

**The Construction and Experience of 'Risk'  
in Pregnancy and Childbirth in Australia**

A Thesis

Submitted to the Department of Anthropology, Faculty of Arts, Macquarie University  
in Partial Fulfilment of the Requirements for the Degree  
Master of Research (MRes), Anthropology  
Submission Date: 9 June 2016

Jaclyn Cruz Coleman

Bachelor of Arts - Anthropology, Wayne State University, 2002

Master of Public Administration, University of Michigan, 2004

## Table of Contents

Title Page	1
Abstract	3
HDR Statement	5
Acknowledgments	7
Chapter 1: Introduction, Literature Review, Methods and Background	9
Chapter 2: An Overview of Dimensions of Risk in Pregnancy and Childbirth	18
Chapter 3: Biomedicine, Vulnerability and Disempowerment	37
Chapter 4: Maternity Risk and “Othering”	51
Chapter 5: Conclusion	70
Works Cited	74

## Abstract

This thesis, *The Construction and Experience of 'Risk' in Pregnancy and Childbirth in Australia*, examines the cross-cultural construction and experience of risk in pregnancy and childbirth in present day Australia. Pregnant and birthing women in Australia experience a pervasive sense of risk to their pregnancies and their babies in birthing. To explore this issue, I interviewed women from four different cultural groups, who were pregnant or who had given birth in Australia and I analysed their narratives of reproductive risk experience. I review pertinent themes that emerged in the interviews in relation to three key risk theorists: Douglas's theories around risk, blame, pollution and taboo, Beck's Risk Society and Foucault's Governmentality. In further analysing women's experiences through the lens of 'risk', I argue that the biomedical paradigm uses notions of risk to disempower women in their reproductive experience and that women who do not acquiesce to dominant society's understanding of 'risk' are in peril of being "othered" or stigmatized.



## **HDR Statement**

This work has not been submitted for a higher degree to any other university or institution. The sources of information used and the extent to which the work of others has been utilized are indicated herewith. Ethics Committee approval was obtained (5201500063).

A handwritten signature in blue ink, appearing to read 'J.M. Cole', is centered on the page. The signature is written in a cursive style with a large initial 'J' and 'M'.



## **Acknowledgments**

I wish to thank all participants involved in my research process for sharing intimate and sometimes confronting narratives of their own experience. I am grateful for the academic guidance provided by my supervisor, Dr Aaron Denham. I must acknowledge his support during numerous administrative hurdles and his flexibility and patience during my pauses in research and writing due to pregnancy, illness, childbirth and caring for a new baby. A final word of thanks to my supportive husband, birth partner, and proof-reader Sam Coleman and to my pembantu, Ibu Ami, for her facilitation of my writing process by providing loving assistance with my daughter (kata akhir dari berkat saya pembantu, Ibu Ami, untuk membantu dengan kasih dan perawatan putriku).





## Introduction

The physiological processes involved in pregnancy and childbirth are shared. However, as is evident in global empirical studies and through inductive reasoning resultant from my research, group and individual knowledge and practice surrounding pregnancy and childbirth are socially and culturally constructed; coloured by historical context, state institutions and structures, and biomedical ideology and technology (Jordan 1993, Davis-Floyd and Sargent 1996 and 1997, Ross 2016). I submit that in Australia, social discourse imparts the idea that women should experience a pervasive sense of vulnerability to misfortune in pregnancy and childbirth. Thus, my research asks how do women experience 'risk' in pregnancy and childbirth? And, how do they experience social and medical practitioner responses to their acquiescence to or non-conformity with cultural norms of 'risk' during pregnancy and childbirth? To answer these questions, I interviewed Australian women and women from three different countries of origin, living in Australia, in order to understand their perceptions of risk in relation to pregnancy and childbirth. I examined women's narratives of experiences using the concept of 'risk' as a framework for understanding their perceptions. The participants in this research spoke of the risks most pertinent in their lifeworlds and together these themes presented a complex, politicized and moralized discourse. Mothers reflexively negotiated their understandings of risk and substantiated their thoughts, actions and roles in pregnancy and birthing in the context of dominant and competing risk ideologies.

Historically, Western notions of risk were the chance of losing *or gaining* something perceived to be valuable. Today, however, risk is largely used to describe the possibility of something *bad or dangerous* happening at some point in the future (Lupton 2013). As described by Chapman (2010), who wrote on reproductive risk in Central Mozambique, risk is a culturally bound construction and is dependent on more than simply danger or dangerousness. Risk is a political, social and cultural creation and tool for moulding society (Chapman 2010). These dimensions, and

their influence, can be quiet, surreptitious and all encompassing - often going unnoticed by women within the dominant system. By reflecting on the manner by which immigrant mothers have negotiated their maternal roles in Australia I uncovered the layered meaning of dominant “systems of value” around risk, which are “either overtly expressed or taken-for-granted” (Napier 2014, 1). Women often regard pregnancy and birth as a time in which women experience a conscious embodiment or “phenomenological indicators” of their maternal performance (Browner and Press 1997) but my study importantly illuminates that in pregnancy and childbirth women's bodies and minds are acted on. Social, cultural and state systems reinforce subordination of women who do not acquiesce to a mainstream risk ideology and those who are compliant with the normalising medical hegemony (Ross, et al 2013) are, in my research, lauded as ‘good’ Australian mothers

I frame my analysis of women's sense of vulnerability to dangers in maternity and the influential dimensions of risk in pregnancy and childbirth in Australia with three theorists' arguments: Douglas's (1966, 2003) theories around risk, blame, pollution and taboo, Beck's (1992) Risk Society and Foucault's (1991) Governmentality. I show how a ubiquitous sense of risk and blame for potential negative outcomes in pregnancy and childbirth is used as a tool by some practitioners in the biomedical community and the bureaucratic state health system to disempower women in pregnancy and birthing in an attempt to achieve certainty and control over outcomes through biomedicine and technology. The biomedical paradigm based in Cartesian dualism, dominant in Western countries including Australia, disconnects health and disease from the individual, cultural and social milieu and makes distinct the mind from the body (Lock and Hughes 6, 1987). My research demonstrates that while women experience pregnancy and birth as individual agents, their experiences are largely shaped and objectified by broader social and governmental institutions. Unknowingly, women reflect and reinforce the biomedical model of care, which often may not be serving their own best interest (Mishler 1981, 1-12). I also extend this argument by demonstrating how a dominant ideology of risk in pregnancy and childbirth is given meaning by

how society defines good Australian mothers and stigmatizes mothers who are non-compliant with the accepted approach to risk discourse and aversion. But first, I show how this work contributes to the growing body of work in the field of the anthropology of reproduction and risk and discuss my methodology and the background to this research.

## **Literature Review**

Numerous anthropologists touched on subjects related to reproduction, pregnancy and childbirth before the 1970s including offering descriptions of feelings of responsibility for foetal growth, pregnancy as a time of vulnerability and other social and psychological aspects of pregnancy, as in this study. It was Jordan's (1978) book, *Birth in Four Cultures*, which set the stage for further, concentrated study of human reproduction in anthropology (Jordan 1993). For my purposes, her work exemplified the hegemonic role of the biomedical model of birth and its impact on women. Since then, medical anthropologists such as Davis-Floyd have laid the foundation for qualitative research on reproduction in the fields of anthropology, midwifery, nursing and women's studies. Davis-Floyd's work on childbirth, obstetrics, and midwifery and her publication (with Sargent), *Childbirth and Authoritative Knowledge: Cross Cultural Perspectives* (1997) proved essential for my research. They examined the technocratic, top-down structure of knowledge in reproduction as a taken-for-granted and reflected on how expert understandings are created, challenged and enacted in different contexts. Anthropologist Rapp's (2002) *Testing Women, Testing the Fetus: The Social Impact of Amniocentesis in America* also provided pertinent analysis of the role of the social system in masking women's personal processes around decision-making in pre-natal testing. Further, the 2003 research "Why Do Women Decline Prenatal Screening and Diagnosis? Australian Women's Perspective" added depth to my understanding of study participants' and my own experience of "emotional distress" relative to decision-making in prenatal screening (Liamputtong et al 2003).

In cross-disciplinary consideration, Lupton (2013, 2011, 2008), an Australian sociologist, explored the social and cultural aspects of risk and written extensively on medicine, public health, risk, the body, and fetuses. Her work grounded my understanding on different theorists, key empirical studies of risk and the "participation of mothers in conforming to societal expectations" (2011, 637). I will briefly introduce the three risk theorists with which I explore of the notion of risk in pregnancy and childbirth however, these theories are more extensively addressed in Chapter Two. My study examines participants' narratives through the lens of risk, using the arguments of three risk theorists: Douglas's (1966, 2003) work around risk, blame, pollution and taboo, Beck's (1992) Risk Society and Foucault's (1991) Governmentality.

Denham (2012) analyses perceptions of risk and blame attribution in the anthropology of reproduction. Denham's approach is rooted in Douglas's theories (1966, Douglas and Wildavsky 1982) around risk and blame. Douglas addresses the utility of stigmatisation enabling a group to make sense of misfortunes and Denham's work traces "trajectories of blame" in order to identify who is perceived responsible for such negative outcomes. These theories proved apt in understanding the lived experience of study subjects whose behaviours or beliefs fell outside of mainstream techno-medical Australian ideology. Further to this, Allen (2004) and Denham (2012) explored 'unofficial risks' in reproductive risk. I use this notion to guide my analysis of the trade-offs women, from non-Western cultural groups, make in weighing how to avoid risk in pregnancy and childbirth in Australia.

In a 'Risk Society' as theorized by Beck, risks are introduced by technology and modernity itself. These risks are political, constructed and individual reflexivity is "constant" (Possamai-Inesedy 411, 2006) and inherent in a risk-society (Beck 1992). Australian sociologist Possamai-Inesedy's research relates significantly to my study. She highlights that the "pregnant woman is the least able to escape the consequences of risk society" as posited by Becks and Gidden (Possamai-

Inesedy 406, 2006). Like Possamai-Inesedy's research into the risk society and childbirth, I explore the "discourse and of the micro and macro context in which risk is experienced and given meaning" (Possamai-Inesedy 409, 2006). She concludes that "the fears and anxieties expressed by all of the respondents of this [her] study [on "Choice and Responsibility in Childbirth in a Risk Society"] are only explicable and rational within this [the Risk Society] context" (Possamai-Inesedy 413, 2006).

Finally, I analyse the narratives of experience in my study in the context of Foucault's perspectives on biopolitics, medicalisation and self- and public- surveillance of women's choices and bodies (1975, 1991), which proves a recurrent theme in my study.

## **Methods and Background**

It was my aim to capture women's subjective experiences of pregnancy and birth, and to understand how women articulate their perceptions of risk in pregnancy and birth through a series of in-depth, semi-structured ethnographic interviews. These interviews resulted in a set of pregnancy and birth experience narratives. I conducted these interviews with twelve women, each interviewed one to three times, for 45 to 90 minutes per interview, primarily between May and June 2015. I contacted some of the women for brief (15 to 20 minute) follow-up phone interviews. The interviews were guided by a set of common questions I developed, and followed by unstructured, in-depth discussion on key themes. I wanted to explore the construction of risk as it relates to the maternal body, social and individual identity, institutional and political structures, value systems and historical context. I aimed to view perceptions and epistemologies of risk in pregnancy and childbirth with an integrative perspective. Phenomenological theory and the research and ideas concerning embodiment and lived-experience framed my analysis. For example, Lock and Scheper-Hughes' (1987) conceptualization of "the lived self", the social body, and the post-structuralist notion of the political body offers a framework that assisted in locating women's

experiences in terms of a multiplicity of agents, influences, perceptions and outcomes. I gave priority to women's experiences as articulated in their first person narratives while also reflecting on the social meaning (Leder 1992).

In the interviews, I took a person-centred interviewing approach, as defined by Levy and Hollan (1998), in order to capture pregnancy and childbirth histories and epistemologies of risk as related to maternity. I used this approach because I needed to be cognisant of how participants related to both myself and the subject matter and of how I related to the subject matter and to the women I was interviewing. My initial research goal was to conduct this project in South Sudan, but due to safety concerns I refocused my research into a comparative study of risk perceptions in pregnancy and childbirth amongst Sudanese, South Sudanese, American and Australian participants living in Australia. I was committed to working with these populations having lived in South Sudan (then Sudan) in 2006-2007. I shared with them the experience of migration to Australia and of navigating a new health system as an American migrant. Zola, a participant and trusted community worker, was indispensable in facilitating introductions to women in the South Sudanese and Sudanese community. I used my personal social and familial connections to identify women from Australia and the USA who would be interested in participating in the research.

It was my goal to emphasize description "firmly rooted in the experiential lives and moral universes" of informants (Hollan 1997, 223). Normative understandings of risk permeated women's experiences of pregnancy and childbirth. As such, it was my intent for women to richly describe their experiences to me, and then, in reflecting upon the underlying elements constituting their risk epistemologies, demonstrate possible conflicts between their beliefs, expectations, and practices, and any rationalizing discourses used to resolve these conflicts and inconsistencies. After establishing a grounded understanding of the surface experience, the interviews became more open, allowing informants to freely associate ideas, thoughts and feelings as they spoke (Paul 1989, 177).

Hollan elaborated that the goal of free association following open-probes was to capture not just what people did and said, but also what they embodied and thought during the pregnancy and birth and then on reflection at the time of the interview (Hollan 1997, 220). Indeed, embodied knowing - knowledge ascertained through physical awareness - challenges the boundaries of the dualistic, Cartesian approach to medicine - viewing the mind and body as separate entities - and emphasizes the "lived-body" and the "primacy of perception" (Merleau-Ponty 1962).

My ethnographic research methodology involved participating in women's daily activities in their homes, in shopping centres, and at a playground during my interviews, in order to build rapport. I viewed culturally bound constructions of pregnancy and childbirth perception and practice, from both *emic* (from within the culture) and *etic* (from outside the culture of the participants in the study) perspectives (Berry 1980). As I was pregnant during the research, I attended three hospital maternity information sessions and tours, and consulted with my own medical practitioners. I maintained a journal of relevant interactions with my healthcare personnel and with familial and social connections. I gave birth during the period in which I was analysing transcribed interviews and in my postpartum period I was writing this thesis with a new baby in my life. For the purpose of ethnographic and practical scrutiny, my pregnancy was positioned in reflexive analysis. The auto-ethnographic approach allowed me to research and write "self-consciously value-centred rather than pretending to be value free" about content that was value-laden (Ellis, et. al. 2011). Based on this, I believe that women can learn from one another and about themselves from the reflexivity implicit in this research. This study can also serve as an informative piece for those in the medical profession who are working in maternity care to better appreciate maternal understandings and practices that often seem a foregone conclusion.

