

Womb is Womb, But is Birth Birth?

A Look at the *Queer* Interaction of Medical Services, Social Context and Identity Understandings in Canadian *Birthing* Experiences

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Considérant l'aspect biosocial de la naissance, cet article explore les influences culturelles et les différences possibles dans l'accouchement des homosexuelles et hétérosexuelles.

As a queer woman who hopes to one day have children, I often wonder if queer¹ women might have different birthing needs and make different choices regarding birth than heterosexual women do. While there has recently been substantial research and attention focusing on “lesbian mothering” (Kranz and Daniluk; Arnup; Epstein 1996, 1993; Nelson; Lewin), there seems to be a “representational absence” regarding queer birthing experiences. Birthing experiences represent an important and unique focus, due both to the fact that birth is the rite of passage involved in “becoming” a parent, and because the birthing scene may be considered a “public” and outwardly visible event as a result of social interactions with public institutions such as hospitals and maternity clinics. Thus, a study of the experiences and choices of queer birthing women may also be considered a study of the general cultural treatment of queers in our society.

Brigitte Jordan’s emphasizes the biosocial aspect of birth in her book, *Birth in Four Cultures*, by acknowledging the importance of “the culture-specific social matrix within

which human biology is embedded” (3). Although Jordan never explicitly studied the birthing experiences of queer women, her research on the influence of the cultural framework within which birth occurs serves as a foundation in understanding how queer women’s birthing experiences differ from those of straight-identified women. It is important to note, while Jordan emphasized the impact of culture on birth, she did so only by comparing birth in different cultures. What is often lacking in studies that compare cultures is a lack of acknowledgement of the diversity, particularly of groups and individuals that are of minority and non-normative status, within the respective cultures.

There are an estimated 200,000 lesbian mothers in Canada,² and numerous ways in which queer women can bring a child into their lives and families. In recent years, lesbian couples have increasingly chosen to have one of the partners become pregnant and birth within their queer relationship. Due to the social and cultural influences on the event of birth, it is intuitive that queer women’s planning and experiences of birth are different from heterosexual women, and yet many people have not considered the differences. Moreover, cultural ignorance regarding the potential diversity of birthing experiences in our society is reflective of the

focus on birth as a medical event. If we step back, however, from the view that “birth is birth because a uterus is a uterus,” our perceptions are able to widen to acknowledge the plethora of possible birthing experiences and social factors that influence them.

The Context

[It is] easy to forget that what happens in a maternity care clinic is a product of work done in legislative assemblies and ministries of health. State policies influence everything from the interactions between caregivers and clients to the clinical outcomes. (Wrede, Benoit and Sandall 28)

In western societies, the identities and practices of queer women explicitly challenge the heteronormative *status quo*. Farah Shroff argues that, “Heterosexism permeates virtually every aspect of Canadian culture: language, guiding practices of all gatekeeping institutions, and social interactions” (287). Recent research has revealed that homophobia continues to be expressed by and in families, schools, fertility clinics, hospitals, courtrooms, taxi drivers, the mass media, research funding, and government policies (Luce 2004, 2002; Kranz and Daniluk; Epstein 1996, 1993; Nelson; Lewin). Whereas this

type of homophobia has had institutional backing in the past, some recent political transitions have altered this.

Since the mid-1990s, government and social policies regarding “homosexuality” and “same-sex relations” have started to change (Kranz and Daniluk; Kuehn and Findlay). While today some Canadians are lobbying the federal government to legally recognize “same-sex marriage,” it was not long ago when the adoption of children, cohabitation (common-law) status, and spousal benefits were not available to any queer Canadians³ (Kuehn and Findlay). Today same-sex marriages occur legally in British Columbia, Saskatchewan, Manitoba, Ontario, Québec, Nova Scotia, Newfoundland and Labrador, and the Yukon. In British Columbia, two women can be named as “parents” on the birth certificate of their child, as long as the sperm for their child originated from an anonymous donor (Luce 2004; Kranz and Daniluk; Kuehn and Findlay). When similar legislation passed in Québec it included the possibility for past births to be re-registered allowing non-biological mothers to finally be legally named and recognized (various personal correspondence May 2003). In March 2004, however, the Canadian government took a step backwards in passing legislation intended to regulate insemination.

