UNIVERSITY OF CALIFORNIA SAN DIEGO

Words Matter: How Authority and Power are Situated in Reproduction and Birthing Podcasts

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by

Brianna Vargas

Committee in charge:

Professor Bonnie N. Kaiser, Chair
Professor Joseph D. Hankins
Professor Rihan Yeh

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The Thesis of Brianna Vargas is approved, and it is acceptable in quality and form for publication on microfilm and electronically.

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"The terrain of reproduction continues to be highly contested and itself a site of resistance—for wherever capitalism exerts control over how we seek to reproduce ourselves and our communities, we find acts of rebellion, however small, that bring us closer to a collective re-appropriation of reproduction from capitalist patriarchy. Where better to begin than with birth itself?"

-Alana Apfel, Birth Work as Care Work

ABSTRACT OF THE THESIS

Words Matter: How Authority and Power are Situated in Reproduction and Birthing Podcasts

by

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Professor Bonnie Kaiser, Chair

I argue that colonialism and capitalism have utilized a specific narrative of reproduction to devalue reproducers and produce and maintain control over their bodies and lives. This builds on the work of other reproductive justice and feminist scholars and activists which seek to challenge this "dominant" discourse and destabilize the notion that there is one correct way to reproduce and birth. This podcast study uses key-word-in-context and critical discourse analyses methods to compare the ways different care providers (e.g., doctors, midwives, doulas) in the US currently situate authority and power regarding individuals (e.g., birthing people and care providers) and decision-making (e.g., knowledge, choices). I selected two podcasts, both interested in "women's rights/health," representative of two different approaches: holistic reproductive health (*Birthful*) and obstetric/gynecologic perspectives (*The Ob/Gyn Podcast*). Frequency count data and critical discourse analysis, drawing on 20 randomly selected episode transcripts from each podcast, revealed four main themes: worth and importance, provider roles in birthing spaces, integral actors in reproduction and birthing decision-making, and shaping

legitimacy. Findings elucidate (1) key differences in the ways podcast speakers ascribe meaning and value to certain types of knowledge and individuals regarding decision-making and (2) subtle and overt ways in which care providers reify or challenge the narrative that positions the birthing person as a passive agent to whom birth happens at the hands of more capable experts. Acknowledging and challenging the presumed role of authority and power in reproduction and birthing has real-world implications for birthing people and their mental health, reproductive justice, and ethics of care.

INTRODUCTION

Within current discourses of reproduction there are severe power imbalances in the many interactions between birthing people and their care providers or institutions like government and the medical industrial complex. I consider authority in the terrain of reproduction because an individual or organization with legitimized authority is understood to wield power or control and granted the ability to make decisions and enforce obedience. This study is a US podcast analysis which aims to explore the ways different reproductive health care providers today situate authority and power regarding individuals and knowledge, thereby reinforcing and challenging certain narratives about reproduction and birthing. Thus, we must consider the overt and covert agendas, power struggles, and daily social interactions that have shaped discourses and the appropriate roles and relationships that are constructed within them.

I use a combination of postmodern Foucauldian discourse theory and Goffman's theory of socialization and performance as the framework to analyze how dominant discourse about reproduction is reified and challenged through everyday interaction and communication. Foucauldian theory asserts that knowledge or truths within discourse are fully entangled with social power and that in the process of legitimizing a supposed "objective and stable" discourse, its political intentions are obscured (Foucault 1969). Goffman argues that individuals are actors who perform socialized, assigned roles and that verbal and nonverbal interactions reinforce these roles in relationship to one another (Goffman 1956). The institutionalized set of ideas and practices about proper ways of reproducing is informed by and enmeshed in a history of oppression rooted in colonialism and patriarchy. This version of the discourse of reproduction is a project that centers the politicization and control of the typically female, reproducing body (Silliman et al. 2004; Ross and Solinger 2017; Oakley 1979). Theory and methodology that emerge from feminist studies and the reproductive justice movement enable scholars to question and challenge this, often harmful and violent, project. This critical lens invites inquiries into how certain types of knowledge and individuals involved in reproduction are granted meaning and legitimacy or decision-making bodily authority; it also invites a deeper analysis of how individuals reify or challenge certain

ideas, practices, roles, and relationships through encounters and their use of language. It is important to recognize that gender as a social construct has heavily influenced the disproportionate targeting of the female body or woman in the discourse and politics of reproduction. In this section, we explore the role of gender and historical situating of (re)producers/women as separate from or opposite to the producers/men and simultaneously acknowledge that not all birthing people are women.

