible, mothers are encouraged to reach down and feel the baby’s head as it emerges—a practice that midwives say helps women to control the speed of delivery, giving the tissues time to stretch. Midwives also use oil, warm compresses, and perineal massage to help avoid tearing, along with flexion of the baby’s head to insure that the smallest fetal cranial dimension presents during crowning. Once the head has cleared—ideally without trauma to the vagina or perineum—fathers or partners often help to “catch” the baby. Midwives then make an immediate assessment of the infant as he or she emerges and is passed up to the mother’s chest where skin-to-skin contact is encouraged for at least the first few hours after delivery. Midwives often say: “Normal is simply what you’re used to,” as a way of explaining how different management styles for the pushing stage at home and in the hospital are maintained over time. Because I have attended so many more home than hospital deliveries, at times I forget just how different

mother-led, upright, unmedicated pushing at home may feel to women who have only experienced hospital deliveries. A birth I attended for a labor and delivery nurse provided me with a potent reminder.

As the contractions intensified and it became clear that Katie was transitioning to the pushing stage, the calm of her labor gave way to panic: "I'm pushing, I think I'm pushing! My body is doing it. It's not me. Can I push?" "Of course," I said, "listen to your body. Try to push and see how it feels." Her friend, a neonatal intensive care nurse, equally concerned, worried: "Aren't you going to check her? What if she isn't ready to push?" "She is pushing!" I said. "She can push. Don't worry. It's OK." Katie: "Are you going to count, should I hold my breath? What do you want me to do?! The baby is coming!" "Let her come," I said. "Listen to your body . . . it's OK . . . good . . . reach down and touch your baby's head . . . breathe . . . gently, gently . . . now let your body do it. Here he comes. Help me catch." As we lift the baby out of the water and onto Katie's chest, there is a flurry of activity as the nurse friend hands me equipment for suctioning. "He doesn't need that," I say quietly. "Look, he is clearing his own airway. He is perfect. Mom is perfect. Everyone just watch for a second. . . . Look what you have done." Gradually, the calm returns. Later in the postpartum period, Katie reflected:

That pushing stage was strange for me. I don't know why, but I was thinking I was going to get in trouble for not doing it the right way, for not following the rules. It felt so good to be up off my back, squatting, and I know all of that is safer for the baby. . . . But, it's actually really hard for me because I am looking back now on all those births I have done for normal, healthy women in the hospital, and I'm realizing how much I, we, interfere with their process. We just have to run the show, rather than shutting up and letting her do her thing. I am so thankful for my experience, but I am sad too . . . it really matters, every little thing we do or don't do really matters for . . . for how you feel about your birth later.

Like Katie's reflections, midwives' discussions of pushing phase practices contain an interesting mixture of symbolic and clinical implications attributed to their approaches. Upright, mother-led pushing increases blood flow to the infant, but also honors the woman's inherent body knowledge. It co-opts and restructures what Babcock (1978) has called "symbolic inversion," where the gradual psychological opening to new messages characteristic of the liminal or transitional period of ritual is intensified by metaphorically turning elements of the normal belief system upside-down or inside-out. In technocratic approaches, and especially where epidural rates are high, normal bodily patterns of interacting in the world are inverted as the woman finds herself legs spread, head lowered preventing eye contact, vagina exposed to a room full of "intimate strangers." Women who are medicated may also be unable to move or actively position themselves, contributing to sensations of vulnerability, powerlessness, and being "at the mercy" of her helpers during the pushing phase. Conversely, the most common pushing positions at home are on a birth stool, squatting, or in hands-and-knees. The midwife's relative position, usually on the floor in front of and below her, produces a mother-up, midwife-down structure in opposition to the mother-down, doctor-up configuration characteristic

of most hospital births. The symbolic ramifications of the mother's position on a birth stool surrounded by her family and care providers, as one mother described it, "feeling like a queen on my throne" at the peak of the transformational experience—the birth itself—cannot be underestimated.

By encouraging mothers to do what feels best to them during the pushing stage, and in offering coaching only if needed, midwives communicate the idea that mothers can tap into an intuitive, instinctive, body-level knowledge, and that: "women's bodies know what to do to birth their babies." In contrast to the message that technology or the skills of the attendant averted potential disaster, midwives consciously attempt to communicate the life-giving power of the female body. Where Davis-Floyd (2001) argues that technocratic births send the message that doctors and technology "deliver" babies, midwives are careful to impart the notion that better reflects their reality—that mothers deliver babies, partners and midwives merely "catch" them.

