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Every woman her own midwife : a study of empowerment through wise woman health care

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EVERY WOMAN HER OWN MIDWIFE:

A Study of Empowerment through Wise Woman Health Care

A Thesis

Presented to

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Master of Arts

by

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ABSTRACT

EVERY WOMAN HER OWN MIDWIFE:

A Study of Empowerment through Wise Woman Health Care

by Kimberly A. Bick-Maurischat

This thesis addresses the experiences of a sample of eighteen women receiving their childbirth or abortion health care within a woman-centered, woman-controlled group setting. It examines how women's experiences are affected when their health is defined as a state of well-being with physical, social and mental dimensions. The nature of this type of health care (called "Wise Woman" care in this study) encourages responsibility and self-reliance. Utilizing questionnaire and interview data, this exploratory study suggests that a woman's perception of her body, her sense of self and her role in her own health care change after experiencing health care with herself at the center of a supportive network.

Acknowledgements

As a woman with children, I have been dependant upon the loving community of support from both friends and family to care for and love my children so that I may work. My deepest love and gratitude to: Kristen, Daryl and Sophia; Denise, Ethan and Michaela; Amber, Nicola and Dylan; Rita, Adira and Miriam; Marianne, Carmen and Christian; Jeanette, Dana and Wesley; Lisa, Meredith and Faye; Will and Adrian; Pat O., and Lisa G. And my sister Jennifer, for her calm computer wisdom. Thank you all for sharing your families, your resources, your respect and commitment to my work.

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Angela Y. Davis, Elizabeth Davis, Janet Ferrare, June Whitson, the women in the prenatal and self-help groups, the women who have shared their birth and abortion stories with me, and to all the women and men with whom I have waited in front of an abortion clinic for the sun to rise, you have touched my life and it will never be the same. Thank you for your courage and inspiration.

My companion in all things, David. Your faith in me is matched only by mine for you, your patience with me has no equal. Your dedication is divine.

My magnificent daughters;

Allegra, your beautiful birth was the begining of the journey.

Phoenix, your trust has shown me the way.

Thank you to the trees.

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and my daughters, Allegra and Phoenix.

Blessed Be Your Dreams.

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to celebrate womyn
they gather
in name, body,
spirit and mind
bearing gifts of dance,
music, art and song
paying tribute to
nature, themselves
for surviving,
for survival
in celebration
in celebrating
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that surround them
these harmonious
sounds give flight to
their vigorous bodies
and promise
to celebrating womyn
everywhere.

laura irene wayne '91 c

CHAPTER I

Introduction

Women have always been healers. They were the unlicensed doctors and anatomists of western history. They were abortionists, nurses and counsellors. They were pharmacists, cultivating healing herbs and exchanging the secrets of their uses. They were midwives, travelling from home to home and village to village. For centuries women were doctors without degrees, barred from books and lectures, learning from each other, and passing on the experience from neighbor to neighbor and mother to daughter. They were called "wise women" by the people, witches or charlatans by the authorities. Medicine is part of our heritage as women, our history, our birthright. (Ehrenreich and English 1973)

Statement of the Problem

Throughout Western history, the healing art of medicine was in the hands of women. Receiving newborn infants, caring for the sick and preparing the dead for burial, women were the healers, the comforters, the confidantes--they were considered wise women. Particularly for the childbearing woman, wise women or midwives were invaluable. By assisting women, the wise woman/midwife gained her knowledge through years of experiences, witnessing the unique variations found in women's reproductive lives. In caring for other women through their childbirth and postpartum time as well as providing secretive wisdom on ways for abortion, the wise woman/midwife offered unique woman-centered and woman-controlled care. The original meaning of midwife--with woman--perfectly describes this caring work. But gradually, through centuries of attack from church, state and the medical profession, the wise woman/midwife has had her independence and authority deliberately and

forcibly taken away (Achterberg 1991). This has profoundly altered the way in which healing medicine is offered.

Two primary aspects of women's reproductive health care, childbirth and abortion, moved into hospital or clinical settings. Medicine, once a healing art directed by members of the local community, is now a well established monopoly. The vast majority of women seeking care for their reproductive needs are forced to turn to large health care businesses. The care provided in these settings usually is conducted in an isolated relationship between a woman and her provider. Although there have been token changes in the hierarchical structure of health care, including the utilization of specialized professionals to address nutrition, lactation, infertility, stress reduction, etc., the majority of providers are allopathic physicians. Being trained as experts in the treatment of diseases, these contemporary "healers" provide care that is typically physician-centered and physician-controlled (Arms 1975, 1994; Bradley 1974; Cohen and Estner 1983; Clement 1983; Donegan 1978; Harrison 1982; Rothman 1982).

This reality presents two primary problems that may adversely affect the quality of health care women receive for these reproductive needs. First, pregnancy, childbirth and abortion are not diseases. Studies show that treatment of these normal aspects of a woman's reproductive life as pathological leads to increased iatrogenic problems (Goer 1995; Wagner 1994). Second, pregnancy is a highly social event involving and affecting many aspects of a woman's private and public life. The decisions she will make during this time will affect the rest of her life. Ideally a woman

should feel not only satisfied but empowered by the choices she makes. Too often, information and support, vital aspects of health care that promote confident decisions, are absent in physician-centered care (Baldwin 1986; Cassidy-Brinn, Hornstein, Downer, and Federation of Feminist Women's Health Center 1984; Davis 1987; Worchester and Whately 1988).

Throughout this slow but effective usurpation of control in health care, resistance has been maintained by those who are most directly affected; women needing reproductive care and those who continue to provide it outside established medical control. From direct resistance by small populations of women and related political efforts has emerged an approach to health care that is entirely woman-centered and woman-controlled. The contemporary development of this approach to reproductive health care is a return to a time when the wise woman was an equal, a friend, a neighbor, and a member of the community who openly shared the wisdom she gained from the women and families she served. This thesis will examine the experiences of two groups of contemporary women who have participated in health care that is decidedly woman-centered and woman-controlled. The two groups examined in this research are groups that focus on pregnancy/childbirth care and self-help/abortion care.

Even within the alternative health movement these groups are radical in their approaches to reproductive health care. Although the two groups are similar in their philosophy and approach, they are virtually unknown to each other. The attack on women's reproductive freedom by health care authorities and others has created an environment of secrecy

and isolation that has interrupted the free exchange of knowledge that once was joined in the healing art of reproductive health care. Existing in such a volatile historical time, these groups unfortunately have been isolated from each other because of their concern over legal prosecution. Moreover, because of the unstable political climate regarding these issues, these groups are unable to support one another in their woman-centered, woman-controlled approach to reproductive health care. The first group, Group A, addresses only the pregnancy and childbirth needs of the women in the group. The second group, Group B, addresses many other reproductive health aspects including menstrual extraction (see appendix E).

This exploratory research, based on lengthy questionnaires supplemented by a group interview session, will address the following questions: when the reproductive functions of women's lives are cared for and nurtured in an environment that supports individual women and validates their experiences as normal and positive, how does this affect a woman's perception of herself, her body and her health care experiences and her view of herself as a patient? When the health care environment requires more personal responsibility, allows for more direct involvement with one's own care and is conducted in an interactive setting, do these women feel more confident, self-reliant and empowered through their health care decisions and experiences? Answers to these questions will demonstrate that it is not just reproductive freedom that empowers women, but also the process by which they make and carry out reproductive choices that promotes confident, empowered women.

Key Terms

Collective Wisdom:	Knowledge gained through experience and shared with others.
Del-Em:	A self-help device used to extract the contents of a woman's uterus. (Appendix E)
Demystification:	Discovering of information and knowledge that was previously kept unknown.
Empowerment:	The process of becoming the active, guiding force within one's own life.
Menstrual Extraction:	Self-help technique of removing the uterine contents by a suction devices known as the Del-Em. In health care groups, it is ideally done as close to the first day of a missed menstrual period as possible. (Appendix E)
Spiral:	Symbol of the Wise Woman tradition, it is used in this study to denote the setting in which Wise Woman health care is conducted. "Spirals never repeat themselves. Spirals remind us that life is movement, that each moment is unique, and that form is the essence of transformation" (Weed 1989, 11)
Validation:	The recognition that one's body and experiences are similar to those of other people. Realizing that one is not isolated by experiences.
Wise Woman Care:	Ancient form of health care provided for women, by women, in a setting of equality where each woman is considered to be a Wise Woman.

CHAPTER II

REVIEW OF RELATED LITERATURE

Within the last thirty years literature examining women and health has increased greatly. A significant part of this interest has focused on reproductive health care. Two major aspects of women's reproductive health care have emerged as the primary recipients of this interest: childbirth and abortion.

Most of the Women's Studies literature regarding childbirth has been a critique of existing male-dominated medical protocols (Arms 1975, 1994; Davis-Floyd 1992; Ehrenreich, and English 1973; Rothman 1982; Sandelowski 1984). Most of the Women's Studies literature addressing abortion has focused instead on the politics of its availability (Baehr 1990; Lader 1966, 1973; Petchesky 1984). Feminist scholars and health activists also have begun to create a positive vision of wholistic childbirth and abortion health care (Baldwin 1986; Boston Women's Health Book Collective 1984; Cassidy-Brinn, Hornstein, Downer, and Federation of Feminist Women's Health Centers 1984; Chalker and Downer 1992; Davis 1987; Federation of Feminist Women's Health Centers 1991; Kitzinger 1984, 1985, 1991; Maia 1989; Peterson 1981, 1984; Weed 1989; Whitson 1987, 1993). This vision clearly articulates a woman-centered, woman-controlled approach to reproductive health care that embraces the wisdom inherent in each woman. The collective wisdom shared among women creates a foundation for an empowering transformation that researcher and healer Susun Weed has referred to as the Wise Woman Way (Weed 1989). Tapping into this older tradition that considers health care needs to be allies

for transformation, Weed and other researchers and healers have put this vision into practice (Chalker and Downer 1992; Demetrakopoulos 1983; Maia 1989; Whitson 1987, 1993). This survey of the related literature, from accounts of nineteenth century activism to elaborations of contemporary wholistic healing models, will show the development of this vision for woman-centered and woman-controlled reproductive health care.

The Movement For Woman-Controlled Health Care

> Women's health care will not improve until women reject the present system and begin instead to develop less destructive means of creating and maintaining a state of wellness (Harrison 1982).

In fact, throughout Western history women continually have worked to maintain a state of wellness for themselves, their families, and their communities (Achterberg 1991; Ehrenreich and English 1973). Although it is not widely known, the seeds of the contemporary struggle to create woman-centered health care were planted during the first half of the nineteenth century. The Popular Health Movement of the 1830s and 1840s was a grassroots social movement that encouraged self-reliance and folk remedies. Coinciding with the earliest formation of the women's suffrage struggle, the Popular Health Movement was "related both in cause and effect to the demand for women's rights in general, and the health and feminist movements became indistinguishable " (Ehrenreich and English 1973, 26). The practical prevention emphasized by these early women's health advocates stood in contrast to the aggressive interventions of untrained "regular" doctors, "heroic" measures that included massive

bleeding of patients and the administering of huge doses of laxatives (Ehrenreich and English 1973, 23).

This health crusade was in large part a reaction to the move by legislators to professionalize medicine. The monopoly created for professional physicians, whose treatments were often worse than the original ailment, was met with radical opposition by women who were barred from formal scientific medical training. Advocating loose-fitting clothing, whole grains and a healthy lifestyle, these non-professional community healers used the slogan "Every Woman Her Own Doctor." Indicating the connection between the feminist health movement of the mid-nineteenth century and the contemporary women's movement, Ehrenreich and English point to the "Ladies Physiological Societies" that sprang up everywhere as the educational equivalent of the know-your-body courses during the 1960s and 1970s.

The current political efforts to control women's *reproductive* health care have their roots in the late nineteenth century, when there was a concerted effort to displace and marginalize the community midwife (Litoff 1986; Petchesky 1984). Until the second half of the nineteenth century, local midwives or Wise Women were respected and acknowledged for their experience in childbirth and abortion matters. Regulation of these female practitioners by a burgeoning male-dominated medical profession began the slow decline of the availability of this woman-controlled care. In 1859, abortion began to be criminalized, and over the next few decades abortion became illegal throughout the United States, except to save the life of the mother. With physicians gaining control over reproductive care, there was

a dramatic increase in medical intervention during pregnancy and childbirth. Women's reproductive health care in the United States began to be defined and dominated by professional male practitioners. Leading this assault was the American Medical Association. It was not until the second wave of feminism in the 1960s that male dominance in reproductive health care was publicly and popularly challenged.

As Western medical professionals established an ever increasing level of intervention and physician-centered protocols for childbirth, questions arose among some sensitive physicians about why childbirth seemed so often to be a difficult and unpleasant experience for the woman. Seeking to uncover the root causes for the continued pain and suffering during childbirth, researchers in the mid-twentieth century turned to the pregnant woman herself. This scientific investigation into the birthing process resulted in research that found pregnant women to be lacking in technique and ability to cope with childbirth. Methods developed by well-meaning physicians and medical advocates were designed to give the laboring woman more confidence and comfort while she continued to remain under physician-controlled care (Bradley 1974; Dick-Read 1972; Karmel 1965; Lamaze 1972).

Declaring himself to be "humbled" before a newborn babe and its mother, Grantly Dick-Read is generally considered the most sensitive of these earlier writers. In 1944 he published Childbirth Without Fear. Observing that a pregnant woman's state of mental health and attitude influenced birth outcomes, Dr. Dick-Read concluded that ignorance of the physiological process of childbirth would lead a pregnant woman to a *self-*

imposed level of fear that in turn increased the level of pain during childbirth. To reduce the ignorance-fear-pain cycle, Dick-Read advocated for education and support of the pregnant woman. The approach, although unique within the medical model of prenatal care, still presumed a level of professional superiority by the presiding physician. However progressive, Dick-Read maintained that it was the prenatal experts--the doctors, the nurses, and the clinic staff--who were personally responsible for a woman's attitude toward childbirth. In describing his role as an obstetrician to a patient during an early prenatal appointment, he says:

> I am here to watch your physical development, to guard you against ignorance and misunderstanding and to be an advisor upon all subjects directly concerning your baby's arrival in a natural and healthy way (Dick-Read 1972, 44).

Absent from analysis such as Dr. Dick-Read's is any effort to return the laboring woman to her place as a central figure in the birth of her own child. Although these researchers maintained basic assumptions of their professionally-based superiority over a pregnant woman, their work opened the gates for a flood of literature that would begin to rethink radically the role of a woman in her own reproductive health care.

The second wave of a strong, popular women's movement was the catalyst for publication of literature that articulated a challenge to the established medical model's routine health care (Arms 1975; Boston Women's Health Book Collective 1984; Ehrenreich and English 1973). Finding the existing model of reproductive health care to be a misogynist, physician-centered monopoly, researchers influenced by these landmark works began to examine closely the power structure of physician-centered

health care and its effects upon the women within its care (Cohen and Estner 1983; Eakins 1986; Edwards and Waldorf 1984; Gordon 1976; Holmes, Hoskins and Gross 1980; Martin 1987; Rothman 1982; Sandelowski 1981; Scully 1980). Central to this discussion of the power structure in conventional medicine was Barbara Katz Rothman's In Labor (1982).

In Rothman's feminist analysis of pregnancy and birth, the welfare of the baby versus the welfare of the mother emerges as the primary conflict in physician centered childbirth management. Looking at the historical development of the male role of physicians in the birth room, Rothman shows their original role to have been heroic both in nature and technique. The early physician-barbers were employed to save the baby only when maternal death seemed inevitable. At this point, a secretive device that facilitated removal of an impacted fetus was used. This secretive tool, now used routinely in hospital deliveries, became known as forceps. Rothman argues that the historical development of male-assisted birth technology stands in stark contrast to the idea of woman-controlled, woman-centered care usually found in midwifery.

This primary conflict between mother and baby in childbirth also has defined the literature regarding abortion care (Petchetsky 1984). While some reforms in hospital practices for childbirth have occurred, due in large part to the public awareness brought about by these publications, examination of abortion care continued to be focused on the political issue of its availability.

Wise Women Speak Out

Emerging from the critique of the scientific medical model, a more woman-centered approach began to be defined. One of the first researchers to consider the pregnant women as a whole human being was British sociologist Sheila Kitzinger. In over a dozen books, Kitzinger was the first researcher to address pregnancy and childbirth issues in a conceptual framework that put the pregnant women in the center. Her "psycho-sexual" approach to childbirth education began to introduce formally the concept of a woman's social and sexual lives as important factors in her pregnancy and birthing experience. Kitzinger saw pregnancy and birth as transformations that affect many aspects of a woman's life. In the preface to the 1984 edition of her 1962 book The Experience of Childbirth, she writes:

> It is sad that still so many women should embark upon childbirth in ignorance of their task in labour [sic] and with inadequate emotional preparation and support for the enormous physical and emotional changes involved. For far too many, pregnancy and birth is still something that happens *to* them rather than something they set out consciously and joyfully to do themselves (9).

Concluding that a pregnant woman's attitude is important to her birthing process, Kitzinger reflected Dr. Dick-Read's earlier attempts at childbirth reform. Kitzinger felt that it was important for a woman not only to be an active participant in her childbirth experience but to have some level of control over the process of her health care. Developing this philosophy over three decades of work, Kitzinger in her 1987 book entitled Freedom and Choice in Childbirth advocates clearly for a more woman-centered approach.

The idea of a woman's direct control over her reproductive life has been furthered by a number of courageous women's health advocates over the last fifteen years (Baldwin 1986; Boston Women's Health Book Collective 1984; Cassidy-Brinn et al. 1984; Chalker and Downer 1992; Davis 1987; Federation of Feminist Women's Health Centers [1981] 1991; Noble 1983; Odent 1984; Weed 1989; Whitson 1993, 1987). This contemporary feminist health movement is reminiscent of the Popular Health Movement during the nineteenth century, when every women was encouraged to be her own doctor. Evolving directly from the women's rights movement that arose in the 1960s, these works pushed even further forward the ideas and concepts that would begin to create a completely woman-centered model of reproductive health care.