Along with many other reproductive justice and feminist scholars, activists, and birth workers, I argue that colonialism and capitalism, which are inherently patriarchal, have utilized a specific narrative of reproduction as a tool of oppression (Mies 1986; Federici 2004; Kanaaneh 2002; Silliman et al. 2004; Apfel 2016; Ross and Solinger 2017). This discourse has been shaped by colonial and capitalist agendas which seek to invisibilize and devalue reproduction and produce and maintain control over "subordinate" individual's bodies and lives (Ortner 1974). Like any other project, it is an ongoing one that must continuously recruit individuals and buy-in to be achieved. In this sense, what I refer to as the "dominant" discourse is not always entirely hegemonic as there are moments where the project fails to wield and assert complete control and authority over marginalized individuals' bodies and families.[1] Concurrently, we can also locate and replicate other ways of birthing and projects of resistance or refusal which become their own valid discourse of reproduction. The following sections explore the historical role of the medicalization of childbirth on the dominant discourse, how it gets situated within the larger anthropological debate of modernity versus traditionalism, and reproductive justice as a movement that aims to disrupt the dominant discourse that discredits certain birthing people, care providers, and knowledge.

[1] Here I use dominant in the sense that this version of the discourse is upheld and recommended by the World Health Organization (WHO) and thus is built into political and legal systems and reinforced through popular media worldwide. Founded in 1948, the WHO is the "United Nations agency that connections nations, partners, and people to promote health, keep the world safe and serve the vulnerable – so everyone, everywhere can attain the highest level of health" (World Health Organization 2023). In the United States, 98.4% of individuals gave birth in hospitals in 2017 (Backes and Scrimshaw 2020).

The dominant discourse of reproduction and the subjects it produces are largely influenced by the widespread medicalization of reproduction and notions of modernity versus traditionalism that particularly emerged in places of early anthropological study. Since the early 13th century, external "state" entities have claimed a stake in reproduction and as Ross and Solinger state, these claims have turned a private human activity into a matter of public concern, sometimes a public obsession (Federici 2004; Ross and Solinger 2017). Feminist scholars critique the capitalist patriarchy's need to control reproduction and position the creation of a new male medical profession in the Middle Ages, which played a critical role in the witch hunts, as a weaponized effort to suppress women as healers and midwives[2] and further assert authority and power over women's bodies (Oakley 1979; Federici 2004; Ehrenreich and English 2010; Apfel 2016). Later in the early 20th century, the conception of the field of obstetrics in the US was seen as another male claim to the female reproductive body as it established its "knowledge and expertise," claiming superiority over birthing peoples' own knowledge and expertise (Oakley 1979). Science and the development of modern medicine constructed the dominant discourse of reproduction and childbirth as a medical subject; in the process the birthing person is transformed from subject: person having babies, to object: person becoming an obstetric patient (Oakley 1979). This shifted the entire domain and landscape of birthing from home to hospital, where new actors emerged as those who wield knowledge, authority, and decision-making power in these spaces.

Furthermore, obstetrics' role in the discourse of reproduction is uniquely entangled with the problematic binary opposition of worldviews that shaped many early anthropological studies: modernity versus traditionalism. The traditionalist worldview was associated with Indigenous communities,

[2] For centuries women were healers without degrees or certifications and were often the only ones serving the poor and women. They were barred from books and lectures, learned from each other, and passed on experience and wisdom (e.g., human anatomy, herbs, and drugs) intergenerationally. The rise of the European medical profession "cultivated their own breed of secular healers: the university-trained physicians" and with this came the legitimization of the medical student and doctor which were only men at the time (Ehrenreich and English 2010). In the US today, legally recognized doctors/midwives and doulas require universal training and certification to practice and provide support (Health Partners 2023).

negatively regarded as unsustainable and backward, and associated with spirituality and subjectivity while the modern worldview was associated with "western" thought, positively regarded as sustainable and advanced, and linked to science and objective truth (Kanaaneh 2002; Iseke 2013; Germond-Duret 2015). This debate created a false dichotomy in which the two worldviews were pitted against each other, and through colonial settler state and patriarchal ideals modernity was deemed the "correct" worldview while anything else was explicitly devalued and called primitive, uncivilized, and backwards. Within this hierarchical dichotomy, obstetrics, and those it recruits (e.g., birthing people and care providers) are considered modern or appropriate. Oakley states, "the modern woman still wishes to have faith in her doctor – to believe that she can hand over to him, without anxiety, the care of herself, and more important, that of her baby" and shows how cultural expectations that favor modernity have certain requirements of "good mothers" (Oakley 1979; Knudson-Martin and Silverstein 2002a; Goldbort 2006a; Callister, Beckstrand, and Corbett 2010a).