The Immediate Postpartum Period (the Reintegration Phase): Celebrating the Mother–Baby Unit

The early postpartum period marks the beginning of the reintegration phase of birth as a rite of passage where women are incorporated into their new social status as mothers. The rituals of the immediate postpartum period at home include the initial assessment of the baby, delivery of the placenta, delayed cord clamping, monitoring of maternal blood loss, encouragement of early nursing, and settling the new family into "the family bed" for the start of their "baby-moon." In the vast majority of homebirths, these are straightforward processes as most mothers and babies who attempt to delivery outside the hospital remain complication-free during and after the birth (Fullerton et al. 2007; Janssen et al. 2009; Johnson and Daviss 2005; Jonge 2009). Because pain medications and pitocin are not administered during labor at home, very few infants require respiratory assistance, and most are vigorous and alert at birth.

At delivery, midwives make an initial assessment of neonatal well-being as they pass the baby up to the mother where he or she is placed skin-to-skin, dried, and covered with warm blankets. Once mother and baby have been assessed as stable, the umbilical cord is cut, usually by the father–partner, but only after it has completely stopped pulsing and the placenta has delivered. This practice, called "delayed cord clamping," is an important component of how homebirth midwives see themselves as different from hospital practitioners in their approaches to the postpartum period. Midwives tend to feel very strongly about how the immediate postpartum period should unfold and argue that it is cruel to sever the cord too early. This conviction is an extension of the midwifery focus on early bonding and is considered especially important when the infant requires assistance. Babies, homebirth midwives assert, will be less stressed, and, therefore, better able to breathe and regulate body temperature if their mothers remain in close contact, touching and talking to them, while their intact umbilical cords continue to pulse, delivering oxygen-rich blood.

Although all of the homebirth midwives I observed and interviewed were trained and certified in the same neonatal resuscitation procedures utilized in the

hospital, and all carried portable oxygen and other resuscitation equipment considered essential for helping challenged babies to transition to extrauterine life, midwives advocate for some practices that differ from mainstream hospital resuscitation rituals. For example, midwife participants argued that resuscitation is not simply the physiological process of assisting ventilation. Infants are seen as active participants in the process and, like adults who can be called back to consciousness after fainting by stimulation and speaking of their names, respond quickly to maternal touch and voice. Midwives, thus, encourage mothers to “call their babies back,” to caress and to speak to them as they are resuscitated.

“Calling the infant back” and delayed cord clamping have both been incorporated into homebirth midwives’ regular Neonatal Resuscitation Program trainings, and are well supported by the clinical research (Emhamed et al. 2004; Grajeda et al. 1997; Gupta and Ramji 2002; Mercer 2002; Mercer et al. 2003; Rabe et al. 2004; van Rheezen and Brabin 2004), although few of the physician participants were familiar with this literature. Ken, a NW obstetrician, noted that this was because of the fact that “our standards of care come down to us from the American College of Obstetrics and Gynecology—the supreme authority on how we are supposed to practice. It takes much more than new research to change a protocol once it has been established.” Interestingly, midwives note that one of the only benefits of their marginalized status is the freedom to change practices based on new clinical research more quickly than they believe physicians, who often find themselves entrenched in institutionally backed rituals, can.

Midwives assert that the ritual integration of the immediate postpartum is not complete until the placenta or afterbirth delivers and the family has had a chance to celebrate the role this organ played in “growing a healthy baby.” Once mother and baby are cleaned up and nursing, the birth guests gather around to observe as the midwife explains the basic anatomy of the placenta. The amniotic sac is held up for family members to see, and participants are encouraged to reflect on how the placenta nourished and protected the fetus during the previous nine months. Siblings often don gloves and help to examine and photograph the placenta.

All of the midwives interviewed and observed for this study discussed the deep respect they hold for placentas, “the most sophisticated life support organ on earth.” Reverence for the placenta ranges from a highly scientific focus on the many functions of the placenta, or the fact that it is the only time the human body grows a “disposable organ” as one midwife put it, to more spiritual and metaphysical interpretations. Metaphors for describing the power and mystery of the placenta include the discussion of placenta as sibling, fetal home, and “tree of life.” The tree of life metaphor is particularly common, and midwives take care to show families the fetal side of the placenta and the pattern of vessels that resemble the branches of a tree. Some also provide “placenta prints” for clients that are made by pressing a fresh placenta against a sheet of watercolor paper to capture this unique vascular pattern. For midwives, the placenta is not simply a biohazard or medical waste, but an important part of the birthing process and another opportunity for maternal affirmation and celebration. The placenta is stored in the freezer for days or weeks until it is either dried, encapsulated, and consumed as a preventative for postpartum depression, or buried. Burial commonly involves an impromptu family ceremony where the placenta is “returned to the earth” and a tree or shrub that carries some

symbolic meaning relative to the baby is planted above it. The largest baby I ever caught at home, a 12lb 5oz boy, had his placenta buried beneath a giant sequoia sapling!