The new law (Bill C-6) relates to many kinds of biotechnology, including the buying and selling of ova and sperm, and the use of clones and stem cell research. Most important to this essay, the law will restrict insemination to those who have licenses to “obtain, store, transfer, destroy, import or export” sperm and ova, once it is fully implemented in 2006 (Government of Canada: section 10.3a⁴). According to this legislation, it will be illegal to use a syringe or turkey baster at home for the purposes of procreation in Canada. While this law seems to equally apply to heterosexual couples, they are less

likely to try inseminating at home when experiencing infertility, compared to lesbians who are not necessarily experiencing infertility to begin with (just problems accessing sperm) and can more successfully use a lower-technology and less invasive approach. Even though the explicit desire of Bill C-6 is to maintain control over “reproductive materials,” thus avoiding ethical and controver-

ceptions [as] medical events rather than intimate life experience lays the groundwork for medicalized birth” (Toevs and Brill: 432). Moreover, as Kim Toevs and Stephanie Brill note, despite the alternative choices available to queer women, “[a] hospital is by far the most common and complex birth environment for lesbians” (442), filled with discrimination and misunderstandings.

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sial issues relating to new reproductive technologies and cloning, it also unfortunately reflects a continued and implicit presence of homophobia in the political and medical establishments, which is not surprising considering the history of social policies regarding public health.

When health-related government and social policies were first introduced in western societies, it was done in an effort to encourage and maintain standards of public health (Tesh; Turner; Risse). Bryan Turner notes, “[t]he medicalization of society involve[d] ... a regulation and management of populations and bodies in the interests of a discourse which identify[ed] and control[led] that which [was] normal” (210). Moreover, “medical professionals [became] the moral guardians of ... society [with] legitimate domination of the categorization of normality and deviance” (Turner 209). White, middle-class, youthful, heterosexual, biological men (Lupton 58) came to signify normality, which helps to explain why now, decades later, queer women face discrimination and misunderstanding when they seek health care, and their experiences (birth or not) are not acknowledged. This becomes even more of a problem due to the fact that the “[making of lesbian]

Disclosure and Discrimination

The sign on the door to the [hospital] maternity unit reads, *Only Husbands Allowed*. (Luce 2004: 53)

When pregnant women enter a maternity ward, or even first meet their doula,⁵ midwife, doctor, or obstetrician, they are usually assumed to be heterosexual. Due to the fact that sexuality is not innately visible, lesbians and their different needs remain *invisible* and ignored, unless attention and clarification is drawn to their difference (Buchholz 307; Andrews 169; Krieger *et al.* 90). While this invisibility can lead women to be treated with respect because they are *seen* as heterosexual, it also means they are not respected or *seen* for who they *are*, and the women face a dilemma of disclosure. Carol McDonald notes that whereas a “politicalization of discourse” exists within queer communities which “exemplif[ies] gay pride and defiance of heteronormative assumptions,” one also risks discrimination if disclosure occurs. Thus, while Toevs and Brill, urge women to “come out” to provide more “understand[ing] [of] who’s part of the family” (446), many queer couples are told by phy-

sicians and/or friends to either “lie” or be treated with disrespect in the maternity ward (Nelson 55).

In order to make the hospital birth experience more safe, respectful and understanding of queer birthing situations, Sue Andrews suggests that midwives and their clients prepare a “cheat sheet” for hospital staff regarding the relationship, names/labels, and roles of the people in their

Moraga’s comments illustrate the ignorance and discrimination that often result from the fact that medical standards are based on white, middle-class, youthful, heterosexual, biological males, and thus neglect the needs of queer women, among others. Charles Briggs and Clara Mantini-Briggs negotiate this in their discussion of “medical profiling.”

In *Stories in the Time of Cholera*

lost when trying to treat a patient.

Prolonged Labour

Experiencing birth, where strength is equated with total surrender into the unknown, often runs counter to the survival skills that have guided many [lesbian and single] women up until this point. (Toevs and Brill 439)

“‘Who are you?’ The receptionist hears no male voice on the line, but a woman, my lover, seeking to know about our son. ‘Read the damn chart,’ Ella snaps back. ‘I’m the co-mother.’”

families the staff will be serving (173; also Buchholz; Tash and Kenney). She also notes that, “[w]hen a lesbian couple chooses to give birth in a hospital, both partners, as well as their midwife, face possible discrimination and ill treatment by staff who may not be open-minded about alternative families” (Andrews 173). Blaire and Iris (Nelson) faced discrimination from their doctor when she informed them that she “[wouldn’t] deliver the baby because she didn’t appreciate our lifestyle” (Iris qtd. in Nelson 55).