Today, in the US birthing is essentially synonymous with the biomedical context and the patient-doctor dichotomy with about 98.4% of all birthing people giving birth in a hospital (Backes and Scrimshaw 2020). However, anthropological, and public/global health literature and journalism have highlighted the stark asymmetry in authority and power that exists within the patient-doctor relationship (Roberts 1997; Silliman et al. 2004; Ross and Solinger 2017; Ginsburg and Rapp 1995a; Fathalla 1995; Sabin 2020; Vargas et al. 2021; Moyer 2022). The dominant discourse of reproduction gives the idea that there is only one correct and safe way to birth, and that this way requires the decision-making for birthing people by credentialed experts, modern medicine, and technological interventions and advancements. This leaves other safe and valid ways of birthing without legitimacy. This ultimately shifts authority and power away from the birthing person and some care providers to "legitimate" care providers and other external entities and individuals. I argue that birthing is yet another space in which the efforts to disempower people that can give birth has troubling and lasting effects on birthing people and their full personhood.

Reproductive justice movement scholars and activists condemn the dominant discourse of reproduction for the ways in which the actors it recruits cause harm to women, trans, nonbinary, poor, and people of color and infringe upon their human rights. They maintain that "safe and dignified fertility management, childbirth, and parenting together constitute a human right" (Ross and Solinger 2017). Movement leaders demand that all decisions about reproduction be made by individuals and couples based on their own preferences and abilities and advocate for them to have the social, economic, and political power and resources to do so. Birthing individuals have the right to give birth with whom, where, when, and how they choose (Ross and Solinger 2017). Birth justice is also at the heart of the social movement whereby activist care workers strive to shift authority and power from the hands of institutions into the hands of birthing people themselves (Silliman et al. 2004; Ross and Solinger 2017; Apfel 2016). Given my experience as a full spectrum birth doula, traditional doulas often act as the mediators between medical care providers and the birthing person in hospital settings. We remind both parties that birthing people have the human right to exercise authority and power over their own bodies and practices related to birthing. Yet, there is still a sense of an inherent hierarchical order of power and authority among both individuals and forms of knowledge. In the last few years, the birth justice movement has gained mixed support from medical professionals and politicians, but overall is supported as seen through California's Medi-Cal health insurance coverage of birth and abortion doula care and the Mamas First Act which aims for national Medicaid health insurance coverage of doulas, midwives, and tribal midwives (California Department of Healthcare Services 2023; Booker 2022).

In the US today, many individuals interact and gather information and knowledge to aid personal decision-making processes through forms of social media. Podcasts are rapidly growing in quantity, over 5 million, and in popularity worldwide as many individuals aim to entertain while disseminating knowledge or opinions through their perspectives. There are 464.7 million podcast listeners globally with predictions of an increase to 504.9 million by the end of 2024. The US has the most podcast listeners in

the world and about one third of the US population listens to podcasts regularly (Ruby 2023). Many reproductive health and birthing podcasts share health education and personal anecdotes and are typically engaged in a form of reproductive justice advocacy. The idea here is that podcast hosts, who are also care providers, explicitly communicate their goal to equip birthing people with knowledge to feel empowered and "make their own informed decisions", as many of them share in their podcast descriptions. Reciprocally, listeners tune in and engage with the material to gain knowledge about birthing that will ultimately inform their own ability to make decisions regarding their reproductive wellness. However, I argue that this may not be occurring in the interaction between the speaker or care provider, and the listener or birthing person in this more "neutral"[3] space compared to actual birthing spaces.