Feminist health activists have sought to demystify female anatomy and its functions. The Federation of Feminist Women's Health Centers, Boston Women's Health Book Collective,and Carol Downer as well as Rebecca Chalker have been central in moving this process forward. The impact of nationwide self-help clinics during the 1960s cannot be underestimated. Echoing their foremothers of a century earlier, these health activists concretely began to develop a radical approach to reproductive health care. In 1971, by combining knowledge of women's anatomy, low-tech medical tools, and feminist philosophy, mother and homemaker Lorraine Rothman developed an entirely woman-centered and woman-controlled method of providing early abortion care (Federation of Feminist Women's Health Centers [1981] 1991). Named for exactly what it entailed, this easy-to-learn technique was called menstrual extraction,

M.E. (For a description of the technique see Appendix E.) Before the decriminalization of abortion in 1973, menstrual extraction, was developed to provide safe, woman-controlled, illegal abortion care. Because menstrual extraction does not require dilation of the cervix, which can be moderately to extremely uncomfortable for different women, M.E. subsequently has been advocated as an easier, less painful early abortion technique. Remaining virtually unknown, this revolutionary contribution has the potential to offer women safe, effective woman-controlled health care in their reproductive lives.

Seeking to demystify further a woman's experience of pregnancy and childbirth, the Federation published Woman-Centered Pregnancy and Birth (1984). Combining basic physiology with a feminist analysis of existing prenatal health care options, the result was a guide that would help navigate a woman through the existing health care system in order to create a woman-centered approach for herself. Focusing on demystifying medical procedures and the birthing process, as well as advising a woman on how to find a good birth attendant, this work put forward a number of important tenets established during the Popular Health Movement of the nineteenth century: information, self-reliance, and prevention. Bringing the ideas found in the the nineteenth century's "Ladies Physiological Societies" together with Kitzinger's recommendation for increased social and emotional support as well as the contemporary movements self-help clinics, Woman-Centered Pregnancy and Birth put these themes to use for pregnant women.

While a few nurse-midwifery textbooks have been published for the professional midwife (Myles [1953] 1993; Varney 1987), midwives Rahima Baldwin (1986) and Elizabeth Davis (1987) wrote woman-centered guides that were aimed at decentralizing information about pregnancy and birth. Sharing years of knowledge and experience gained from their work as mothers and empirically trained midwives, both Baldwin and Davis formalized basic physiological information and ancient midwifery wisdom. Returning such vital information to the hands of pregnant women and their non-professional midwife attendants, these midwives made an important contribution.

Medical reformers during the mid-twentieth century explored mental well-being and its effect on childbirth (Bradley 1974; Dick-Read [1953] 1972). Two decades later feminist writers and health activists had expanded this tenet of modern childbirth education to include women's control and self-determination (Baldwin 1979, 1986; Boston Women's Health Book Collective 1984; Cassidy-Brinn et al. 1984; Chalker and Downer 1992; Davis 1987; Federation of Feminist Women's Health Centers [1981] 1991; Kitzinger 1984, 1985). A related feminist theme, trusting the innate wisdom of each birthing woman to guide her through the birthing process also began to be explored (Demetrakopoulos 1983; Noble 1983; Odent 1984). Whereas the medical reformers saw women as lacking in technique or method, new researchers observed that women inherently knew how best to facilitate the birth of their babies (Jordan 1977; Odent 1984). Validating a woman's inner knowledge about her body and

its process, became an important tool in developing an approach to health care that reflected the needs of individual woman.

Drawing on this evolving body of literature on women and health, researcher and healer Susun Weed has created a model of woman-centered healing in her book Healing Wise (Weed 1989). By comparing various traditions of healing (See "Three Traditions of Health Care" p. 19), Weed has created a model that draws upon the ancient wisdom of wise women and midwives. Describing the health care process as an ever-changing ever-moving spiral, Weed puts women and their reproductive functions at the center. Describing three traditions of healing--the scientific, the heroic and the wise woman--she compares philosophy and treatments to develop the "Wise Woman Way of Healing." Pointing out that whereas the scientific tradition assumes "measurable repetition" and the heroic tradition assumes "endless cycles" in maintaining human health, the Wise Woman Way assumes unique variations. Where scientific practitioners use treatments of drugs and surgery, and the heroic physicians advocate stimulants or purges, the wise woman offers unconditional love and nourishment during times of healing and change. Taking this view of health in general and applying it to women's reproductive health care in particular, Weed has created a contemporary approach to creating woman-centered, woman-controlled health care.

A few wise women have come forward to make the woman-centered, woman-controlled vision of reproductive health care a reality. Envisioning women as equal participants in the decision-making process, actively monitoring their own pregnancies, learning basic assessment skills,

and receiving information from other pregnant women in a support group context, Womancare, a prenatal self-help clinic, was born in 1973. Describing Womancare's group prenatal sessions, the authors of Woman-Centered Pregnancy and Birth advocated women having contact with each other in a focused atmosphere as the strongest way for women to be able to control their childbirth experiences. In describing this process they wrote:

> A pregnant woman who is part of a group has more access to information about alternatives as well as more power to actually change physicians' practices in her community than if she were acting alone (Cassidy-Brinn et al. 1984, 173).

Although this woman-centered, woman-controlled prenatal clinic was short- lived, due to local medical authority pressure, the ideas and concepts of these women and activists live on in the practices of the prenatal/birth groups this researcher studied. This group approach to providing prenatal care is rare even within the midwifery community. One recent article entitled "Group Prenatal Care" by midwife June Whitson (1993) describes the prenatal group process as facilitating "tremendous transformation" in the women in her practice. Because women participating are at all different stages of pregnancy, many questions and issues concerning safety, fear, and personal changes can be addressed. Whitson says that even though current childbirth practices include some form of childbirth education, the group context is a far more complete approach. After over twenty years as a home birth midwife she says:

> I have found no better way [for pregnant women] to learn than from other women and men who have a wealth of experience and information to share. I have seen women and their families grow in confidence, awareness and understanding of the pregnant process by listening to others, considering carefully and sifting through

> information. This learning process is very transforming and empowering. (Whitson 1993, 23)

Providing prenatal care that is directed by the pregnant woman is a unique way of providing woman-centered and woman-controlled reproductive health care. Acknowledging the uniqueness of each woman's body and experience, Whitson says further that "no two women, no two births are the same" (23). Acting as "guardians," midwives like June Whitson watch while women and their families find their own way to birth.

THREE TRADITIONS OF HEALTHCARE

	Scientific	*Heroic*	*Wise Woman*
Symbol	line/monolith	circle	spiral
Time Span	1500 AD to now	1100 BC to now	50,000 BC to now
Overall Vision	homeostatic	dualistic	holographic
Lineage	Newton, Descartes	St. Paul, Hippocrates, Galen	crone, midwife
Overview	The whole is the same as its parts	The whole is the sum of its parts	The whole is more than its parts
Assumes	measurable repetition	endless cycles	unique variations
World View	atomic	good/bad	inter-connected web
Place of Power	machine/tests/drugs	healer	self
Disease/death	the enemy	result of toxins	natural allies for transformation
Cure	fix/fight	clean/punish	nourish
Body view	machine	(dirty) temple of the spirit	perfect manifestation of completebeing
Healer as	mechanic	savior/ruler	compassionate, self-loving one
Mode of communication	medical language, commanding,threatening	unfamiliar terms, criticism, ultimatums	Familiar imagery & language , verbal & non-verbal encouragement
Troubled one says	"It's beyond me. I want the experts to do it."	"I've been bad and need someone to help me."	"I seek support so I can let go to my depths."
Healer says	"Trust the test results."	"I'll save you."	"I'll play with you in the sacred garden."
Preferred Treatments	drugs/ pain relief/surgery	stimulants/purges/ enemas	unconditional love and nourishment

This chart is an adaptation and expansion of Susun S. Weed's "Three Traditions of Healing" found in her book Healing Wise (1989) with elements developed from Sheila Kitzinger's Home Birth: The Essential Guide to Giving Birth Outside the Hospital (1991).

THREE TRADITIONS OF HEALTHCARE

	Scientific	*Heroic*	*Wise Woman*
Health care Relationship	power-over, hierarchical, class distinction often present	power-over, authoritarian, class distinction often present	mutual relationship, shared decision-making, no class distinction
Health care Setting	hospital	territory alien to woman	home or other familiar surroundings
Caregivers	doctors/nurses/ certified mid-wives and other experts	professional care that is authoritarian	woman's family and friends
Health care Process	focus on medical event, depersonalized, knowledge and information not shared, little emotional support	focus on result of healer's actions,	focus on the experience,shared knowledge, validation, demystification, self-determination
Woman/womb	dysfunctional	unclean	central
Techniques for reproductive care	Ob/Gyn intervention, drugs, surgery	aggressive therapies, stimulants, purges	respect, emotional support, comfort skills, e.g., massage, hot and cold compresses, holding, local herbs
Pregnancy	unstable, pathological process	problematic	natural, normal
Birth	dangerous, impossible, illness	trauma	empowerment
Abortion	necessary evil	unnatural	empowerment

This chart is an adaptation and expansion of Susun S. Weed's "Three Traditions of Healing" found in her book Healing Wise (1989) with elements developed from Sheila Kitzinger's Home Birth: The Essential Guide to Giving Birth Outside the Hospital (1991).

CHAPTER III

RESEARCH METHODS

Subjects

The focus of this study was women who had received reproductive health care that was woman-centered, woman-controlled, and conducted within a group setting. In an attempt to narrow the scope of the study, only two types of groups were sought: groups focusing on prenatal/birth care and groups focusing on menstrual extraction/abortion care. Through the interests of this researcher in women's alternative health care, the researcher was able to locate one prenatal/birth care group, and three menstrual extraction/abortion care groups, all in California. Because these types of groups are rare, as many potential participants as possible were contacted within these groups.

After contact had been established with a facilitator from each group, the researcher distributed twenty questionnaire packets to these facilitators (Appendices A--D). The facilitators then distributed the questionnaires to women who agreed to participate in the study. Because of the initial low response rate, the researcher made further contact with the facilitators and requested to be able to contact personally women whom they had perceived as interested in participating. Ten of the participants were contacted in this manner. In all, over forty questionnaires were distributed; eighteen questionnaires were returned to the researcher--thirteen from the prenatal/birth group and five from the menstrual extraction/abortion group. The respondents were categorized according to the type of care in which they participated: prenatal/birth care or menstrual

extraction/abortion care. For the purposes of this study, the prenatal/birth respondents were called Group A and the menstrual extraction/abortion respondents were called Group B. All of the women who responded to the questionnaire have been included in this study. All of the subjects volunteered their participation; the only compensation was childcare, provided by the researcher, to enable the women an uninterrupted amount of time in order to complete the questionnaire.

Methods

Two methods of data collection were employed: an original questionnaire, and a follow up group-style interview with a volunteer sub-sample from Group A. (The obstacles to arranging a similar interview with Group B is explained below.) Because of family and other demands, one woman from the prenatal/birth group was having difficulty completing the lengthy questionnaire. She asked to participate in the follow-up interview. Her participation was included in the analysis of the data in the following way: her comments were included within the discussion of the four components of this type of health care (Collective Wisdom, Demystification, Validation, Self-Reliance), but her participation is not reflected in the Wise Woman Herstories of Chapter IV or in any numerical analysis of the data.

In developing the content of the questionnaire for this study, previous studies designed to assess health care satisfaction were reviewed. Because studies of abortion have continued to focus on issues of legality and availability, measurement of abortion care satisfaction has been

neglected by researchers. Prenatal and childbirth health care have been the subjects of the majority of assessment research. The most influential of these studies were conducted using tools that consisted of predetermined scales of evaluation (Humenick and Bugen 1981; Littlefield and Adams 1987; Lomas, Dore, Enkin and Mitchell 1987; Wallston and Wallston 1978). These tools can be organized loosely into three assessment categories: maternal-infant mortality, physical morbidity, and "psychosocial" morbidity (Oakley 1983). There are few studies designed to measure empowerment as a dimension of health care satisfaction (Locklin and Naber 1993; Oakley 1983). Ann Oakley comments that the reluctance of researchers to evaluate such "psychosocial" outcomes is due to the difficulty inherent in such measurements. She says that most obstetricians and perinatal epidemiologists "have been fascinated with death. Why is this? One reason is that death is easy to measure; either someone is dead or is not." Further commenting on the reluctance to measure "soft" outcomes Oakley says:

> Indeed, it [measurement of psychosocial dimensions] would appear to be utterly counter to the canons of the scientific method. If one adds to that the fact that advocates of the importance of the third outcome ["psychosocial"] and practitioners of the neglected art of trying to find out about it are not really scientists at all but something oddly called social scientists, (surely a contradiction in terms), then one has an excellent formula for disregarding the third outcome measure altogether. (Oakely 1983, 100)

It was determined that developing a questionnaire that measured the "psychosocial" or "soft" outcomes was necessary in order to test the hypothesis of empowerment through the experience of reproductive health care in a woman-centered, woman-controlled setting. Therefore, an

original questionnaire utilizing the respondents own words was developed as a data collecting method for this study (Appendices C and D).

The second method used in this study was a follow up group-style interview with a sub-sample of study participants. Attempts at organizing a follow up group-style interview began approximately one month after the last questionnaire was received by the researcher. The interview with Group A was organized by both the researcher and the group's facilitating midwives. The midwives and the researcher asked the women who had completed questionnaires to contact the researcher to determine a mutually agreeable time and location for the interview. Five respondents agreed to participate in the follow-up interview. Due to illness, one woman became unavailable. Five women and seven children were present for the interview, including the one woman and her children who asked to participate in the interview only. After this group interview was arranged, the researcher asked the two facilitators if they would participate in a separate interview regarding their perceptions of the health care in this study. They agreed. The interview with the facilitating midwives was conducted at a public restaurant and lasted approximately one and one half hours. The researcher, the two midwives and an apprentice midwife were present. Only the facilitators were interviewed. Questions regarding the development of the group format, their perceptions of their role within the group and their assessment of birth outcomes were asked during the interview.

During the interview with the group participants the researcher did not take notes, in order to establish a non-hierarchical relationship with the

interviewees. The interview lasted approximately two hours. The questions were developed to further assess individual participation and perception of health care in the group format. To facilitate group interaction and allow the researcher to witness it, the questions were intentionally broad. Both of the interviews were tape recorded with informed consent of the interviewees.

An interview with a sub-group of Group B was not conducted. The issue of confidentiality was paramount to these participants and therefore they were reluctant to participate in an interview. Thus the data from Group B included only the questionnaires from the five respondents.

Confidentiality

Because the legal issues surrounding menstrual extraction are undecided, the issue of confidentiality was more important to members of Group B. The researcher was unable to contact many potential participants directly and instead had to rely upon "contact" members to distribute information requesting participants. The legal issues, the inability to contact group members directly, and the small population of potential participants resulted in a low response for the menstrual extraction/abortion aspect of this study. Nevertheless, the same issues that created the difficulty in getting participation for this study, resulted in the increased importance in including these participants in a study of this type.

Confidentiality for both groups was maintained through anonymous questionnaires returned to the researcher in self-addressed stamped envelopes included in the study packets distributed to the facilitators of

each group. Upon receipt of the questionnaires, the researcher assigned a pseudonym to the questionnaire for identification throughout the duration of the study. Because anonymity from the researcher was not required by Group A, the identities of the four women who voluntarily took part in the group interview were thereby disclosed to the researcher.

Analysis of the Data

After the completed questionnaires were returned, and the interview with the sub-sample from Group A was completed, organization of the data began. Upon receipt of the anonymous questionnaires by mail, a letter was assigned to the questionnaire. Beginning with the letter A, these letters became the first initial of a pseudonym that was later used to identify the questionnaire. Entering the data into a computer, the questionnaires were compiled and organized in the numerical order of the questionnaire. Each question was listed with the responses by the participants following in alphabetical order. By organizing the data in this way, the researcher was immersed in the responses of each questionnaire and able to closely follow their development. A notebook was kept throughout this process to record any patterns or ideas that developed. After this was completed, setting up the interviews with both the sub-sample from Group A and the facilitating midwives began.

The interviews with the sub-sample from Group A and the facilitating midwives were both transcribed from audio tape into a computer. The interviews were not edited in any way. Because the interviews were not formally structured, the dialogue was conversational

and this was reflected in the transcript. Notations regarding content were made directly onto the transcript as patterns and themes emerged in relation to the literature and the questionnaires.

When compilation and organization were complete, the researcher continued to read and re-read the questionnaires and interviews to discern patterns and common themes. Initially, in trying to develop a scheme for analysis, a number of different models were applied. Defined in the Women's Studies literature as key components of feminist health work, learning, teaching, demystifying, and sharing knowledge became the most useful concepts in developing a scheme for this analysis (Worcester and Whatley 1988, 20). These components, although evident in the data, were insufficient for describing the many dimensions of the experiences that emerged. In an effort to more adequately reflect the complexity of the women's responses, the researcher began to develop additional categories. Of the initial key components, one became a main category heading while the others became sub-headings within different categories. The categories that were developed to summarize the women's experiences seemed to grow naturally from their own responses. In returning to the literature while working the data, a scheme that had not appeared useful before was re-discovered (Weed 1989). Though needing to be expanded to include additional dimensions of group-centered health care, the scheme seemed to fit accurately the patterns that emerged in the data (refer to "Table of Health Care Traditions," p. 19).

CHAPTER IV
EVERY WOMAN HER OWN MIDWIFE

Group A: The Spiral

The following is a composite portrait of a Wise Woman Prenatal Group.

As the midday sun breaks through the fog, ten women at various stages of pregnancy gather together. A few of the women are alone, several have their partners and most have a child or two orbiting the large wooden community room. Everyone removes their shoes as they enter the room and then, with the help of the little ones, a circle is created on the floor with pillows. Women with bigger bellies strategically place additional pillows for back or belly support, while other women and men help children arrange toys, cups of juice, and bags of snacks. The room is filled with sounds: women greeting one another, new partners being introduced and welcomed into the circle, and the sound-bursts of children happy to be with their bi-weekly playmates. Each pregnant woman finds a space and, after a brief trip to the toilet to self-check their urine for sugar levels, they all begin to settle in for the next few hours of Wise Woman group prenatal work.

The rhythm of the room shifts slightly. The women and their partners begin to listen to one another, checking-in with a focus on their pregnancies and births-to-be. One of the first questions asked is whether or not Jane will return to the group today. It has been three weeks since her birth and all the families are wanting to hear her birth story. Nobody knows for sure, but the facilitating midwives think the possibility is strong she will bring her newborn to this meeting. Next the conversation turns to

Denise, who wants to share an experience that happened to her in the grocery store. She tells of another woman, earlier in her pregnancy than she, who began to chat with her about pregnancy and birth. The woman asked Denise who her doctor is. Denise told her she doesn't have one, she has a midwife and is planning to give birth at home. The other woman was silent for a moment and then asked, "Aren't you scared? How can you do that?" The woman's voice trailed off but Denise says she knew what the woman wanted to ask: "How can I put myself and my baby in that kind of jeopardy--what if?" Some of the other women and partners nod their heads in silent affirmation. They are familiar with the exchange.