Building on the works of Denham and other anthropologists using narratives of experience to examine risk and reproduction (Frodyce and Maraesa 2012), I turn the lens on Australian ('Western') culture and I use Harkness and Super's (1996) "ethnotheories" - an organized set of, often implicit, ideas shared by a cultural group - approach to child development as a way of viewing and understanding the reasoned customs, practices, and beliefs that form the cultural system of pregnancy and childbirth. I argue that whilst most women and health practitioners seek to minimize risk, the perception of what those risks might be or entail is different, and the correlate discourse and action accommodates realities for *that* woman's experience, not necessarily the empirical reality of the systems meant to be serving them (Maraesa 2012, 225-226).

In the months following data collection, I transcribed all the recorded interviews and revisited my handwritten notes from interviews I was unable to record. I continually revisited and analysed the data, and compared it to academic literature in the fields of the anthropology of reproduction and childbirth and the sociology of risk in order to form the most relevant approach for response to my findings. Coding of the material enabled me to layer, connect, and match seemingly distinct phenomena into emerging theoretical and contextual concepts. I delimited coding to reduce information in the brief timeframe allowed. By collating and layering theoretical and contextual ideas I was able to sort and align information with the core research question: How do women experience 'risk' in pregnancy and childbirth? And, how do they experience social and medical practitioner responses to their acquiescence to or non-conformity with the norms of 'risk' during pregnancy and childbirth? (Pace 2012).

The research methods and contingencies received ethics approval from the Macquarie University Human Research Ethics Committee (ref: 5201500063). Pseudonyms are used throughout to conceal the identities of the research participants.





## Chapter 2: An Overview of Dimensions of Risk in Pregnancy and Childbirth

This chapter considers notions of maternal responsibility and blame in pregnancy and childbirth relative to three key risk theorists. I make evident that acknowledgement and acceptance of, or resistance to, perceptions of risk is a moral and value-laden endeavour as Australian society has created an understanding - complete with unspoken and spoken rules and expectations - of risk as inherent in pregnancy and childbirth. Working from Lupton (2013) and various dictionary definitions, I define risk as the supposition of uncertainty and danger, and the probability and impact of that danger occurring. I propose policies, laws, and informal norms create taken-for-granted patterns of thought and behaviour (Harkness and Super 2009, Adam and van Loon 2000, 1-31, Napier 2014) centred around risk relative to women fulfilling their roles as mothers in Australia.

In this thesis, I argue that pregnant and birthing mothers (and their medical practitioners) in Australia publicly engage in a discourse of risk and risk avoidance and that women are expected to acquiesce to constructed perceptions of risk within given social and cultural contexts even if these perceptions of risk do not adhere to their own logic. Douglas (1966, 2003) posits that threats such as miscarriage, foetal abnormalities or other maternal misfortunes are linked to or closely associated with a community's beliefs or expectations of what is normal and deviant in pregnancy and birthing. As I will illustrate in the narratives below, women become part of the discourse and the practice of state and hospital recommended risk avoidance and minimisation strategies in pregnancy and birth thus perpetuating the intimate involvement of the state and biomedicine with the lives of pregnant and birthing women.

For many women, challenging the socially normative system of risk is infeasible due to 'risk' being a taken-for-granted (Adam and van Loon 2000, 1-31). The desire to adhere to cultural

norms is often so powerful that many women would not recognize the disjuncture between their own pregnancy beliefs and practices unless asked to reflect upon it. When ideas do emerge that contest (or differ from) the dominant approach to risk in pregnancy and childbirth, they are often met with derision from mainstream age-group peers and the expert (biomedical) community (Douglas 2003).

I visited Philipa, a new mother, in the suburban home she and her partner had recently purchased. After greeting me at the door, she sat down in a comfortable purpose-built breastfeeding and baby-soothing rocking chair and ottoman. Philipa had set up a breastfeeding station with water (“You have to stay hydrated when you are breastfeeding” she mentioned), some lollies (“You need the sugar sometimes when you are breastfeeding” she added), and both a paper notebook and an application on her phone opened for logging and monitoring breastfeeding times and assumed milk consumption quantities. I had offered to buy coffees and brought her the decaffeinated latte she requested. She remarked on how little she missed at her job in the public service except the morning coffees from a café near her work. She set down her latte, letting it go cold as we spoke, and focused her attention on the materials (cloth, nipple shield, and pillow) and the mechanics of breastfeeding.

In our conversations, Philipa often used “you” instead of “I”. From this, I understood her experience of pregnancy and birth was not just her own, but a shared way of life for many Australian women. “With friends with babies, you hear about risks all the time” Philipa said. “You trust the people around you to be guiding you and telling you.” As we talked, examples of perceived threats to pregnancy poured out, and she listed food items, such as lettuce from restaurants as a danger because one couldn’t know how well or if the lettuce had been washed. She nodded knowingly, raising her eyebrows, saying “salmonella.”

Philipa's partner had given her the New South Wales Government's *What Not to Eat in Pregnancy* information sheet. She indicated that she saw the list as merely suggestions at the beginning of her pregnancy, but by the end she said that she was almost fully compliant with the guidelines. The document, available on the Internet and in hard copy as a brochure, read: "Use this handy guide to help make decisions about what to eat and what to avoid during pregnancy. Foods to avoid are listed for a range of reasons, but in most cases there is a higher risk those foods may contain harmful bacteria such as *listeria* or *salmonella*" (NSW 2015). Red is "Don't Eat", Yellow is "Eat with Caution" and Green is "OK to eat". The website also highlighted the threat of toxoplasmosis, alcohol, cigarettes and excessive caffeine (2015).

"It was almost like...the further along I got, the more paranoid I became. The longer you got on, the longer you invested. And if you lost the pregnancy... the idea of having to start [pregnancy] all over again just really upset me. It was traumatizing." Philipa felt self-reproach for taking Tums for nausea and reflux, and taking Movicol to ease her constipation. "I felt incredibly guilty and stressed for taking medications. I felt like I should just suck it up [tolerate illness and discomfort]." She said that it was the "unknown" about the medications that created a fear of harming her baby.

Although pregnancy and childbirth are a part of the common human experience, there are unknown elements of that experience for all women, which hold the potential to harm the mother and/or baby. In a highly developed state system of medical care, there is social agreement on what behaviour in pregnancy is considered risky. "The [moralizing] language of risk is likely to perform a standardizing, centralizing role...as it makes use of natural dangers" (Douglas 2003, 4) and thus, plays a political role in perpetuating women's dependence on the state and biomedicine for maternity services. The women I interviewed sense a moral obligation to follow socially prescribed behaviours since to do otherwise could be judged potentially harmful to an unborn child or to the

expectant mother herself. There is an implication that independent decision-making in regard to certain behaviours is not only unnecessary, but could be considered risk-taking. Potentially perilous behaviours such as eating taboo foods, shaped what Philipa would come to negotiate, discuss, and practice during pregnancy.

Another person who expressed her concern about risk avoidance in pregnancy, was Juliet, a soft-spoken American woman in her mid-thirties. Juliet was studying for her PhD in Canberra and was early in her second pregnancy. I asked if she was following the guidelines in the brochure. “I haven’t yet decided” she replied timidly. I asked if she had an idea of what was prohibited. She was able to immediately list medications, milkshakes, soft cheeses, soft-serve ice cream, sushi, and alcohol “until the second trimester, then in moderation.” She leaned in and confessed that she had ingested all of these things in moderation in what was still her first trimester – “except sushi *unless* it was cooked sushi”.

The NSW information sheet, *What Not to Eat*, was widely discussed amongst my age-group peers. Early in my own pregnancy, I saw this brochure in the maternity ward when attending an information session and tour at a local hospital. I did not pick it up. I later searched for, and found it on the Internet, having heard repeatedly about its advice from age-group peers – male, female, colleagues, and friends. I believe that due to my research on the social construction of risk in pregnancy, I approached the guidelines differently than my peers. I evaluated the statistical likelihood of becoming afflicted with listeriosis or salmonella and the impact of eating the prohibited foods. I considered first- and second-line treatment options and their safety for pregnant women. Ultimately, there was little I followed according to the information sheet. This decision to use my own best, informed judgement conflicted with the accepted public health discourse. However, the information I was relying upon – primarily from academic medical journals – provided reliable and specific information that allowed me to have a different understanding and to

take a different approach to the guidelines of the brochure. My decision not to follow the guidelines was met with reproach on numerous occasions by strangers and age-group peers. When I challenged their perceptions with my justifications, people generally discontinued the conversation but their sense of judgment had been conveyed.

As an example of the reproach one might experience when not adhering to such guidelines, I recall having ordered a Caesar salad while out with friends. When the waiter delivered the salad, a male friend announced “You can’t eat that!” I asked, “Why?”. He began to examine my meal and list off the ‘dangers’ for a pregnant woman. “It has an aioli-based dressing for a start – they might make it here and use raw egg. The salad itself [lettuce] might not be washed well. You’re not supposed to eat salads out [at restaurants]. You have prawns on that...Aren’t you *not* supposed to eat shellfish when you’re pregnant?” he paused, his eyebrows lifted, polling our peers. “Allergies?” he suggested. Like a detective he concluded loudly, “Ah, and there is a soft-boiled egg on top!” Had he been a stranger, I would have felt the need to defend my food order with zeal and rational calculations to undermine what constituted his understanding of risk for pregnant women. As he was a friend with whom I often debated issues of the day, I shrugged and began to eat. These biomedical methods of social control are enforced by citizenry “persuading subjects that certain ways of thinking and behaving” (Lupton 1997, 99) are *right* and *moral*. I considered the Foucauldian perspective on power, medicalisation and the public’s surveillance of women’s choices and women’s bodies (Foucault 1975) in relation to this experience. My friend, in essence, was colluding with the state and biomedicine to ensure that the idea that I could become afflicted with salmonella or listeriosis and be blame-worthy for my choices remained in the back of my mind throughout my pregnancy.

At my first appointment with my obstetrics and gynaecology (OBGYN) specialist doctor (at 8 weeks pregnant), I asked, “What do I really, really need to be concerned about in pregnancy?”

Before she could reply I continued, “I intend to *not* live in fear...I am not a risk averse person by nature.” Dr. Thomson was a blond Australian in her mid-thirties who had recently come to the private sector from a public hospital. She paused and reviewed my file before answering. She said, “You exercise 3-4 times a week, drink 1-2 units of alcohol occasionally”. She asked about my diet. I replied “I don’t eat meat but I do eat eggs, dairy, and seafood.” She suggested an iron supplement might be needed at some stage. She then said, “If you kept doing exactly what you were doing before your pregnancy, I would suggest you’ll have a perfectly healthy pregnancy.” I said, “What about sushi...Listeria?” She repeated through a wide smile, “If you kept doing exactly what you were doing before your pregnancy, I would suggest you’ll have a perfectly healthy pregnancy.” I considered my OBGYN’s time spent in Fiji during her medical training and wondered whether this influenced her construct of risk for her patients. I wondered if her awareness of my research topic had influenced how she advised me. And, I noted her statement: “If you kept doing exactly what you were doing before your pregnancy, I would suggest you’ll have a perfectly healthy pregnancy.” seemed carefully structured to avoid any legal issues. Her reality of risk construction and communication for my pregnancy was undoubtedly influenced by the legal liability of doctors in the biomedical industry. To this end, she gave only suggestions and advice I that could accept or reject but not a prescriptive course of action (Farnoff and Turbow 2015, 41-44).

The *What Not to Eat* information is commonly communicated peer to peer, or from state produced literature to maternity patients in a waiting room, or in the literature provided to newly pregnant women by a midwife or doctor. However, few medical professionals verbally discussed this brochure with the women I interviewed, or provided advice in this regard unless the expectant mother made a specific query. For the most part, doctors and midwives, who are often limited by time constraints and bureaucracy, distribute institutionalized messages about dangers to mother and child within state-sponsored literature, as a catch-all, addressing rare and unfortunate situations, imprinting the message of ‘imminent’ jeopardy in the minds of the expectant mothers.

In researching women's responses to the *What Not to Eat* brochure, I also interviewed some Sudanese and South Sudanese women who had immigrated to, and were residing in Australia. The Sudanese and South Sudanese women said that this information *may* have been in the literature midwives gave to them during their pre-natal visits but they were uncertain. None seemed concerned that this had not been clearly presented to them and they did not seem particularly aware of or concerned by the restrictions set out in the messaging. However, for Australian-born women in my study sample knowing the *What Not to Eat* information was a way of being pregnant; the socially-acceptable method and condition of forbearance. They understood the particular risks as a shared value system, and decisions to follow or not follow advice on 'risky' foods were enacted cautiously by these women.

How does this pervasive sense of risk avoidance become a social construct? Beck (1992) offers the theory that industrialized society manufactures risk to make sense of a potential harm and that "perceptions of risk are intimately tied to understandings of what constitutes dangers, threats and hazards and for whom" (Adam and van Loon 2000, 3). In the "Risk Society", Beck poses that risk is not optional, it is enforced and omnipresent and as such it cannot be rejected as risk is part of the fabric of existence in developed society (Beck 1992).

Additionally, Beck states that technology "produces" risk and that risks are the product of industrial society's advances. Even if one were to argue that technology itself does not produce risks, it is the knowledge of risk that technology has enabled. Reproductive technology has added layers of risk by further enabling identification and classification of what is normative and deviant in the body. In addition, technology is embedded hierarchically in the dominant social structure, thereby diffusing and perpetuating the core values of the society through its use (1992). For example, during my pregnancy my weight gain slowed due to gastroenteritis at 31 weeks of



pregnancy. Based on a numerical average of Australian women's 'healthy' weight gain in pregnancy, at 36 weeks I was sent for a specialist scan to ensure my baby was still growing according to a numerical average for foetal development (despite a healthy fundal height - an external measurement of uterine growth). The ultrasound scan allows sonographers and obstetricians to approximate a foetus's weight and then determine a pregnancy's 'risk' because of the ability to create and use normative valuing. The design of the interactions that took place between the technology, the medical practitioners and myself fused together the technocratic model and my belief system so that these became one and the same (Davis-Floyd 2004). I experienced considerable concern about my baby's growth and felt driven to gain weight despite having been told that my baby was "small but near the 12-15th percentile which is not unusual for someone your size" following the scan. This study emphasises how societal consciousness of the now countless potential hazards known through technology 'plant the seed' of risk in the minds of women and fills their discourse.

While modern technology has made air travel common for most people now days, even this can be construed as a risk-taking behaviour for a pregnant woman. An acquaintance, Ella, was pregnant at the time of my research. She described a conversation with her doctor which took place when she was 14-weeks pregnant and planning to travel by air. He advised, "Air travel and exercise will not be possible during the pregnancy due to your advanced age [37 years]." Ella silently and immediately rejected the advice but she reflected further in the days following the consultation, and remained in the "safety" of her home despite the fact that her pre-pregnancy activities of yoga, swimming, and frequent air travel (a condition of her high-paced corporate work) were still quite comfortable for her. "All it takes is [someone] *planting that seed* and then the worry sets in" she said. This example demonstrates how a woman's perception of individual risk (and risk to her baby) takes place in a context of reflexivity; she internalizes the messages following the arousal of fear by someone, peer or medical, claiming expertise (Lupton 2013, 23). A mother can

comply with the precepts of risk or she can act against the precepts but either way, in a 'Risk Society', the experience of pregnancy and childbirth is permeated with concepts of and decisions around risk.