Similarly, in *Waiting in the Wings*, Cherrie Moraga recounts an occasion when her partner called to see how their son was doing:

Ella called the hospital this morning to inquire about the baby, having to put up with the usual deterrents: “Who are you?” The receptionist hears no male voice on the line, but a woman, my lover, seeking to know about our son. “Read the damn chart,” Ella snaps back. “I’m the co-mother.” *Co-mother*—a concept about which even San Francisco hospitals haven’t a clue. I cannot comfort Ella much when she is bruised by the hospital’s ignorance. (63)

(2002), Briggs and Mantini-Briggs use the term *medical profiling* to “refer to differences in the distribution of medical services and the way individuals are treated based on their race, class, gender, or sexuality” (10). While this treatment may be intentional, it also stems from a lack of understanding of social relations based on difference. Likewise, Nancy Kreiger, Diane L. Rowley, Allen A. Herman, Bylye Avery, and Mona T. Phillips note that when coming from a place of privilege, it is sometimes difficult to recognize that others face systemic oppression, physical violence, low-socio-economic statuses, and problems accessing health care, which in turn affects people’s physical and psychological well-being. While the majority of health research has neglected to focus on “minority” health issues or even consider using subjects from diverse backgrounds, an awareness that divergent social classes, and racial, ethnic, aged, sexual, gendered, and gender identity groups have sometimes even opposing standards of health, risks, and “norms” in health care. Moreover, “the complexity of understanding the social realities of multiple statuses” (Krieger *et al.* 1993: 99) often goes unnoticed by health care workers. It is unfortunate how much social context can be

The importance of the social context of a queer woman birthing is not lost on Toevs and Brill. Instead, Toevs and Brill argue in *The Essential Guide to Lesbian Conception, Pregnancy, and Birth* that quite often queer women face prolonged labour due to their social position. Co-founders of Maia Midwifery and Preconception Services, and queer mothers themselves, Toevs and Brill have assisted multiple lesbians conceive and birth in a queer friendly environment. They argue “that in order to be a lesbian parent, or single parent by choice, you must be an inwardly strong woman who feels ready to confront judgments of the outside world” (439). While their suggestion addresses the births’ social environments, to me it seems essentialist and/or on the verge of a stereotypical generalization.

This stereotypical approach is reminiscent of the way some people speak of the way First Nations’ women birth quietly and painlessly (Rockwell; Dufour). Generalizations like these are usually given without context or reason, as if First Nations women and possibly queer women must be physiologically different. What must be understood about birth is that factors such as social support and relations, positioning and physical activity of the women during labour, use of touch, and expectations regarding birth affect how the labour in terms of length and pain is experienced (Kitzinger). Recognizing the role of these factors on the birthing experience is key in not generalizing or stereotyping how particular *groups*

of women experience birth. While Toevs and Brill try to situate and explain why queer women may experience longer labours, they do not seem to allow for diverse experiences nor other possible explanations as to the reason except for their being resistant to social norms and oppression. I think that while not ignoring the possible effects of their explanation, other possible causes and explanations need to be recognized.

The Birth Certificate

Birth certificates play a fundamental role in how births, and those involved in them, are legally and socially recognized and accounted for. Birth certificates are used by Vital Statistics to acknowledge “new citizens” and their families. G. C. Bowker and S. L. Star note: “[t]he classifications entered on the certificate[s] are themselves systematically recorded so as to constrain the kinds of story that the statistics tell” (103). Although they are talking about death certificates, it equally applies to birth certificates. Either way, these certificates attempt to be objective and, in doing so, silence realities. This is where controversy has arisen lately, both in hospitals and in courtrooms, with lesbian mothers.