Denise tells the group it made her angry, but also it rekindled her own doubts and fears, "Just for a moment, I began to doubt myself. I want to have my baby at home but just one little conversation in a grocery line and suddenly I'm thinking of all the 'what ifs'." When Denise is finished with her story and her reaction to it, several members of the group say the same thing has happened to them. One woman says that she mostly feels sad when people seem so filled with doubt and fear about a woman's body and its natural ability to give birth. Someone else says she can understand the woman's reaction, "I thought having a baby at home was a totally irresponsible choice before I had Joseph in the hospital." A few more nods of agreement are shared. Bob, Carols' partner, says that a few of his co-workers have basically said the same thing to him; "How could you let your wife do that? I would never let my wife try something like that!" A few of the other women react with anger and indignation, and this emotion goes around the room for a time until someone asks Bob how a comment

like that affects him. Bob, who at first seems a bit reluctant to share his perspective, says, "Well, it's frustrating to get into an ideological debate about it. They don't see the positive parts of it at all; they only focus on the negative, the problems that might or might not happen. I don't know how the other guys [in the room] feel, but I do feel a lot of cultural pressure to be the protector and all that." At this point Maria, one of the facilitating midwives who has been listening, asks the group, "Well, what about those scary 'What ifs' ?" For the first time since they all entered the room there is silence among the adults.

For the next hour or so, previously unspoken fears are quietly shared from each member of the spiral. Words that express the need for control or the lack of it, fears of pain, death, responsibility and grief all seem to move in and out of the spiral like a collective breath in and out. Fears are spoken, fears are heard: mothers hemorrhaging and dying, babies not breathing or stillborn. There are no answers and there are no promises, only the comfort that quiet listening and sharing can offer. Letting go of expectations and trusting the babies as an inner knowing of life's perfection is repeated. The rhythm shifts and one of the midwives begins a song:

> It's in everyone of us to be wise,
> Find your heart, open up both your eyes,
> We can all know everything without ever asking why,
> It's in everyone of us to be One.

Most of the group join in the song, someone leaves to use the bathroom, and others are still heavy in their thoughts, feelings and emotions. Everyone is thinking about the births and the babies yet to be.

As Jane arrives with her infant, the spiral of families shifts to include the mother and her newborn. The group is filled with familiar faces and new families that have joined since the birth of Jane's child. Her return into the spiral is like that of a sister, returning from a long journey. Jane's mother and older daughter, Tamara, walk in behind her holding hands. The reunion is joyous. Jane offers her baby to the arms of the midwives who attended her in labor, so she may more easily embrace each of the pregnant women in her group. The families sit down and the telling of Jane's birth story begins.

Jane's story is a welcome affirmation of normal birth after the groups' previous discussion. Honoring this new mother with their excitement and respect, the women listen closely to Jane's reflections on her labor and birth experience. Over the last few months, they have heard Jane's fears and worries, listened to her decisions and preparations, and they have shared with Jane their own pregnant journeys. These women have shared and witnessed Jane's transformation from pregnant woman to new mother. Her story is important; it confirms for each of them that when it is their time, they too will be strong. They too will make their journey from pregnant woman to new mother. The women begin to *re-member;* they will give birth.

The rhythm shifts again when Jane is finished. It is time to check in with the babies. The facilitating midwives move around the room, taking time to be with each woman and the growing baby in her belly. They listen to what she has to tell them about her body and the baby growing inside. Some of the women carefully watch, listen or massage the woman-of-the-

moment's tired legs or feet, while others take this opportunity to chat with one another. Partners and siblings-to-be are asked their opinion on fetal position and the best place to hear the baby's heartbeat. Gently, the facilitating midwives lay their hands on each woman's belly and caress both the woman and the baby, checking fundal height, fetal heartbeat, and position.

After all the women have been touched and listened to, the Wise Woman prenatal is moving to a close. Most of the families gather their belongings and begin to leave. One or two women stay behind to share a more private moment with the facilitating midwives. The afternoon sun is full as the group ends another prenatal spiral.

Wise Woman Herstories

Identity

The sample of thirteen women in Group A of the Wise Woman health care study were all between the ages of 26 and 40, with the majority of the respondents being between 31 and 35. All thirteen of the women were mothers having thirty children between them, ranging in ages from 1 month old to 10 years old. In addition to being mothers, ten of the women reported being self-employed: homemaker, business owner, massage therapist, goat farmer, caterer, artisan, and computer graphics consultant. The other three women reported their occupations as being a registered nurse, student and bakery clerk. They all identified themselves to be some type of European ethnicity. Almost all (10) of the women were married, two women were in relationships and one was single.

Religious influences and affiliation for the women in Group A were reported as being very diverse and mainly untraditional. Of the thirteen women, only two women identified themselves as being a part of a large organized religious body (Judaism and Christianity), four women reported having no affiliation, and the remaining seven women responded with an eclectic religious affiliation or influence, including being Goddess-identified, Buddhist, pagan and "open-heartedness."

None of the thirteen respondents in Group A identified herself as being politically conservative. One woman identified herself as being "entirely individual," three others described themselves as centrist, and the remaining nine women placed themselves to the left of center (six progressive, one moderately left, two strongly left).

Wise Woman health care is definitively woman-centered. In order to determine if feminism was a contributing factor in the participants' decision to look for alternative health care, two questions were asked. First, did they define themselves as feminists and second, were they active in the women's movement? To the first question, seven women said yes, three women said no. The remaining three women reported being ambiguous about the term "feminist" or preferred to be identified as a humanist. To the second question, the majority (ten) of the women said yes with varying degrees of activity with only three women reported no activity at all.

Summary Each of the women in Group A of this study was a unique individual. Though each brought her own background and herstory into the spiral of alternative prenatal health care, there were some demographic similarities. A composite picture of a woman participating in this study

shows that she was an English speaking Euro-American mother with young children, involved in a significant relationship, and between 31 and 35 years old. She was self-employed and does not belong to an organized religion, but regards herself as a spiritual being. She defines herself as politically progressive and involved in the women's movement, and identifies herself as a feminist. Primarily she was unique. From career and political identity to her choices in health care, individuality was clearly important to her.

Body Herstories

The women in Group A were asked to recall their relationship to their bodies as children, as teenagers, and as adults. Not all of the women in the study answered all of these questions. Of those that did respond (ten), the relationship as children that was described by most (eight) of the women was one that was generally good, comfortable feeling and was self-involved. The women recalled enjoying their bodies and being active as children participating in athletics, exercise and/or dance. Two of these women additionally reported that their comfortable feelings were ended by the intrusion of other people. One woman felt that "gradually through spanking, I felt my body wasn't my own." Another participant recalled not having any negative thoughts about her body "until someone pointed out 'flaws' to me--then I became self-conscious."

There were two women in Group A who reported negative or conflicted feelings about their bodies as children. One of these women clearly remembers being told that "something was wrong with it [her body],

touching it was bad or evil." The other woman responded that although she felt strong, "I didn't want to be a girl at times. I felt sort of a 'tomboy.' I felt strong. But I also felt I was chubby." Half of the women who answered questions about their bodies as children included some comment about their body weight in their responses (3 fat/chubby, 2 skinny/slender).

In adolescence, the body relationships became more complex. Sexuality and image began to play a large part in becoming self-conscious as a teen. All thirteen women answered the questions about this time in their lives. Five women reported having positive feelings about puberty and their teenage years, while two women reported positive feelings about menarche. Four out of those five reported sex as pleasurable and/or giving them a sense of power. One woman described her teenage experience in terms of a newly found sense of power. She said she began to "understand that females had a certain power over males through the use of their bodies." Another woman saw her teenage experience this way, "My body gave me a lot of power with boys, it also gave me a lot of (sexual) pleasure too."

Over half of the women in Group A reported mixed or negative feelings about their bodies in the teenage years. Because of constant criticisms, mental, physical, and sexual abuse, two of these women reported developing very negative feelings. Eight of the thirteen women remarked about their physical appearance in negative ways: wishing to be prettier or thinner, or believing themselves to be too fat, too skinny, ugly or altogether inept.

Moving into adulthood, the earlier, more positive childhood relationships began to re-emerge for all of the women. Their body/self relationships were described as being more comfortable and healthier. Seven of the thirteen respondents reported being pregnant or giving birth as transforming their relationship with their body. One woman stated, "I feel very proud of what my body can do. Giving birth was a highly empowering experience." For another woman, giving birth gave her a "profound love and respect for my body and what it can do." Similarly, another group member felt that she "finally learned to appreciate my body and all that it enables me to do and experience."

For the women who reported the most negative relationships with their bodies both as children and as teenagers, the transformation is striking:

> During and after my second pregnancy, I began to have such wonder at the incredible thing my body is and how incredible the reproductive capacity is. I began to honor my periods and bless them for what they brought to my life in the way of healing, my babies and rejoicing in the whole birthing cycle and my inward journey.

> [As an aerobics instructor] I just thought of it [my body] as a "machine" to do what I wanted--one that could always be better "conditioned." However, when I became pregnant at 26, all that changed. That pregnancy taught me to love and respect my body as an intricate component of myself.

There were, however, some mixed or negative feelings reported as adults, and these too were related to pregnancy and birth--the impact on both lifestyle and body. The seven women who gave any negative comments about their bodies as adults saw themselves as postpartum

flabby, tired and with a general feeling of nostalgia for the energy of their pre-motherhood days. One woman describes clearly her mixture of emotions, "I have mixed feelings about my body. Sometimes I love it--feel strong, voluptuous, sexual. Sometimes (when tired) I feel old, worn out, and overweight."

The women in Group A were asked to describe their images of pregnancy and birth while they were growing up. All thirteen of the women answered the question; two had no memories or thoughts about pregnancy or birth, while, of the remaining eleven women, six had positive images and five had negative images.

All of the negative images reported were of pregnancy and birth as being a violating, humiliating experience, where the woman was given no choice in the treatment of her body. Additionally, three of these five women commented that they thought babies were born by Cesarean section. These vivid childhood memories of pregnancy and birth are shared by two women. For these two women, not only is there no choice in getting pregnant (being raped/it just happens) but in their images of giving birth itself, power is again in the hands of someone else:

> When I was 10 or 11 my friends and I played a game where the girls were kidnapped and "raped" after being gotten drunk. They'd get pregnant and have the babies by cesarean. I think this came from seeing a film of a neighbor's cesarean. We never talked about what happened to the babies. Among 5 or so of us, no one ever suggested birth happened any other way. Somewhere way back, I know I decided I wanted my babies at home.

> I don't recall having very specific thoughts about birth and pregnancy until I was much older. I thought babies came through the stomach somehow. I couldn't conceive ever being pregnant or being a parent

> although I just thought that it would happen. Parenting didn't seem to be much to look forward to. Pregnancy seemed to be part of the package of being female. There wasn't much choice involved.

Birth stories told to two other women by their own mothers had a profound effect on their images of both being pregnant and giving birth. Although as children each woman made a different decision about what she would do, the imagery played a significant role:

> I'm thinking about my mother whose first birth was my older sister who has some developmental disabilities and we all believed it was because she suffered anoxia [lack of oxygen] at birth. It was in the days when you get knocked out and she didn't know what really happened. She was not talked to honestly about the birth. *And from that point on always knew when I was growing up--I will not be put to sleep during my births. I will be awake and I will be in charge. I will know what's going on.* I always thought that was the right thing because that's what my mother did. She saw a situation and she took charge of it and so I guess when it was my turn, well I will be in charge here, I will not have drugs. I will have a natural childbirth. [italics added]

> I never saw it as difficult or dangerous, but my mothers stories of giving birth made me feel it could be humiliating, violating even. She didn't feel that way, but I was horrified about having pubic hair shaved, perfect strangers poking fingers in my vagina, nurses being unkind. It seemed like something you had to go through to get a baby, which somehow made it all okay. *I didn't want to have a baby.* [italics added]

For other women in Group A, who remembered their mothers or other family members being pregnant, the imagery had a positive effect for them. As young children witnessing the older women in their lives being pregnant, the women recalled seeing pregnancy as being special and normal. One of these women, the oldest of four, remembered her mother's pregnancies with each of her siblings. She recalled thinking her mother

"and all pregnant women had a sort of white light around them and they were very special. I decided very early on that I definitely wanted children and the pregnancy and birth experiences."

A few of the women specifically remembered their mothers giving birth to their siblings. These images were described as being quite normal and natural in their childhood lives. One woman remembers her mother laboring at home with her father semi-present and a lot of "funny breathing while I read The Three Billy Goats Gruff to her." Another woman remembers going on "long trips to Cleveland to see a special doctor who believed in natural childbirth." She recalled her littlest sister's birth this way, "My mom had her naturally, then came home one hour later and we had MacDonald's with her on her bed."

When asked if they had been present at a birth other than their own, eight of the women said yes and five of the women said no. At least twelve births were attended by these women and they all reported feelings of wonder, amazement, and respect. There were no significant data given on the cesarean rate of these births. In one of the stories reported, the beauty of the birth itself overshadowed a queasy stomach:

> It was late night/early morning after a night of partying. I rushed this woman to the hospital, she had it 10 minutes after we got there. I puked (I think it was the partying!). But I saw the whole thing and I loved it!

Body Herstories Summary As children, all but a few felt generally comfortable with their bodies. This significantly changed for all but one of the women as they conveyed their teenage years. All of the women described feeling more self-conscious and unsure about the bodily changes

of puberty. They all stressed their body weight as not being what they wanted (varying descriptions of being too fat or too skinny). As they became adults, another shift was noticed for the majority of the women. Their feelings of inadequacies about their bodies as teenagers grew into respect and love as adults. The majority of the women in Group A of this study attributed this shift to their pregnancy and birth experiences. Whether their images of pregnancy and birth, as children, were good, bad, or mixed, the women all reported that their memories were significant in determining their attitudes about pregnancy and birth for themselves.

Health Care Herstories

The thirteen women in Group A of this study were asked to describe their previous experiences with health care providers. All of the women reported using established Western-style medical care in varying degrees for their previous health care needs. In addition to using Western medical care, a couple of the women reported using alternative practitioners. Among these thirteen women and their experiences with a variety of practitioners, the majority felt dissatisfied with their care. Only four women reported feeling satisfied or positive about their previous health care. The nine other women reported feeling not only dissatisfied in general, but also distrustful, disrespected, frustrated, and abused. They reported their experiences as being impersonal, a waste of time, too expensive, and uncomfortable. The practitioners were described as arrogant, abrasive, hostile, insensitive, and rough. One woman saw her extensive health care due to childhood hypothyroidism as, "a necessary

evil." In describing her first pelvic exam she also said, "I went to a female physician, hoping she would be sensitive--it was awful!! She was rough, quick and didn't talk, let alone explain anything. I hurt for hours and hours after."

Communication problems with medical practitioners was a theme reported by nearly all of the women. In particular, six of the women felt their practitioner did not ask enough questions, did not encourage discussion or was patronizing to them. One woman puts it this way, "I didn't trust doctors. They would assume they knew all about you, without asking you anything." And another woman felt "frustrated, like most of it was a waste of time. Many appointments with doctors and nurses pissed me off because *I was not taken seriously.*" [italics added]

Regarding their communications with their previous health care practitioners, seven women reported not feeling comfortable asking questions. They described their experiences as not only being superficial, but also degrading and patronizing. One group member said her gynecological experiences made her feel, "like an object or worse." Another woman felt patronized and because of those experiences she felt she was unable take an active role in her health care and was "supposed to do what they said to do." This woman's response provides a clear summary of the kind of objectification over half (nine) of the women in Group A reported during previous health care, "Seeking the advice of someone who doesn't see you as a whole person is a degrading experience."

The women (four) who reported feeling the most comfortable overall with their practitioners were also the women who, as children and

adolescents, had the most comfortable relationships with their own bodies. When they were asked to describe if they felt comfortable asking questions of their practitioners, all four of the responses showed that they were either very clear about their health care needs before seeking the advice of a professional, or that they felt confident in their own "right to know about the condition of [their] own bodies."

Of the four women who reported feeling generally satisfied with their previous health care, mixed feelings about professional medical care began to emerge upon further inquiry. Three of these women reported that, when it came to their own pregnancies and births, they either didn't trust doctors or that they knew they, "couldn't give birth in the hospital." Another woman who reported feeling "quite satisfied" with her extensive Western health care experiences, also commented that

> birth seemed so natural and home the perfect place to give birth. I coached my best friend's two hospital births and I saw medical technology snowball--after accepting one procedure another one would be presented and so and so on.

One woman who reported her overall experiences with both Western and alternative medicine to be positive, also reported that, "I didn't feel there was much time or that I was encouraged to ask questions." In addition, in commenting about her decision to look for alternative care, she wrote that she did not trust "the medical doctors to allow the birth process to unfold in its own timing. [We] wanted control and to be able make the choices we wanted for our birth."

To further understand the women's previous health care experiences, they also were asked if they felt that their health care choices

were respected by their practitioners. Of the twelve women who responded: eight women reported yes, they felt they were respected; three others reported no; one woman said sometimes; and another gave no response. However, the women who reported their choices were respected gave a variety of reasons, from feeling their own self-assuredness to not going against the will of their doctor. One woman thought she was respected because, "I've been pretty clear on my decisions and I think they [health care practitioners] can see that." Another woman expressed self-confidence, "if [they don't respect me], I change practitioners." Not all the women who felt their decisions were respected felt that same self-confidence, "My choices were respected because I didn't go against what they suggested." Another group member wrote, "Of course, my choice was their recommendation. Had I opted not to follow their advice, I would probably have met with hostility."

Finally, the women in Group A were asked what specifically led them to search for alternative health care. Birth related reasons were reported by ten women, financial reasons were reported by two women, and one woman had a pre-existing friendship with the facilitating midwives. Of the birth related reasons, two women reported "always knowing" they wanted a home birth and the eight others reported wanting more control, not trusting the doctors, or being influenced by a previous birth experience or birth story. One woman had a cesarean section with her first son and felt that, "no one respected, listened to or validated my reservations about the surgery." Another woman, whose baby was able to avoid a cesarean, also reported feeling anger, "at the way I was treated while giving birth to my

first son." Another woman reported being influenced by all the birth stories she heard:

> My mother's stories of pregnancy and birth had a strong impact on me. Actually *all* the stories of pregnancy and birth I'd heard. No one had what seemed like a spiritually intact experience to me. All had lost something regardless of the baby. No one I knew had grown or been empowered by their [birth] experience. But I had read stories, beautiful stories, of women who had grown, who had owned their entire experience and knew it was theirs on all levels. I wanted that.

