Abortion, Birth, and Feminism: What Makes a Pro-Life Midwife?

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Literature Review

A wide spectrum of beliefs and motivations exists in the midwifery community. While midwives in general are perceived as being more supportive than physicians of women's autonomy and choices (Jenkinson, Kruske, & Kildea, 2017), an ideological divide exists between hospital-based nurse-midwives and direct-entry homebirth midwives. Cheyney (2010) found that homebirth midwives and the women they serve typically distrust the medical system because it constructs women's bodies as defective machines that need to be "fixed" by technology. They believe a woman is the best expert on her own body and most medical interventions are unnecessary and harmful, whereas homebirth is safe, peaceful, and empowering.

Typically, homebirth midwives practice within the laws of their state, which means applying for a license if available and following the rules to keep the license (for example, not attending a breech birth or a birth past 42 weeks). They believe in supporting women outside of the patriarchal medical system, but are willing to submit to the political/legal system so they can practice without being prosecuted. My research focuses on the values, attitudes, and beliefs of a subgroup that I have tentatively called (Barrett, 2019) radical midwives: midwives and other homebirth attendants who believe that, since childbirth is a private family ritual (as articulated by Ina May Gaskin, 1975, p. 12), the woman has an absolute right to choose where and when she gives birth as well as who attends her birth, with zero interference by the state. Radical midwives are not interested in seeking legitimacy from the state; they believe their legitimacy comes from being a woman serving women. They are willing to risk prosecution (by practicing without a license or other recognition from the state) to honor their belief in women's autonomy.

The midwifery community is home to a range of beliefs on the topic of abortion. While pro-choice identities have gained increasing visibility within the community of birth

professionals, especially on social media as millennials seek to integrate intersectional feminism with the fight for childbirth rights, many homebirth midwives, including some radical midwives, identify as pro-life. Given the public furor surrounding Texas SB08 (the 2021 heartbeat abortion ban) and the concern that women in Texas and other states will resort to illegal home abortions, possibly with the support or assistance of midwives, it is important to understand the attitudes of midwives, both in Texas and in other states, toward abortion. For radical midwives in particular, since they hold women's bodily autonomy as essential, the question of a right to abortion on demand hovers very close to the issue of women's rights in childbirth. It's easy to see why many radical midwives consider themselves pro-choice. (Whether they would help a woman obtain an illegal home abortion as readily as they would attend a homebirth beckons a separate, parallel investigation.) However, if a radical midwife considers herself pro-life (or chooses not to participate in or refer for abortions for whatever reasons), what does this tell us about her understanding of women's autonomy, and how does she understand her own understanding? How does she reconcile these two things she holds as sacred: women's autonomy and preborn life?

The social impact or praxis rationale for the proposed study will be close to the heart of researchers and birth professionals across the spectrum. My research seeks to test whether the pro-life position or the pro-choice position is more closely aligned with "feminist understandings of autonomy as a relational, rather than individualistic, construct" (Jenkinson, Kruske, and Kildea, 2017, p. 7). According to these authors, a "feminist understanding of autonomy...focuses more on wellbeing than on choice:

> By understanding the social and family relationships, context and constraints on woman's decision making, the pregnant woman and fetus retain their status as a single unit, with

> fetal wellbeing best protected by supporting maternal wellbeing (Harris, 2000; Laufer-Ukeles, 2011)" (p. 7).

The main drivers of abortion, such as poverty and domestic abuse, affect the wellbeing of both mother and baby, and pro-choice actors frequently confront the pro-life community with rhetoric that highlights the struggles mother and baby face after birth if abortion is not chosen. I wish to explore how a feminist understanding may contribute to developing more effective advocacy for both halves of the motherbaby dyad after birth.

To effectively address the many questions around this topic, I intend to first lay the groundwork by establishing what it means to be a pro-life midwife. How do these midwives understand themselves, connect with others, identify publicly, and so on? Do they fit stereotypes of right-wing religious voters? Do their beliefs impact their practice of midwifery or the care their clients receive? What *is* a pro-life midwife, and also what is she ***not***? From this foundation, I can explore how radical midwives fit in (or don't fit) with pro-life midwives generally and what their unique conception of their role may offer to the conversation around childbirth, abortion, pregnancy care, and the law.