To explore why, in Australia, pregnant women are seen as physiologically more vulnerable than the general population I consider Douglas's views on risk, blame, pollution and taboo. In social rhetoric and amongst the Western women I interviewed it was commonly mentioned that in pregnancy women had "compromised immune systems". While the food itself may not actually constitute a likely danger; the threat of bodily pollution and the risk avoidance ritual that women engage in and discuss is of great importance in order to ensure the mother has understood her responsibility for care of her foetus and her role in ensuring Australia is globally perceived as a 'healthy state'. Women in Australia have become "accountable for many of the ills and misfortunes which affect children that once were considered bad luck or the result of fate" (Lupton 2011, 638). A mother's body, as a symbol of her society, must actively work to ensure purity (safety) of her body and establish clear lines for preventing pollution (risk) thus, delineating Australian norms (Douglas 1966, 140).

Mothers-to-be are also confronted with technology in the form of expected, routine medical testing, as a means of controlling risk. One mother, Juliet, decided not to follow the standard Australian biomedical protocol of having an ultrasound of her foetus at 12-weeks pregnant. "I didn't feel overly concerned and I felt like it was inviting worry". This viewpoint reflected that of women in Liamputtong's study on refusal of pre-natal screening and diagnosis, which terms the experience "the risk of knowing" (Liamputtong 2003, 99). Juliet admitted that my own experience strongly influenced her decision. At my 12-week ultrasound I was told by an obstetrician-sonographer that I had a "46% chance of having a normal child". My foetus had "abnormally" thickened (above 3.5mm) nuchal translucency (a collection of fluid under the skin at the base of the

foetus's neck). I was referred for amniocentesis (drawing of amniotic fluid) or chorionic villus (villi material of the placenta) sampling to assess the "likely" chromosomal abnormalities. Following chorionic villus sampling and a worrying wait of three weeks, I was advised that there were no known chromosomal defects. If this technology was not available, the risk would not have existed.

Juliet's doctor provided her with statistics of risk, which seemed 'higher risk' than with her first pregnancy (nine years prior). "It was a significant jump. I got the feeling she assumed I would even do the genetic testing [not just an ultrasound]. I declined." Juliet thought through her decision process aloud, "If I do a scan, maybe I have to consider tests which I have to wait it out for, which means I have lingering worry in the back of my mind. The chance of it [a negative outcome] happening was less than the likelihood of it inducing worry." Juliet saw "worry", stress and resultant heightened cortisol levels as detrimental to the foetus.

Research by Rayna Rapp (1998) into patients' refusal of prenatal diagnosis through amniocentesis uncovers similar complex social forces and personal meanings in decision-making. The mere existence of and access to this routine reproductive technology pushes women into the role of "moral philosopher" through the act of using or refusing technology. Deciding whether to find out if a foetus has chromosomal abnormalities is a decision made by an individual deeply enmeshed in the influence of social forces. Rapp's work examines reproductive technology and its applications, and analyses how social, cultural and political worlds intersect with women who bear the physiological and decision-making burden (1998).

Juliet's refusal to engage with the revealing technology nonetheless required her to interact with technologically shared notions of risk (1998). "I wanted to see my baby but...it would be enough [reassurance; access for a foetal connection] just to hear the heartbeat." Referring to

genetic testing Juliet said, “I know it [the pregnancy] is right. The timing. I know you have to be aware of coincidence but I am big believer in prayer and deep down, I know this pregnancy is happening how it should. I have a peace about that,” she smiled, satisfied with her internal negotiation of how to engage with risk as a pregnant woman. A sort of empowerment rested within Juliet and this gave her the strength to forego the routine technology of reproduction. I hypothesized this may have come from her personal historical context and her faith. As much as she tried to convince me that she was "too tired" to fight perceptions of how she enacted her pregnancy after a drawn out divorce and still in the midst of a custody battle for her son, it seemed the experience had fortified her resolve in matters important to her. Further, she reiterated how prayer and her religion gave her strength.

Davis-Floyd’s (2003) work describes “technological transcendence” – the hope of surpassing or controlling all that is biological and natural. The 12-week ultrasound examination is often the first step in the technological and bureaucratic routine that the pregnancy and birthing experience can become. Some mothers, like Juliet, pause to question whether there is an imperative to use ultrasound just because the technology exists. I was pregnant at the time of the interviews and discussions with Juliet. I was not then aware of how much I would come to admire her empowerment to resist.

I consented to ultrasounds, repeatedly. Over 40 weeks, I had 16 ultrasounds for what, in the end, was medically termed a “low-risk” pregnancy. Low-risk is an ambiguous term used to mean the opposite of high-risk, that is to say, not showing signs of medical or social risk factors such as diabetes, previous pre-term birth, vaginal birth after a previous caesarean, or substance abuse. As today there is no pregnancy or birth that comes without a risk label, even if it cannot be generally and agreeably defined, Beck’s concept of a Risk Society is well demonstrated. The use of the ultrasound enables biomedical professionals to move women from the low-risk category to the

high-risk category and back again, in accordance with biomedical based calculations and opinions. The use of foetal monitors and ultrasounds allow doctors to treat and attend to technology and readings from the technology rather than the individual mother and her baby. Though I did enjoy the connection I felt I established with my baby through these images, there was an element of the experience in which I was joining the sonographers in pathologising – looking for peril (Molander et. al. 2010; van der Zalm and Byrne 2006).

My analysis of risk is further supported by the critical perspective offered in Foucault's (1991) concept of governmentality, which poses that individuals are influenced and controlled by a range of government systems wherein power and forms of social control are embedded in both visible state systems and within everyday institutions and discourses. Neoliberal governmentality focuses particularly on the ways in which members of society are required to monitor and govern themselves. Rule is diffuse, to the individual level, and control is distributed through everyday practices. Knowledge of risk in pregnancy and childbirth is produced by biomedicine and, indirectly, the modern nation-state through ascribing peril and alluding to what is normative and good for the citizenry (1991). I argue that biomedicine and the neoliberal model of empowerment communicate "risk and self-care regimes" to women (Howes-Mischel 2012, 132). The pregnant and birthing mother is expected to accommodate the current dominant version of risk rather than an embodied experience of health or danger (2012, 123-140).

While Foucault's work offers powerful insight into the surreptitious education that drives individuals to enact and embody the dominant ideology, one must also consider subjective experiences and agency and, in particular, what Kerr (1999) identified as the ways in which people attempt to resist or refuse dominant systems. My focus on the lived-experiences of women and my incorporation of narratives from women who are not part of mainstream Australia helps to balance how neoliberal governmentality can be viewed in the context of this research. In neoliberal

governmentality political reconfigurations are justified because women *are* participants, even if complicit ones, in the reproduction of dominant ideologies and this, in part, is because of the demonstrated consciousness implicit in embodying an understanding (Good 1994, 69-70).

Angelina, a 29-year-old South Sudanese woman in her third pregnancy gave birth to one baby in Africa and her second baby in Australia. My interview with Angelina exemplifies both bio-power through neoliberal governmentality and subjectivity. I asked Angelina if she had wanted to do the tests (such as blood tests or ultrasounds) recommended to her during her pregnancies in Australia. “They [medical practitioners] can predict the sicknesses [of the foetus] with their tests. This is good. But, I didn’t want the swab at 30-36 weeks.” She thought the swabbing of vaginal and rectal tissue in order to detect Group B Strep infection, which is found in approximately 25% of healthy, adult women's vaginas and rectums was too invasive and she was concerned that they were suggesting she might have a sexually transmitted disease. “They told me I need to do it for the baby. I didn’t want to but did it” she said. Angelina reported that she tested negative and as such did not have to receive intravenous antibiotics during the delivery. She concluded “You want to do what makes your people, [your] community proud”. While Angelina was coerced into having this optional test, she had considered she might be able to refuse. In her consciousness of this subjectivity (the desire to refuse an intimate, invasive test) she externalized and marginalized resistance as an option (Marinetti 2007, 49). In self-surveillance, even in a new and different country, Angelina was able to govern herself, in view of her social body (Lock and Hughes 1987, 18-23), according to the aims of the dominant powers (Dean 1999).

The experience, for women in my study, of the ‘Count the Kicks’ campaign, in the context of neoliberal governmentality, highlights how mothers’ and medical practitioners’ practices and discourse around risk are both defined by (and continue to define) the norms of society and the state. The ability of modern medicine to prevent deaths and stillbirths has created a moral

obligation for medical practitioners, in both public and private health systems in Australia, to aggressively sustain a baby's life following a period when the foetus is considered 'viable'. What constitutes viability in itself is contested and value-laden, and claiming viability, sometimes at 22-28 weeks of gestation can have consequences for the foetus such as lifelong disability and severe health problems such as hearing loss, vision problems, developmental delays, and lung and intestinal abnormalities (Allen, Donohue and Dusman 1993, Department of Health – Government of South Australia 2013, Department of Health – Queensland 2014, CDC 2016). Australian non-profit organization Still Aware raises awareness of stillbirth in Australia to ensure every 'viable' foetus survives. They actively encourage the surveillance of foetal movements with the “Count the Kicks” campaign.

The “Count the Kicks” website reads:

A baby's only direct link to the outside world is through its mother. It is best not to wait to report an irregular movement pattern. Listen to your instinct. Contact your carer immediately. Don't wait. Usually your doctor, maternity ward or midwife will monitor your baby's heartbeat or conduct an ultrasound, reassuring you that all is normal and well. In some cases, not feeling a baby moving is the only warning sign that is noticed before a baby is stillborn. (Still Aware, 2016)

The language of embodied knowing - “listen to your instinct” - is used first to confirm the mother's responsibility for listening to and responding to her body and her baby. The language then changes tack to instil fear and a sense of risk by saying “Contact your carer immediately. Don't wait”, thus simultaneously negating embodied knowing by making women dependent on biomedicine to confirm her knowing. The wording reinforces anxieties, putting the obligation on the mother to understand and respond to risk in a timely manner, and at once asserts the mother's knowledge can only be confirmed by someone external to her experience - her medical practitioner and their technological tools.

Some medical practitioners provide mothers “kick charts” and there are mobile applications (for smart phones or similar) for supporting the surveillance effort. The idea of the campaign is that changes in a baby’s movement pattern may identify problems with a pregnancy before the baby’s heart rate is affected or before a stillbirth happens. The American Congress of Obstetricians and Gynecologists (ACOG) recommends timing how long it takes a pregnant woman (from 28 weeks pregnant) to feel 10 kicks, flutters, swishes, or rolls. Ideally, they are asked to feel at least 10 movements within 2 hours and if the mother does not, she is advised to call her medical provider (ACOG 2014).

Philipa described the midwives’ pressure to ‘count kicks’ during her third trimester. She felt “paranoid” and when “the baby slowed movement because of less space to move in the last weeks” she grew particularly anxious. She called the midwives and went to the hospital for foetal monitoring (a belt around the mother’s abdomen with sensors to check the baby’s heart rate and for contractions). “I had it [foetal monitoring] twice in the two weeks before I had her. It was a Friday and I couldn’t feel her. I went in that day and had the monitoring and I had an obstetrician appointment on the Monday and she sent me back on the Tuesday for more monitoring – for a recheck. I was afraid that I would miss something in that last...when she wasn’t moving. Something I should have noted that would require her to come out sooner, or you know that something wasn’t right with her. You’d feel like you should have known.”

Philipa continued, “Toward the last stage, once the baby becomes viable, like once you pass that 26 weeks mark, my OBGYN said to me ‘you need to make sure you feel her moving every few hours and if you haven’t felt *good* movement in a couple of hours you need to put your feet up and have a drink of something sugary like apple juice and make sure she is moving’. To me, that *really* puts responsibility on the mother to be monitoring her foetus and I found that really stressful.”

Philipa was aware, at some level, that she as the mother, was accountable for her own surveillance.



"The silly thing is...I knew there was information on it but if I read the baby should move 12 times in a 24 hours period, I don't want to be bloody counting! I was working off every 2-4 hours that I could feel her move. Their [the baby's] movements change dramatically, every week to two weeks, from a swishing feeling to being like a washing machine...movements become stronger when the baby gets stronger." Philipa continued to describe the physical experience, "then it starts to dissipate because the baby is getting squashed...movements that feel really, really different. So, towards the end they don't move around as much, they are sleeping more, all those sort of things. I contacted the hospital a couple of times to say 'I don't think the baby is moving' everyone told me something different. Someone would say, 'have you felt her move in the last 12 hours? Then it's fine' and then someone else would say 'if you have not felt her move in 2 hours that's not okay' and my cousin is a doctor and she said 'have you felt her move in the last 24 hours?'"

"I think the way litigation is, they [medical practitioners] don't have a lot of choice. They don't want to be responsible. But they also don't want...I am sure there is an average. They pick the lowest common denominator you know [to protect themselves]. And that is sucky. So, in the lead up to getting to the hospital, you feel responsible...even more responsible because you'd feel like *you* missed a cue." For Philipa the healthcare system, non-profit organisations, and medical practitioners created an atmosphere of moral responsibility for the mother to ensure foetal survival. In line with Douglas's view that blame for risky behaviour serves as a means for enforcing dominate ideologies within societies; the ritual of 'kick counting' assimilates and distances the mother from state and biomedical practice diluting the certainty of liability in an era of litigation and scrutiny over medical practitioners' outcomes.

Despite Philipa's awareness and vigilance, the response from medical community was ambiguous and varied. Yet, her perception of risk and practice of risk avoidance measures and rituals were motivated by what is, in Australia, institutionally commonplace. She described feeling

that liability was left with her and that she needed to persist in communicating with the midwives and doctor until she was asked to come into the hospital for checks. This experience, around “Count the Kicks” became a significant memory of pregnancy for Philipa.

I too had an experience of negotiating an understanding of risk and the appropriate response as it relates to foetal movement, a mother’s imbued sense of responsibility, and biomedical affirmation. Having had a severe bout of gastroenteritis while overseas without access to Western medical care during my pregnancy, I consulted with my OBGYN by email asking if there was anything I should look out for/take precautions with in terms of the pregnancy. I reported to her in this email that I felt my baby making her regular movements after breakfast, in late afternoon and around the time I went to bed each night. She replied, “I think if you are in an area where you don't have easy access to a scan/skilled sonographer etc., making sure the baby moves a lot is probably OK. Happy babies kick a lot and sick babies don't. It's very reassuring that your baby is moving well.”

At the time, I took my OBGYN’s reliance on my embodied experience of my baby’s movement as a sign of her respect for a mother’s authoritative knowledge over her body. However, this reassurance was given from her perspective of my *not* having access to a “skilled sonographer”. Indeed, women who do not experience a “sufficient” number of movements were asked to go to a medical facility to have their baby’s heartbeat monitored or to have an ultrasound conducted in order for them to feel confident in their baby’s health as part of “counting the kicks”. One might suggest many women subscribe to the “Count the Kicks” approach, given that when I went to the hospital in labour the midwives were very surprised I had not yet experienced foetal monitoring as many “nervous mothers” come in just to have checks well before labour begins. The moral obligation of risk evasion is placed with the mother but only biomedical practitioners can confirm the test of her capacity to correctly read her body.