In western societies, birth certificates were established to maintain legal records of live births and families of origin, allowing one space for a father to be named, and one for a mother. As family forms have changed over the centuries and decades, birth certificates have acknowledged social changes, making it acceptable to list only a mother, if the father was “unknown.” Yet, when coupled lesbians have tried to register two “birth mothers,” they have been denied the ability and right to do so. In British Columbia this should now be limited to lesbian couples who conceived with a “known” donor (due to the Human Right’s decision regarding “anonymous” or “unknown” sperm donors; see Kranz and Daniluk 64;

Kuehn and Findlay 9), however, it is quite possible that ignorant or homophobic hospital staff and birth attendants may still pressure or confront queer couples regarding who is named on the birth certificate. Medical staff and society in general are not used to the presence of a non-birthing mother, and acknowledging her presence (whether on a birth certificate or just generally) has proved a difficult

counts in *Lesbian Motherhood*:

The women spoke of birth as an intense and exhilarating shared experience.... Blaire was with Iris (biological mother) through the labour and was holding her as birthing began. When Blaire felt the pain Iris was in, she began to cry. When Iris looked up at Blaire and felt Blaire’s dis-

Having two “female” bodies present, involved, and embodied in the birthing experience as parents, also relates to issues of who became pregnant and is birthing *this* time.

task, along with the possible differences she (her role) attributes to queer birthing experiences.

The Presence of a Non-Birthing Mother

... It is possible that the midwife was responding to this couple in the same way she responded to heterosexual couples, without considering that perhaps two women can give birth differently than a man and a woman generally do. (Nelson 63)

The presence or existence of non-birthing mothers at births is significant. While historically women’s voices have been silenced, particularly in regards to their birthing and labour experiences (Sterk *et al.*; Jordan), women’s voices are finally being socially acknowledged on this topic, and the non-birthing mother provides yet another perspective. Moreover, the experience of the non-birthing mother is unique, in that she is a *female* partner to the birthing woman. Her experience of the birth may in some ways resemble that of the male partner of the birthing woman, but it differs considerably in other ways. This is demonstrated through a story Fiona Nelson re-

tress, she worried about Blaire and wondered how she could endure seeing Blaire go through this ordeal at the next birth. On an emotional level, they inhabited each other’s bodies as this birth also became future births and somewhere in the middle of it all the *two of them* gave birth to their son. (64)

The notion of shared experiences, or embodying the birthing partner’s pain and emotions, is key in the limited research on lesbian births (Nelson; Toevs and Brill).

Moreover, having two “female” bodies present, involved, and embodied in the birthing experience as parents, also relates to issues of who became pregnant and is birthing *this* time. Toevs and Brill note that, “if one partner in a couple was unable to conceive or hold a pregnancy and now the second partner is ready to give birth, this can retrigger the non-pregnant mom’s feelings of inadequacy, resentment, or envy that she isn’t the one who’s about to have the baby” (431). Thus the birth must be understood within its context, whether that refers to the conception or events long forgotten, such as sexual abuse.

Some recent literature has discussed

the issue of flashbacks of sexual abuse during a birth, as they seem to be a fairly common experience for those involved in the birthing process (Toevs and Brill; James-Philp; Lainsbury). Due to the sexual, intimate, and emotional atmosphere of birth, birthing women often experience flashbacks. Additionally, Toevs and Brill note, "Sometimes seeing your partner in so much pain, or seeing how out of control she feels, or seeing various tubes and monitors attached to her body, can trigger personal sexual abuse issues" (447). Moreover, female partners of birthing women apparently experience more flashbacks than male partners, which may reflect the physical differences between most men and women's bodies (Toevs and Brill). The issue of flashbacks points out that not only are there general differences between "queer" and "straight" birthing experiences, but a diversity of experience that crosses identity boundaries—a key focus of this paper.

Conclusion

If we regard health as a desirable but limited resource, then we can perceive improvements in health standards as an aspect of the extension of citizenship rights in contemporary society. (Turner 216)