Health Care Summary The majority (nine) of the the women gave moderately to highly unfavorable reports about previous health care experiences. While the remaining four women initially did not have negative experiences to report, they did seek unconventional home births because they felt birth would not be well served in the sphere of Western medicine. While they may not have made this choice in response to any specific care they received, they clearly stepped outside of current medical and cultural thinking about birth. The women in my study may or may not have consciously sought to reject mainstream medical care for their birth experiences, but in choosing Wise Woman prenatal care, they began the process of redefining pregnancy and birth outside of the established medical profession.

Collective Wisdom

Wise Woman Way: Unconditional love and nourishment.

It seemed so different and not very personal/private, that was a turn off. However, after only one session I was hooked. What a fabulous idea; women at all stages of pregnancy sharing their concerns and experiences and support. Abigail, Wise Woman Group A member

Collective Wisdom is the foundation for Wise Woman health care. It is a non-hierarchical process that respects each woman's unique herstory as representing knowledge to be gained and to be shared. Respect for each woman's intimate knowledge of her body and experiences is inherent in Wise Woman health care. The women in my study articulated that through listening and speaking in the Wise Woman spiral, they began to discover that they were possessors of inner knowledge regarding their female bodies; they were part of the collective wisdom that they shared with each other.

Sharing Knowledge

All of the women in Group A stated that sharing knowledge and personal information about their lives had a positive effect on their experience in Wise Woman prenatal care. Feelings of friendship, cameraderie, and community were described by the women in the group. Some of the women characterized sharing knowledge and information as, "wonderful," "I loved it." Isabel said, "I felt very excited by it. I felt meeting as a group and having others stories would really help." The feeling of warmth and understanding is illustrated by Karyn, "It felt like home. It was so natural and flowed so well; I knew it was what I was looking for."

Twelve of the thirteen women in the study found sharing personal aspects of their lives to be an important part of the wise woman health care process. The women described sharing personal aspects with each other as creating connection, healing and contributing to their overall health and well being:

> It [sharing personal aspects] gave me a sense of connection with other women. (Gabriel)

> Absolutely it was important to share with others. Having others share right back--we all opened to one another. Because of it [sharing with each other] we were more open to our own experiences - that is healing. (Eva)

One respondent, who did not feel that sharing knowledge was an important part of the health care process, however also commented that it was "interesting conversation . . . providing another point of reference" and later, she described hearing other women's stories as the most valuable aspect of the Wise Woman health care process.

Although five of the women at first reported varying degrees of uneasiness with the Wise Woman model, they were able to overcome their initial reaction, as Abigail described above. Gabriel and Carol illustrate this response further:

> I thought it was interesting, but at first I was uncomfortable being around other women. (Gabriel)

> At first I wasn't too keen on the idea of group prenatals. It seemed like it could be a bit too "touchy-feely" for me. Since I was more accustomed to more one-on-one health care and didn't quite know what this meant or what to expect. But, after I went to prenatal group, I found that I really enjoyed it and really enjoyed seeing and hearing about the changes that the other women were experiencing. (Carol)

The Wise Woman prenatal group was an ever changing spiral of pregnant women and their families. Families leave, after the birth of their babies, and new women and their families join at any time. The women themselves were also in a constantly changing state of being pregnant. Issues and concerns changed throughout each woman's participation in the group. Because of this flux and turmoil, a safe and nurturing environment was an essential part of the shared knowledge aspect of Wise Woman care. Creating a safe space for the exchange of information was reported to be largely a function of the women opening up and talking with one another. However, feelings of initial discomfort were common. Although four women reported feeling very comfortable sharing personal aspects of themselves, the remaining eight who responded on this point reported some feelings of hesitation, reservation, nervousness or fear in sharing with other group members. All eight of the women who reported feelings of unease also reported becoming more and more comfortable with sharing as the group process and its ability to provide support became known to them. Frances, a self-described practical thinker, felt, ". . . a little reserved at first until I got to know them better, then it was fine. I wouldn't open up willingly though." Joanne recalled feeling the environment created by the facilitating midwives was so safe and reassuring that even though she many times felt shy, she also "proudly [shared herself] with the other women."

Feeling comfortable enough to share intimate aspects of one's past was a crucial step in contributing to the collective wisdom that is the foundation for such health care. Although many of the women in this

study felt shy or uncomfortable at first, as they began to see the collective wisdom aspect unfold, they became less and less nervous. Eva and Lillith explain:

> [I was] nervous often and sometimes scared about how I would be received. But always happier about it afterward. I never felt judged by the group or the midwives, if anything they saw me more positively than I saw myself. (Eva)

> The more chances I took sharing the more support I would get back. (Lillith)

Wisdom Within

Being respected, honored, and needed for their inherent wisdom motivated the exchange of knowledge in the Wise Woman prenatal group. Radically shifting possession of knowledge from the outside experts to the women themselves is central to the Wise Woman model. Participating equally in sharing knowledge and information was a responsibility not easily accepted by many women in this group. One of the facilitating midwives describes having to "really point out to them clearly, 'You're the experts, we need you.'" It was challenging for the women to look to themselves and each other for information that they were used to receiving from doctors or other health care practitioners. Isabel relates:

> At first I wondered why it was so important to the midwives that I attend the groups, I felt uncomfortable hearing other people's personal information. I was bewildered by the lack of controlling energy from the "experts" [the midwives]. Later I learned to participate and really get something out of the process.

Karyn described it another way:

> The midwives do their work before the birth by having the moms and the families do theirs.

Group-centered health care requires that knowledge and information be brought forth and shared by all participants. The facilitating midwives, Maria and Ruth, emphasize that, without the women sharing what concerns them directly, the importance of the Wise Woman process would be lost. In conversation, Maria explains it this way:

> It [the knowledge] comes from within them. We don't put out the agenda, it comes from them. And then when one person puts out, "I'd like to talk about something," it emotes something in other people so they begin to talk about something that is relevant to everybody.

Ruth adds:

> It dispels that image that they are coming to the authority for information in order to accomplish this most difficult task, that they couldn't possibly do it without us. That's the energy that is so destructive in the medical model process. That women feel that they need classes in order to give birth, rather than sitting in a circle and re-membering the knowing that they each have for one another, to offer it to each other and to themselves.

These comments by the facilitating midwives were echoed by the women themselves:

> The knowledge and experience brought out by others was the most important aspect to me. (Abigail)

> Hearing others experiences and seeing my experience reflected in theirs was invaluable. (Donna)

Teaching = Learning

The interactive nature of sharing knowledge with each other often brought up issues that might not have been addressed in another health

care setting. Twelve of the thirteen women reported they definitely felt that topics and issues were addressed that would not have been discussed in another setting. The one respondent who felt that the sharing of information "did not really" help encourage discussion about a wider range of issues, clearly states in other responses that interaction was important to her overall experience of Wise Woman care. Issues about work and working, traditional medical care, death, childhood immunizations, vaccinations, relationships and families, herbs, homeopathy, sex after birth, breast-feeding, toddler nursing, reaction of baby's father during pregnancy and birth are some of the topics reported by the women in Group A as examples of the breadth of discussion. Eva and Abigail elaborate:

> [We talked about] fears that pertained to my life and how it would be affected or was being affected. My marriage too, and all the changes it went through. Spiritual issues, deeper meanings of dreams during pregnancy. And the ultimate fear - what if the baby dies? Also, the issue of it [pregnancy and birth] being a solo journey--I had to do it myself, wanted to do it myself--and the kinds of support that I would require. Past hurts and unresolved feelings that the experience called up. Issues about my relationship with my mother and other family members, and its impact on my experience. Group prenatal care is like getting midwifery care and group therapy all at the same time. (Eva)

> We created a safe place to talk about all issues. Not just the physical aspects of pregnancy, but the emotional and spiritual aspects as well. You don't talk about those things with an OB in a ten minute office visit. Also, as others in the group spoke of something it often raised thoughts for myself and continued discussion. Their openness increased my openness and in turn we all gained more from one another. (Abigail)

As Abigail points out, the group process is an organic process. Not only did the women report that more issues were addressed than in other

health care settings, but that sharing their knowledge with one another created new questions and answered questions not yet thought or spoken. Donna comments:

> I didn't know what to ask. I hadn't experienced many births or mothers or children. So, I needed to learn fast and furiously; others bringing up issues and the responses and discussion that followed helped me so much. I came to it [group prenatals] not knowing what the questions were a lot of the time. Things came up that answered questions that I didn't know I had!

Respectful Listening

The women in this study reported that equality in their spiral of collective wisdom required them, to share themselves openly with the other women in the group and to learn how to listen to and respect each woman's shared words. Nan articulated that "being able to hear other people's issues that may be different from your own" was an important tool she acquired in the Wise Woman spiral. She further recalled that this listening many times "reflected [her] own experience and helped [her] to understand what was going on" for her. Hanna and Brigid explain further:

> For me, it was beginning to be able to listen to other people. Instead of coming to a group, pregnant and having my needs and just being attended to, I had to sit and listen and that was really the beginning of me learning how to do that. I'm much better at that, I listen to other women talk and *learn* something valuable for myself, not from speaking myself, but just from listening to other people. (Hanna)

> Maybe not getting to say the thing I thought I really wanted to say, but really learning something very valuable about that subject or another one. Some of their questions answered my own questions. (Brigid)

All of the women reported that developing the ability to listen patiently and respectfully to the other women's experiences helped them to

be less judgmental with themselves and each other. Joanne described the process as "tapping into other people's experiences opens the compassion channel, which, in turn, opens the channels into one's self."

Nan explains this process for her as teaching her to be

> more patient, and when somebody is talking about their issues and it pushes your buttons I've learned in this group to say "Why is this causing a reaction in me? What does that have to do with me?" Rather than seeing that person as really screwed up and being judgmental about other peoples issues. Watching people talking about their issues during prenatal and then having them come back and tell their birth story and seeing, did those issues come out? Or were they overcome?

Two other women echoed this aspect of listening to another woman's story as helping them with their own issues and preparation for birthwork. Eva said,

> There were a lot of times when people would come back and tell their birth stories and I would suddenly see them in a whole new light and realize those things that I might have been feeling judgmental about, even if I never voiced them, were just different. It was not a limitation or that something was wrong with them, . . . it was just different and their experience was just their experience. So the prenatal group experience for me was kind of an opening into that whole way of being in a group and seeing myself reflected in other people.

For Donna, whose birth experience required transport to the hospital, the impact of having heard other women's experiences was a powerful tool that helped her during that difficult time. She recalled that,

> When somebody would come back with a difficult story, it was so healing to hear her just embracing this very, very difficult experience and I know that helped me with my own very, very difficult experience in the hospital. So, okay it wasn't easy to let go of

> the expectation, but to have someone who preceded me and was able to embrace that was wonderful, incredible. It helped me. I know that when I think back on the nine months with them [the group], I ask myself if it helped me. Yes, it did. It helped me incredibly to be able to ride the wave of my whole experience; my wave went over to the hospital.

Dancing With Wisdom

The experience of sharing knowledge and information between women at all stages of pregnancy was described by some of the women as a "double-edged sword." The group was open, at any meeting, for new women and families to join. Once the facilitating midwives determined that there were no high-risk factors, women could join at any stage of their pregnancy. This generally meant that new or prospective members were present at many of the prenatals. One woman said, "There was one week towards the end of my pregnancy, when I didn't know anyone there." The possibility of a new person joining at any time was reported to be disconcerting, but was balanced by the very nature of group process. Brigid described that she did not always feel comfortable saying certain things because she didn't always know all the people in the spiral. She said "a lot of times people can't come for weeks. Some people came and some people didn't. You didn't know who you were going to see."

The ever-changing composition of the Wise Woman spiral was definitely felt to be a challenge by most of the women. The experience of feeling both overwhelmed and appreciative of the changing nature of the spiral was articulated by over half of the women in the group.

Including children in what is most often done in isolation with specialized one-on-one health care, is challenging and reassuring in the Wise Woman spiral. As Donna described it,

> all of a sudden everyone in the group had older kids and it was like a madhouse. Here I was coming from a no-kid life and suddenly--it was an incredible experience. I got to hear father's stories and I got to experience people's families and kids, but sometimes it was totally overwhelming.

Ruth, one of the facilitating midwives, recalled that in the beginning having the children present was also challenging for her. She admitted being "uncomfortable, personally, with doing the work with the children there; it felt too chaotic, too unfocused, all the words we use when we separate." Yet she believed including the children was "revolutionary, another step of empowerment, we don't have to divide ourselves up into segments, that mothers are mothers and to speak of mothering and yet to do it with the children out of the room is not very effective."

Witnessing, sharing and working with all aspects of the childbearing experience is part of what makes Wise Woman health care so unique. To bring together women in all stages of pregnancy and birth offers each of them the interconnecting power of transformation. In the scientific or heroic traditions, processes of creating connection, sharing knowledge and respecting the collective wisdom in each person are absent. Instead women arrive for their monthly ten minute appointment with their specialized practitioner. Despite the other pregnant women waiting in the lobby, women tend to read one of the many "How To" childbirth and parenting magazines while they wait in polite silence together. Whereas the prenatal experience of most women in the United States are private isolating

experiences, the group prenatal care creates a community of pregnant and newly postpartum women. Eve characterizes being together with other women in the Wise Woman prenatal spiral as "dancing with wisdom." She describes this further:

> One of the best things about the group prenatals was that the [spiral] had women in it at all different stages of ripeness and all different levels of experience. That was the richness, the reassuring part and the learning part for me. It definitely goes both ways and the very thing, the openness of the group, it felt like a weaving, women coming in and going out. It was like a dance.

Demystification

Wise Woman Way: Playing in the sacred garden.

It helped to see other people go through their individual experiences. Some had wonderful normal births. Some had to transfer to the hospital in the end. Some lost babies. A human experience, that supported individual choices and lives. Monique, Wise Woman Group A member

Demystification is a cornerstone of Wise Woman care. It is through the process of collective wisdom that demystification occurred for the participants in this study. Pregnancy and birth have become culturally isolated experiences in our modern lives, women sitting in the Wise Woman spiral, shared and learned that they were not alone in their fears, concerns and expectations. The majority of the women expressed discovering beauty in the diversity of pregnancy and birth experiences among their pregnant "sisters." The women reported hearing other women's experiences of the unknown, (pregnancy and birth), as supportive and enlightening. They expressed their fears, heard the realities, and began

to recognize the real variety of their experiences through their participation in Wise Woman health care.

Exploring the Unknown

Eight of the women in Group A reported being present at a birth other than those of their own children. While there were no specific data given on the actual numbers and settings of births attended by these women, those who reported attending a birth in a hospital setting also reported that this experience influenced their decision to look for alternatives to the medical model for their own birth experiences. There were two women who had attended numerous births. They described their impressions as "AWE, WONDER, BLISS" and "Each one is a miracle." Joanne, a Wise Woman group member, explains her attendance at a home birth as giving her "the chance to experience other possibilities. I think my body learned a lot." The remaining five women in Group A reported having not been present at another woman's birth.

The women were asked about their initial thoughts regarding home birth. Their responses varied from "I thought it was crazy" to "It sounded wonderful and joyous." Three of the women described initially wondering why "someone would want to give birth at home," or feeling afraid of "the distance to medical care," or thinking (as Brigid did, quoted above) that home birth was crazy.

However, upon making the decision for themselves, eleven of the participants thought it was a "viable and natural way". Frances felt very practical about the choice between home or hospital, "How nice to be at

home without being stuck in those horrid little rooms being surrounded by people [I] didn't know." Isabel, who had only witnessed calves being born and thought "it was kind of gunky," describes her changing view of home birth, "I thought it was romantic when I was a teenager. When I actually made the decision for myself, I thought it was scary sounding, but better than the hospital."

Even though most of these women felt they had always wanted a home birth for themselves, only two had attended a home birth. For the remaining women, who had either never been present at a birth, or had witnessed birth in a hospital or ABC setting (Alternative Birth Care), home birth was still a mystery. Demystifying the pregnancy and birth experiences by sharing collective wisdom about their bodies and their experiences, began to reshape many of the women's self-images about giving birth. Eva, who reported hearing others women's negative and powerless birth stories as affecting her own image as a giver of birth, felt transformed by hearing women returning to the Wise Woman spiral with their birth stories. She explains:

> The first time I heard someone tell their birth story, it just was amazing how much more confident about birthing I felt. It was suddenly more real, it wasn't something I read about, a baby and a mother after the fact, it was real!! It really boosted my confidence about being able to give birth. (Eva)

Isabel, who had a romantic notion of home birth as a teenager, describes her own confidence being strengthened by hearing "all those other women who had given birth at home, or were planning to, and they'd all gotten through it feeling satisfied with themselves. It gave me confidence to hear other women's stories." And Donna, who as a child only thought babies

were born by cesarean section felt she was able to "see and hear that babies do come!"

Fears and Realities

In the Wise Woman tradition, the troubled one says, "I seek support so that I can let go and go to my depths." This is met by the healer's response of, "I'll play with you in the sacred garden" (Weed 1989, 3). In Wise Woman group prenatal care, the women in the group provided the support necessary for each pregnant woman and her family to "let go to their depths." Eleven women reported having a specific fear or concern about their pregnancy and birth. While only two of the women reported having no fears or specific concerns. Some of the fears described by the women were:

> "If there was a problem, could we get to the hospital on time. Would I be able to go into and face the pain without drugs."
>
> "My main concern was if something happened to harm the baby or if the baby died, would I be able to live with myself?"
>
> "I was totally afraid of being so far from a hospital."
>
> "None other than general fears about childbirth and the unknown."

Being able to articulate fears and then have them reflected by the group was reported as a crucial aspect of "going to one's depths" by every participant in the group. The group's ability to dialogue and respond to each woman's fears was reported by all the women to be a nourishing and positive experience. Donna felt that the conversation among the women and men in the Wise Woman spiral helped her to ease her fears and "it helped me find my own fears and expectations and try to go into them and

release them. [The group] supported me to be good to me." Karyn also felt that "exposing" her fears in the Wise Woman setting was useful in her preparation for birth. She said, "It got them [issues] out in the open--exposed by the light and scrutinized. Scary issues lost their power, which enabled me to move on to the work of birth." Eva described learning a lot within the Wise Woman group when "questions of death, harm and responsibility were explored in depth repeatedly. I learned so much, and grew so much in the group. The group centered approach was the key to my happy experience." As in the shared *knowledge* aspect of Wise Woman care explored earlier in this chapter, the interactive aspect again is emphasized in Donna's words:

> The fears that came up would be discussed and responded to by others who had those same fears and had moved through them. It helped so much to be with mothers and fathers who had children already. If one person didn't have a response another did.