My research shows that normative understandings of risk in maternity are a socially constructed endeavour. Using three risk theorists' arguments: Douglas's (1966, 2003) theories around risk, blame, pollution and taboo, Beck's (1992) Risk Society and Foucault's (1991) Governmentality I have examined taken-for-granted, everyday experiences of understanding and negotiating risk in pregnancy. The individual, the state, the ideology of biomedicine, and social reinforcement serve to constitute and reconstitute what risk means. Further, these theories lead us to examine the role of knowledge, power, and blame in pregnancy and birthing and how women who do not abide by normative constructions of risk become "othered".



### **Chapter 3: Biomedicine, Vulnerability and Disempowerment**

The women I interviewed wanted to ensure safety and security in their pregnancies and in birthing for both the baby and themselves, but understanding risk, a politicized idea and potent tool was a complex negotiation. The nuance of risk presents in interactions and discourse between individual mothers and medical professionals during pregnancy and childbirth. Despite people in neo-liberal society understanding themselves as autonomous beings (Foucault 2003, 34), conceptually, danger is the “body of knowledge built around the expert”, which can create “strong asymmetries of knowledge and hence power” (Tansey and O’Riordan 1999, 88). Thus, women’s bodies, in pregnancy and birthing, effectively became an object for intervention under the precepts of the prevailing ideology.

Themes that emerged from pregnancy and childbirth narratives of participants make evident the dominant paradigm of biomedicine, in which socio-cultural and individual processes are reduced to biological ones, in their experiences. Through the strength of Western bio-power to coerce and the neo-liberal Australian government's capacity to “work through freedoms” I demonstrate how the biomedical model acts as the authoritative voice among the women I interviewed and I pose, for women in Australian society generally (Dean 1999, 21). In a critique of biomedicine, I examine Jane’s experience of pregnancy, caesarean, and the air of authority exhibited by her obstetrician. I explore how she and other informants including Molly, Zola and Salwa, disempowered as patients, became complicit in the hegemony of biomedical discourse and practice (Davis-Floyd and Sargent 1997).

Jane was an Australian woman who gave birth in a public hospital with a private doctor in Sydney in 2015. Jane was thirty, a social worker, and had recently had her first child, a son. Jane’s

story was compelling and reminiscent of many I heard discussed in social situations. I came to her home for our interview and I began with the open-ended statement “So, tell me about your experience of pregnancy and childbirth.” Knowing my subject of research in advance, as a peer in my mothers’ group, she addressed the topic of risk with very little prompting or questioning.

“It’s part of my...what’s the right word, cynicism about him [her obstetrician], and if I have any cynicism about it him, it’s about how he kind of hammed it up, to kind of play on insecurities.” Jane paused to ascertain her own knowledge of biomedicine. “I had seen a couple of documentaries, I read a little bit, I read on [internet] forums and I had seen in, like, literature, about the kind of the medical model and how medical professionals might choose particular medical interventions and why they choose these interventions for selfish reasons or not. And...he [her obstetrician] operates in a public hospital but only sees private patients and he *does* provide elective caesareans, which I understand not all obstetricians do.”

Jane was aware that caesarean sections have been frequently performed despite the lack of evidence for necessity and she was conscious of the “medical models” hegemonic status in reproductive care. Despite the World Health Organisation’s statement, “there is no justification for any region to have higher caesarean rates than 10-15%” (WHO 2015) in Australia in 2012, 32.4 % of all births were delivered through caesarean section (AIHW 2014).

Jane seemed to want to justify her obstetrician’s invalidation of her determination of how she would birth her child or substantiate her acceptance of the approach to childbirth she conceded to. “One of my concerns and one of my first questions for him was what his rate of caesareans was...I was a bit concerned he was going to push me into that way of thinking...he told me it was 30%, which I thought was pretty good considering he does elective Caesars. He seemed respectful. However, getting to know him along the process, I do think he had particular personal views about

caesareans and made it clear at times what they were. I think it's more convenient. I am not saying obstetricians do caesareans because they want to be home by dinner but there is an argument to be made for caesareans. Control over how things play out more. At the end of the day he is a surgeon. His job is surgery. I knew that going into it. I was a little bit naïve I think, that having raised the questions he would then accommodate my views more...If he felt like it was needed he would have no hesitation doing everything he could to make me feel like that was the decision that I should make. I am not saying he forced me to have a caesarean, because he didn't... he had ways to make me, push me to sharing his views about that which, was a bit sad I guess."

Jane's beliefs around her own capacity for birthing were saturated with the biomedical paradigm of risk. Her obstetrician engaged her in influential interactions and dialogue in spite of her clearly-voiced wishes for a "natural birth". His authoritative knowledge would be "persuasive" to her because it seemed "reasonable and consensually constructed" (Jordan 1997, 57).

Following an ultrasound, which showed a low-lying placenta previa (a condition in which the placenta was partially blocking the neck of the uterus) Jane returned to her obstetrician. She was approximately 20 weeks pregnant. "He kind of sort of took this approach, like yes well now I am in this basket and this basket is the people who don't know it yet but they are going to have caesareans. That was just a gut feeling. He didn't say that to me, except toward the end he was recommending it to me quite strongly. He confirmed what she [the sonographer] said and used a lot of exaggerated language to kind of, um, get my anxiety a little bit higher." Jane's sense of agency in her pregnancy and in interactions with her practitioner weakened; feeling there was no way for a lay-person to dispute what the technology revealed and obstetrician interpreted and reported (Davis-Floyd and Sargent 1997, 8).

Jane described the interactions with her obstetrician at 36 weeks. “Okay, you’re full term now, you’re not engaged at all’ [the obstetrician said] and I’d be like okay some people don’t engage until the end.” She continued in the voice of the obstetrician, “we can wait and see. If you want my opinion the baby is very big, the placenta is in the way, and that is why he isn’t engaging’ - this is all ad-libbing, I don’t remember exactly. [Again as the doctor] ‘I just want you to understand that if your water breaks, you need to call an ambulance and you need to get here as soon as possible and you need to tell emergency you have a low-lying placenta and you need to tell them you have the risk of cord prolapse because this is like, serious business.’” She felt he had set it up to make her feel as if she would be the cause of the emergency for the baby and he would come and “save the day”. One might also consider the obstetrician’s communications as evidence that if Jane had chosen a path other than the one he prescribed, a scheduled caesarean, the doctor would resent the lack of “control over how things play out”, a distinctive feature of biomedicine.

Jane continued, “The rational side of me knew there was stuff going on there but as soon as someone challenges; and uses their authority and experience to challenge, um, the safety of the pregnancy, you lose all your power. I mean, what are you going to say, ‘Oh no I want - I’d like to - risk my pregnancy!’ . It’s not equal. I knew it was possible to have a birth with a minor previa...but the anxieties as a parent not wanting to make things more complicated for your baby than it had to be. It ultimately overweighs everything. Even though your rational mind...” Jane paused, and then added, “I’d rather not risk it. I am comfortable with the decision. I don’t have regrets. But I am sad I didn’t get to have a...what I consider a natural birth experience.”

Embedded in her obstetrician’s biomedical framework were assumptions that his role was to eliminate risk using the application of all surgical technology, professional experience and scientific education available to him. The doctor's action and words came from a dualistic system that understood her body as a machine, independent of other forces. Jane, the mother had a non-



dualistic, more integrative perspective on birthing. Her wishes for a "natural birth experience" were diminished through doctor-patient relations, which were routine for the obstetrician and unique for the first-time mother. Jane was able to identify the power dynamics at play on reflection but at the time, she became compliant in virtue of not wanting to endanger her baby. The power relationship, enacted through risk discourse between an experienced, technology-enabled medical practitioner and Jane, was just a part of "the way things are" (Jordan 1997, 56). Jordan (1997) noted that anything but mainstream biomedical practice is delegitimized by the social processes and as such, the mainstream is the social order in which women are embedded (1997, 57-58).

Jane gave birth to her son via a scheduled caesarean section. When asked if she would return to that obstetrician for future pregnancies and births Jane replied, "I don't think so...when it came down to it, he was amazing with the caesarean. I don't think he understood my needs the whole way through the process. Or, he might have understood them but he didn't agree with them. That's hard when you aren't on the same path." She lauded his technical skill as a surgeon but understood that surgical skill alone does not make a good doctor. However, as with the women in Sargent and Stark's (1987) research into interpretations of caesarean delivery; Jane saw the most important outcome as having a healthy baby, not the delivery process. Jane's obstetrician's ascription to the "myth of calculability" – the wish of technocrats and scientists for the elimination of uncertainty through defining, preventing and managing risk – had cost Jane what she really desired before the birth but became a reasoned trade-off (Lupton 2013, 7).

Jane wasn't the only woman I interviewed who had been made passive through a complex, hierarchical system rooted in mind-body dualism as a maternity patient. The Australian approach to biomedical practice around pregnancy and birthing has shifted from overt dominance over women's bodies to symbolic acts of violence through persuasion and coercion (Napier et. al. 2014, 19). Today, compliance is attained through the subtext of healthcare consultation, which can reproduce

gender and ethnic stereotypes (Hedegaard 2014), but I argue little has changed since Molly gave birth to her first child in rural Victoria in 1980.

We sat by the fire in Molly's sitting room off the large kitchen. She set aside her knitting as we had cups of tea. Molly began by disclosing, "I was quite passive. I didn't know how to be empowered. I don't like saying that about myself but I tended to just trust the people who were supposed to take care of me in that process." I sensed lingering sadness from Molly but it was in relation to how she had come to understand pregnancy and childbirth in the decades following her own experiences. In rural Australia, the paradigm shift from the scopolamine era of medicating women to detach them from the birthing process back to childbirth without intervention and the choices in between had not taken hold in 1980. Molly described an environment in which medical practitioners established legitimate authority and women willingly delegated the responsibility of birthing to them.

I asked Molly to try to recall her feelings at the time about risk or danger. She described her pregnancy as feeling "safe in myself. Not what was happening out there [with the medical community or socially] but with what was happening in there," Molly said pointing to her body, then resting her hand on her stomach. She described an "innate belief", "an instinct" through "connection with that baby" in pregnancy. With great joy Molly described how she loved being pregnant then returned to her thoughts on birthing. "You want to believe everything is okay. Because then [if it is not okay] what do I do?" she asked. With a tone of annoyance, she added, "When you are dealing with steely-faced men without compassion."

Molly recalled her second pregnancy (she had initially miscarried at 11 weeks pregnant) and her first birth. "There were no ultrasounds. No blood tests. Urine tests though, every visit. Once a month initially until about 30 plus weeks. I was relatively youngish. It was fairly standard.

Routine. Then, I ended up in an emergency situation and it really had not been discussed. That was really awful. It all went pear-shaped, big time.” Molly recalled her labour and delivery. “I don’t know much about him [the doctor]. Perhaps that is a reflection on myself.” Molly attributed her own lack of knowledge, proximate to the knowledge women have access to in the present day, as a root cause for her negative experience of labour and delivery.

“I was driven to the hospital I was booked into. On the Monday [the first day of labour] the doctor came a couple of times. On the Tuesday I was progressing but the baby was face up. I was having pethidine and so much gas, I couldn’t talk. They [medical practitioners] left me alone.... they were watching tv or something. There was no consultation.” Molly was transferred from the rural Victorian public hospital to a Catholic hospital in Melbourne by ambulance. “I don’t even know if they tried to turn him [the baby]. I was introduced to a specialist who I had never met before. The conversation started around caesarean. He [the baby] was born early Wednesday morning. My first memory was waking up, hearing what [sex of the baby] I had, then throwing up. Morphine. I was on the ceiling looking down. It was horrible from a mental and health perspective.” Molly continued, “I didn’t know I had choices. They [medical practitioners] just let nature take its course. I didn’t feel like it was about me at all.”

Molly placed her trust with medical professionals whose risk calculations were not transparent and not personalised. Molly described feeling that she was not in a position to ask for more attention or care as it was her first time in such circumstances. She assumed their inattention to be routine. The biomedical approach claimed authority and detached Molly from her embodied experience. As such, birth happened around her. Her experience of pregnancy, in which she felt intuitively “safe in myself” had turned into everything “happening out there”.

Molly's second child was born in Perth and the same model of care continued. She laughed aloud as she described how mortified she was when the doctor "walked in with gumboots on. A white PVC apron! I am a visual person so the impact was just dreadful! For my last two [children] the doctors came in fully masked. It was awful not to see who he was. I don't think I knew the doctors' names. I felt like a bit of a number, a sausage factory." The technocracy of biomedicine was exhibited through the uniform of the obstetrician. Molly assumed he was dressed that way because of the complications of her first birth. The visual suggested that her body was the source of dysfunction, likely to become 'messy' and that the only person able to exert control in that situation was a doctor who also had to be protected from the disorder of birth. Despite the uncertainty exhibited by the obstetrician and felt by Molly she was proud to report that she had two vaginal births after a caesarean.

When asked about who was responsible for birth experiences and positive or negative outcomes for the mother and baby she paused and asked "what do you mean?" I suggested, "Who is at fault if something goes wrong?" She replied, "Fault...hmm? I don't think there is a 'fault'. There are circumstances. As a mother, in labour, do you trust the people looking after you? You [the mother] have to have ownership." She saw herself as embracing feminist values and she saw her doctors as products of a patriarchal, hegemonic medical system but even after more than 30 years of reflection she ascribed responsibility to herself.

Molly internalized the burden of blame for her choices, or for "making no choice at all" (Denham 2012, 185). Like Denham's (2012) research on biomedical trajectories of blame, my research demonstrates a similar neoliberal process wherein explanations for material risk and the attribution of responsibility or blame are located with the individual mother.

In recent years, women have greater access to information and can experience “information overload” regarding unfortunate outcomes in maternity care (Loxton et al, 2013). As a consequence, women are deemed responsible for behaviours “performed or avoided” to reduce risk to mother and child (Denham 2012, 185). Molly saw her experience through the lens of the present day and blamed herself for not being empowered like the women “nowadays”.

Research on the role of men in the pregnancy and birth process has grown over recent years but remains limited (Reed 2005). Molly discussed the role that the father of her children [her then husband] played in the births. “I don’t think he knew what was going on at all” she said illustrating the need for men to be a part of the birthing conversation, if needed, so they can make informed decisions aligned with the wishes of the mother. Molly considered that the father must have been the one giving the doctors consent for interventions but she was uncertain if that was the case. I suggested to her that doctors, nurses, and her husband were all external factors impacting on her birth experience and I asked what that would have meant to her if something unfortunate had happened to her son in that process. She shifted her views and in slight contradiction to her previous claim of responsibility, she said, “I don’t think fault is as cut and dry as that.” Molly momentarily broadened her perspective to consider how others could be subject to blame. “It’s just one of those things,” she said before turning the lens back on herself, diminishing the responsibility placed on her husband or the medical practitioners.