Historical and Thematic Grounding for the Study

Overview: Abortion in Texas

SB08, known as the Texas Heartbeat Act, went into effect September 1, 2021. The law bans most abortions in the state by forbidding a physician to perform or induce an abortion on a woman unless he has either tested for a fetal heartbeat with negative results or diagnosed and documented a medical condition in the woman that necessitates an abortion. The bill includes the following justification statement: "Texas has compelling interests from the outset of a woman's pregnancy in protecting the health of the woman and the life of the unborn child." Leaving aside

for the moment the debate over whether the preborn child is deserving of equal legal, medical, and human rights protections with the mother, let us take a closer look at the notion of the state's "compelling interests" in a woman's pregnancy in general. Most of America gives at least lip service to the notion that the medical system (which is shaped indelibly by the regulatory arm of the state) exercises a compelling interest in how women give birth to their children at the end of pregnancy. 98% of U.S. babies are born in hospitals. A small army of dedicated women (i.e., radical midwives) works constantly to challenge this by offering birthing women an alternative outside the system. How do these midwives, in Texas and elsewhere, feel about the state's claim to a compelling interest in the choices of pregnant women? Can a midwife oppose the state's claim to regulate birth while also believing the state has power to forbid abortion and that it is right to do so?

Overview: The Homebirth Resurgence

From Home to Hospital

Pre-industrial to Industrial. Prior to the 20th century, childbirth in Euro-American societies looked little different than childbirth in other parts of the world. It was a natural life process that belonged to women. Only gradually, from the 18th through the 19th century, did male physicians start to assume a role in obstetric management and push traditional midwives out of the way. (See "The History of Midwifery and Childbirth in America.") However, childbirth still took place primarily in the home, even for upper-class women who utilized the services of physicians. Women who birthed in institutions were likely to be indigent.

20th Century. In the 20th century, the developed world diverged sharply from other societies (which, however, it would soon pull along in its wake as Western medical professionals contributed to international development and the creation of medical systems after the Western

model). In order to justify the presence of professionally trained male obstetricians at a woman's labor and lying-in, childbirth was reconstructed as a disease in need of expert management ("The History of Midwifery and Childbirth in America"). In the process, maternity care was shifted from a community endeavor supervised by female family members in the mother's home to a professionalized service rendered by nurses in sterile hospitals. The hospital was advertised as not only safer, but more civilized. Only lower-class and poor women -- so the new narrative went -- birthed at home on the floor or nursed their young at the breast like animals. We can identify several high-industrial cultural values that emerged and were reified through this process.

Patriarchy. Patriarchy, already embedded in the culture, was normalized in the hospital setting, where male authority figures in a male-styled structure (top-down, results-driven, achievement-oriented, "left brain"-dominant) were responsible for determining the "appropriate" choices for women. In the American model, nurses were subservient to doctors, who had a higher level of training though they might have less contact with the patient (Davis, 2004). Of course, this meant male physicians dominating female nurses. Although female physicians have become normalized in the 21st century, the hierarchical model remains.

Depersonalization, objectification. The body was rendered a scientific object, divided from the holistic self (the mind, spirit, emotions). According to Davis-Floyd (1992, pp. 152-153, in Cheyney, 2010; contrast Cheyney, 2011), hospital ritual produces a patient who "'believes in science, relies on technology, recognizes her inferiority [i.e., dependence]," rather than relying on her own connection with her body senses to decide what treatment she needs or wants. Thus fragmented, she is trained to accept external interventions that track as well as alter the course of her labor. Hospital ritual follows the same routines as the prison system as identified by Foucault: "fixing them [laboring mothers] in space [via IV and stirrups]...coding their continuous

behavior [via fetal monitor]...forming around them an apparatus of perfect observation" (1977, p. 231, my interpretation in brackets). In the words of one radical midwife co-participant, the system is built on "'doing things *to* women instead of with and for them as requested'; women's bodies are objects to be acted upon, not embodied subjects to be consulted" (Barrett, 2019, p. 15).

Dehumanization, subordination. Scientism constructed the body as defective and technology (tests, medications, interventions) as superior. The "cultural hegemony of the medical model of childbirth" (Beckett & Hoffman, 2005, citing Davis-Floyd, 1992; Davis-Floyd & Sargent, 1997; DeVries, 1996) is "embedded in a modernist epistemological framework that conceives of the body in mechanistic terms and seeks to eliminate risk through the application of science, professional expertise, and technology" (p. 125).

Commodification. Late industrial capitalism would not be complete without rendering the mother's body as a machine and her baby as a product. The job of doctor and nurse, aided by technology, is to ensure the machines work predictably to churn the babies out safely and on time. (See Cheyney, 2010.) The job of the hospital system and insurance payer is to profit from the process. This is the "American way of birth" (Mitford, 1992, in Beckett & Hoffman, 2005, p. 125).

Protectionism. The origin of midwifery licensing laws lies with anti-midwifery agitation by doctors resulting in legislation to restrict or prevent midwifery practice ("The History of Midwifery and Childbirth in America"). As Kline (2019) documents, and as elder midwives like those I name below insist, midwives' willingness to accept legislative control resulted in their subordination to the medical system.