When we consider how the new Canadian federal policy (Bill C-6) limiting non-intercourse insemination to licensed facilities reflects the relationship between health care and citizenship rights, the ignorance and/or bias of policy makers in regards to the needs and desires of socially marginalized peoples becomes clear. In regards to Turner's comments, I recognize that the stories and realities of the queer perinatal needs and experiences serve as only one example of how diverse sexual orientations, gender identities, ethnicities, classes, ages, cultural backgrounds, educations, and dis/abilities are often not respected, understood, or

acknowledged by "standard" medical practice, nor society in general—and thus reflect a general lack of basic citizenship rights. Moreover, just as there has been a "representational absence" regarding queer women's birthing experiences, the absence of research regarding birthing by people who have an intersex condition or who are trans-identified is greater (as is the probability that they face even more misunderstandings and hardship from their care providers and society in general when they birth). While their experiences, unfortunately, continue to be marginalized here, it is my hope that their stories and realities will soon be more readily recognized. Therefore, while human rights legislation continues to expand queer rights and access to equality and care, the reality is that there is still much to be done regarding negotiating the diverse needs that people have, and providing the best care for their respective needs.

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¹By "queer" I refer to people and practices that are seen as non-normative by mainstream western society. Queer people may identify as "gay," "lesbian," "bisexual," "transgendered," "intersex," "transsexual," "genderqueer," "two-spirited," "polyamorous," "kinky," or by another label, or no label at all. While this paper focuses on queer women's birthing within relationships of two female-identified persons, I acknowledge that queer women also birth as single women, in heterosexual relationships, and within group relationships, as well as with partners who are trans-identified, have intersex condi-

tion, or are two-spirited.

²This estimate is based on Statistics Canada's female population numbers for 2003 (of women aged 20 and over), combined with the formula explained by Rachel Epstein in "Lesbian Families" (127, note #1).

³It should be noted that since the laws regarding these issues are provincially based, some queer Canadians still do not have these legal rights.

⁴This section states: "(3) No person shall, except in accordance with the regulations and a licence, obtain, store, transfer, destroy, import or export (a) a sperm or ovum, or any part of one, for the purpose of creating an embryo;" (Government of Canada). The author would like to note that in the fall of 2004 (since the original submission of this article) there were meetings across Canada to discuss the implications and interpretations of Bill C-6. During these meetings, when asked about lesbian self-insemination, "The Health Canada reps agreed that in no way is [this Bill] intended to incriminate what people do in the privacy of their own homes" (Greenbaum). The problem remains, however, that this is still not made clear in the wording of the Bill, leaving its applicability ambiguous, and thus possibly still discriminatory.

⁵The ancient Greek word *doula* referred to well-respected women who were experienced in childbirth and service to others.

References

- Andrews, S. "Chapter 13: Gynecological and Obstetric Care of Lesbian and Bisexual Women." *Varney's Midwifery*. Ed. H. Varney. Boston, Ma: Jones and Bartlett, 1998. 167-174.
- Arnup, K. *Lesbian Parenting: Living with Pride and Prejudice*. Charlottetown, PEI: gynergy books, 1997.
- Bowker, G. C., and Star, S. L. *Sorting Things Out: Classification and its Consequences*. London, UK: MIT Press, 1998.