Unique Variations

As every woman's body shape, type, and cycle is individually her own, so it is with her pregnancy and birthing. Yet, many women think of themselves as the being the only one who feels a particular feeling. They think they should be doing something differently than they are. The women in this Wise Woman study were no different, in their thinking themselves to be the only one with a particular issue or fear. But, through sharing and listening, they all reported being able to appreciate and respect their own body for its unique variations. Additionally, they began to see and experience this in other women as well. Frances learned to "have no expectations. I thought my pregnancy and birth was unique and amazing."

She further describes the Wise Woman group approach as teaching her, "how different, easy, difficult etc. every birth was, . . . that made me realize that I really could have 'No Expectations'!!" Hanna said being with other women experiencing the same thing as she was [pregnancy] gave her a "heightened awareness of the fact that we were all different but could consciously respect each others differences."

In reporting what it was that they felt they contributed to the Wise Woman group, the women showed the diversity of experiences among them. One woman said, "I am a positive relaxed person. I didn't have a lot of fear going into my pregnancy. I was pretty confident." In contrast another woman said, "I complain a lot, I wouldn't want anyone to think they were the only one who wasn't in utter bliss the whole time."

A number of women said they felt their most important contribution was sharing themselves openly and honestly with the group. Eva felt that she was "always willing to share my experiences, good and bad. I allowed my fears and vulnerability into the group which, I hope, encouraged others to do the same." Carol reflected similarly, saying that by "sharing my stories, and opinions and my sense of humor" she contributed to the diversity of the Wise Woman group. Another woman felt that she was "the straight one, coming from a traditional Western [medical] place" and that she brought another side to the topics discussed in the group. A single mom of three said that she helped others to realize "if I could do it, that somehow they could manage as well." And finally, another woman humbly remarked that the positive birthing of her 8 and 9 pound twins was

"perhaps inspirational. It was amazing to me and a tribute to the [Wise Woman] approach to birthing."

Validation

Wise Woman Way: Perfect manifestation of complete being.

It felt special to have a community of pregnant women. I was worried I would be the only one with a certain anxiety or problem but I never was. It helps to feel mutually healthy. Isabel, Wise Woman Group A member

The sense of isolation most women experience during pregnancy, was compounded for the women in this study. Validation, especially in times of change and increasing isolation, is another cornerstone in the Wise Woman way of health care. By sharing their collective wisdom the women in Group A of this study not only began to demystify the pregnancy and birth experiences for themselves and each other, but also provided validation for these experiences. Validation is essential in a culture where women's needs and experiences are viewed as anomalous.

Connection

Two women in Group A of this study reported feeling they had adequate support outside the Wise Woman spiral for their decision to birth at home. The remaining eleven women found they either had mixed support, ambivalent support or no support at all. Most of the women reported feelings that reflected Donna's experience:

> Mostly, [I felt support], but what I did was not talk about it with those who I thought would in any way try to change my mind or weren't supportive. I would have loved to share it more because it was such an important and exciting decision for us. I felt sad there was so

> much judgment and criticism. I was shocked sometimes by people who otherwise were quite open.

The thirteen women in this study all reported the group-centered approach assisted them not to feel isolated, alone, and unusual in their experience of pregnancy. Eva describes it this way:

> I cannot imagine how women get through pregnancy any other way. It is the most enormous physical, emotional and spiritual journey I've ever made and I felt support on all levels by the group. [Wise Woman] prenatals gave me the courage and support to work through feelings of fear, loneliness and bewilderment. Pregnancy and birth became joyful, enlightening experiences.

In that pregnancy and birth are a uniquely female experience, Monique said that it is women who need "to support each other through this [process]," and that sitting in the group, listening to other women with similar thoughts and concerns, "gave me more confidence that I had made an informed decision."

The women also reported "getting to know other pregnant women," being able to "connect with other women with similar [Wise Woman] prenatal and birthing care" and "making friends with other women with babies the same age" were important validating opportunities found in the Wise Woman model of care. Isabel explains this further, "I didn't feel alone. I [felt] part of a community. I [felt] normal and was reassured because our concerns were similar and taken seriously by the [facilitating] midwives."

Confirming the Normal

Most of the women in this study expressed relief at feeling they were normal and that their concerns and most private issues were not unusual.

Lillith stated, "[The group] helped me to feel okay because their concerns were so similar to mine." The interactive and cooperative nature of Wise Woman care is expanded upon by Karyn, "When you hear other women going through stuff--maybe like yours, maybe not--it is a relief. I could be more positive about resolving my issues."

Over half of the women in this study reported that feeling validated as normal was an important part of their being healthy. Isabel stated she "was worried that she would be the only one with a certain anxiety or problem, but [I] never was." This experience was reported by women who were nervous or afraid to share very personal issues. Through the open and honest environment that was created in this Wise Woman spiral, sharing not only common concerns and questions but also very intimate aspects of their lives was facilitated. Abigail felt that the group offered "100% support for all aspects of your pregnancy and birth plan. They helped with the most mundane questions and the deepest concerns; so many points of view and varieties of insight was invaluable." For instance, one group member needed to talk about her fears and concerns about having genital herpes. She said it was "hard because people don't know about it." But she found that three other women in her group also had the same condition and talking about it together, significantly lessened all of their worries, isolation, and fear, while simultaneously educating other women in the group about this hushed issue. One woman described listening to such fears as providing "such a relief to know your experience is shared by others. I was often touched by another's courage in being open and vulnerable--it gave me permission and courage to do the same and be

healed by it." Hanna further described listening to others as "[giving me] a deeper perspective on [my] life and experiences."

Another issue often hidden from view was also discovered to be held in common by the women in the group. One woman recalled, "One day we counted who was pregnant before or without marriage and who became pregnant after marriage. It was 50/50." She further noted, "It was comforting to know we shared the same experiences of exhaustion and difficulty."

Self-Determination

Wise Woman Way: Empowerment

I could never have given birth to my daughter the way I did in any other setting. I was free to move around. I didn't sit down once. Just walked all around the house, kneeling over some piece of furniture for the contractions. I went to the toilet a lot, made lots of low, moaning, groaning birth noises. ***I felt safe and comfortable, there was absolutely no fear.*** *I started serious labor at 3:30 p.m. and at 5:30 I finally called my partner at work to come home (I was taking care of my son). Even before that, I didn't perceive the contractions as being painful, just really intense. I was completely open and relaxed. At 6:30, my friend Kate came over and my son and partner left to go eat. Kate said "It won't be long now." I don't think she really knew. So we belly danced to Jean-Luc Ponty and she asked if she should call the midwives. I told her, "Not yet" but I was thinking,"Why?" At about 7:00 p.m. I started having double peaking contractions and decided to tell Kate to call [the midwives]. When one [contraction] was over, I felt fine and told them not to hurry. About 5 minutes later I had this urge to get the birth room ready--fast. I yanked back the white comforter, got out the box with the birth kit. I climbed on to the bed and leaning over pillows, my water broke with a "POP." Then the intense contractions were over and there was a pause. Shortly, I felt an intense need to push, which I did. Then there was the "Ring of Fire" and her head was out. And with another push her body was born.*
Karyn, a Wise Woman Group A member. Her son was born by an unnecessary cesarean section three years earlier.

Reported in the Health Care Herstories section of this chapter, all but one of the women in this study had been dissatisfied with their previous health care. Primarily, they reported not choosing established medical care for their pregnancy and birth because they wanted more control. Karyn clearly shows the level of self-determination not available in many other settings. Relying on only the wisdom of her body for guidance, Karyn gives birth alone. However unique, this powerful birth story demonstrates the ability of Wise Woman care to elicit confidence, healing and responsibility within the women.

Responsibility

Whether the women in this study willingly took the responsibility for their own experiences or had to learn to accept it, they all reported being responsible for their experiences as empowering. As Maria explained earlier in this chapter, "the women are the experts," and because of this they must take more responsibility for and participate more actively in their experience than in any other kind of health care or birthing context. From the beginning, the women are responsible for monitoring their own health through self-exam of urine, blood pressure, and participating in fetal assessment. From contributing to the collective wisdom they all share to decisions about the birth of their babies, the level of responsibility is greatly increased. Hanna said "I had to take more responsibility for everything, from checking my own urine to making the bed I was to birth in."

All of the women said that learning to take more responsibility for themselves and their births had a profound effect that extended into other areas of their lives. Nan felt she was empowered through her Wise Woman birth experience to take more control over the health care decisions regarding her family. She said that:

> It's about personal responsibility. Kaiser can say "This, this and this prenatal test" and now I feel I can say "I don't think I need this test." The doctor will say, "They need antibiotics for an ear infection," and I can say "Well, does he really need antibiotics for an ear infection? What are my choices here?" I feel empowered, that I'm responsible here and it's my job and my husband's job to make the choices about my kids, not the pediatrician's or the obstetrician's.

Taking more direct control over their own health care and pursuing alternatives to the scientific model were reported by ten of the women who had previously sought the majority of their care from the medical establishment. Eva said that before her Wise Woman experience

> there was a lot of fear around taking responsibility for somebody else's health, like my daughter's health. But the empowering part of the [Wise Woman] process was, I took more responsibility and it made my experience safer and better and more right for me. It gave me the strength and the confidence to do that.

Each of the following quotations from a different woman illustrates the theme of transformation as health care recipients.

> I expect to be treated as an intelligent woman capable of making informed decisions. I expect my body to be treated gently and respectfully. (Joanna)

> I'm much more skeptical of traditional [scientific] care now. At the end of my pregnancy we had a non-stress test done to make sure everything was okay. This was a very negative experience for me. (Carol)

> My own personal and professional selves have changed dramatically toward more alternative interventions for the health care of myself and my family. (Hanna)

> It has given me more confidence in my body. It has helped me to feel that there is a place for modern medicine (when needed) and also a need for support of a more human-based alternative health care. (Monique)

> I expect health care practitioners to listen to me, I take it for granted that I can figure out my own health care problems and needs and use the M.D. as a consultant. (Isabel)

Three of the women who did not report an increase in their own ability to make choices, did comment that they began the process of understanding where scientific models can be appropriately used. They reported a deeper

understanding of the ability of scientific care to play a more complimentary or emergency role, rather than being the primary source for health care. Donna said that in response to her home-to-hospital transfer, she and her baby used both scientific and Wise Woman care to the "hilt." She said that she gained "Perhaps a deeper realization of their [the two traditions] need to respect and support each other."

Empowerment

Most of the women, who reported becoming more self-reliant, also reported this as having a profound impact on their lives. Ten women reported that their birth experience was truly the most empowering action in their life. One woman, in comparing Wise Woman care to scientific or heroic health care models, said that, "[Wise Woman] care empowers women, gives them back their bodies and sexuality, [scientific] does exactly the opposite." Karyn commented that giving birth was:

> the most empowering thing I've ever done. [Wise Woman care] not only met my needs but taught me *how* to meet my own needs by empowering me. The day my daughter was born, the seed was planted for me to leave an abusive relationship.

Feeling empowered by their Wise Woman birth experience is repeated by almost all the women in this study:

> Giving birth is probably the most empowering experience of my life. (Joanne)

> I feel very proud of my pregnancies and births - I did a great job. (Lillith)

> Pregnancy was a gift, giving birth was the peak experience of my life. (Eva)

> That Birth was the BEST!! I felt totally in tune with my body and the universe. (Monique)

In reflecting on her difficult experience of transporting to a hospital for her birth, Donna described herself as being prepared because Wise Woman care "directed and redirected everything back to myself." She said staying "present with ourselves and taking responsibility back . . . wasn't easy, I got really mad at the midwives a lot." But, she adds:

> every time the hospital came in and said 'What about this?' We were able to respond with 'Well, we need to talk about this'. At one point we had this major confrontation with the doctor and the nurse and through it all we were able to be our own advocates and our child's advocates in the hospital.

Nan describes her reaction to her first birth experience:

> It wasn't until after my first child was born in the hospital and it was a disempowering experience that I began to have bad feelings. I started thinking about what was missing, what I didn't get, what went wrong. You know every time I watch Oprah, she talks about her best friend giving birth to her godchild. Her best friend wanted to have a natural childbirth and Oprah was there saying 'Honey, have the epidural.' Here she is, this woman with an incredible sense of accomplishment about running her first marathon. I really keep meaning to write her a letter and say, How would you feel, when you get to that point where you feel like you can't do it and what if somebody came to you and said 'It's o.k. honey, get in the car, I'll drive you to the end.'

Eva describes her first child's birth at home as long and tiring, yet, she says, because of the fact that the midwives never:

> once said anything to make me think that it was anything other than my choice or experience,. . . I saw myself in a totally different light, it was like whoa--you are a pretty intense person. I could go the distance, I could really do what I needed to do. If they had shepherded me too much, or directed too much or even a little bit,

some of that would have been lost. It was the greatest gift of my life to have my child that way, to have that whole experience be mine.

GROUP B: The Spiral

The following is a composite portrait of a menstrual extraction group.

The evening is warm, and with the last verse of a lullaby, Jane sings her children to sleep. Rocking her youngest child in her arms, Jane begins to feel a quiet strength swell within her. Her decision to end her suspected pregnancy has been challenging in fewer ways than she might have imagined. She recalls the phone call to her friend Elinor, and then the meeting with the women in the Wise Woman spiral who would assist her in this decision. She remembers how reassuring and confident she felt after meeting with them--talking over her feelings, her fears and her expectations for her experience. Discussing the group's knowledge as well as the whole procedure she and her husband would take active part in, gave both of them the same sense of respect and control they had felt at the home birth of their son three years ago. Jane lays her sleeping child in bed and joins her husband, who has been readying the house to receive the Wise Woman group later that evening. Jane's favorite music is playing softly in the background, candles are lit, tea is brewing and the women begin to arrive.

The women arriving at Jane's house came together over three years ago, with different herstories and lifestyles, to learn how to provide basic Wise Woman care for themselves and other women. In addition to learning how to examine their own bodies for health and normal well-being, the women in this group have become adept at many different skills

needed for providing menstrual extraction for themselves and other women. Although their backgrounds and lifestyles may be diverse, they have a common desire to provide an empowering alternative to mainstream abortion care. Carefully learning from other women who also have dedicated themselves to this endeavor, they have learned that abortion care can be safe, respectful, and nurturing--in their own hands, it can be a truly empowering experience. This is why Jane called her friend.

After all five of the women--Elinor, Amy, Kristen, Deanna and Fran, arrive at Jane's house, they sit down and chat for a few minutes over a cup of tea. The group, which now includes Jane and her husband, will make all their decisions together. The details of who will be doing what are decided and the Wise Woman group moves into the couple's bedroom to begin the menstrual extraction. As Jane removes her clothing and climbs onto her bed, she tells the group that this is the same bed in which her children were conceived and born. This thought fills her with strength as she reflects on her ability to control her own fertility. Jane asked for both her husband and Amy, another woman in the group, to be her support people--holding her hand, giving her juice and encouragement--while her friend Elinor handles the cannula that will be inside her uterus. With more candles lit, Jane reclines against her mate and tells the women in the group they may begin.

Each of the women respectfully checks Jane's uterus and they confer with her again about her dates and verify that her uterus feels about seven weeks past conception. Then Jane reaches for her speculum and inserts it

into her vagina herself. Looking at each of the people in the room, Jane turns to Elinor and gives her permission to begin.

At each step of the extraction, Elinor and the other women check each other's work and tell Jane what is happening. They monitor her cramping sensations and inform her when blood begins to appear in the Del-Em (TM) tubing. Jane, breathing deeply and steadily throughout, lets go a low moan as the suction increases. Her husband strokes her hair and gently holds her hand, while Amy watches her face to see if Jane needs a break. Massaging Jane's shoulder muscles, Amy provides quiet support. In reverence the women continue their work while Kristen takes a turn with the cannula, checking the feeling of the interior uterine wall to be sure that all the lining has been extracted. Each of the women looks at the tubing and twenty-five minutes after they began, Jane's menstrual extraction is finished. As Elinor removes the cannula, the room takes a collective breath. Jane's husband reaches over and kisses her gently.

While Jane and her husband relax on their bed together, the women begin to clean-up. Kristen and Fran take the Del-Em into the bathroom and by pouring the contents over a strainer, verify that Jane was indeed pregnant. They return the contents to Jane. As Jane gets dressed, her husband prepares food for the women who have come together for he and his wife. Taking the jar with her blood in it outside to her garden, Jane empties the jar under the rose bushes where her children's placentas are buried. Once again, Jane feels herself swell with strength. This time she is filled not only with respect for herself and other women, but with power--a

power that comes from self-determination, a power that comes only from within.

Wise Woman Herstories

The women in Group B of this study have been either practitioners, participants or both in Wise Woman self-help groups. Their experience ranges from participating in one extraction to having over fifteen years worth of work. The women in this section whom I am discussing as Group B are actually from different groups in different geographical areas. They are practitioners entirely independent of and unknown to anyone in Group A. Over twenty questionnaires were distributed to a variety of different contacts. For many social and political reasons, including the recent increase in attacks on abortion activists, only five women participated in this part of this study. Because this type of health care model is virtually unknown, I have decided to include Group B in this exploratory study of Wise Woman health care.

Identity

The five participants in Group B were between the ages of 21 and 40 years old. They were all English speaking, Euro-American women. Two of these women were single, two were involved in relationships and one was married. Two women in Group B were mothers. All of the participants identified themselves as politically left of center and active Feminists. Three women reported their religious affiliation to be Jewish. The women

in Group B reported a variety of careers: bartender, painter, women's health worker, sex worker and customer service representative.

Body Image Herstories

As children, the women in Group B reported a variety of feelings associated with their bodies. The responses of these five women went from feeling very healthy to feeling alienated, and varying degrees of each in between. Two women described being curious about themselves and about boys. One of these women additionally reported that she "felt shame being curious" about her own body. Another woman, who reported feeling alienated from her body as a child, felt that because she was frequently ill, her mother became over-protective and this "engendered a sense of mistrust about [her] body in the world."

The women in Group B reported similarly to the women in Group A regarding their bodies as young adolescents and teenagers. Four of the women made comments about their body weight: "I thought I was fat," "I felt overweight," "I was told I was too fat," and "I felt fat." Although they reported feeling or thinking themselves to be fat, as well as being self-conscious and insecure, three women went on to describe themselves as being "attractive," "strong and athletic," and feeling "mostly okay" about their bodies during their adolescent years. One woman could recall very few positive aspects other than her "avid masturbation life."

Regarding their body relationship as adults, the Group B participants in this Wise Woman study reported similarly to the women in Group A, generally feeling more comfortable in their bodies as adults. Whereas all five women reported some negative feelings about their bodies as either children or teenagers, they also all reported liking and accepting their bodies as adults. Two women reported feeling connected and aware of their body rhythms as positive influences on their overall body relationship. As an adult, one woman now sees her body as "a partner in [her] fertility cycle."