Out of the Hospital, Back to the Home

Sixties Counterculture. From the 1960s to the 1970s, while almost all American babies were being brought into the world in hospitals with their mothers heavily medicated during labor (a time that authors like Arms, 1975, 1994, and Davis, 2004, look back on as the "dark ages of childbirth"), a few radicals started to look backward and inward. The hippie-caravan-turned-commune organized by spiritual leader Stephen Gaskin and his eventual spouse, midwife Ina May Gaskin, was one of the initial groups to bring midwifery back to the world of educated middle-class white women, and they did so with a panache rooted in their community's free-love ethos. As narrated in Gaskin's 1975 memoir/manual *Spiritual Midwifery*, women birthed in vans and tents and cabins, surrounded by fellow women, enjoying their partners' and children's affection, finding birth to be a peak spiritual and embodied experience. (Traditional midwives serving communities of color had not fully disappeared, but retreated in the face of legislation and persecution.)

Christian Fundamentalism. In the 1980s, the Religious Right began its rise. The spectrum of movements and ideas that arose and continue to exist under the general umbrella of religious patriarchy includes the Quiverfull movement. Rather than a defined sect, Quiverfull is a philosophy that crosses denominational lines. Quiverfull families and churches believe that (1) children are a blessing, (2) God is solely responsible for opening and closing the womb, and (3) Christian couples ought to seek as many children as God will give (a "full quiver") in order to multiply and influence (or take back) the culture for God. (For a critique, see Joyce, 2009; for an insider apologetic written by a "grandmother" of the movement, see Campbell, 2003.) Although Quiverfull was a manifestation of an outward-looking impulse to engage society, it encouraged and significantly overlapped with a general inward-looking "retreat to the home" among fundamentalist or conservative Christians (homebirth, homeschool, home church) who wanted to

"come out of Babylon." Manuals for childbirth that appealed to this demographic included *Born in Zion* (1992, out of print), by controversial lay midwife Carol Balizet, which taught that the husband should take spiritual authority over the wife's birth experience (and birth choices), and (for Catholics) *Birth and the Dialogue of Love* (1981), by Marilyn Moran, which encouraged unassisted childbirth (no midwife, just husband and wife, as it was when the baby was conceived).

Class. From the 1980s into the 2000s, women in the mainstream started to realize they had choices in childbirth, from birthing in the hospital without pain medication to birthing at home with a midwife. (See Beckett & Hoffman, 2005.) Resources like Ricki Lake's documentary *The Business of Being Born* exposed the dangers and profit motives embedded in the medical system, inspiring more women “make the choice to birth outside of the medical system to avoid patriarchal systems of power and medical management” (Rigg, Schmied, Peters, & Dahlen, 2018, p. 2), but may have unintentionally contributed to constructing homebirth as a luxury option for middle-class white women.

Mainstreaming of the Profession. As licensing laws were passed in more states, homebirth midwifery became recognized as a legitimate profession, conventionally organized with licensing boards, professional associations, and continuing education. (See "The History of Midwifery and Childbirth in America" and Kline, 2019, as well as regularly updated summaries of state laws and requirements at the Midwives Association of North America and Midwifery Education Accreditation Council websites.) On the other hand, integrating midwives into the medical system (despite their willingness to become part of the system through licensure) proved to be more challenging and consistently relies on the goodwill of legislators on a state-by-state basis. (For example, both New Mexico and Texas have a history of midwifery, particularly

parteras among the Hispanic community, extending back to before statehood; however, New Mexico integrates licensed midwives into the health care system and allows them to bill Medicaid, whereas Texas does neither.) Legislators who oppose midwifery expansion usually cite concerns of public health or safety, both of which are presumed to be protected by the medical profession (Beckett & Hoffman, 2005).

Activism. Moving into the 2010s and forward, a new breed of political activists emerged in the birth community, using social media to advance intersectionalism in birth work. These include self-identified radical and queer doulas who seek (for example) to serve LGBTQ populations, expand access to home abortion knowledge, or advocate for BIPOC women in hospital settings. (See Carathers, 2019.)

The New New Age. The early 21st century is a time of DIY spirituality. In keeping with this trend, radical midwives and midwifery teachers like Maryn Green and Whapio Dianne Bartlett portray childbirth as a new frontier for innovation, intuition, and self-expansion, even at the quantum level. (See, for example, Maryn Green's Taking Back Birth podcast and her e-publication, "The Indie Birth Manifesto," coauthored with Margo Blackstone. I'm attempting to track down a new citation for the manifesto, which is no longer available at the original link.)