- Briggs, C., and Martini-Briggs, C. *Stories in the Time of Cholera*. Berkeley, Ca: University of California Press, 2002.
- Buchholz, S. E. "Experiences of Lesbian Couples During Childbirth." *Nursing Outlook* (November/December 2000): 307-311.
- Dufour, R. "Giving Birth in an Igloo." *Born Up North: The Evolution of Birthing Practices in Northern Canada*. Eds. M. O'Neill and F. Saillant. Montréal, QC: Editions St-Martin, 1994.
- Epstein, R. "Breaking with Tradition: North American is Experiencing a Baby Boom Among Lesbians." *Healthsharing* 14 (Summer/fall 1993): 18-22.
- Epstein, R. "Lesbian Families." *Voices: Essays on Canadian Families*. Ed. M. Lynn. Toronto: Nelson Canada, 1996, 107-130.
- Government of Canada. *Bill C-6*. Online: http://www.parl.gc.ca/37/3/parlbus/chambus/house/bills/government/C-6/C-6_3/C-6TOCE.html Accessed: October 31, 2004. Last updated: 2004.
- Greenbaum, M. Personal communication, November 17, 2004.
- James-Philp, J. "Painful Memories: The Midwife's Role in Helping Fathers." *Midwifery Today* (Autumn 1999): 25.
- Jordan, B. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* (4th ed). Prospect Heights, Ill: Waveland Press, 1993 [1978].
- Kitzinger, S. *Rediscovering Birth*. Boston: Little, Brown and Co, 2000.
- Kranz, K. C. and Daniluk, J. C. "We've Come a Long Way Baby ... Or Have We?: Contextualizing Lesbian Motherhood in North America." *Journal of the Association for Research on Mothering* 4 (1) (2002): 58-69.
- Krieger, N., D. L. Rowley, A. A. Herman, B. Avery, and M. T. Phillips. "Racism, Sexism, and Social Class: Implications for Studies of Health, Disease, and Well-Being." *American Journal of Preventative Medicine* 9 (3) (1993): 82-122.
- Kuehn, S., and findlay, b. *Queer as Family: the Legal Rights and Responsibilities of Lesbian, Gay, Bi-Sexual and Transgendered Families in B.C.* Vancouver: West Coast LEAF, 2002.
- Lainsbury, D. "Child is Father to the Man: A Survivor of Childhood Sexual Abuse Speaks Out." *Midwifery Today* (Autumn 1999): 25-27.
- Lewin, E. "On the Outside Looking In: The Politics of Lesbian Motherhood." *Conceiving the New World Order: The Global Politics of Reproduction*. Eds. F. Ginsburg and R. Rapp. Berkeley, Ca: University of California Press, 1995, 103-21.
- Luce, J. "Imaging Bodies, Imagining Relations: Narratives of Queer Women and 'Assisted Conception'." *Journal of Medical Humanities* 25 (2004): 47-56.
- Luce, J. *Making Choices/Taking Chances: Lesbian/Bi/Queer Women Assisted Conception, and Reproductive Health*. Vancouver: British Columbia Centre for Excellence on Women's Health, 2002.
- Lupton, D. "The Social Construction of the Body." *The Handbook of Social Studies of Health and Medicine*. Eds. G. L. Albrecht, R. Fitzpatrick and S. C. Scrimshaw. Thousand Oaks, Ca: SAGE, 2000. 50-63.
- McDonald, C. Personal communications, June 13, 2004.
- Moraga, C. *Waiting in the Wings: Portrait of a Queer Motherhood*. Ithaca, NY: Firebrand, 1997.
- Nelson, F. *Lesbian Motherhood: An Exploration of Canadian Lesbian Families*. Toronto: University of Toronto Press, 1996.
- Risse, G. B. "Chapter 4: Medical Care." *Companion Encyclopedia of the History of Medicine*. Eds. W. F. Bynum and R. Porter. New York: Routledge, 1993. 45-77.
- Rockwell, S. L. "The Delivery of Power: Reading American Indian childbirth Narratives." *American Indian Culture and Research Journal* 19 (3) (1995): 71-85.
- Shroff, F. "All Petals of the Flower: Celebrating the Diversity of Ontario's Birthing women within the First-Year Midwifery Curriculum." *The New Midwifery: Reflections on Renaissance and Regulation*. Ed. F. Shroff. Toronto, ON: Women's Press, 1997. 261-310.
- Statistics Canada. *Canadian Statistics-Population by Sex and Age Group*. Online: <http://> Accessed: August 15, 2004. Last updates: 2000.
- Sterk, H. M., C. H. Hay, A. B. Kehoe, K. Ratcliffe, and L. G. VandeVusse. *Who's Having This Baby?: Perspectives on Birthing*. East Lansing, Mi: Michigan State University Press, 2002.
- Tash, D. T. and J. W. Kenney. "The Lesbian Childbearing Couple: A Case Report." *Birth* 20 (1993): 36-42.
- Tesh, S. N. *Hidden Arguments: Political Ideology and Disease Prevention Policy*. New Brunswick, NJ: Rutgers University Press, 1996.
- Toevs, K., and Brill, S. *The Essential Guide to Lesbian Conception, Pregnancy, and Birth*. Los Angeles, CA: Alyson, 2002.
- Turner, B. *Medical Power and Social Knowledge*. Thousand Oaks, Ca: Sage, 1995.
- Wrede, S., C. Benoit and J. Sandall. "Chapter 2: The State and Birth/The State of Birth: Maternal Health Policy in Three Countries." *Birth By Design: Pregnancy, Maternity Care, and Midwifery in North America and Europe*. Eds. R. Devries, C. Benoit, E. R. Van Teijlingen, and S. Wrede. New York: Routledge, 2001.