The rituals of reintegration—delayed cord clamping, maintenance of the mother–baby unit (even during resuscitations), and celebration of the placenta—communicate important messages to mothers about the sufficiency of their bodies and the sacredness of their birth experiences. Midwives say that celebrating and honoring a woman for the life she has given, when combined with feelings of elation produced by endorphins, or the endogenous opiates released during unmedicated deliveries, lead to a postpartum phenomenon many call “Superwoman Syndrome” where women “feel like they can do anything.” Colleen (a NW midwife) explained: “One problem we have is “Superwoman Syndrome” where moms think they can do anything after having an unmedicated, vaginal birth at home. . . . That is great, but we also want them to rest and allow their pelvic floor musculature to heal, and there they are, up calling everyone they know and trying to go back to doing it all.” “Superwoman Syndrome” may be seen as an embodied or somatized marker of the personal power ritually communicated to and integrated by women as they claim their reintegrated identities as homebirthing mothers.

Rituals of the immediate postpartum period at home transmit the message that the mother’s body is well equipped to meet the needs of the newborn by providing oxygenated blood through the intact umbilical cord, comforting warmth during skin-to-skin contact, and nourishing colostrum from the breast. The supremacy of technology takes a backseat to the sufficiency of nature as midwives capitalize on the triumph, joy, and celebratory feel of the reintegration phase to enhance the maternal pride, power, and love they believe are essential components of healthy bonding and empowered mothering. The importance of early bonding is also emphasized by keeping mother and baby close even during resuscitations, encouraging “calling back” of the baby, and delaying cord clamping or cutting. Davis-Floyd (2004) argues that technocratic postpartum protocols send the messages that birth is a medical event, that mother and baby require close surveillance during dangerous extrauterine transitions, and that technologies in the form of the isolette or warmer, for example—symbols of the replacement of mother’s womb by the “womb” of culture—best provide the means to care for babies. Conversely, in the first few hours of a newborn life, homebirth midwives intentionally communicate the sufficiency of the mother’s body, the centrality of the mother–baby unit, and the celebratory over the clinical.

Discussion: From Ritual to Resistance

Lévi-Strauss (1967) has argued that the immense power of ritually induced healing lies in the symbolic mapping of bodily experiences onto metaphoric spaces defined by myth and ritual. As the structure and content of ritual carries participants into new representational spaces, the physical body is transformed along with the participant’s social status and sense of self. The performance of birth at home enables women to map their own individual experiences onto a collective, mythic world—in this case, the mythic world of “natural,” “alternative,” “empowered,” or “woman-centered” childbirth. Emotionally charged symbols (birth tubs, home

and reinterpreted technologies like the doppler) allow social worlds to be manipulated, and it is this manipulation that facilitates a corresponding transformation of the mother's embodied, birthing experience (Dow 1986).

However, the rituals of homebirth midwifery care are not simply about assuring personal transformation via the transmission of counterhegemonic—empowering values—although many women certainly described their experiences this way. Midwifery rituals, as I have argued, are also self-consciously political in their intent. As the popular bumper sticker “Midwives: Changing the World One Birth at a Time” suggests, homebirth is a performative medium for the promotion of social change. Midwives and their clients assert that homebirth can lead to social transformation by ensuring that babies are “born in peace” (another popular bumper sticker reads: “Peace on earth begins with birth. Support midwives!”) and by empowering women to become grassroots activists, standing up against an obstetrical hierarchy that monopolizes the birthplace and removes women's choices about where and with whom to give birth (Boucher et al. 2009; Craven 2007). In this way, homebirth can be seen as strategic ritual practice designed to transgress and recreate cultural categories, as well as a medium for the negotiation of power relationships, and not solely as a method for communicating messages about social norms. The synthesis of midwifery values (like listening to a woman's body during pushing) and more medical practices (like monitoring heart tones) are not passive accommodations of dominant birth paradigms, but a set of highly coded and intentional efforts to control key symbols and, thereby, to defy the hegemonic order of medicalized birth.