Against This Background: Radical Midwives

Values, Attitudes, Beliefs

Previously (Barrett, 2019), I used narrative inquiry to gather data from birth workers who fit a profile I tentatively called "radical midwife." The term -- like the women it describes -- resists being pinned down too closely. Similar to Rigg, Schmied, Peters, and Dalhen's (2018, p. 2) designation of “unregulated birth worker” or UBW referring to a birth attendant who is not a registered health professional (but may be a doula, bodyworker, traditionally trained midwife, or

ex-registered midwife), these women (they are, for all practical purposes, always women) are, by way of general definition, direct-entry midwives who resist regulation by practicing selectively in unregulated states, practicing underground, or practicing without a license in regulated states. A few other titles (some contributed by my participants, some discovered through observation, and some imagined by me) include *birth keeper*, *autonomous midwife*, *birth friend*, *community midwife*, *granny midwife*, *independent midwife*, *maverick midwife*, *midwife in the new paradigm*, *midwife outside the system*, *nonconformist midwife*, *renegade midwife*, *rogue midwife*, *self-identified midwife*, *sovereign midwife*, *space holder*, *traditional midwife*, *underground midwife*, *undocumented midwife*, *unlicensed midwife*, *unregistered midwife*, and *unregulated midwife* (see Barrett, 2019). What sets radical midwives apart from lay midwives who practice without license for personal reasons is their devotion to resisting medical colonization of women's bodies and female spaces. They believe authentic midwifery ("with-woman" care) honors, above absolutely all, a mother's bodily autonomy and the integrity of the physiological birth process. Through my ongoing observation of social media spaces as well as in the narratives of my participants (Barrett, 2019), certain core values of radical midwives have emerged.

Feminism

The feminist commitment of radical midwives and their allies often, but not always, invokes the priorities of radical feminism: creating spaces where women are free to be independent, biologically, intellectually, sexually, and in any other way, without requiring the contributions of or accepting control from men. (See, for example, birth workers Emilee Saldaya and Yolande Clark of the *Free Birth Society* and *Bauhauswife* podcasts, respectively, who frame their content in radical feminist terms, but normally without using the word, and/or feature guests who are known in other spaces to identify as radical feminists.) Although abortion is not an

essential tenet of feminism per se, abortion access came to embody the notion of female autonomy or freedom from the patriarchy, particularly through the work of 1960s feminists (like the Jane Collective) who distributed abortion information and materials.

Autonomy

Radical midwives are committed to honoring women's authority over their bodies and total freedom to make choices. Usually, autonomy and informed choice are constructed as inseparable. Cheyney (2010, p. 36), in a study of homebirth midwives that included some unregulated midwives, found that midwives "focus on empowering [women] through knowledge sharing" and "attempt to make sure that 'the flow of information is back and forth and not top down'" (p. 37).

Privacy

In short: birth is a private family ritual, not the business of the state or medical system. This value is expressed ardently by elder midwives such as Ina May Gaskin (1976), Carla "Baba" Hartley, and Gloria Lemay (see below).

Legitimacy

According to my participants (Barrett, 2019) and other sources like Maryn Green's *Taking Back Birt*h podcast, a midwife's legitimacy is bestowed by the families she serves, not a governing body or license. Rather than create a moral conflict of interest by coming under state jurisdiction, radical midwives refuse to consent to a contract with the state that limits their freedom to serve women.

Anti-hierarchy

Cheyney (2010, p. 42) argues that the spontaneous upright birthing encouraged by midwives, as opposed to hospital lithotomy position, is a deliberate inversion of the mother-

down, doctor-up medical hierarchy. As Maryn Green says frequently on episodes of *Taking Back Birth*: "The woman is always the center of her spiral." The homebirth paradigm decouples the doctor from having any essential role and repositions the mother at the center, with the midwife as her faithful satellite.

Political, Cultural, Religious Influences

Elder Midwives

Based on informal observation in social media spaces (compare Kline, 2019), the most influential "elder" midwives of North America (i.e., those who have been practicing for several decades; have attended births numbering in the hundreds and upwards; have trained numerous midwifery apprentices, taught classes nationally or internationally, and/or founded institutions of midwifery learning; and have persisted in practicing despite political or medical opposition) would include -- but are not limited to -- Ina May Gaskin, Carla "Baba" Hartley (recently deceased), Sherry Holley, Gail Hart, and Gloria Lemay. Elders influence current and aspiring midwives through social media as well as books and articles.