Summary While participation in this aspect of my Wise Woman health care study was unexpectedly low, the data reported does articulate some similarities among the five women in Group B. The women reported vastly differing experiences of their bodies as children yet, as adolescents they began to echo one another's experiences of teenage insecurity, self-consciousness and lower self-esteem. Although the women reported feeling both attractive and strong, four women also described negative attitudes about their body weight. As the women moved into adulthood they began to feel more at one with their bodies, reporting their awareness of their cycles and physiology to have a positive impact in this direction.

Health Care Herstories

Among the five participants in Group B, three women reported feeling dissatisfied with their overall health care prior to their Wise Woman group involvement. The other two women reported being fairly satisfied, although they reported never having sought medical attention for anything they considered serious. Among the negative reports about

previous health care experiences, three felt frustrated, ignored, objectified and mistrustful, two felt overmedicated by a physician, and one woman was molested at 15 years of age by her pediatrician.

While only three of these five women in Group B reported feeling very dissatisfied with their previous health care, all five women reported that their previous health care experiences contributed to their decision to look for alternative care. All five women reported their own bad experiences as well as bad experiences by friends as playing a major role in this decision. One woman stated that after having a "horrible experience with an OB/GYN," she declared she would "never again to go to a male OB/GYN and to be more discerning and in control of [her] care." A first experience in seeking birth control was frightening and demoralizing for another participant. Not only did she not get the method of birth control she asked for, she was told she had a cyst. Without any further explanation from the health care provider, she left thinking she had cancer. A shockingly disrespectful pelvic exam was shared by another woman, "While his fingers were still inside my vagina, the doctor turned to the nurse and said, 'Look! Look how big she is!', in reference to the size of my vagina."

When asked to describe their images of pregnancy and abortion, only four participants recalled these images during their childhoods. Pregnancy was described by four of the women as being "painful and scary," "cool," "mysterious," and "awe inspiring." Two women reported a memory of abortion. Each woman recalled very different images. By high school one woman knew "it was a realistic option." For the other woman, "abortion

was extremely sad. My aunt had a late term abortion when I was 8 or 9 due to German measles. The whole family dealt with it as a very tragic event. She was depressed for awhile."

The women in Group B all commented that fear of abortion again becoming illegal, wanting self-reliance, self-empowerment and knowledge of women's bodies to be in the hands of women specifically lead them to search for alternative health care. When they found Wise Woman care in the form of menstrual extraction self-help groups, they all reported excitement. One woman recalls thinking menstrual extraction was a "great idea, but wondered about the safety and the skills of the women doing it." Two other women remember being "excited to hear that women created this for other women" and "happy to know that there were women taking reproductive health care into their own hands." In comparing her previous experiences to the alternatives she was beginning to hear about in college, one participant explained that, "Once I started exploring alternative self-help models, it blew my mind. Women didn't have to go through some of the negative experiences that I and my friends went through--just for basic care!"

Summary Each of the women in Group B reported a specific health care experience as being particularly negative for them. Additionally, these negative experiences influenced their decision to look for alternative reproductive health care. Discovering self-help/menstrual extraction as an alternative, the women in Group B all reported being exited or relieved that such knowledge and power was in the hands of women.

Collective Wisdom

Wise Woman Way: unconditional love and nourishment

There is no [Wise Woman] self-help without the group. The conception and the actualization is about sharing knowledge and not hoarding it. If it wasn't a group context it would be a clinic or illegal back alley. The only difference is that the clinic is safe. Emma, Wise Woman Group B member

Sharing Knowledge

All of the women in Group B stated that sharing knowledge within the group context was important at some level to their experience within the Wise Woman model of care. They described feeling more comfortable, positive, and confident about using menstrual extraction for their own as well as other women's abortion needs. Further, four of the women also stated that they felt that learning about their bodies within the group context was "invaluable." Emma reported that sharing personal knowledge and experience helped to lessen her own anxiety and contributed to her sensitivity to what other women might be experiencing. She stated that, "I think for the first time, I was really confident, comfortable and less anxious than at a regular doctor's office visit." Beatrice, another Wise Woman group member commented, "hearing other women's experiences has been very helpful and positive." Additionally, she felt that "learning about women's health in a unified group of very committed women" was one of the most valuable aspects of the Wise Woman model of care. Denise, a long-time practitioner within this model, felt that she "learned a lot of information and saw how much we could help each other by sharing our knowledge." She further stated that sharing knowledge

within the group had a far-reaching effect on her life. She recalled that Wise Woman care "made me a stronger person and much better able to deal with sexism in all arenas of my life."

Because of the secrecy involved in practicing menstrual extraction for these Wise Women spirals, the groups generally are comprised of women who have pre-existing relationships with each other. This is very different from Group A, the Wise Woman prenatal model, where the women were unfamiliar to each other before meeting within the group. One woman in Group B, felt that having already-established relationships within the groups in which she was involved was definitely a drawback. She stated that "the better groups I've been in have been groups where we weren't very close to begin with and never became super close. Too much personal shit can get in the way of really learning and practicing." In contrast, the four other women, all from different groups, felt that sharing personal aspects with each other in the group was important for various reasons. Beatrice said it was important to her experience because "how each of us felt about abortion, past experiences or no personal experience . . . helped us to be aware of where someone might have discomfort or anxiety."

Wisdom Within

Within the Wise Woman model, each woman is the "expert" regarding her own body. Recognizing this non-hierarchical structure for the women in Group B was not as difficult as it was for the women in the Group A prenatals. In seeking out this model of health care, the women in Group B consciously chose to go outside the recognized sphere of medical

authority. In doing this, they specifically sought to take control of their own reproductive health care needs. Even with this desire firmly established for themselves, the non-hierarchical spiral of the Wise Woman model was a profound experience for these participants. Denise recalled, "It was like entering a whole new world." In comparing the Wise Woman model to the scientific model, Emma shared similar beliefs. She stated that recognizing the woman's own inherent knowledge "is the essence of self-help work. The woman who is having any health care provided, is the person who is the most in control as opposed to being the least in control within the medical model." Sharing similar beliefs, Beatrice said, "You [Wise Woman participant], are respected. Your knowledge of your own body and your opinions are respected. You are expected to learn and teach."

Learning = Teaching

Learning and teaching menstrual extraction (M.E.) was a primary motivation for women seeking out this health care model. Each woman in the Wise Woman model of care is respected for her own body wisdom. This is reflected in the learning = teaching aspect of this model. All five participants related that being able to learn M.E., and then to pass these skills on to other women was important to them. The interactive nature of this model required discussion of issues that would be overlooked or ignored in many other health care settings. Issues fundamental to the women within the Wise Woman spiral would not only be talked about but also addressed in greater detail than in a hospital or clinic. Because it is the women themselves who co-direct the flow and depth of the knowledge

they are gaining, the responsibility of each participant is equal that of every other woman in the Wise Woman spiral. Emma commented,

> There is as much time and space as women need to talk about their questions and issues. By sipping tea in a living room we are more likely to talk about whether we have a conflict about doing an M.E., or a medical question or anything else. It is the difference between talking to a friend and talking to a doctor.

The women shared their experiences and bodies as teaching tools. They reported learning about: female anatomy, recognition and treatment of Sexually Transmitted Diseases (STDs), pain tolerance, sex, home remedies, birth control, and fertility awareness methods. Through this exchange of teaching and learning, they all reported becoming more confident in themselves and each other, as well as recognizing the normalcy of their individual bodies and experiences.

Respectful Listening

Sharing knowledge, teaching = learning and trusting each woman's inner wisdom are aspects of the Collective Wisdom component of Wise Woman care that are rooted in being able to listen respectfully to each other. Without careful and respectful attention given to each woman as she shares both her body and knowledge, Wise Woman health care would lose much of its value. The women in Group B reported that not only were they listened to by the other women in the spiral, but because of the groups' non-hierarchical structure, their responsibility and respect for one another increased. In describing her only menstrual extraction experience, Catherine remarked: "I never met the group of women before they arrived at my house. They were very calm, respectful and efficient about

communicating with me." She further remarked that she felt "a lot of support from the group around consciously ending the pregnancy." Denise had this perspective about her M.E. experience, "It [sharing and listening] was the whole point. We discussed everything in advance and shared the responsibility." Emma reported that she felt "care, respect and attention to personal needs. The level of listening is incomparable." She went on to say that, "in the menstrual extraction aspect [of the Wise Woman model], there is a commitment to practice listening, so that listening to a woman is not something that only happens during the extraction."

Demystification

Wise Woman Way: Playing in the sacred garden.

[Wise Woman ways] led me to trust in how much knowledge and power we can hold in our own hands,. One doesn't have to have an M.D. after one's name! Catherine, Wise Woman Group B member

Demystifying the layers of misinformation surrounding women's bodies is essential in order to gain a clearer understanding of what normal variations actually are. Demystification as a cornerstone of the Wise Woman model, is clearly expressed in the self-help aspect of the menstrual extraction group. The process of demystifying both the female body and the health care experience in groups A and B was similar. But by learning directly on each other's bodies, the women in Group B were involved in a significantly more hands on approach.

Exploring the Unknown

If pregnancy is secretive and mysterious in our culture, then abortion, shrouded with fear and misinformation, is invisible. Three of

the women in Group B had previous abortion experiences within the scientific model. They reported these abortions as being passive, impersonal, and degrading health care experiences. At 19, when Emma had an abortion in a clinic, the procedure was never explained to her. She recalls:

> My doctor recommended that I be knocked out because it might be too traumatic an experience. So, I went to another clinic and basically have no memory other than being on a gurney in a hallway with ten other women in various stages of upsettness. Feeling like being on a conveyor belt. The comparison is really dramatic, I wasn't present in any way for what was going on with my body. That wasn't necessary.

Catherine and Denise both reported similar reactions to their previous abortion experiences. Preferring the Wise Woman model, Catherine said that her menstrual extraction was "a million times more positive and caring. The others were very cold, impersonal production lines." Denise said that although her clinical experience within the scientific model was "quick and easy . . . it was a dependant situation, nothing like doing an extraction with a group. I prefer M.E." Although these abortions were legal and relatively safe, and the women probably were relieved at the availability, these experiences left Emma, Catherine, and Denise feeling objectified and isolated. During an important moment of action in their lives, these women momentarily became passive recipients of the scientific model's technology. When two of these women needed to have abortions again, they chose to do it within the Wise Woman way by menstrual extraction. Their experiences were in Catherines' words, "dramatically different."

Fears and Realities

The women in the menstrual extraction group provided support and understanding for each other. Sharing their fears and concerns about their bodies and ending a pregnancy was met by the women in their spiral with nurturing support and information. Three of the participants in this study described some level of fear or concern about the menstrual extraction process: how much pain, how much cramping, how much blood, etc. These three women all expressed that their fears were met with both compassion and information from the other members in the group. They reported that hearing other women's stories about their own experiences "significantly lessened" their fears about their own ability to handle or "cope with the pain."

Validation

Wise Woman Way: Body as perfect manifestation of complete being.

It was like entering a whole new world. Powerful, deep acceptance, and understanding. Denise, Wise Woman Group B member

The Wise Woman tradition sees the body as a "perfect manifestation of complete being." Whereas both the scientific and the heroic traditions view the body as an object to be saved, fixed, and improved, the Wise Woman model does not. For a woman seeking health care in the scientific or heroic models, those negative views are intensified and often times internalized. Within the Wise Woman tradition, the unique variations in each woman are seen as central, natural and, most importantly, normal.

As reported in the Health care Herstories earlier in this chapter, the women in Group B described their previous health care in other models as defining their needs and bodies as both problematic and traumatic. Through participating in the Wise Woman model, the participants reported their views of their bodies to be changed in many ways. Instead of feeling like objects, they became central in their own care. Instead of being mystified by their bodies and the health care process, they gained clarity and understanding. Instead of feeling isolated, the women found their bodies and their experiences to be validated in the Wise Woman spiral.

Confirming the Normal

All of the women in Group B expressed that through sharing with the other women in this model, they learned that their bodies, concerns, and experiences were not unusual or abnormal in any way. Beatrice stated that "hearing other women's experiences helped to put things in perspective--everyone has hang-ups, insecurities, and health issues." Feeling validated within the Wise Woman spiral was shared by all the women. In the M.E. groups, women were able to confirm their similarities while respecting their differences. As Beatrice described further "the [Wise Woman model] helps you to recognize differences as well as similarities. It helps you find your version of normal and feel comfortable with that."

All five of the women reported that many of their concerns were alleviated through the relaxed discussions within their Wise Woman spiral. Questions about STDs, traditional remedies, sexuality, pain tolerance, risk levels, the menstrual extraction procedure, infections,

normal vaginal secretions and feelings related to ending a pregnancy were reported as topics discussed in the Wise Woman spiral. Beatrice described hearing other women's experiences as very helpful and positive. She said,

> [Wise Woman self-help] has made me feel much more comfortable with any bump or lump or infection I've had since I've been in a group. I've had the support system of women to help me try to assess the problem, get information and deal with treatment myself.

Working directly with other women gave these participants greater confidence in their lay practitioner skills as well as validating the natural process of their own bodies. They reported developing a thorough grasp of their own anatomy that was "not just from books." By working and sharing with one another, the women in these groups created a comfortable environment, an environment that four of the women reported as providing relief and understanding about the natural workings of their bodies. Beatrice felt particularly comforted by "talking and showing gynecological problems to each other." She further noted that "figuring them out together [was] great--often it is nothing, but [problems] can still be worrisome and the support of information from the other women [was] so helpful."

Self-Determination

Wise Woman Way: Empowerment

When the four women arrived, there was a quietness and respectfulness about them. We talked about how they do what they do, dividing the tasks etc, and then we moved into our bedroom. It was so incredible to be able to do this in my own bedroom. I chose music that was very powerful and spiritual to me. We set up lots of pillows around, with my husband behind me like a big chair and a girlfriend on each side holding my hands, I felt very supported. I remember the light being soft and just feeling incredibly supported and absolutely respected. There was never any need to justify or explain myself to these people. I'll never forget one of the most powerful things during the M.E. experience was after I had inserted the speculum and the primary [Wise Woman] was getting ready to inject something into my cervix. She looked up at me, our eyes locked and there was an incredible look of love in her eyes. I felt love flow between us. I had never seen this woman before, it was amazing, I don't even know her name.
Catherine, Wise Woman Group B member

Each year in the United States, approximately a million and a half abortions are provided within the scientific and heroic traditions of health care (Chalker et al. 1992). When other forms of birth control fail, abortion within the scientific tradition, is regarded by the vast majority of the practitioners as a necessary evil. Unless abortion occurs spontaneously, the Heroic tradition views it as an unnatural and provocative act. Since the development of menstrual extraction over twenty years ago, hundreds of women have used menstrual extraction (Wise Woman abortion care) for their abortion needs (Chalker et al. 1992). In a very closely knit community of highly skilled women, menstrual extraction has quietly been providing abortion in a format that challenges the negative assumptions about abortion. Because the Wise Woman way of health care regards women with respect and honors self-determination as a birthright, abortion

is another ally for transformation. Abortion within a Wise Woman model is a unique opportunity for empowerment.

Responsibility

Taking more responsibility for their own health care process and choices, all of the women in Group B reported that Wise Woman care altered their role as a health care recipient. Because of the personal, hands-on involvement in their health care, the women reported feeling a positive and enriching enlargement of their roles. Before participating in the Wise Woman spiral, four women recalled feeling misled or confused in obtaining health care information via models. These four women further reported that getting the "right" information was difficult at best and impossible at worst. After participating in the Wise Woman spiral, all five of the women reported feeling more self-sufficient, and more assertive in being able to obtain health care information for themselves. All five of the women reported that the most valuable part of this care was becoming more self-sufficient. Additionally, the women reported that through taking more direct responsibility for themselves and the other women in the group, they became confident and empowered. Catherine described the development of this process as "regular women taking charge of their bodies and learning skills to serve other women outside of mainstream medical care." Furthering this point, Donna remarked that within the self-help aspect of Wise Woman health care, it is "the woman is truly in control of her health care, not 'done' to by a professional."

By taking more responsibility and being actively in control of their reproductive health care, the women in this study all found they felt even stronger about the inadequacies of other models of health care. The women described themselves as being more aware and sensitive to the impersonal level of care found in health care settings. Beatrice reported feeling that working in a group setting has reinforced and validated her frustration with previous health care situations. She said that "working with a group of women who treat you as an equal, respect your choices and really try to help you help yourself has just highlighted the frustration I feel when I go to doctors for information and answers and leave with nothing." Denise emphatically stated, "I don't have to accept health care I don't want." And Emma reported that because her expectations are higher she "feels victimized" when she receives health care in other settings. Anne reported that through the Wise Woman model she felt "much more empowered" in her interactions with health care providers in other settings.

Empowerment

The women in Group B reported that Wise Woman care provided the opportunity for greater control and increased understanding of their bodies and the health care process. They also reported that through these efforts in the group setting, Wise Woman care became a tool for their own empowerment. The women having a menstrual extraction had all the information they needed, they had time to discuss personal issues, and were in an environment that was familiar and comfortable to them, an environment in which they were the central guiding force. Catherine felt

that menstrual extraction was "more positive than I ever expected. It was so loving, respectful and caring. It felt great to do it in my own home where I created a sacred space." Denise described her experience as "empowering, [M.E.] was easier and less painful than I expected." As a long time practitioner, Emma has observed that during the menstrual extraction experience, "women get to be present in their bodies, they are encouraged and supported to do this. The women are relieved afterward at how in control of the situation they actually were. They really appreciate the warmth, the caring and the respect that group members have for the intimacy of the experience."

Chapter V

WOMEN, MIDWIVES AND FEMINISTS

Summary

The purpose of this study was to determine how woman-controlled, woman-centered reproductive health care effected its participants. In summarizing the data for this exploratory study, the findings for Groups A and B will be combined. The only difference between the two groups was the specific type of reproductive health care in which they participated. Therefore, the groups can be combined in reporting most of the findings. Where important, the two groups will be distinguished.

The eighteen women who participated in this exploratory study were all unique individuals who shared similarities in demographic characteristics and backgrounds as well as the experiences of woman-controlled, woman-centered reproductive health care. The women were all of European-American ethnicity, between the ages of twenty-one and forty. They worked in a variety of careers, and fifteen of the eighteen women also were mothers. Most of the women were married or involved in a significant relationship and were self-described as politically progressive. Most of the women readily identified themselves as feminists, and all but two considered themselves active in the women's movement.

The women were asked to describe their relationships with their bodies as children, as adolescents and as adults. The findings showed most of the women to have felt generally comfortable, with their bodies or that as children they did not give much thought to them. Reporting varying

degrees of physical, emotional and sexual abuse, three women had negative views of their bodies as children.