Similarly, I spoke with Zola about her sense of risk, danger and empowerment as a pregnant and birthing mother. I visited Zola several times at her place of work during my research. Zola came to Australia from Sudan on a spouse visa nine years prior when she married her husband who was already resident in Canberra. He had come as an asylum seeker who had previously been imprisoned for his activism. Zola had earned a masters degree and was employed at the local government level helping to settle and support migrants.

I asked Zola who is responsible when something bad happens to a baby before it is born. To further clarify, I suggested deformities, disabilities, or when a baby is born with Down Syndrome. She thought on her own pregnancy and said, “[If that had occurred] I didn’t blame self. I couldn’t. No guides, no support, or sharing information with other women.” She clarified that she would have been unable to access the information necessary to ensure a safe pregnancy in Australia. She felt alone in her pregnancy as a new immigrant with limited language skills. “Maybe my English not enough.” Zola expressed feeling “guilty” that other women immigrants also have this experience. Zola said she tries to share information with other women for easing integration (housing, medical, etc.) so they “don’t have to come up with the right questions” and in order that they have someone to speak to about their concerns. Zola saw the Australian government as lacking in their support to her and other immigrant women and if a woman could not obtain information on how to “respect the rules of the Australians,” she would feel badly but the Australian Government would be accountable for not helping her. “I don’t know anything [in Australia]. In Sudan, I know everything.” Zola’s focus on the institutional problem of minimal immigrant support in Australia and cultural recognition and safety were pervasive in our conversations.

“The women from Sudan here in Australia get not enough information on how to protect the baby [in the womb].” Zola understood there to be local realities for ensuring safety in pregnancy and childbirth. The biomedical paradigm however has been criticised for assuming itself free from cultural distinction (Mishler 1981). Therefore, Zola’s medical practitioners were unlikely to see the unfamiliar Australian ways as nuanced responses to an Australian situation. Zola felt she should have been shown these local interpretations. With this information, she could negotiate how to practice risk aversion. “For women that come on the 100 Partner Visa it is especially hard. The migrants have it not as easy as the refugees for coming to Australia. Migrants don’t receive support

and information. This means the mother is then responsible for her miscarriage because she was unable to get the information she needed to keep the baby safe. Every mother wants the best care for her baby. But here we don't know options." As a result of her work at the community level and her role as an activist, Zola often spoke for other immigrant women, not just to her own experience. And her voice did indeed represent the South Sudanese and the majority of Sudanese women I interviewed in that institutional entities would be culpable for unfortunate events in maternity for mother or child; either as a result of their failure to convey the information to the mothers or as a result of direct practice or inattention. Despite having said this much, Zola felt it was her responsibility to "ask the right questions" and to have good enough language skills to access the information held by the state on medical practices ensuring healthy mothers and babies.

A couple of the women I interviewed, like Salwa, distributed accountability for maternity care between herself, the medical practitioners, and the institutional lack of support for immigrants. To avoid risks, Salwa reported "I did whatever they [medical practitioners at the hospital in Australia] told me to do". Salwa migrated to Australia from Sudan on a spouse visa, like Zola, and described not knowing what she ought to do, but felt obliged to follow the "rules" that she could interpret. Her first baby was born premature in a hospital in Egypt. She felt very guilty for the child's premature birth and aimed to bring her second baby to full-term by following the advice of the medical practitioners in Australia.

Salwa spoke of having had a double medio-lateral episiotomy (two surgical cuts of the perineum from the vaginal opening on an angle toward the anus). She did not recall being consulted or giving consent to the intervention during the birth of her second child. "After, they [medical practitioners] said it was because I had the procedure...do you know the procedure girls have done in Sudan?" I nodded and replied, "I think we call this female circumcision here. Is this what you mean?" She nodded and continued, "Mine was only a small procedure. Because it's not

like in the old days, mine was very small and I had already had one baby in Egypt. I don't know how this [female circumcision] could have done something that they need to do this [double medialateral episiotomy]". Without having been consulted, Salwa could not have known what the perceived risk was which served as the impetus for an episiotomy. Research tells us that the use of interventions like episiotomy to accelerate or augment birthing (i.e. where the perineum is responsible for impeding labour progression) when medically unnecessary, is more dependent on the provider, hospital type and even time of day. There is also considerable variability in the rates of use of episiotomy by country, which demonstrates that the physiological need for such intervention has little to do with the woman's individual body and circumstances (Lappen and Gossett 2010; Weber and Meyn 2002).

Salwa described the "horrible" weeks following this birth during which a knot was tied in the stitches over a nerve ending at the site of her episiotomy causing considerable pain. When she reported this to the midwives they checked "down there" and denied there was any cause for this pain. Salwa's mother was visiting in Canberra from Sudan at the time to provide her support. Salwa returned home from the postpartum check and cried to her mother of her pain and their denial of a cause for her pain. She showed her mother "down there" and "my mother wept, 'My child, what have they done to you' and I wept too."

Kitzinger (1997) wrote on the "authoritative touch" in pregnancy and childbirth as a form of under-acknowledged communication between medical practitioners and women. Through physical interactions, such as vaginal examinations and episiotomies, messages of disempowerment are sometimes conveyed which result in women feeling as Salwa felt: "violated" (Kitzinger 1997, 209-232). Salwa's narrative is not uncommon. A recent Queensland study on the extent women report being informed and involved in decisions about pregnancy and birth procedures



demonstrated that “26% of the women who experienced episiotomy reported being neither informed nor consulted” (Thompson and Mille 2014, 6).

Salwa could not understand whether risk was a factor and if it was the reason for episiotomy. She regretted her acquiescence but didn't believe she could have asked more questions or asserted herself at the time as she was unsure who, in Australia, was responsible for decision-making around risks if present and how these risks would be managed. In order to have a healthy baby, Salwa was prepared to follow all of the “rules” of the Australian biomedical system. Her first baby being born premature caused her great worry and the second birth resulted in the violation of her bodily integrity. Salwa was ultimately embittered to the experience of birth. “If I were to do it again, I would ask medical practitioners to explain things to me better. I would be more confident. If I had a third, but I won't. I wouldn't go to that hospital again” she concluded.

Jane, Molly, Zola and Salwa - women from across a range of cultures and ages - understood themselves to have particular vulnerability to dangers in birthing. This socially constituted sense of susceptibility enabled medical practitioners to exert power over these women in the birthing process. The experience of these women makes evident that risk in pregnancy and childbirth is a politicized and potent means, conveyed through physical interactions and discourse, to ensure women's complicity in a dominant biomedical ideology for birthing. I postulate that the mothers, as independent agents, are subject to blame built on this ideology, which influences perceptions of risk which can disempower women.

In the next chapter, I delve deeper into dominant risk ideologies, uncovering systems of values, which are reinforced by women (again, often through complicity) and influence women's identities as good Australian mothers. The women in my study who did not conform experienced stigmatization as mothers in a social process termed “othering”.



## Chapter 4: Maternity Risk and “Othering”

The women I interviewed who were living in Australia and had come from Sudan and South Sudan shared experiences of being subjected to subversive “othering”, discrimination and outright racism. While none of the informants spoke of *how* to become an Australian in discussing their fears about pregnancy and childbirth, from their stories emerged experiences of acquiescence to perceptions of biomedical risk and a discourse of risk avoidance that, for some was enacted, and for others not practiced but understood. There was an underlying knowing amongst these women that risk avoidance is a “moral enterprise” and that “those people who fail to engage in such behaviours may thus often find themselves stigmatized and subject to moral judgments” (Lupton 1999, 15). Some informants’ experiences indicated that they challenged biomedical precepts of risk in belief and practice, but those experiences left them feeling segregated and outside the mainstream. Furthermore, amongst my research participants, women who did not conform to conventional beliefs and practices of the Australian biomedical community sensed a lack of respect, or an insensitivity to their non-mainstream knowledge systems. For the women from Sudan and South Sudan, this indifference toward their forms of knowledge exacerbated the experience of being ‘other’ in Australia by the delegitimizing of their perceptions.

In Australia, as every pregnant woman is categorized as either low-risk or high-risk: there is no ‘risk-free’ pregnancy. How women discuss, interpret and carry out their pregnancies and births is relative to risk as constructed at a particular time and in a particular place (Harkness and Super, 1996). As I conducted my research throughout my pregnancy, I became aware that participating in risk discourse and risk avoidance practice was central to being perceived as a good mother. In my experience, every decision a pregnant woman makes is enacted under the surveillance of friends, family, the medical community, and even strangers ready to offer advice and correction. To ‘do’ pregnancy and birth ‘correctly’ is both an internal and external negotiation of risk. The dominant

discourse and practice legitimizes a mainstream understanding of, and adherence to risk, and invalidates the experiences of ‘others’ who do not comply. Those women who do not adhere to or agree with the taken-for-granted understandings of risk in pregnancy and childbirth, as established by the central social group, may feel excluded and disempowered in their experiences of maternity. This feeling is especially powerful for immigrants who believe this invalidation of their knowledge occurs because they are outsiders or because they are not part of the Australia that is of European-ancestry (Grove and Zwi 2005).

Toona, a Sudanese woman residing with her family in Canberra, was able to navigate the complexities of the health system and respond according to its concepts of “risk”, while framing the new knowledge and unfamiliar practices in orientation with her mother’s and Sudanese peers’ knowledge and, importantly for her, God’s will. As I arrived for our interview, I could see Toona placing a covering over her long hair through the sheer curtain over the window beside the front door. When the door opened, there stood a beautiful woman in her late twenties, wearing an elegant ankle length dress with matching hijab, offering a welcoming smile. Toona asked if I minded whether she breastfed her son, and I encouraged her to continue. We chatted as new friends. We discussed babies, studies, life in Canberra and our families. Toona was enrolled at an Australian university and her husband worked as a career interpreter of Arabic at one of the nearby embassies. During our interviews, Toona was on a leave of absence from her Masters studies in systems engineering to care for her baby. We paused our talking when her mother entered the room. “She is sorry, she doesn’t speak English,” Toona said, speaking for her mother. I offered that Toona could translate my greeting and that would be fine. Her mother gently placed both her hands on my right hand and cupped it while slightly bowing her head and then gently slid her hands away. “She is here for three months. She has come from Sudan each time I have baby” Toona explained. Her mother collected the newborn son in the folds of her ‘tobe’, a transparent fabric wrapping over her

long dress, and returned to the kitchen where she was feeding one of Toona's other sons. Toona had three sons under four years of age but she was full of energy each time we met to talk.

When asked about her fears in childbirth, Toona replied, "Who would help me and afterwards? I tell my friends in Sudan, 'you are lucky' [because they attend the births of their sisters and friends and care for each other after]. But then I get the right information [in Australia] and I have the healthy babies. They are not lucky." Toona saw Australia as "modern" and the public medical system in Australia as something women should value wholeheartedly.

Maternal and infant mortality rates in Sudan are far greater than those in Australia. World Bank data shows that in South Sudan the infant mortality rate is 60 per 1,000 live births and in Sudan, 48 per 1,000 live births. In South Sudan the maternal mortality rate is 718 and in Sudan 311 per 100,000 live births (the ratio is based on the number of women who die from pregnancy-related causes while pregnant or within 42 days of pregnancy termination). In comparison, World Bank data shows that for 2011–2015 the infant mortality rate in Australia was three per 1,000 live births (World Bank 2016). The Australian Institute for Health and Welfare website shows that in 2008–2012, there were 105 maternal deaths in Australia that occurred within 42 days of the end of pregnancy, representing a maternal mortality ratio of 7.1 deaths per 100,000 women who gave birth (Humphrey et. al. 2015).

Toona was convinced that the positive, healthy outcomes for her babies were an acceptable trade-off resultant from giving birth in Australia. She would not have the benefit of women caring for her for the 40 days of confinement following the birth typical in Sudan. Neither would she have the porridge traditionally served to women in the customary confinement following birth. Her mother would have to fly a great distance to be at her side, and then only after the delivery of her children. Toona described to me the birth of her first child, a vacuum-assisted delivery in a public

hospital in Canberra. “[The] Midwife says anything has risks but we do what we must. Then they did the cut [episiotomy]. They did not do anything without asking. They do their best to help you,” she said with confidence. “God functionalizes the doctor to help you. However, if the baby got sick, you accept. If not Australia maybe [the medical practitioners] intend the wrong thing for you but not in Australia. Having babies is from God – something natural so don’t worry. Just go to the right hospital”. Toona’s faith was melded with the medical practices she experienced. She was able to frame biomedicine as an act of God – an act with results best achieved in Australia. Toona did not give the same authority and credence to the hospitals in Sudan, staffed by doctors and nurses who deliver babies regularly, as she did to those in Australia.

Toona expressed, “I know a Sudanese woman doctor. She sees me recover and asks [me] how it works.” Toona mimicked the doctor’s surprise and then added, “She is a doctor and she doesn’t know!”. The female doctor from Sudan was further evidence for Toona that the Australian way is the *best* way. Toona described the quick post-partum recovery of her perineum and pelvic floor, by following the advice of Canberra midwives and a physiotherapist. They had instructed her on healing and training her pelvic floor after the birth and she diligently completed her exercises. She saw the Sudanese – even a highly-educated female doctor – as uninformed compared to her Australian counterparts. Toona gave more examples to emphasize this point. “[The] Midwives tell me to walk, when I visited after 12 weeks [of being pregnant]. They say walk from first day.” ““You haven’t start yet?”” she said imitating the midwife’s voice. They fear in Sudan they miscarry walking too much in first months but I ask the midwives here, they say if your body is fine, you start walking...Sudanese women are not following the exercise recommendations.” She looked at me and questioned “Maybe they do not realize the importance. The benefit?”. Toona described being given all the information she could need by the midwives, yet appeared conflicted in her own understanding of why Sudanese women in Canberra would not have, or use, the information she felt so important to her pregnancies and childbirths.

For Toona, receiving biomedical obstetric care was closely associated with being modern (Fordyce and Maraesa 2012, 6). She had lived in Australia a short time, just over four years, much of which time was spent pregnant, birthing and raising young babies. Her exposure to the Australian way of life was, in great part, tied to and shaped by the Australian state biomedical system. Her access to the hospital, midwives, and biomedical care was central to her enculturation as an Australian. Her recollection of the Sudanese ways of being pregnant and giving birth were not forgotten. However, Toona's beliefs and practices from Sudan were replaced with biomedical perspectives and methods of achieving healthy outcomes, which resonated with forging a new Australian cultural citizenship and friendships. She eagerly joined a walking group organized for pregnant women through the child health centre and devotedly attended her local new baby clinics for infant weigh-ins. "All the Australian women that I met, they know how to follow, I mean the right way for them and the baby. All of them they know this information from the hospital." Her desire to be seen as a modern Australian citizen practicing Australian notions of being a good mother required a risk-averse disposition. She desired having the same information and following the same path through maternity. She agreed to the biomedical strategies for minimizing risk, (episiotomy and vacuum assisted delivery) which endeared her to midwives and doctors, and them to her. Tacit but influential, the underlying morals and practices of age-group peers and the biomedical system in Australia were successfully guiding Toona, an uncommonly active participant, in how to be a good mother and a good citizen in her new country.