Political Philosophies

Again based on informal observation (but see also Johnson, 2016), radical midwives are influenced by diverse political philosophies and practices such as libertarianism, anarchism, Marxist feminism, or Evangelical conservatism. Based on their social media posts, they may be explicitly leftist, favoring state involvement in social welfare and health care but not to the extent of regulating abortion; moderate but independent; or conservative/traditional on topics like abortion and sexuality, but anti-authoritarian when it comes to childbirth. While individuals appear somewhat predictable based on the content they tend to post, the political beliefs of the group or subculture resist categorization or caricature.

Abortion as a Matter of Law

Historical Shifts

The role of midwives of the past in helping women to procure abortions is somewhat disputed. Knowledge is limited, since traditional midwives were often illiterate and "women's work" was rarely the subject of written history. Many premodern societies accepted abortion under the umbrella of fertility regulation, as in ancient Egypt (Moore, van der Meulen Rodgers, Coast, Lattof, & Poss, 2021); in ancient Rome it was considered a convenient means of eugenics, along with infanticide ("Infanticide in the Ancient World"). In modern times, enslaved women in southeast Asia and the Americas used herbal abortion and infanticide to wrest back a portion of control over their bodies and offspring from their masters (see "The History of Abortifacients" and Fox-Genovese, 1988). Before modern science, the early stages of pregnancy were a mystery, which meant "the pregnant woman had significant power in defining pregnancy [when it began as well as how she knew] and the law was based on her bodily experience" (Peterson, 2012, n.p.), even in Euro-American societies that restricted or forbade abortion in law.

Prior to advanced scientific knowledge of gestation or the artificial concept of trimesters, the social and medical consensus in the medieval and early modern Euro-American world held that life began at "quickening" (i.e., fetal movement detectable by the mother), and so abortion before this stage was not ending a life but merely "bringing on the menses." The surgical removal of a developed fetus would have been the province of a male physician in a dire emergency, usually if the mother was dying or had died in childbirth. Thus, midwives might provide abortifacient herbs for early abortion with no sanction from church or state. Nevertheless, the major world religions (such as Hinduism, Judaism, and Christianity) have consistently condemned abortion in their sacred texts and commentaries. Christian teaching as

early as the second-century Didache condemned both abortion and infanticide -- so common as to be inconsequential in the surrounding Roman culture -- as murder. While the Catholic Church did not formally declare abortion murder until 1588 (a decision rescinded by the succeeding pope and not reissued until 1869) (Shain, 1986), and the punishment for abortion in medieval European societies, where pregnancy was an ambiguous concept in law, was often less severe than for murder (ranging from fines to servitude to three or seven years of penance; Garver, 2012, and Harris-Stoertz, 2012), Christian sources had long agreed that once "ensoulment" (thought to coincide with quickening, at about 40 days into pregnancy) occurred, life had certainly begun.

Ironically, while the standard conservative Christian position on abortion (represented by the Catholic and Evangelical wings) harmonizes with scientific findings on the earliest stages of human life ("Life Begins at Conception") and may have been influenced by new medical discoveries in the 1800s (see Peterson, 2012), some sources argue that it was the medical profession -- not religion -- that drove the criminalization of abortion, but not for scientific reasons. Instead, "it was doctors, not women, who defined the morality surrounding abortion" (Hovey, 1985, p. 18) because redefining abortion to encompass early pregnancy and making it (like childbirth) a medical event with public implications rather than a private matter would shore up their professional influence and "restrict competition from homeopaths and midwives" (Peterson, 2012). "AMA doctors discredited women's experiences of quickening as unscientific and emotional" (n.p.), denying women's intuition and self-awareness in pregnancy just as during the birth process. Even exemptions for the life or health of the mother "further solidified the alliance between the state and doctors...by allowing doctors to adjudicate the legality of

abortions" (n.p.). The enactment of legal restrictions on abortion paralleled the rise of the medical profession, from the 1820s when the first law hit the books in Connecticut to the 1960s when abortion was a felony in every state but one (and yet mainline Protestant and some Evangelical groups had more liberal statements on abortion than the government).

Just as with childbirth, doctors offered to proctor the state's "compelling interest" in the life of either preborn or born children, an interest that is presumed at some point to override either the mother's interest in her offspring or her decision-making capacity over her womb, and in return, the state offered doctors a monopoly on providing abortion services. Against this backdrop, second-wave feminists who sought unfettered freedom to abort without physician approval were seeking a reprieve from the paternalism of patriarchy.