Almost all of the women conveyed increased feelings of insecurity and self-consciousness impacting their body relationship as adolescents. Perceiving outside judgments of their bodies to be negative, eleven of the women commented that their body weight was inadequate. Despite these judgments, the women clearly expressed that they continued to feel strong, powerful and sexual. This strong sense of self may have been a contributing factor in their decision to choose alternative reproductive health care.

The women articulated reconciliation, respect and appreciation toward their bodies as adults. Most of the women in Group A described their experiences of pregnancy and birth as being the catalyst for such change. Since eleven of the thirteen participants in Group A were either first time mothers or had experienced their prior prenatal care outside of the established medical model, it is possible that their experience in alternative care contributed to their sense of reconciliation, respect and appreciation for their bodies as adults. The findings were similar for Group B. The five women in Group B articulated acceptance and appreciation for their adult bodies. Again, because these women were participants in woman-controlled, woman-centered health care as adults, these findings may be attributed to their participation in such health care. Larger-scale research comparing women's experiences with this type of care and with conventional medical care can clarify further the distinctive impact of Wise Woman care.

The most striking finding to emerge from the Herstories was that women who had negative experiences with their bodies as children and adolescents reported a powerful transformation in their body relationship as a direct result of their pregnancy, birth or self-help care experience. For example, a woman who described her childhood and teenage body as "not her own" also articulated that pregnancy "taught me to love and respect my body as an intricate component of myself." Another woman, who described herself as alienated from her body during childhood and adolescence, said that having knowledge and lay medical skills has helped her to be more "in her body."

Images of pregnancy/birth and pregnancy/abortion held different significance for each group. Because abortion is shrouded in mystery, only two women in Group B had any memory from before adulthood relating to abortion. The Group B women reported that they became involved in self-help abortion care because of fears of abortion again becoming illegal, or because they want abortion techniques to be in the hands of women.

Most of the women in Group A could recall mothers or other family members being pregnant. The images reported by these women were equally mixed between good and bad. Most of the women reported that they were influenced by these images.

Asked about their experiences of previous health care, the women gave generally negative reports. Almost all of the women described a specific negative experience in a previous health care situation. Although most of the negative experiences (molestation, over-medication, rough examinations, patronizing attitudes) were described as occurring within

conventional medical health care settings, a few women described problems communicating to alternative care practitioners (chiropractor, nurse-midwife). The negative experiences were described as degrading, dehumanizing, cold, impersonal and humiliating. When asked if she felt comfortable asking questions of practitioners, one woman commented: "No, seeking advice of someone who doesn't see you as a whole person is a degrading experience." Another woman reported not trusting doctors because "they would assume they knew all about you without asking you anything." Overwhelmingly, prior health care experiences contributed to the women's desire to look for a different approach.

After a careful review of related literature, four themes began to emerge as defining aspects for woman-centered, woman-controlled health care: Collective Wisdom, Demystification, Validation and Self-reliance. In characterizing Wise Woman care from others models, these themes became useful in analysis of the data. All of the women in both groups reported experiencing most of these aspects in their Wise Woman health care experience. Their experience of these aspects varied in both intensity and effect. One woman reported that through the experience of giving birth to her daughter, she was empowered to leave an abusive relationship. Another woman said she never had wanted to have a baby because of the "horrible" birth stories she had heard. This same woman described pregnancy and birth in Wise Woman care as "the most empowering thing I have ever done!"

All of the women reported a shift in their perceptions of themselves as health care recipients. After participating in Wise Woman health care,

the women reported feeling more confident and capable of being able to determine and provide appropriate health care for themselves and their families. Almost all of the women described having higher expectations of health care. The following are descriptions by the women of how their attitudes and expectations changed after their participation:

> It has given me more confidence in my body. (Monique)

> Working with a group of women that treat you as an equal, respect your choices and really try to help you understand yourself has just heightened the frustration I feel when I go to the doctors for information and answers and leave with nothing. (Beatrice)

> My expectations are higher now. I am not likely to be intimidated on any level by care that is not up to my standards, or by a doctor who disagrees with me. I am more secure about myself, my knowledge, my right to choose for myself. (Eva)

> I expect health care practitioners to listen to me. I take it for granted now that I can figure out my own health problems and needs and use the M.D. as a consultant. (Isabel)

Even the one woman who initially said there was no change in her attitude, reported in the next sentence that:

> I am more conscious of sticking up for myself and making sure [doctors] don't do something they're not supposed to do. (Frances)

Conclusions

Transition in our concept of power is radical. It involves seeing power not as property to own, not as something we exert over others, but as a verb, a process we participate in. This is a huge evolutionary shift. (Macy 1984).

The Wise Woman model of health care is radical. All of the women in this study reported feeling transformed by their participation. Some articulated this transformation as empowerment; others simply stated they

felt more confident in themselves and their bodies. For almost all the women, participation in Wise Woman care exposed conventional health care to be inadequate.

Because the Wise Woman Way considers health care to occur within an equal relationship, the women felt validated and respected for their inherent knowledge. Sharing this knowledge required greater responsibility and greater participation than in other health care settings. These findings show clearly that a shift in a perception of their own power occurred. They gained confidence that they described as enabling them to demand greater respect from health care practitioners. Since most of the women reported feeling disrespected, overwhelmed, and passive in previous heath care settings, this finding has significant implications. This researcher, as a feminist researcher and a health activist, hypothesized that women's participation in woman-centered, woman-controlled reproductive health care would have such an effect.

A careful review of the literature suggests that the medical establishment has a strong interest in maintaining a health care system that does not include empowerment as a dimension of health care satisfaction. In fact, a 1989 study of prenatal care conducted by the World Health Organization (WHO), found that "assembly line prenatal care is not productive" (Young 1990). Endorsed by the American College of Nurse-Midwives (ACNM), the recommendations in this report were met with resistance by the American College of Obstetricians and Gynecologists (ACOG). After extensive analysis of nationwide prenatal care, the WHO multi-disciplinary panel recommended that prenatal care significantly shift

its orientation. Placing a greater emphasis on pyschosocial needs, increasing women's role in defining needs and planning services, and taking a preventative approach to high-risk pregnancies were found to reduce negative birth outcomes. The WHO report went on to recommend that a team approach to health care be taken. Incorporating broader health care components such as health education, nutrition and peer counselling.

These recommendations by The World Health Organization are a long time in coming. The Popular Health Movement advocated for a similar, albeit simpler, approach to health care during the nineteenth century. Contemporary feminist activists and researchers from many disciplines also have suggested that elements such as those recommended in the WHO report are effective elements of the health care process. Considering the historical intolerance and the attitude of professional superiority that scientifically trained physicians have maintained toward other health care practitioners, the resistance by ACOG to creating a more woman-centered, woman-controlled approach is not surprising.

Although the sample of Wise Woman health care recipients in this study was small, they all reported experiencing some level of empowerment. This exploratory study suggests that research with a larger sample of Wise Woman participants would produce similar results. This study hopefully will prove to be a beginning of empirical research designed to show the important influence direct responsibility and control in one's health care can provide. Further studies into health care as a socially transformative tool are recommended. Robbie Davis-Floyd's Birth as an

American Rite of Passage is an important foundation upon which further studies can be developed (Davis-Floyd 1992).

Restrictions on abortion care are increasing. The majority of the literature on abortion undoubtedly will remain centered upon a defense of its inclusion in women's reproductive health care. This is truly necessary when complications from unsafe, illegal abortions continue to be one of the leading causes for female death worldwide (Gomez and Portugal 1992). However, research also is needed on the actual process of abortion health care, and how that process can serve either to empower or disempower a woman.

It is the sincerest hope and recommendation of this researcher that continued development of the ideas presented in this study will further shift the power imbalance found in women's reproductive health care to empower women in the direction of their own care. Change is never easy. When power is held in the hands of a few, change is revolutionary. Within the Wise Woman approach to care there is potential for just such a change. Through the components of Wise Woman care that emerged from analysis of the women's experiences, the power of healing and transformation in reproductive health care returns to the hands of those it affects. The Wise Woman way offers the opportunity for every woman to become her own midwife. For decades, feminist health workers have sought to redefine the dominant health care model so as to be more inclusive of women's needs. Sharing knowledge, demystifying the female body, validation of experiences and self-determination are key components for empowerment in a feminist model of women-centered health care.

With alternative models for care being marginalized by health care corporations, woman-centered and woman-controlled health care finds renewed importance in this long struggle. It is the purpose of this study to describe and analyze one such model for woman-controlled health care; group centered reproductive care. It is within this spiral setting for prenatal and abortion care that the women of this study learned, taught, demystified, validated, and shared the collective wisdom of their bodies with one another. They found strength, diversity, compassion and empowerment. Together they found they were their own midwives.

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APPENDIX A
Participant Information Letter

Dear Group Participant;

I am a graduate student in the Women's Studies Program at San Jose State University. In partial fulfillment of the requirements for the M.A. degree, I am conducting a study of the experiences of women in an alternative woman-controlled and woman-centered health care environment. Your participation in this study would be completely voluntary, totally anonymous and would involve completion of a questionnaire regarding your health care experiences. The questionnaire will require approximately 1 1/2 hours of your time. I hope to publish the results of my study, but any information that could result in your identification will remain confidential.

If you are interested please read the attached consent form before beginning the questionnaire. Please try to complete the packet within two weeks and return it to me in the envelope included. After I have received all the questionnaires you will be contacted by your group facilitator or myself to schedule a follow-up group interview that will last approximately 1 to 1-1/2 hours. If you require childcare assistance for either the questionnaire or the group follow up interview, I will arrange for childcare to be made available. If you have any questions about this study, I will be happy to talk with you, I can be reached at (XXX) XXX-XXXX.

If you have any questions or complaints about research subjects' rights, or in the event of a research related injury, please contact Serena Stanford, Ph.D., Associate Academic Vice President for Graduate Studies and Research, at (408) 924-2480.

I truly appreciate your time and effort,

Kim Bick-Maurischat

APPENDIX B
Letter of Informed Consent

Dear Participant:

The following is to inform you of your rights as a participant in this research study. Please read this carefully before completing the attached questionnaire. If you have any questions or concerns, please contact me at the number below.

Title of Study: Every Woman Her Own Midwife: A Study of Empowerment Through Alternative Woman-Controlled Community Health care.
Investigator: Kim Bick-Maurischat, Social Science graduate student at San Jose State University.

1. I have been asked to participate in a research study investigating empowerment through woman-centered health care.

2. I will be asked to complete a questionnaire about my experience and then to participate in a follow-up group interview with my health care group. This interview will occur at a mutually agreed upon time and place and will be conducted by the investigator, Kim Bick-Maurischat.

3. I understand that no risks are anticipated for any participant.

4. I understand that no discernible benefits to me will result from this study.

5. I understand that this study is completely anonymous and that every effort will be made to insure anonymity.

6. I understand that the findings of this study may be published, but that no identifying information of the subjects or the groups will be included.

7. I understand that childcare will be provided to allow me adequate time and attention to complete the questionnaire (approx. 2 hrs.). This childcare will be provided free of charge by the investigator, Kim Bick-Maurischat, or a mutually agreed upon provider.

8. Questions about the research may be addressed to the principal investigator, Kim Bick-Maurischat (xxx)xxx-xxxx. Complaints about the research may be presented to the Chairperson of this Thesis committee, Rivka Polatnick PhD, Professor of Women's Studies, (408) 924-5595. Questions or complaints about research, subjects' rights, or research-related injury may be presented to Serena Stanford, PhD., Associate Vice President of Graduate Studies and Research, at (408) 924-2480.

APPENDIX B Cont.

9. I have given my consent to participate voluntarily. I understand that I may refuse to participate in the study or any part of the study. I understand that I am free to withdraw from the study at any time and that no part of my statements may be used should this occur. I understand that such withdrawal will not jeopardize my standing with any institutions or San Jose State University.

10. I have received a dated copy of this consent form.

The signature of the researcher on this document indicates agreement to include the anonymous subject in the research and attestation that the subject has been fully informed of her rights.

Investigators Signature Date

APPENDIX C

QUESTIONNAIRE: GROUP A

Thank you for agreeing to participate in this study. The study focuses on women's experience of their reproductive health care. For that reason I have chosen to develop a questionnaire which relies upon your words rather than a superimposed scale of evaluation. With this in mind please answer the questions as honestly, specifically and fully as you can. If you need more space than is provided, please use the additional paper that is included and **be sure to mark the question number you are completing on these additional sheets.** I recommend that you read over the entire questionnaire before you begin to answer the questions. Please attempt to complete the questionnaire within two weeks. The completed questionnaire can be mailed directly to me in the attached envelope. When I have received all the questionnaires, I will contact you to arrange for a follow-up group interview. If you have any questions or concerns regarding this questionnaire or this study you may contact me directly. Thank you for your time.

1. What is your age?
   15-20____ 21-25____ 26-30____ 31-35___
   36-40____ 41-45____ 46-50____ 51-55___

2. What is your occupation?

3. What ethnic group(s) do you feel best describe you?

4. What is your relationship status? Do you have any children? What are their ages?

5. Do you have a religious affiliation? Please describe your affiliation.

6. Please mark the political category that best describes you.
   progressive_____ center_____ conservative_____
   moderately left_____ moderately conservative____
   strongly left_____ strongly conservative_____
   Other_____

7. Do you see yourself as a part of the Women's Movement? Would you define yourself as a feminist?

8. Please describe your relationship with your body as a child. What were the positive aspects? What were the negative aspects?

9. Please describe your relationship with your body as a teenager? What were the positive aspects? What were the negative aspects?

10. Please describe your relationship with your body as an adult? What are the positive aspects? What are the negative aspects?

11. Where and/or how did you receive information, education and or images about your body while you were growing up?

12. Can you describe what your images, impressions or memories of pregnancy and birth were while you were growing up? What did you think pregnancy and birth was, what would it be like, and how did you feel about it?

13. How did you feel about your health care experiences in general before you decided to look for alternative reproductive health care?

14. What led you to search for alternative choices in your reproductive health care?

15. What did you think your options for alternative health care were?

16. Did your past reproductive health care experiences or other health care experiences contribute to your decision to look for alternatives? If so, how?

17. Could you describe your relationship with any past health care providers?

    a) Did you feel comfortable asking questions regarding your health and your health care?

    b) Do you feel you were able to make informed choices with the information provided by your practitioner?

    c) Did you feel your choices were respected by your practitioner?

    d) Were you satisfied with your care? Why or Why not?

18. Have you ever been present at a birth other than your own? Could you describe ***your*** impressions of that experience?

19. How did you first hear or learn about Midwifery care?

20. How did you first hear or learn about Home Birth?

21. What were your initial thoughts upon hearing about birth at home?

22. How did you feel about this midwifery practice and their group approach to prenatal care?

23. Did you finish your prenatal care and give birth within this midwifery practice?

    a) Please describe your feelings about your pregnancy and birth experience. How did the experience compare to your expectations of it?

    b) Did you have support for your decision to have a Home Birth?

    c) Did you have any fears or reservations about choosing to have a Home Birth?

d) Do you feel that the group centered approach contributed in any way to your overall experience? Please explain.

e) Have you had previous childbirth experiences with more traditional medical care? How would you compare your past experiences to your alternative reproductive health care?

24. Please list what you were hoping to achieve through your participation in the alternative midwifery care?

25. Did the interactive aspect of the group help you to discuss issues that you might not have talked about otherwise? If so, please describe these issues.

26. Was sharing aspects of one's life an important part of the health care process?

27. How did you feel about sharing personal aspects of yourself with other women?

28. How did listening to other women's experiences affect your own health care experience?

29. What effect, if any, has this experience in alternative care had on your attitude toward health care? Have your expectations changed?

30. Were there any skills that you developed or improved through your participation in the self-care aspect of the prenatal and birth process? Please describe them as specifically as you can.

31. How would you describe your self-confidence **before** participating in the self-help health care process regarding the following:

- your ability to trust your body?

- your ability to make decisions regarding your pregnancy and birth options?

- your ability to obtain information regarding your health care?

- your ability to make decisions regarding the health and well-being of yourself?

- your ability to make decisions regarding the health and well-being of your family? (if applicable)

32. How would you describe your self-confidence **after** participating in the self-help health care process regarding the following:

- your ability to trust your body?

- your ability to make decisions regarding your pregnancy and birth options?

- your ability to obtain information regarding your health care?

- your ability to make decisions regarding the health and well-being of yourself?

- your ability to make decisions regarding the health and well-being of your family? (if applicable)

33. What was **most** valuable or useful to you about the group prenatal experience?

34. What was **least** valuable or useful to you about the group prenatal experience?

35. How do you feel you contributed to the group?

36. What do you see as the main difference in this type of health care and other reproductive health care you may have experienced?

37. Has this participation in alternative health care changed your perspective about yourself as a health care recipient? If so, please explain how.

38. Is your participation in alternative health care consistent with your values and behavior in the rest of your life?

39. Is there anything you would like to add regarding your health care experience in an alternative setting?

APPENDIX D

QUESTIONNAIRE: GROUP B

Thank you for agreeing to participate in this study. The study focuses on women's experience of their reproductive health care. For that reason I have chosen to develop a questionnaire which relies upon your words rather than a superimposed scale of evaluation. With this in mind please answer the questions as honestly, specifically and fully as you can. If you need more space than is provided, please use the additional paper that is included and **be sure to mark the question number you are completing on these additional sheets.** I recommend that you read over the entire questionnaire before you begin to answer the questions. Please attempt to complete the questionnaire within two weeks. The completed questionnaire can be mailed directly to me in the attached envelope. When I have received all the questionnaires, I will contact you to arrange for a follow-up group interview. If you have any questions or concerns regarding this questionnaire or this study you may contact me directly. Thank you for your time.

1. What is your age?
   15-20___ 21-25___ 26-30___ 31-35___
   36-40___ 41-45___ 46-50___ 51-55___

2. What is your occupation?

3. What ethnic group(s) do you feel best describe you?

4. What is your relationship status? Do you have any children? What are their ages?

5. Do you have a religious affiliation? Please describe your affiliation.

6. Please mark the political category that best describes you.
   progressive____ center_____ conservative_____
   moderately left_____ moderately conservative____
   strongly left_____ strongly conservative_____
   Other_____

7. Do you see yourself as a part of the Women's Movement? Would you define yourself as a feminist?

8. Please describe your relationship with your body as a child. What were the positive aspects? What were the negative aspects?

9. Please describe your relationship with your body as a teenager? What were the positive aspects? What were the negative aspects?

10. Please describe your relationship with your body as an adult? What are the positive aspects? What are the negative aspects?