For the participants in my research, knowing what a risk is, how to discuss it, how to manage it, and how to avoid it is a generative process - one that is defined by and defines what people perceive to be objective phenomena. Culture also plays an important contextual role in the construction of risk. Lupton acknowledges that people located in different contexts often present "competing logics" and different meanings when confronting a risk (Lupton 1999, 40). In the case

of Sudanese and South Sudanese informants in Australia, “risk” is understood through layers of iterations – traditional knowledge, embodied experience, national health systems, and peers. Each woman must construct (or deconstruct) precepts of risk in order to make decisions for their maternity care and to place themselves within, or outside, the dominant group.

The Australian (Western) response to uncertainty has been to adhere to the biomedical model - systemizing and quantifying the management and mitigation of risk in an effort to construct a sense of control over the uncontrollable or the unknowable (Lock and Hughes 1987). In an attempt to control the experience of pregnancy and childbirth, women use statistics and ritual responses (patterned, repeated, symbolic enactment of a belief or value designed to align the belief system of an individual with that of society) to those statistics to construct a sense of security in their pregnancies and in childbirth (Davis-Floyd 2013). In numerical terms, the likelihood of infant mortality and/or maternal mortality in Australia (compared with other nations including South Sudan and Sudan) is particularly low. However, there is still uncertainty, and as a consequence, there is a customary response that serves as a foundation for a shared way of understanding risk and a shared way of enacting pregnancy and childbirth (Davis-Floyd 2001).

The experience of avoiding risk is as social as it is personal for women like Juliet. Juliet wanted to ensure her baby’s life and health but she also aimed to ensure that her public practice of pregnancy would be a demonstration of not taking a risk “no matter how small”. “*The Panic Free Pregnancy* book says it’s okay to dye your hair but I haven’t covered the greys yet. I wouldn’t have a problem doing it but I feel better not doing it. I don’t *need* to” Juliet said. I wondered why she felt she ought not to when the book she referenced said it’s okay. She recalled tabloid magazines commending the Duchess of Cambridge [Kate Middleton] for letting her grey hair show during her pregnancies because “you’re not *supposed* to dye your hair when pregnant”. I asked Juliet, “Do you think you not dying your hair provides the baby protection?” She thought carefully about her



response. I added, “Unconsciously?” She replied, “It comes from our culture! There are things I logically know, the chance of them causing harm is not realistic but because ‘Grandma’ [said with fingers making quote signs] says maybe you shouldn’t, I still don’t. I am just too tired, too tired to fight perceptions.” There were a number of elements, or “experts” Juliet considered when choosing how to discuss risk and enact risk aversion behaviours. *The Panic Free Pregnancy: An OB-GYN Separates Fact from Fiction on Food, Exercise, Travel, Pets, Coffee, Medications, and Concerns You Have When You Are Expecting* book, is described as a science-based book. “Grandma” might be representative of ‘old wives’ tales’ while the tabloid magazines make evident the role the media plays in conjuring perceived dangers. And, Juliet didn’t want to “fight perceptions” of doing ‘wrong’ amongst her peers. Even decision making around hair dying became a complex internal negotiation set against various external mediums communicating messages of risk. At the end of one interview Juliet said, “I can see the contradictions in my answers. The ideas are pervasive but not medically accurate...it’s interesting.”

Similarly, yet distinctly different in outcome, Grace, originally from South Sudan, wanted to have what she termed a “natural” childbirth. The medical practitioners were concerned with her symptoms associated with pre-eclampsia. Grace described that she went, “by instinct, how I feel. And instinct was telling me everything is fine. It was very stressful because the hospital said ‘no’ to allowing a natural birth. They try to convince you the baby will die. We had to be really strong with them to refuse. They monitored me for four days and always talked about caesarean. The male doctor said he declared he was not responsible for what happens to me or baby. Then comes an Indian woman doctor and I felt supported.” The female doctor agreed to watch Grace’s condition and kept her in hospital for observation for two weeks before Grace was able to have a natural (non-induced) start of her labour and vaginal delivery of a healthy baby girl. Grace recognized the safety aspects of giving birth in an Australian hospital yet she also resisted the

hospital's construction of risk and their efforts to impose their notion of risk to shape her birthing practices.

Both the male doctor and Grace had concerns about how her birthing experience would transpire. He used language of responsibility and blame to demonstrate his perceptions of danger for her and the baby in the birth. Having only interviewed mothers and not their doctors or midwives during this research, one can imagine that Grace's doctor's attitude towards her may have, in part, been influenced by the dramatic increase in lawsuits related to obstetric care in Western countries (Kraus 2003; Farnoff and Turbow 2015). He placed accountability for risk taking with the mother, thus ensuring that if anything unfortunate occurred, it would have happened because Grace was not doing *everything* required, according to biomedicine, to protect herself and her baby. Watching and waiting to see if intervention would be necessary was not an option for a doctor who practiced "cautious medicine" (Douglas 2003, 14). Within the constructs of normative medicine Grace would be blame-worthy for bringing her "other" understandings of her body and birthing into a technocratic process. Grace and her partner David believed this marginalisation of her knowledge was more prominent because of their country of origin and skin colour. Having publicly asserted her own agency and rejected the routine clinical practice for pre-eclampsia, it was implied that Grace was not acting as a 'good mother' (Davis-Floyd 2001). In going against the doctor's requests, the patient assumed the role of authority over her body and the birth, and the practitioner took a stance that would allow him to avoid litigation in the event of an unfortunate circumstance related to the care of the patient.

Grace recognized that her condition created greater risk of danger to herself and her baby but she viewed the situation very differently than the doctor. "At home [in South Sudan] we use encouragement and this works. We don't believe in this C-section unless you are doing this to save the mother. It [giving birth] is hard but they do it. We perform things to make the baby come – we

have our own ways and own knowledge.” She continued to describe why the male doctor’s approach felt as if her wishes were not being respected. “I had been praying. People need a chance to try. They [medical practitioners] need to keep you happy but they make you more stressed.” Grace saw the doctor as culpable if something unfortunate were to happen due to the tension she felt from his lack of support, and so inhibiting her healthy progress, or “opening”, in birthing. Thus, despite his best efforts to use his authority to discredit Grace's cultural knowing, the obstetrician made himself, in her eyes, even more blameworthy for complications in birthing.

To examine why even normal, “low-risk” pregnancies and childbirths in Australia give the impression of being fraught with danger, one must consider not just the likelihood of a dialectical relationship between perpetuating anxieties around reproductive risk and the protection of women and the foetus but also a relationship between the ritual acts of risk avoidance and the reinforcement of good mothering behaviours sanctioned and expected by the dominant social group.

The Australian women in my study felt that through socialization they came to share in the belief that ritual acts, like placing a baby in a cot on its back would prevent infant morbidity and mortality. In 1986 in Australia, death rates for infants and children were at 8.8 per 1,000 live births. Today these rates are less than half that; however, such statistics tell more than one story (AIHW 2016). The outcome is not entirely attributable to safe sleeping campaigns. For example, improved vaccination rates and a reduction in transport related deaths played a significant role (ABS 2006 and AIHW 2016). However, the action undertaken by following ‘safe sleeping’ guidelines imbues one with a sense of individual agency against uncertainty and having an infant mortality reduction success story to tell the public as a result may actually have come at the cost of arousing fears within women and the public alike, who demand an ethical behaviour, demonstrated through ritual acts (Malinowski 1963). The dominant culture perpetuates a dogma of causal connection in addressing a problem of infant and maternal morbidity and mortality by moralizing the rhetoric and

practice of pregnancy and childbirth, and this continues into early child rearing. SIDS and Kids, an Australian-based non-profit organization's website describes uncertainty in the cause of SIDS (Sudden Infant Death Syndrome) but states "the campaign has reduced the incidence of Sudden Unexpected Death in Infancy by 80% saving 8,959 babies' lives" (SIDS and Kids 2016). SIDS and Kids deduces that the reduction "in the number of babies dying of SIDS has come about because parents have been made aware of ways to sleep baby safely" (2016). The website goes on to note "vigilance" on the part of parents and the community "is still required" (2016).

This pervasive feeling of worry, and the need to actively demonstrate that worry by appearing restlessly responsive to pregnancy and childbirth is a part of the construction of a good mother and good Australian as taken-for-granted by those within the context of the dominant culture (Theodorou and Spyrou 2013). Salwa described herself as someone on the outside looking in: "Australians are so cautious... It's like pregnant Australians have OCD. They are so afraid" she sighed. While Salwa described having had difficult pregnancies and nausea throughout, she did not have the social expectation, within the Sudanese community, of turning pregnancy into a danger as a socially negotiated reality. In considering her historical factors and place of origin, Salwa explained, "It made me angry that at home [in Sudan] people don't even know the basics and are dying, and here people are so excessive [in the care of their pregnancies]."

Beginning with frequent discussions amongst age-group peers, followed by pre-natal courses at the hospital before giving birth, to postpartum reinforcement of "correct" care and behaviours in the hospital and in our own homes, the social institution constructed a 'reality' of danger in regard to infants' sleep. During a pre-natal class at the private hospital where I gave birth to my daughter, mothers and their partners in attendance were told that if the hospital staff found mothers sleeping with their babies in their beds it would be "noted" as a high-risk behaviour that would be "flagged" for the after-care midwives who do home visits (a service provided by the

state). I approached the midwife after the class and asked, “What happens if your behaviour is ‘flagged’?” The midwife replied that midwives will “check on the safety of the sleeping situation for the baby after returning home”. It seemed innocuous enough but as a mother who would soon bring home a baby I did not want to tempt the possibility of social services coming to my home and did not ask further questions.

Salwa had experienced exactly this; she mimicked the midwife’s excited tone, “Put the baby in a crib!” Salwa continued, “It made me feel like an idiot and I didn’t know if I should trust myself, what I already knew.” This was her second baby and she had slept with her first baby, who was born premature, as soon as she could, in the hospital in Egypt. From what she knew and wanted, “The baby sleeps next to the mom. But they [midwives] say this is not healthy and it scares people.” Salwa said that her fear of having a second premature baby led her to follow all medical advice in Australia without question. “I didn’t know if I should trust myself, what I already knew. But it [the rebuke] scares people.”

Co-sleeping (also known as bed sharing) became a controversial subject in industrialized countries during the last century, despite research outcomes on the safety of co-sleeping being essentially inconclusive (Thoman 2006). SIDS and Kids issues a brochure which is endorsed by the Australian Paediatrics & Child Health Division of the The Royal Australasian College of Physicians (RACP) and the Australian College of Midwives (ACM). The brochure instructs parents to “sleep baby in their own safe sleeping space” because sharing a sleep surface with a baby increases the risk “in some circumstances” (SIDS and Kids 2016). There is an insidious fear that parents will accidentally smother babies and some suggest SIDS is more likely in bed-sharing arrangements. In a clinical review, Thoman, a behavioural scientist from the University of Connecticut illustrated the need for further research and evidence on bed sharing from areas as diverse as epidemiology, physiology, and anthropology (2006). Indeed, McKenna (1986, 1990, 2005) an anthropologist, is

proponent of co-sleeping, given appropriate conditions such as the co-sleeping parents not using alcohol or drugs before bed, etc. McKenna, who is also a media commentator on baby and parent sleeping arrangements, cites numerous emotional and biological reasons, including babies achieving better sleep, parents' breathing regulating babies' respiration - acting as an aid to ensure that babies do not stop breathing, and ease in breastfeeding which reduces illness in infants, as breastfeeding provides greater immunological benefits (2005).

While I did not bring my baby to bed with me in hospital, I did on numerous other occasions until she reached 14 weeks of age, when she was more easily settled in her own bed. Despite the Australian Government's warnings, I cautiously rationalized, based on academic literature (Glaskin and Chenall 2012, 1-19 and McKenna 1986, 1990, 2005), that I was making a safe choice. In response to the degree of surveillance the Australian health care system committed to co-sleeping and the categorization of the activity as 'high risk', I as the mother, would be seen as an "autonomous decision-making unit" liable for the outcome (Rapp 1999, 58). Indeed, I had a greater fear of the social, state, and medical community repercussions than I did about the actual act of bed-sharing. The rhetoric used by the RACP and ACM created a pervasive feeling of stress about the act of co-sleeping without offering grounding for creating safe spaces and lacked concern for, or acknowledgement of the potential advantages to the baby.

I followed the '*safe* co-sleeping rules' as elaborated in McKenna's research (2005). I made certain to have the baby in the centre of the bed with no blankets or pillows near her face. I made certain that my husband was aware she was in bed with us and that neither of us had alcohol before bed or went to bed too tired to wake easily. I was still apprehensive about co-sleeping, and I did not admit to co-sleeping with my baby for fear of judgement by my peers, since they had expressed complacency with the state and biomedical system's stringent guidelines. When I finally confessed, I recited data from academic journals to defend my actions. I added "surely more than half the

world co-sleeps and I suspect the SIDS people (against co-sleeping) aren't doing studies on deaths in sub-Saharan Africa where this is *the* way to raise and care for a baby." In response, two of my age-group peers confessed to having done the same and they had also not shared the information with others for fear of judgment and social discord or worse still, that they would be blameworthy in the event of a child's death, ensuring complete societal exclusion.

As a mother in Australia, one is responsible for obliging this perceived and present 'reality' by projecting a moral image through actions or stated actions, during pregnancy and after. Salwa and I wanted to sleep with our babies but our "capacity for agency and autonomy" was influenced by the Australian society's warnings (Lupton 1996, 38). The appearance of understanding risks and discussing one's compliance with risk avoidance behaviours seemed almost more important than avoiding the risk itself (Rapp 1998, 46). Salwa, in fear, gave up co-sleeping with her infant. I slept with my infant but paradoxically, I made a performance (for midwives and peers) of not sleeping with my baby.

There were however, women like Zeneb who challenged the biomedical precepts of risk in her belief and in her practice. Zeneb was in her mid-thirties. She was born in Australia but strongly identified with her Sudanese/Egyptian/Lebanese background. She was strong-willed, swore, and smoked, but became gentle when she spoke to her sons, who were on the play equipment a few meters from us at the playground during our interview. She described being chastised by nurses for flipping from her back-lying position onto her hands and knees during childbirth. "I was like an animal!" she said laughing but Zeneb described feeling immediately more comfortable. She remained on her hands and knees and soon after delivered her son with ease. The lithotomy position (a woman lying on her back with bent legs raised, often in stirrups) is used the majority of the time for hospital birthing in Western countries (Dirogu et al 2016 and Priddis and Schmied 2012). Zeneb's refusal to be in this position actually resulted in greater efficacy in her birthing

experience, as her pelvis (and the birth canal) could be widened; however medical practitioners have often found positions other than lithotomy to challenge their own comfort and convenience (Davis-Floyd 2001). I agreed to be in the lithotomy position during the end of second stage labour (I felt too weak to hold myself upright in any other position during pushing) and my obstetrician seemed quite relieved to roll up her stool and sit comfortably at the end of my bed with her tools all within arms' reach. In many cases, a medical practitioner's "field for maneuvering" takes precedence over the good for a birthing woman (Davis-Floyd 2001).