Impacts of Abortion Legislation

How is Texas SB08 likely to impact women's preference to procure illegal home abortions or self-abortions, as opposed to crossing state lines or simply not attempting to seek an abortion? The literature is conflicted on this point, and I am attempting to track down full-text sources (including the following citations) to get a clearer picture. In a 2011 *State Politics and Policy Quarterly* article, Michael J. New argues, based on a review of data from 1985 to 2005, that pro-life laws (laws restricting abortion) caused a significant decrease in abortion rates. In a 2019 *Current Opinion in Obstetrics & Gynecology* review, Conti and Cahill identified an increased interest in (if not incidence of) self-induced abortion. Ralph et al. (2020, published in *JAMA*) found, in one of the first population-based estimates of self-managed abortion, that 1.4% of respondents reported having attempted SMA, which the authors generalized to 7.0% of the general U.S. population. Raifman et al. (2021, to be published in *Contraception* 2022) suggest that border state abortions increased following a previous Texas abortion bill. Given that these

findings are newer, it's hard to know if the trends will smooth out and resemble New's findings more as time goes on. However, Gerdts et al. (2016) found that, along with the closure of more than half of licensed abortion facilities within a year, TRAP laws in Texas -- namely, HB2 in 2014 -- led to a 13% reduction in abortions within six months. Although a 2012 study by the Texas Policy Evaluation Project (see Grossman, White, Hopkins, & Potter, 2014) suggested that Texas had and would continue to have a higher rate of self-induced (illegal) abortions due to onerous abortion legislation, accurate information about women's self-abortion practices is notoriously difficult to obtain.

Role of the Internet

On the other hand, the ever-increasing availability of information and the high digital literacy of millennials and Gen-Zers may skew in favor of more women attempting SMA or looking for underground assistance. The internet has made available an astonishing library of open-source content on women's reproductive health, including materials for home abortion: out-of-print books and newer ebooks, as well as herbs and supplies.

Conceptualizing Intentions and Methodological Grounding

The study is a multi-part investigation that employs embedded participant-observation, case studies, phenomenological description, thematic analysis, and discourse analysis to explore and synthesize the beliefs expressed by various populations and sub-populations of midwives. Data will be collected in multiple exploratory stages, progressing from an initial survey to open-ended interviews and focus groups, to build a comprehensive analysis that examines the data from multiple perspectives. For example: How do potential participants define the concept of "pro-life" and measure themselves against it? What factors (such as religiosity) appear to influence them, and how can these be measured? As themes emerge from the data contributed by

pro-life midwives, how do they compare or contrast with the discourse of midwives who identify as pro-choice, and does this give insight into how to frame interview questions that touch on autonomy? Are there differences in the discourse between licensed homebirth midwives and radical midwives regarding abortion? Each stage of exploration will provide further insight into how the next stage should be constructed. Ultimately, I intend to bring the data to bear on the following research questions, with an eye to the hypotheses listed in the next section.

Theoretical Grounding

Feminist theoretical perspectives are, obviously, relevant to discussions of women's autonomy in pregnancy and childbirth. While remaining aware of the background of political activism through the several waves of feminism, I'm primarily interested in unpacking the "feminist understandings of autonomy as a relational, rather than individualistic, construct" (Jenkinson, Kruske, and Kildea, 2017, p. 7) -- which I first encountered in the literature on women's healthcare autonomy, but which Dryzek, Honig, and Phillips (2011) imply is the major contribution of feminist scholars to political theory -- in order to explore the ways in which "fetal wellbeing [is] best protected by supporting maternal wellbeing (Harris, 2000; Laufer-Ukeles, 2011)" (p. 7) *and* vice versa. Can this understanding of autonomy accord with the classical liberal assumption "that individuals are for the most part motivated by self-interest" and are "the best judges of what this interest requires" while being obligated to meet their duties to others and the state which protects their individual rights (Dryzek, Honig, & Phillips, 2011, pp. 9-10)?

While a philosophical marriage between feminism and classical liberalism may sound unusual, it seems to inform the thinking or value system of some midwives, particularly radical midwives, and in fact both elements were part of second-wave feminism's push for abortion access, though not directly linked. According to Peterson (2012), "American feminists often

based their arguments on abstract principles of individual rights" and "emphasized women's right to control their bodies without state interference," while European feminists "drew upon the established belief that most women only had abortions out of legitimate need" and "argued that these self-identified welfare states were obliged to protect women, especially poor women, from the burdens of unwanted pregnancy" (n.p.). From observation, radical midwives like Maryn Green and Margo Blackstone and similarly radically minded birthworkers like Yolande Clark and Emilee Saldaya tend to mingle feminist language and perspectives with notions of radical individual responsibility. While these women could hardly be described as classical liberals, they seem to yearn for an expression of "rights" in which the individual's choice to take on full responsibility for her/his life -- because s/he is the sole best judge of how to do so -- functions as a vehicle of self-actualization. Their resistance-by-secession from the system suggests a worldview in which individual choices, like the family ritual of birth, are fundamentally private and literally nobody else's business (including the state). Rather than petitioning the state to legalize what they want to do, they ask to be left alone (because they will just do what they want anyway). In fact, this was articulated as early as the 1970s by Ina May Gaskin in *Spiritual Midwifery*: "[T]he rights of women, the newborn, and the family during the passage of childbirth are among those unenumerated rights [of the Tenth Amendment] which are to be retained by the people" (1976, p. 12). The obligation of the government in protecting women's childbirth rights is simply not to interfere. Some might apply this logic to abortion as well; what do my pro-life midwife participants say?