11. Where and/or how did you receive information, education and or images about your body while you were growing up?

12. Can you describe what your images, impressions or memories of pregnancy and abortion were while you were growing up? What did you think pregnancy and abortion was, what would it be like and how did you feel about it?

13. How did you feel about your health care experiences in general before you decided to look for alternative reproductive health care?

14. What led you to search for alternative choices in your reproductive health care?

15. What did you think your options for alternative health care were?

16. Did your past reproductive health care experiences or other health care experiences contribute to your decision to look for alternatives? If so, how?

17. Could you describe your relationship with any past health care providers?

    a) Did you feel comfortable asking questions regarding your health and your health care?

    b) Do you feel you were able to make informed choice with the information provided by your practitioner?

    c) Did you feel your choices were respected by your practitioner?

    d) Were you satisfied with your care? Why or why not?

18. Have you ever been present during an abortion other than your own? Could you describe ***your*** impressions of that experience?

19. How did you first hear or learn about the self-help group concept?

20. How did you first hear or learn about menstrual extraction?

21. What were your initial thoughts upon hearing about the menstrual extraction procedure?

22. How did you feel about the group approach of the self-help model?

23. Have you used the menstrual extraction procedure to end a pregnancy or a suspected pregnancy?

    a) Please describe your feelings about your menstrual extraction experience. How did the experience compare to your expectations of it?

    b) Did you have support for your decision to use menstrual extraction?

    c) Did you have any fears or reservations about choosing menstrual extraction to end your pregnancy?

d) Do you feel that the group centered aspect of the menstrual extraction experience contributed in any way to your overall experience? Please explain.

e) Have you had previous abortion experiences with more traditional medical care? How would you compare the different experiences?

24. Please list what you were hoping to achieve through your participation within the self-help group?

25. Did the interactive aspect of the self-help group help you to discuss issues that you might not have talked about otherwise? If so, please describe these issues?

26. Was sharing aspects of one's life an important part of the self-help group process?

27. How did you feel about sharing personal aspects of yourself with other women?

28. How did listening to other women's experiences affect your own health care experience?

29. What effect, if any, has this experience in alternative care had on your attitude toward health care? Have your expectations changed?

30. Were there any skills that you developed or improved through your participation in the self-care aspect of the self-help group? Please describe them as specifically as you can.

31. How would you describe your self-confidence **before** participating in the self-help health care process regarding the following:

- your ability to trust your body?

- your ability to make decisions regarding your pregnancy and abortion options?

- your ability to obtain information regarding your health care treatment?

- your ability to make decisions regarding the health and well-being of yourself?

- your ability to make decisions regarding the health and well-being of your family? (if applicable)

32. How would you describe your self-confidence **after** participating in the self-help health care process regarding the following:

- your ability to trust your body?

- your ability to make decisions regarding your pregnancy and abortion options?

- your ability to obtain information regarding your health care treatment?

- your ability to make decisions regarding the health and well-being of yourself?

- your ability to make decisions regarding the health and well-being of your family? (if applicable)

33. What was **most** valuable or useful to you about the self-help experience?

34. What was **least** valuable or useful to you about the self-help experience?

35. How do you feel you contributed to the group?

36. What do you see as the main difference in this type of health care and other reproductive health care you may have experienced?

37. Has this participation in alternative health care changed your perspective about yourself as a health care recipient? If so, please explain how?

38. Is your participation in alternative health care consistent with your values and behavior in the rest of your life?

39. Is there anything you would like to add regarding your health care experience in an alternative setting?

APPENDIX E

A New View of a Woman's Body

8 • Menstrual Extraction

Through working for abortion reform in the early 1970s, the early self-help clinic in Los Angeles became acquainted with the new, gentler suction method of removing the uterine contents—a method which was to revolutionize abortion technique. Out of this work they evolved the technology for removing a woman's flow, on a monthly basis or less often, and called it menstrual extraction.

They unearthed articles in Russian and Chinese medical journals showing hand-operated vacuum equipment and recommending the procedure for contraceptive purposes. They were aware of research in the United States on early-termination aspiration abortion without cervical dilation and with the use of a large syringe attached to a flexible plastic cannula (similar to a soda straw) or a portable foot pump.

The group found that menstrual extraction was not difficult to learn and that the introduction of a sterile four-millimeter cannula into the uterus was not traumatic because it did not require that the cervix be dilated. There was no cutting or scraping, so simple sterile procedures were sufficient; anesthetics were not necessary; and the suction was sufficient to extract all or most of a woman's flow in around 20 to 30 minutes.

The discovery that almost any woman could learn the technique of menstrual extraction was accompanied by the discovery of several obvious and very practical uses for it. Women could free themselves of heavy, crampy periods, or avoid having a period if it would interfere with travel, vacation or perhaps an athletic event, and could extract the contents of the uterus if there was the possibility of unwanted pregnancy.

Although menstrual extraction evolved out of work to make abortion safe and legal, the 1973 Supreme Court decision changed the group's primary interests to research of the method. They did not expect that all women would use menstrual extraction as a backup when birth control failed. They were aware, however, that one or two menstrual extractions a year carry far less health risks than either an IUD or the Pill.

Menstrual extraction and early termination abortion are similar technically, but menstrual extraction is not performed in a medical setting. When done by an experienced group, it can be used simply as a home-care procedure by women wishing to gain knowledge about their bodies and menstrual cycles and to exert more direct control over their reproductive lives.

Although prior discussion with her doctor as to her intention in using this particular technique is not absolutely necessary, having a physician available, should any medical questions arise, would further increase the safety of the procedure.

Menstrual extraction can be done in a woman's home or a self-help group's meeting place and the woman having her flow extracted controls all aspects of the procedure. Women generally learn the tech-

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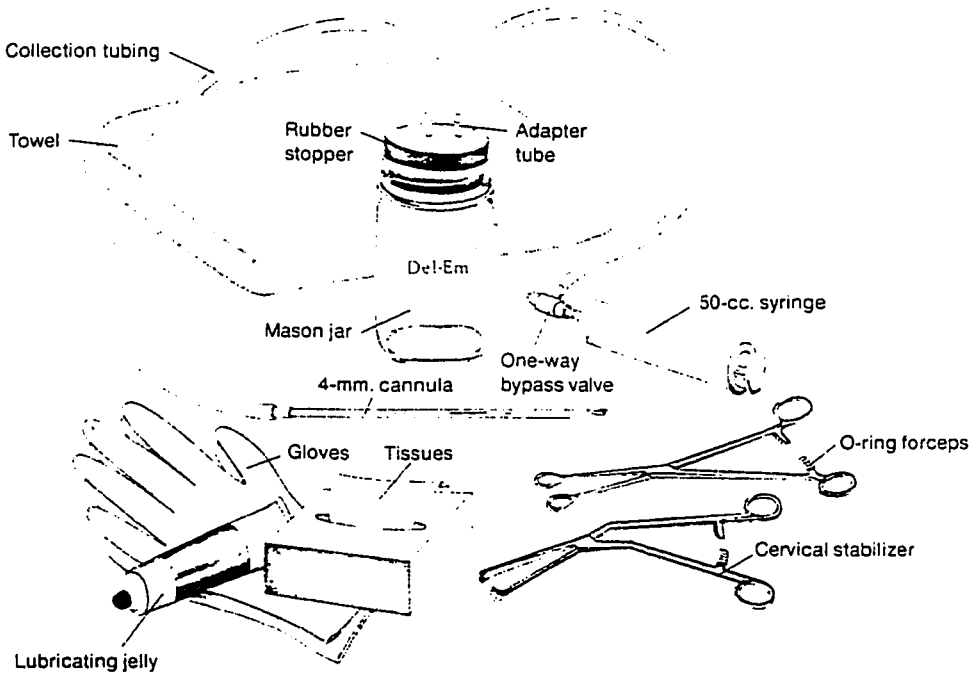
nique by participating in groups with more experienced women, first observing and then having their own menstrual extractions. Although the rudimentary aspects of the procedure can be learned in a few weeks, the knowledge and skill necessary to the reasonable safety of the procedure usually develop over a period of several months or even a year. Without this body of knowledge, the isolated woman, who generally has little or no familiarity with her own body, is risking the dangers commonly associated with self-abortion.

One frequent objection to menstrual extraction is a fear that the introduction of a cannula into the uterus will cause infections or other complications. Over the past decade, hundreds of women doing menstrual extraction in the United States and in other countries have reported that they do not have more or fewer infections than other women and have noted that the passage of a very small cannula into the uterus does not appear to have any effect on a woman's ability to carry a future pregnancy. It would seem, however, that the primary reason for this excellent safety record is the rigorous selection process any group doing menstrual extraction follows and the care with which the procedure is carried out. Women who have a tendency toward infection probably should not elect to have menstrual extraction. If they do, they take extra precautions. Sometimes a woman who is highly motivated but has a very sensitive cervix chooses to tolerate the additional discomfort in order to have an extraction.

Menstrual extraction should not be viewed as an attempt to avoid menstruation or short-circuit natural functions. It is a means for a woman to exert influence over changes in her body which she could not control before, in order to eliminate occasional discomfort or inconvenience or an unwanted pregnancy.



8–1 Menstrual extraction equipment

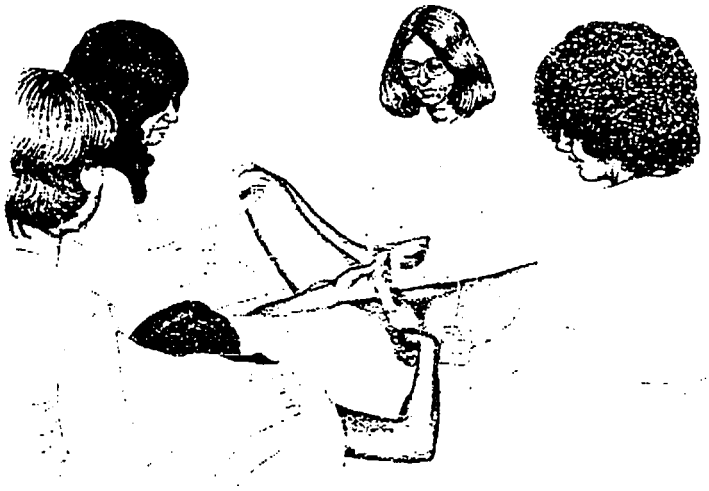
8–2 A woman having a uterine size check before menstrual extraction

8–1 Lorraine Rothman, one of the original members of the group which developed menstrual extraction, invented the Del-Em. After years of being a housewife, raising four children and numerous pets and working around her husband's biology lab, finding the components she needed was easy. She took a Mason jar from her pantry, a large stopper, some aquarium tubing and a 50-cc. syringe. She made inquiries at industrial supply houses and found a one-way bypass valve, which prevents air from returning once it has passed through. The total cost was just a few dollars, it worked, and anyone could make one. A kit similar to this one is currently being marketed for use in physician's offices. This illustration shows the basic supplies and equipment needed for menstrual extraction.

Many women report that their best experiences with menstrual extraction have taken place six weeks after their last period, give or take a week. However, we know of menstrual extractions that have been done with complete safety and success up to eight or nine weeks after the last period. If the group has been doing self-examination consistently, they will be very familiar with the size and placement of the uterus and there will be much less chance of miscalculations.

8–2 The menstrual extraction usually takes place on the first day of a woman's *expected* period or several hours after her period starts. It can be done in comfortable surroundings, often in the woman's home. One or more experienced women in the group do a uterine size check to determine the size and position of the uterus, so that the group does not find itself dealing with a more advanced pregnancy than they are prepared for. Such a case could result in an incomplete extraction, which usually involves resorting to medical personnel who have access to the necessary equipment and skills to complete the procedure.

8-3 A woman inserting her speculum



8-4 The woman who is having the extraction pumping the Del-Em

Wearing a surgeon's plastic glove, one woman inserts her index and middle fingers into the vagina. Pressing down on the abdomen just above the pubic hairline, she can feel the outline of the uterus between her hands. In early pregnancy, the uterus is usually the size of an unshelled walnut, and firm.

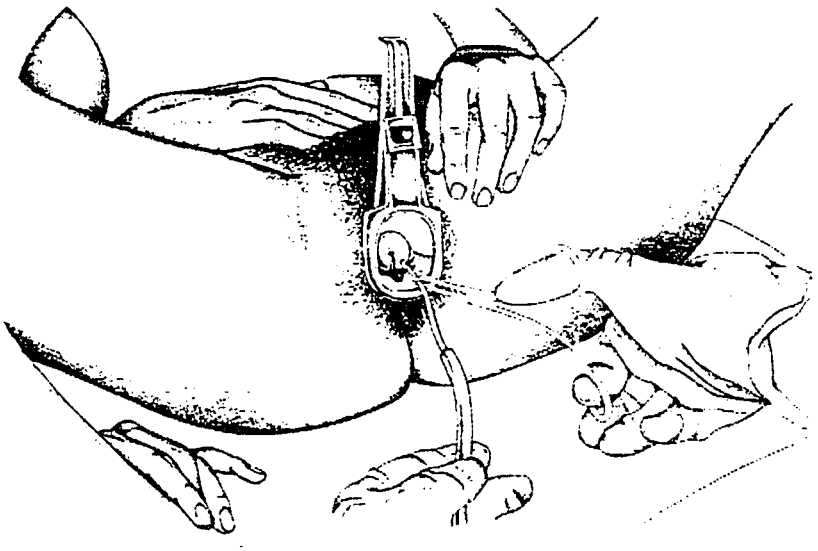
8-3 The woman who is having the extraction then inserts her own speculum and checks her cervix with a mirror. Then the other members of the group check it also. If she is pregnant, her cervix might very well be puffy and have a bluish tint. This change usually occurs in the first three months of pregnancy.

It is very important to the group to have information about the woman's menstrual cycle and her past experiences with menstrual extraction, irritations or infections or signs of pregnancy. Although the whole group should evaluate this information before proceeding, the final decision to proceed is always left to the woman who is having the extraction, provided she is sufficiently familiar with the technique to evaluate the information.

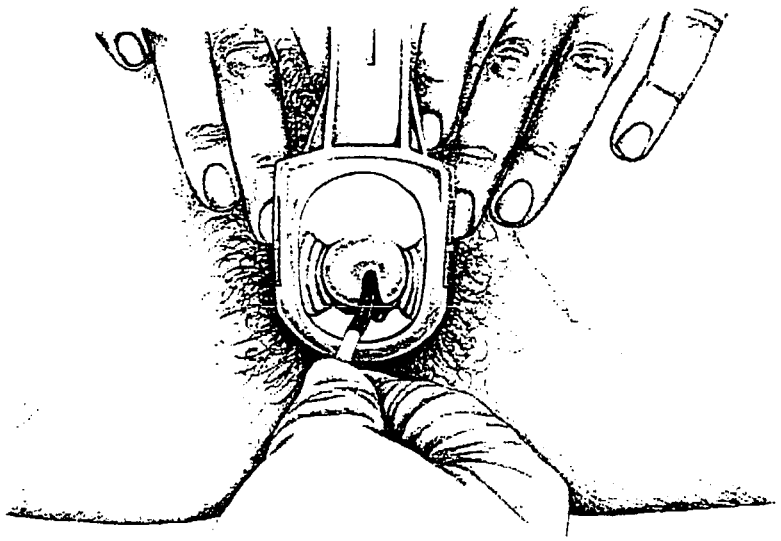
8-4 The next step is to pump up the vacuum in the Del-Em. Some women prefer to have the vacuum established before the cannula is inserted and this can be done by pinching the tube attached to the valve. Others prefer the suction to be built up slowly after the cannula is inserted into the uterus. If the woman decides to use the stabilizer, which looks like a pair of tweezers, it is attached to the cervix at this point. The stabilizer is used to keep the cervix from moving.

8-5 The cannula is now inserted carefully through the cervical canal into the woman's uterus. With the size four or five cannula, there is normally no need for dilation (stretching of the canal). The woman holding the cannula will feel it pass through the inner cervical opening and know the cannula tip is in the uterus.

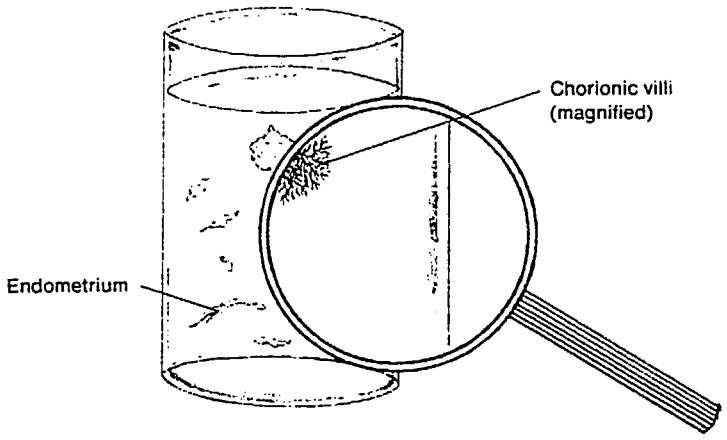
8-5 A self-helper inserting the cannula



8–6 A woman holding the cannula with O-ring forceps



8–7 The cannula inserted into the uterus



8–8 Chorionic villi in a glass

8–6 If the cannula does not go in easily, it is helpful to grasp it with the O-ring forceps to give it more stability.

8–7 When the cannula is in the uterus, the woman doing the extraction turns the cannula first in a clockwise direction, then in the opposite direction, and moves it forward and back as well, to make sure she is picking up all of the uterine material.

The woman having the extraction should always be in control. If her cramps are too heavy or if she feels too uncomfortable, she can ask that the extraction be stopped.

8–8 If a pregnancy has been interrupted, it is important that the extraction be complete. This can usually be determined by the woman, who will feel the stronger cramping that indicates the emptied uterus is contracting down to its usual size. The woman holding the cannula will usually notice a difference also. The cannula is harder to move in and out, and the interior of the uterus, which at first felt smooth, feels rough, something like a washboard, when it is empty. The contents of the uterus—blood, clots or small bits of tissue—are examined in a shallow dish or glass. If chorionic villi, the yellowish material with branchlike structures which is the beginning of the placenta, are present, then it is a good sign that the menstrual extraction ended the pregnancy.

After menstrual extraction in which the woman was pregnant, the group stays in phone contact. If the woman thinks that she is still pregnant, the group may decide to repeat the procedure. In those rare instances when there are any signs of an infection, such as fever or discharge, heavy bleeding or pain and tenderness in the pelvic area, she must consult a physician immediately to obtain antibiotics since untreated uterine infections can be quite severe. She will know that the menstrual extraction was complete if the signs of pregnancy are gone with a few days and any minor cramping or bleeding has disappeared.