As a result, women who internalize homebirth ideals in opposition to the core values of U.S. society, either consciously or unconsciously, may come to reject many of the core tenets of technocratic society and, instead, embrace perspectives on child-bearing and rearing that differ from dominant ideologies. Performance theorists refer to the process whereby rituals facilitate the construction of a new interpretive framework through which subsequent acts or messages are evaluated as “framing” (Bell 1997). Women who successfully internalize views of their bodies as sufficient to meet the demands of labor and delivery may also “frame” their abilities to parent through such constructs. Long-term, exclusive, on-demand breastfeeding, bed sharing, slings, cloth diapering, and attachment parenting, for example, are likely to be embraced by homebirthers in opposition to scheduled feedings and plastic baby-care devices like bottles, cribs, and strollers (Davis-Floyd and Cheyney 2009).

The mothers who participated in this study talked extensively about the transformative nature of their unmedicated labors and births at home, discussing at length how homebirth with a midwife changed them. However, given the marginalized position of homebirth in the United States and the fact that while this option is on the rise (MacDorman et al. 2010), a relatively small number of women choose it, it is important to consider whether homebirthing rituals merely affirm rather than create new meaning for participants. Perhaps the rituals of home delivery are more accurately interpreted as rituals of intensification, and not as those of reversal or transformation (van Gennep 1960). Certainly, many women come to midwifery care because they already hold strong beliefs about the power and sufficiency of the birthing body, while others choose home delivery because they are disenfranchised from the medical system, un- or underinsured, and lacking reliable transportation (Cheyney 2008). Regardless of where women begin their journeys, birth at home

often functions simultaneously to both transform and affirm the positions and identities formerly held. As Klassen (2001:85) has argued, childbirth is not necessarily a change or separation from a woman's previous social world, "but a move deeper into the center of family and home."

What remains unclear from this research is what happens to ritual participants when plans for a home delivery go awry because of complications that require medical intervention. A major limitation of this study is the voluntary nature of sampling, which increased the likelihood that women who had successfully completed homebirths would seek out participation. A more comprehensive analysis of transfer of care narratives, and any transitional rituals mothers, midwives, and backup physicians use to manage the stress of home-to-hospital transports, might help to explain how the symbolic content of homebirth care is negotiated, adapted, and internalized when pregnancies or deliveries do not go as planned. How, for example, do women who end up requiring the technologies and interventions provided by obstetricians in the hospital view their bodies, their midwives, and their relationship with the medical establishment? Do mothers who transfer care to backup physicians reject notions of their bodies as capable in favor of the benefits of technology? Or do they find ways to contextualize their experiences as exceptions, holding to the ritualized practices and values of homebirth models of care? These questions require further examination.

In conclusion, I have argued that, during homebirth as a rite of passage, midwives deliberately manipulate ritual in attempt to communicate the sufficiency of nature over the supremacy of technology. Capitalizing on the semiotic potential, heightened emotion, and the liminality of the birth itself, midwives seek to overturn mechanistic views of the faulty female body in need of medical management, replacing them with the language of connection, celebration, power, transformation, and mothers and babies as inseparable units. Homebirth practices, thus, are not simply evidence-based care strategies. They are intentionally manipulated rituals of technocratic subversion designed to reinscribe pregnant bodies and to reterritorialize childbirth spaces and authorities. For many, choosing to deliver at home is a ritualized act of "thick" resistance (Ortner 1995) where participants actively appropriate, modify, and cocreate new meanings in childbirth.

Notes

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1. See Davis-Floyd (1998) for an in-depth discussion of the different types of midwives practicing in the United States.

2. The American College of Obstetrics and Gynecology is vehemently opposed to home delivery. Committee Opinion #476, ACOG's position statement on planned homebirth, is published in the February 2011 issue of *Obstetrics and Gynecology* (ACOG; 2008).

3. "Sufficiency of nature" is a phrase first developed by Robbie Davis-Floyd and used throughout "Birth as an American Rite of Passage" (2004). She uses it to describe the holistic model of care's reliance on the wisdom of nature as opposed to the technocratic model of care and its respective dependence on the "supremacy of technology."

4. There are 27 states where Certified Professional Midwives (midwives trained specifically for OOH care) are legally authorized to practice. In 23 states, as well as in the District of Columbia, CPMs are at risk of criminal prosecution for practicing medicine without a license.

5. See Cheyney (2010) for a discussion of flexibility and variation within these approaches.

6. All names are pseudonyms.

7. Encouragement of the “birth song” by midwives and the embracing and naming of that voice by birthing women in this study differs from MacDonald’s discussion of birth vocalizations. In her work on midwifery in Canada, MacDonald (2007:125) describes constructions of the “birth song” (esp. if it is particularly loud or involves swearing) as evidence that the birth was not as “natural” as it could have been.

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