Methodology

Preliminary data collection includes using social media to identify subgroups within the population (for example, midwives who are overtly religious or overtly feminist) and assessing

comparatively how they respond to discussions of abortion. Formal data collection consist of three stages. Participants will be recruited by multiple means:

- by posting a study announcement in social media groups relevant to women's healthcare: groups for midwives, student midwives, birth doulas, midwifery clients, pro-life or pro-choice activists, and fertility awareness professionals; the announcement will invite interested participants to click through to the study website to take a convenient electronic survey
- by emailing an invitation to direct-entry midwifery practices discovered via web search (for example, in published membership lists for state midwifery organizations or in search engine results for midwives by city, region, or state)
- by directly contacting midwives with whom the researcher has an established personal relationship to advise them of the study opportunity
- and, possibly, by soliciting one or more opinion leaders in pro-life and pro-choice activism to share the study announcement with their social media followers

Participants who click through to the website will access a self-scheduled, self-paced electronic survey of approximately 30 minutes duration. Participants who complete the survey will be automatically invited to join the second stage of the study, consisting of a qualitative interview of approximately 60 minutes where they will be asked to provide their views in greater depth. The researcher will communicate with this self-selected group of participants by email to schedule interview times and advise them that the interview will be audio recorded for note-taking purposes. Following each interview, selected participants will be offered the opportunity to join a 90-minute focus group (the third stage). Survey questions are designed to elicit a participant's

political and religious leanings in order to map these against whether the participant identifies as pro-life or pro-choice. Tentative survey and interview questions are included here. Focus group questions will be developed out of the results of the first two stages.

Survey Questions (Tentative)

For the following question, please choose one:

1. I describe myself as

    A) pro-life

    B) pro-choice

    C) both pro-life and pro-choice

    D) something else

For the following questions, please respond to each statement on a scale from 1 to 5.

    1 = STRONGLY DISAGREE

    2 = DISAGREE

    3 = UNCERTAIN

    4 = AGREE

    5 = STRONGLY AGREE

2. Women have the right to control their bodies.

3. A fetus is a person.

4. Life begins at conception.

5. A woman has the right to choose when, where, and with whom she gives birth.

6. A pregnant woman has the right to decline any healthcare treatment.

7. Obstetric personnel often push unnecessary interventions on women giving birth in hospitals.

8. Women need access to abortion to achieve equality with men.

9. Women need access to abortion in case of rape or incest.

10. Women need access to abortion in case of fetal deformity.

11. Patriarchy is a threat to women's rights today.

12. A woman should not have to talk to her doctor before choosing an abortion.

13. Abortion should be safe, legal, and rare.

14. The medical system wants to eradicate midwives.

15. Homebirth is a safe option for low-risk women.

16. Birth is safe; interference is risky.

17. Women need access to abortion for any reason or no reason, simply because they choose not to continue the pregnancy.

18. Most women get an abortion due to relationship problems.

19. Most women get an abortion due to financial problems.

20. Most women get an abortion to advance their careers.

21. Most women get an abortion because they don't believe their baby is a human being.

22. A fetus is a clump of cells.

23. Licensing protects the public by making midwifery care safer.

24. God creates life in the womb.

25. Abortion should be legal at any stage.

26. Abortion is murder.

27. Abortion should be illegal after a heartbeat is detected.

28. A woman has the right to choose where, when, and with whom she will terminate her pregnancy.

29. Home abortion can be done safely with the right equipment.

30. Women resort to self-abortion when they can't get a legal abortion.

31. Women died regularly from self-abortion or illegal abortion before Roe v. Wade.

32. Overturning Roe v. Wade would have a negative impact on women's equality.

33. Babies in utero are sentient, spiritual beings.

34. A fetus can hear, respond to, and communicate with its mother.

35. The Bible forbids abortion.

36. An aborted baby goes to heaven.

37. Abortion is healthcare.

38. A woman has the right to give birth at home without assistance.

39. Taxation is theft.

40. It is important to help the poor and less fortunate.

41. A wife should submit to her husband.

42. Women are more emotional, while men are more logical.

43. The Bible is literally true.

44. Better sex education would reduce the incidence of abortion.

45. America needs to turn back to God.

46. America is a nation built on systemic racism.

47. The United States is a republic.

48. The United States is a democracy.

49. The Electoral College should be abolished.

50. Removing prayer from schools was a good decision.

Interview Questions

Part A

1. Do you identify as pro-life, pro-choice, or something else? Tell me what that means to you.

Part B

2. Have you ever been approached by a client or prospective client who disclosed having an abortion in the past? What did you say? If this has not happened to you, tell me what you would say if it did.