Zeneb's non-compliance perturbed the midwives. "I think Middle Eastern and African ladies have a greater sense of trust in their own bodies" Zeneb pondered aloud, and acknowledged how this could be unsettling for the midwives who believe they have the authoritative knowledge. Zeneb felt as if she were being told what to do and exclaimed to the midwives "I am not a teenager; I am a woman." This self-empowerment and assertion of agency over her reproduction was met with what Zeneb described as "discrimination". The midwives attending to her were "consciously neglectful" and "cold". Zeneb assumed this was because she appeared foreign and they knew she was Muslim. "If you had brought your husband, with his Australian accent you would be treated differently. Doctors and nurses, they treat you different when you are with a man – they treat women in labour, in pregnancy – as clouded and unfocused" she added. Zeneb's descriptions of her negative maternity care experiences appeared almost punitive for her refusal to acquiesce to a biomedical model "vested in the patriarchal capitalist system" (Davis-Floyd and Sargent 1997, 11). Despite being an Australian citizen by birth, Zeneb's cultural identity placed her in the class of "other" for the midwives. She was "located differentially in lower categories of a hierarchical system by both individual actors and institutions" (Viruell-Fuentes 2007, 1525). Her non-compliance with the hospital's (and its staff's) conception of risk resulted in her marginalization as a patient, despite her refusal to be disempowered as a woman.



In contrast to the ‘official’ risks (those believed by biomedicine to cause mortality or morbidity) propagated by the government and medical establishment, many women experience what Allen describes as unofficial risks. Unofficial risks are non-scientific or they are not officially recognized understandings of risk, which many of the informants experienced (Allen 2004). Denham’s research amongst Nankani-speaking people in Ghana identifies examples of unofficial risks including witchcraft and behavioural taboos (Denham 2012, 177). Implicitly, the health care system and the midwives are encouraging mothers to become “individual agents who are responsible to make the choices, as communicated by health professionals and educators that are in their [and the babies] best interest” (Denham 2012, 174-175). However, these biomedical practitioners failed to see the cultural risks and barriers that women from non-mainstream cultures experience in accessing and using information.

When discussing the availability and accessibility of pre-natal information, Zola, a Muslim woman, referred to an expectation by midwives that all expectant women should attend pre-natal and breastfeeding classes, in order to acquire maternity information. However, these classes include partners and husbands attending with the pregnant women, and Zola indicated that many Muslim women would not attend the classes to discuss “women’s business” in front of male non-relatives. “We miss the information because of this. You know all this culture, all the Muslims, they would come if without partners.” Zola was conflicted, as she felt she would be held accountable by biomedical practitioners and the state for any problems with her pregnancies or childbirths because she did not attend the classes, but under the circumstances - with non-related men attending the classes - she also felt it was a violation of her culture and religion to attend. In essence, the hospital was asking Zola to make her maternity decisions by weighing the unofficial risk - violating her religious beliefs, which could result in negative consequences for her, her baby or the birth and official risks - compromising her own and her baby's safety in biomedical terms as a result of not knowing the Australian ‘rules’ and procedures in maternity care.

From Zola's experience of one-on-one appointments with midwives, she also felt the information was conveyed in a manner which instilled fear in Sudanese women. She, and other Sudanese and South Sudanese informants, felt the need for a balance of information about childbirth, both information that is given and that which is withheld, in order that women would have enough basic information to enact birthing safely, but not so much as to create fear. The Sudanese and South Sudanese women I spoke with identified stress and fear-creation by the medical practitioners as a physical barrier in childbirth. They felt that a woman in labour should be relaxed and not afraid, in order for their body to "open" to realize a good, safe birth. Fear would cause "obstructions" in birthing.

Zola said that her aunt had advised her that her risk of injury in childbirth would be reduced and her labour would be made easier if she used *dukhan*. Zola lamented that this form of ethnomedicine was not possible in Canberra in an apartment. "It makes you strong for birth they [relatives in Sudan] said. I think they are right [about *dukhan*'s efficacy and purpose]". *Dukhan* is a ritual that consists of creating smoke from particular woods (often a form of acacia) below a woman sitting atop a chair with a hole in the centre of the seat. The woman wears no under garments, allowing the smoke to 'enter' her. I learned from my informants, this ritual is done for a number of reasons: cosmetic (before weddings); preventative (for strength in birthing); and also healing (rheumatism and post-partum). Salwa and Zola referred to the inability to practice *dukhan* in terms of limitations to their post-partum recovery. Following childbirth, all women experience bleeding from the vagina, called lochia. The lochia usually changes from fresh red blood to light pink spotting, to a white discharge over a number of weeks. The Sudanese informants worried about profuse bleeding from the uterus after giving birth, as they were unable to perform the practice of *dukhan*, which is used to 'dry' the womb and tighten the woman's uterus and vagina. Moreover, for some women the soreness of the perineum and at times, the uncomfortable

contraction of the uterus can be aided by this treatment. Although this particular maternal health concern was widely recognized by the biomedical community, the treatment was not. Consequently, women like Zola and Salwa are unable to practice ethnomedical rituals that are important in reducing maternal health risks.

In the hospital setting, the Sudanese and South Sudanese women participants in this research did not feel they could demand that the established system recognize their cultural needs as birthing mothers. For them, as in-patients, a request to enact practices, even practices unrelated to medical outcomes, such as the father whispering the *Azhan* (Islamic call to prayer from the Koran) into the ear of the newborn baby or requesting food items, which the women used as ‘folk medicine’, could create a division between themselves and those in mainstream Australia. These small rituals meant a great deal to the well-being of the women that would have enacted them, but the study participants’ accounts suggested that their Australian care providers did not acknowledge or support the women in their wishes to perform rituals and rites. Indeed, Zola hoped that the hospitals would be interested in having dialogue with different cultural groups in Canberra, to see how unofficial risks could better be accounted for, and responded to, as part of the mainstream system rather than as an exception to it. She felt the central authority (the hospital) needed to find ways to integrate or at least accept the cultural group’s understandings of risk in order to better serve their maternity needs (Lupton 1996).

As it is, the Australian medical system’s questioning of particular practices, and the requirement for women to request permission to enact them (such as bringing food into the hospital from the outside) reinforced the sense of being an “other” for the women from Sudan and South Sudan. The everyday experience of childbirth seemed managed in formulaic fashion – with hierarchy and standardization – by the Australian healthcare system. Realities of risk, for pregnant and birthing mothers with views divergent from the mainstream, became an experience of

negotiation in the realm of politics of citizenship (Harper and Ramen 2008). The women I interviewed who fell outside of the “technomedical hegemony” (Davis-Floyd 2001) had their perceptions of unofficial risks as reality dismissed as an “otherness” and as a consequence, their needs became acceptably (by mainstream Australia) and excusably (by those who had been ‘othered’) marginalized.



## Chapter 5: Conclusion

This thesis explores and analyses narratives of risk in pregnancy and birth in order to explain how 'risk' amongst pregnant and birthing women in Australia is constructed. I sought to understand: How women experience 'risk' in pregnancy and childbirth? And, how do they experience social and medical practitioner responses to their acquiescence to or non-conformity with cultural norms of 'risk' during pregnancy and childbirth? My ethnographic research was conducted with participants from South Sudan, Sudan, the USA, and Australia. In interviews, these women answered core questions about women's experiences of risk and further, the research illuminated how constructs of 'risk' can be used as means of social control, which can disempower and stigmatize women.

In reviewing Douglas's theories around risk, blame, pollution and taboo, and his (1966, 2003) theories around risk, blame, pollution and taboo, Beck's (1992) Risk Society and Foucault's (1991) Governmentality in relation to narratives of risk in pregnancy and birth experience, I conclude that women are complicit or actively engaged in a process of risk construction through politicized and moralized social systems resultant from the dominant ideologies of biomedicine and the state. Infinite risk is used as a tool to communicate ideas around blame and taboos to ensure that the citizenry uphold the will of the state and biomedical practitioners. Simultaneously, the state and biomedicine make diffuse liability for unfortunate outcomes through the social reinforcement of technocracy and the mother as the agent responsible for the well-being of her foetus and her body in pregnancy and birthing.

It is worth stating that there were a number of limitations to this study. The research sample size was small due to time constraints and only three informants (myself included) were pregnant at the time of the interviews which limited how demonstrably 'experience-near' the research could be.

However, my interviews and conversations with women provided more than enough content for analysis. Nonetheless, further research would benefit from a larger sample size, including women who would be pregnant and birthing at the time of the research. In addition, including more women of greater age variation presents an opportunity to examine risk perceptions across time. Considering the variation in perceptions between first and subsequent pregnancies would also prove beneficial to the analysis. Finally, expanding the informant pool to include birth partners and medical practitioners would undoubtedly offer valuable alternative perspectives on risk in pregnancy and childbirth not captured in this study.

The knowledge I gained through this research impacted my experience of pregnancy and childbirth in Australia. In short, if I had been made aware of the above after, rather than concurrent with, my pregnancy and childbirth, I believe I would have felt misled and entrapped. It is easy for women in a society of neoliberal governmentality to believe their will is simply their own. However, I posit that the notion that women's pregnancies are threatened and that danger lurks in birthing is an Australian (Western) "ethnotheory", which influences women's experience and decision-making. Women must rationalise disjuncture between embodied or cultural knowing and the technocratic, biomedical hegemony they enact pregnancy and birth within. By viewing risk from outside mainstream Australia, I was able to see how the role of authoritative knowledge, power, and blame in women's acquiescence to normative constructions of risk is legitimized through discourse. In so doing, I came to reject many of the dominant ideas around risk in pregnancy and childbirth. When I felt stigmatized or judged, I reminded myself that this was a conscious disengagement with what is normative. However, the participants in my research had already lived their experience of pregnancy and childbirth - worrying, rationalising, being marginalized.

Through my pregnancy and in my birthing choices, I frequently reflected on whether this disengagement from the mainstream was part of my evolving individual practice or a political statement. In the end, my only aim was to ensure I was embodying my choices with a sense of security and peace, something all pregnant and birthing women deserve. How the participants in my study engaged with risk discourse, risk avoidance rituals, and even risk mitigating technology did not make for good or bad mothers, or good or bad Australians. Rather these women represented a spectrum of social, cultural and historical contexts. All the participants in my research affirmed their best intentions to ensure safety and security for their pregnancies, foetuses, and babies. There was no “us” and no “them”. Just mothers with thoughts, feelings and opinions which were as individually pertinent to pregnancy and childbirth outcomes as the current risk rhetoric. It is for this reason that this research has proven meaningful and relevant. The pervasive sense of risk in pregnancy and in birthing Australia today is a constructed reality and has demonstrated serious implications for the women in my study in terms of lived experience. These women’s experiences were reflected upon, often years and sometimes decades later with sadness remembering their anxieties through pregnancy or recalling their lack of influence over their babies’ births and a sense of cultural and sometimes bodily violation. Some of the women openly voiced in their interviews that they hoped this research would be read by medical practitioners working in maternity care so that they could truly understand these ramifications and the potential to make small but significant changes to improve the lived experience of maternity for women in Australia.





## Works Cited

- ABS. 2006. Statistics Catalogue number 4398.0 - Causes of Infant and Child Deaths, Australia, 1982 to 1996. Last updated 6 December 2006.  
<http://www.abs.gov.au/ausstats/abs@.nsf/mf/4398.0>
- ACOG. 2014. American College of Obstetricians and Gynecologists “Practice Bulletin” number 145: Antenatal Fetal Surveillance. *Obstetrics and Gynecology*. 124. 182–192.
- Adam, Barbara and Joost van Loon. 2000. “Introduction.” In *Repositioning Risk: The Challenge for Social Theory in The Risk Society and Beyond: Critical Issues for Social Theory*, edited by Barbara Adam, Ulrich Beck and Joost Van Loon. 1-32. London: SAGE Publications.
- AIHW Media Release. 2014. *More babies born in Australia*. Canberra, 16 December. Accessed: May 15, 2016. <http://www.aihw.gov.au/media-release-detail/?id=60129550053>
- AIHW. 2016. Child Health, Development and Wellbeing webpage accessed 16 November: <http://www.aihw.gov.au/child-health/health/>
- Allen, Denise. 2004. *Managing Motherhood, Managing Risk: Fertility and Danger in West Central Tanzania*. Ann Arbor: University of Michigan Press.
- Allen, Marilee C., Pamela K. Donohue, and Amy E. Dusman. 1993. "The Limit of Viability – Neonatal Outcome of Infants Born at 22 to 25 Weeks' Gestation." In *The New England Journal of Medicine* 329, no. 22: 1597-601.
- Beck, Ulrich. 1992. *Risk Society: Towards a New Modernity*. Translated by Mark Ritter. London: SAGE Publications.
- Berry, JW. 1980. “Introduction to methodology”. In *Handbook of Cross-Cultural Psychology*, Volume 2: Methodology. Edited by HC Triandis and WW Lambert. 1-29. Boston, MA: Allyn & Bacon.
- Broder, Michael. 2004. *The Panic-Free Pregnancy: An OB-GYN Separates Fact from Fiction on Food, Exercise, Travel, Pets, Coffee, Medications, and Concerns You Have When You Are Expecting*. 84-118. New York: A Perigee Book.
- Browner, Carole H. and Nancy Press. 1997. “The Production of Authoritative Knowledge in American Prenatal Care”. In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, edited by Robbie Davis-Floyd and Carolyn Sargent. Los Angeles: University of California Press.
- CDC. 2016. Preterm Birth, Maternal and Infant Health. Updated 16 November 2016. <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/pretermbirth.htm>
- Chapman, Rachel. 2010. *Family Secrets: Risking Reproduction in Central Mozambique*. Nashville: Vanderbilt University Press.