3. How did the client respond?

4. What was the tone of the relationship going forward?

5. How do you feel about the conversation, looking back? Would you handle it differently next time?

6. Why do you think she felt comfortable opening up to you about her abortion history?

7. Do you feel you expressed your values and stayed true to them?

Part C

8. Have you ever been approached by a client or prospective client who was seeking advice or help for an illegal or home abortion? What did you say? If this has not happened to you, tell me what you would say if it did.

9. How did the client respond?

10. What was the tone of the relationship going forward?

11. How do you feel about the conversation, looking back? Would you handle it differently next time?

12. Why do you think she felt comfortable opening up to you about her abortion intentions?

13. Do you feel you expressed your values and stayed true to them?

Data Analysis

Survey question #1 will be used to separate survey respondents into two groups and make a rudimentary determination of how likely midwives are to identify as pro-life versus pro-choice. According to Shain (1986, p. 1), the two camps tend to divide starkly; pro-life and pro-choice activists "tend to be women who are completely different from one another in sociodemographic characteristics and in overall values." If findings from the 1980s still hold true, pro-life individuals "are

> more likely to be Roman Catholic or fundamentalist Protestant; are, in general, more strongly committed to organized religion; are on the traditional/conservative end of the spectrum with regard to women's role in life, premarital sex, sex education and civil liberties; and tend to have achieved a relatively low educational level" (n.p.).

While the rise of millennial and, now, Gen-Z contributors has transformed the pro-life movement into a more complex organism that includes secular, feminist, and politically progressive voices alongside the traditional elements listed above, it may be possible to build a profile of the overall value system of the average or representative pro-life homebirth midwife. A Mann-Whitney U test will be used to determine whether differences in responses to other survey questions between the two groups are statistically significant and, from that, determine whether the value statements correlate with (and/or can predict) homebirth midwives identifying as pro-life or pro-choice. Interview responses will be transcribed and analyzed using techniques of thematic analysis.

Research Questions and Hypotheses

RQ1: Do midwives perceive it as a conflict in their value system if they support a woman's total autonomy regarding where, when, and with whom to give birth and yet do not affirm a "right to choose" to end the life of her fetus?

RQ2: What makes a radical midwife, who defines herself by her commitment to women's autonomy, willing to accept this tension in her beliefs?

RQ3: Midwives resist the patriarchal construction of women's bodies by the medical and legal establishments. How do pro-life midwives articulate this resistance, especially when engaging with the broader pro-life community where patriarchal structures may be accepted as normal?

RQ4: How does identifying as pro-life affect the way a midwife practices? If a woman seeks out a midwife for advice about an illegal home abortion, or discloses a past abortion, how is the midwife likely to respond?

H1: Pro-life midwives have constructed a sophisticated understanding in which a woman's autonomy and a baby's right to life coexist and are complementary, not contradictory.

H2: Pro-life midwives ground their value system in deeply held religious or spiritual understandings of divine purpose, human responsibility, and the sacredness of life.

H3: Pro-life midwives ground their value system in a deeply feminist understanding of autonomy, even if they do not consider themselves feminists.

H4: Pro-life midwives emphasize and prioritize the wellbeing of the mother during and after the pregnancy.

Working Summary/Discussion/Conclusion

Midwives give personalized care and support a woman's ability to make health care choices without coercion, reflecting "feminist understandings of autonomy" (Jenkinson, Kruske, & Kildea, 2017, p. 7). This research proposal builds on previous investigations of the experiences and beliefs of homebirth midwives and homebirthing mothers. Echoing the findings of authors like Rigg, Schmied, Peters, and Dalhen (2017, 2018, 2019) and Cheyney (2010), I previously found (Barrett, 2019) that "radical midwives construct a sophisticated value system

that inverts patriarchal categories by prioritizing women's bodies, choices, and knowledge" (p. 18). This project simultaneously fleshes out previous findings and takes them in an new direction by interrogating the beliefs of homebirth midwives, specifically radical midwives, around the polarizing issue of abortion rights.

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