- Davis-Floyd, Robbie. 2001. "The Technocratic, Humanistic, and Holistic Paradigms of Childbirth" In *International Journal of Gynecology and Obstetrics*. Volume 75, Supplement Number 1, November, S5-S23.
- Davis-Floyd, Robbie. 2013. "The Rituals of American Hospital Birth". Accessed: 15 May 2016. [www.davis-floyd.com](http://www.davis-floyd.com).
- Davis-Floyd, Robbie E. 2003. *Birth as an American Rite of Passage: Second Edition, with a New Preface*. Berkeley, University of California Press.
- Davis-Floyd and Sargent, Carolyn. 1996. "The social production of authoritative knowledge in pregnancy and childbirth" in *Medical Anthropology Quarterly*, June 1996, Vol.10(2), pp.111-20
- Davis-Floyd and Sargent, Carolyn. 1997. "Introduction." In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*, edited by Robbie Davis-Floyd and Carolyn Sargent. Los Angeles: University of California Press.
- Dean, Mitchell. 1999. *Governmentality: Power and Rule in Modern Society*. London; Thousand Oaks, California: SAGE.
- Denham, Aaron. 2012. "Shifting Maternal Responsibilities and the Trajectory of Blame in Northern Ghana." In *Risk, Reproduction and Narratives of Experience*, edited by Lauren Fordyce and Aminata Maraesa, 173–190. Nashville, Vanderbilt University Press.
- Department of Health – Government of Queensland. 2014. "Queensland Clinical Guideline: Perinatal care at the threshold of viability" Maternity and Neonatal Clinical Guideline. September. <https://www.health.qld.gov.au/qcg/documents/g-viability.pdf>
- Department of Health – Government of South Australia. 2013. South Australian Perinatal Practice Guidelines, Perinatal care and the threshold of Viability. September. [Http://www.sahealth.sa.gov.au/wps/wcm/connect/8ddf798042ac004d9f11bfad100c470d/Perinatal%2Bcare%2Bat%2Bthreshold%2Bviability-WCHN-PPG-09122013.pdf?MOD=AJPERES&CACHEID=8ddf798042ac004d9f11bfad100c470d](http://www.sahealth.sa.gov.au/wps/wcm/connect/8ddf798042ac004d9f11bfad100c470d/Perinatal%2Bcare%2Bat%2Bthreshold%2Bviability-WCHN-PPG-09122013.pdf?MOD=AJPERES&CACHEID=8ddf798042ac004d9f11bfad100c470d)
- Diorgu, Steen, Keeling, and Mason-Whitehead. 2016. "Mothers and Midwives Perceptions of Birthing Position and Perineal Trauma: An Exploratory Study." *Women and Birth*, Women and Birth.
- Douglas, Mary. 2003. *Risk and Blame*. Taylor & Francis e-library, 2003.
- Douglas, Mary. 1966. *Purity and Danger - An Analysis of the Concepts of Pollution and Taboo*. London: Routledge.
- Douglas, Mary and Aaron Wildavsky. 1982. *Risk and Culture - An Essay on the Selection of Technological and Environmental Dangers*. University of California Press.
- Ellis, Carolyn and Tony E Adams and Arthur P Bochner. 2011. "Autoethnography: An Overview." In *Historical Social Research/Historische Sozialforschung*, no. 4 (138): 273-90.

- Fanaroff, Jonathon M. and Turbow, Robert. 2015. "Legal Issues in Neonatal-Perinatal Medicine." In *Fanaroff and Martin's neonatal-perinatal medicine: diseases of the foetus and infant*, 10<sup>th</sup> edition. 49-67. St Louis, Missouri: Elsevier.
- Fereday, Jennifer and Muir-Cochrane, Eimear. 2006. "Demonstrating Rigor Using Thematic Analysis: A Hybrid Approach of Inductive and Deductive Coding and Theme Development." In the *International Journal of Qualitative Methods* volume 5 (1) March.
- Fordyce, Lauren and Aminata Maraesa. 2012. "Introduction." In *Risk, Reproduction, and Narratives of Experience* edited by Lauren Fordyce and Aminata Maraesa. 1-17. Nashville: Vanderbilt University Press.
- Foucault, Michel. 2003. "The Ethics of the Concern of the Self as a Practice of Freedom." In *The Essential Foucault*. Paul Rabinow and Nikolas Rose (editors), 25-42. The New Press: New York
- Foucault, Michel. 1991. 'Governmentality' Translated by Rosi Braidotti and revised by Colin Gordon. Edited by Graham Burchell, Colin Gordon and Peter Miller. *The Foucault Effect: Studies in Governmentality*, 87–104. Chicago, Illinois: University of Chicago Press.
- Foucault, Michel. 1975. *The Birth of the Clinic, An Archaeology of Medical Perception*. New York, Vintage Books.
- Glaskin, Katie, and Richard Chenhall. 2013. *Sleep around the world: Anthropological perspectives*. First edition. New York: Palgrave Macmillan.
- Good, Byron. 1994. *Medicine, Rationality and Experience: An Anthropological Perspective*. Cambridge, UK: Cambridge University Press.
- Grbich, Carol. 2003. *New Approaches in Social Research*. London: SAGE Publications.
- Grove, Natalie J. and Anthony B. Zwi. 2006. "Our health and theirs: Forced migration, othering, and public health". In *Social Science & Medicine* 62 (8): 1931-42.
- Harkness, Sarah and Charles M Super. 1996. "Introduction" in *Parents' Cultural Belief Systems: Their Origins, Expressions, and Consequences*. Edited by Sarah Harkness and Charles M Super. 1-24. London: The Guildford Press.
- Harkness, Sarah and Charles M Super. 2009. "Parenting Across Cultures" in *SGI Quarterly*. Accessed: 13 May 2016. <http://www.sgiquarterly.org/feature2009Jan-2.html>.
- Harper, I. and Raman, P. 2008. "Less than Human? Diaspora, Disease and the Question of Citizenship". In *International Migration*, 46. 3–26.
- Hedegaard, Joel. 2014. "The production and maintenance of inequalities in health care: A communicative perspective." Doctoral Thesis. Jönköping University, School of Education and Communication, HLK.

- Hollan, Douglas. 1999. "The Relevance of Person-centred Ethnography to Cross Cultural Psychiatry". In *Transcultural Psychiatry*. 34(2):219-234.
- Howes-Mischel, Rebecca. 2012. "Local Contours of Reproductive Risk and Responsibility in Rural Oaxaca". In *Risk, Reproduction and Narratives of Experience*. Edited by Aminata Maraesa and Lauren Fordyce. Nashville: Vanderbilt University Press.
- Humphrey, MD, MR Bonello, A Chughtai, A Macaldowie, K Harris and GM Chambers. 2015. AIHW. *Maternal Deaths in Australia 2008-2011*. Published 10 June 2015. Accessed on 16 May 2016. <http://www.aihw.gov.au/publication-detail/?id=60129551119>.
- Jordan, Brigitte. 1999. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Fourth edition. Prospect Heights, Ill.: Waveland Press.
- Jordan, Brigitte. 1997. "Authoritative Knowledge and it's Construction". In *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives*. Edited by Robbie Davis-Floyd and Carolyn Sargent. University of California Press: Los Angeles.
- Kerr, Derek. 1999. "Beheading the king and enthroning the market: A critique of Foucauldian governmentality". In *Science and Technology*, 63 (2). 173-203.
- Klein MC, J Kaczorowski, JM Robbins, RJ Gauthier, SH Jorgensen, and AK Joshi. 1995. "Physicians' beliefs and behaviour during a randomized controlled trial of episiotomy: consequences for the women in their care". In *Canadian Medical Association Journal*. 153(6), 769-779.
- Kraus, Frederick. 2003. "Perinatal pathology, the placenta, and litigation". In *Human Pathology*. June - Vol 34.6. 517-527.
- Lappen, Justin and Dana Gossett. 2010. "Changes in Episiotomy Practice: Evidence-based Medicine". In *Action in Expert Review of Obstetrics and Gynaecology*. Volume 5(3). 301-309.
- Leder, Drew. 1992. "A tale of two bodies: the Cartesian corpse and the lived body". In: *The Body in Medical Thought and Practice*. 17-35. Edited by Drew Leder. Dordrecht: Kluwer Academic Publishers.
- Levy, R. and Hollan, D. 1998. "Person-centred interviewing and observation in anthropology". In *Handbook of Methods in Cultural Anthropology*. Edited by H. Russell Bernard and Clarence Gravlee. 333-364. Lanham, Maryland: Rowman and Littlefield Publishers.
- Liamputtong, Pranee, Janel. Halliday, Rosemary Warren, Lyndsey F. Watson, and Robin J. Bell. 2003. "Why Do Women Decline Prenatal Screening and Diagnosis? Australian Women's Perspective." In *Women & Health* 37, no. 2: 89-108.
- Lock, Margaret Nancy Scheper-Hughes. 1987. "The Mindful Body: A Prolegomenon to Future Work in Medical Anthropology". In *Medical Anthropology Quarterly*, New Series, Vol 1 No 1, March. 6-41.

- Loxton, Deborah, Chojenta, Catherine, Anderson, Amy E., Powers, Jennifer R., Shakeshaft, Anthony, and Burns, Lucy. 2013. "Acquisition and Utilization of Information About Alcohol Use in Pregnancy Among Australian Pregnant Women and Service Providers." *Journal of Midwifery and Women's Health* 58, no. 5: 523.
- Lupton, Deborah. 1997. "Chapter 5 Foucault and the Medicalisation Critique". In *Foucault, Health and Medicine*. Edited by Alan Peterson and Robin Bunton. London, Routledge.
- Lupton, Deborah. 2008. "‘You feel so responsible’: Australian mothers' concepts and experiences related to promoting the health and development of their young children". In *Emerging Perspectives in Health Communication: Meaning, Culture, and Power*. Edited by Heather Zoller and Mohan Dutta. 113-128. Routledge: New York.
- Lupton, Deborah. 2011. "‘The best thing for the baby’: mothers’ concepts and experiences related to promoting their infants’ health and development". In *Health, Risk & Society*, October, 13(7/8), 637-51.
- Lupton, Deborah. 2013. *Risk*, 2nd Edition. Routledge: New York.
- Malinowski, Bronislaw. 1963. "Chapter 9 - The Group and Individual in Functional Analysis" and "Chapter 10 - Myth as a Dramatic Development of Dogma". In *Sex, Culture and Myth*. London: Rupert Hart-Davis.
- Marinetti, Michael. 2007. *Social Theory, the State and Modern Society*. Berkshire, England, Open University Press.
- McKenna, James. 1986. "An anthropological perspective on the sudden infant death syndrome (SIDS): the role of parental breathing cues and speech breathing adaptations". In *Medical Anthropology*. Volume 10, 9-92.
- McKenna, James. 1990. "Sleep and arousal patterns of co-sleeping human mother/infant pairs: A preliminary physiological study with implications for the study of sudden infant death syndrome (SIDS)" In *American Journal of Physical Anthropology*, Volume: 83 Issue: 3: 331-347.
- McKenna, James and Thomas McDade. 2005. "Why babies should never sleep alone: A review of the co-sleeping controversy in relation to SIDS, bedsharing and breast feeding". In *Paediatric Respiratory Reviews*. June, Volume 6, Issue 2: 134-152.
- Merleau-Ponty, Maurice. 1962. *The phenomenology of perception*. Translated by Colin Smith. New York: Humanities Press.
- Mishler, Elliot. 1981. "Viewpoint: Critical Perspectives on the Biomedical Model". In *Social Contexts of Health, Illness, and Patient Care*. Cambridge UK: Cambridge University Press.
- Molander, Eva, Siw Alehagen, and Carina Berterö. 2010. "Routine ultrasound examination during pregnancy: a world of possibilities". In *Midwifery*, (26), 18-26.

- Napier, David et al. 2014. "Commission on Culture and Health". In *The Lancet*. Vol. 384, No. 9954, 1607–1639.
- NSW Food Authority, 2015. *What Not to Eat*. <http://www.foodauthority.nsw.gov.au/foodsafetyandyou/life-events-and-food/pregnancy/foods-to-eat-or-avoid-when-pregnant>
- Pace, Steven. 2012. "Writing the self into research using grounded theory analytic strategies". In *TEXT Special Issue: Creativity: Cognitive, Social and Cultural Perspectives*. Edited by Nigel McLoughlin and Donna Lee Brien. 12 April.
- Paul, Robert A. 1989. "Psychoanalytic Anthropology". In the *Annual Review of Anthropology* Vol.18:177-202.
- Possamai-Inesedy, Alphia. 2006. "Confining Risk: Choice and Responsibility in Childbirth in a Risk Society." *Health Sociology Review* 15, no. 4: 406-14.
- Priddis, Dahlen, and Schmied. 2012. "What Are the Facilitators, Inhibitors, and Implications of Birth Positioning? A Review of the Literature." *Women and Birth* 25, no. 3: 100-06.
- Rapp, Rayna. 1998. "Refusing Prenatal Diagnosis: The Meanings of Bioscience". In *Multicultural World in Science, Technology, & Human Values*, Vol. 23, No. 1, Special Issue: Anthropological Approaches in Science and Technology Studies (Winter), 45-70.
- Rapp, Rayna. 1999. *Testing Women, Testing the Foetus – The Social Impact of Amniocentesis in America*. New York and London: Routledge.
- Reed, Richard K. 2005. *Birthing Fathers: The Transformation of Men in American Rites of Birth*. New Brunswick, USA: Rutgers University Press.
- Ross, Emily. 2016. "Locating the Foetal Subject: Uncertain Entities and Foetal Viability in Accounts of First-time Pregnancy." *Women's Studies International Forum* 58: 58-67.
- Ross, Kathryn, Perkins, Stephen M., Mix, Tamara L., Knottnerus, J. David, and Worley, Virginia. 2013. *"Because It Is My Body, and I Own It, and I Am in Charge": Power and Resistance in Biomedical and Midwifery Models of Birth*, ProQuest Dissertations and Theses.
- Sargent, Carolyn and Stark, Nancy. 1987. "Surgical Birth: Interpretations of cesarean delivery among private hospital patients and nursing staff" in *Social Science and Medicine*, Vol 25, No 12. 1269-1276.
- SIDS and Kids Long Brochure. 2015. Accessed: 14 April 2016. <http://www.sidsandkids.org/wp-content/uploads/SIDS053-Safe-Sleeping-Long-Brochure-Updates-web.pdf>
- Still Aware, 2016. <http://stillaware.org/count-the-kicks>. Accessed: 22 April 2016.
- Tansey, James and Tim O’Riordan. 1999. "Cultural Theory and Risk; A Review". In *Health, Risk and Society*. Vol 1. Number 1.

- Theodorou, E. and S Spyrou. 2013. "Motherhood in Utero: Consuming Away Anxiety". In *Journal of Consumer Culture*. (2): 118 – 135.
- Thoman, Evelyn. 2006. "Co-sleeping, an ancient practice: issues of the past and present, and possibilities for the future". In *Sleep Medicine Reviews*. Volume 10, Issue 6 December.
- Thompson, Rachel and Mille, Yvette. 1994. "Birth control: to what extent do women report being informed and involved in decisions about pregnancy and birth procedures?". In *BMC Pregnancy and Childbirth*. 14/62.
- Van der Zalm, JE and PJ Byrne. 1996. "Seeing baby: women's experience of prenatal ultrasound examination and unexpected foetal diagnosis" in *Journal of Perinatology*, Volume 26. 403-408.
- Viruell-Fuentes, Edna A. 2007. "Beyond acculturation: Immigration, discrimination, and health research among Mexicans in the United States". In *Social Science & Medicine* Volume 65, Issue 7, October. 1524–1535.
- Weber, AM and L Meyn. 2002. "Episiotomy use in the United States, 1979-1997". In *Obstetrics and Gynecology*. Volume 100 (6): 1177.
- WHO. 2015. *WHO Statement on cesarean section rates*, Executive Summary. WHO reference number: WHO RHR/15.02. Accessed: May 15, 2016. [http://www.who.int/reproductivehealth/publications/maternal\\_perinatal\\_health/cs-statement/en/](http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/cs-statement/en/)
- World Bank. 2016. "Data/Indicators." <http://data.worldbank.org/indicator/SH.STA.MMRT> and <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN>. Accessed 16 May 2016.