This analysis is centered on exploring what kinds of themes emerge regarding authority and power in maternal health decisions in birth education podcast conversations and whether there are differences in how authority is situated across care providers. How do care providers reinforce or perpetuate certain roles, relationships, practices, and hierarchical structures through their language, especially those intent on removing individual power and agency from certain individuals and groups? What conditions are necessary for empowerment and disempowerment to occur? In Anthropology of Power, Cheater and her colleagues discuss empowerment efforts and question whether power is being tangibly transferred to the historically powerless or whether this is a delusion (Cheater 1999). In other words, I am interested in how power and authority emerge in an allegedly postcolonial and postmodern world where the older rules of colonial domination are supposed to have less relevance. A corpus linguistic and discourse analysis will allow us to explore how power imbalances between key actors in

[3] I refer to podcasts and social media as neutral spaces of interaction between birthing people and care providers. By neutral, I mean that they are spatially and temporally located more distantly from places and moments where decisions about individual's reproduction and birthing are actively being made. In comparison, I would argue that terrains of encounters that occur during hospital births, prenatal doctor office visits, and reproductive health legislation (i.e. Roe v. Wade) are not neutral interactions because decision-making is occurring.

reproduction and birthing today are perpetuated, reinforced, and resisted through communication and encounter.

RESEARCH QUESTIONS

The key aim of this analysis is to compare the ways that care providers situate authority in podcasts regarding decisions about reproductive health and birthing. I will conduct a qualitative linguistic and discourse analysis on two podcasts to explore the following questions:

1. How do traditional birth workers (e.g., doulas, midwives) and biomedical care providers (e.g., obstetricians, obstetric nurses) situate and describe birthing people and providers in their conversations? Who or what is imbued with authority and power? How does their use of language reify certain roles and relationships between individuals?
2. How do care providers position and deploy language that implies authority and power in the context of decision making and birthing practices? What does their language communicate about forms of knowledge and larger discourses of power?

I intentionally chose two podcasts with different approaches but with the key similarity that both podcast hosts share an interest in women's rights and women's health, evident through their podcast profiles. Yet, we may still find interesting differences in how providers situate authority and power. I argue that, even in the attempt to equip birthing people with knowledge to inform their own decisions in birthing spaces, there are subtle and not so subtle indicators of authority and control in relation to decision-making.

METHODS

I conducted analyses using key-word-in-context (KWIC) and critical discourse analysis methods, drawing on podcast transcripts. The KWIC automation method allows the researcher to quickly locate

every use of a particular keyword and explore the way it is being defined and used in each unique context (Bernard, Wutich, and Ryan 2017). This discourse-centered methodological approach allows for a focus on the dialogical processes by which individuals, institutions, and knowledge are socially constructed through spoken discourse and how social meanings inform identity and relations of power (Farnell and Graham 1998).

I selected two podcasts representing holistic reproductive health and obstetric/gynecologic perspectives based on popularity and available number of episodes: *Birthful* and *The Ob/Gyn Podcast*, respectively. Each podcast has thousands of views and downloads and over 70 publicly available episodes and both podcast hosts happen to be from New York. *Birthful* is an active podcast hosted by a working doula who discusses a huge range of topics related to pregnancy, birth, and postpartum (e.g., unique birth stories, midwifery care, birth plans, effects of electronic fetal monitoring) with top expert and new parent guests. Her website reads: "Here to inform your intuition." Importantly, as a disclaimer in the podcast description, she notes that she is not a doctor, the show does not dispense medical advice, "always consult with your care provider." There is no such disclaimer on *The Ob/Gyn Podcast* whose last episode aired in 2020*;* the about section reads, "A podcast dedicated to bringing you detailed information on topics in Obstetrics & Gynecology." This podcast is hosted by a board-certified Ob/Gyn medical doctor and director of Ob/Gyn at a hospital who aims to educate people about topics in Obstetrics and Gynecology (e.g., discussions of peer reviewed articles, diabetes in pregnancy, ethics of breastfeeding with HIV, maternal mortality) in an "accessible and entertaining way." Guests include medical students, doctors, and specialists.

I randomly selected 20 transcripts from each podcast and ran analysis using MAXQDA software. To understand how language use in context reifies certain roles and relationships and how power is situated within these conversations, I established two sets of keywords related to the two research questions through a combined deductive and inductive approach: (1) types of individuals (e.g., care

providers and birthing people) and (2) indicators of decision-making most related to authority and power (e.g., choice and decision) (Table 1). The keyword lists were informed by listening to and learning about the two podcasts and hosts, my experiences working as a full spectrum birth doula, and exposure to various reproductive health literature and other reproductive health podcasts. Many of these keywords were also some of the most frequently used words across the two data samples. Using MAXQDA software, I analyzed all transcripts to identify the keywords and export those words with immediate context – the 15 words before and after keywords – to explore the language podcast hosts are using in conversation to situate individuals and decision-making (Ryan and Bernard 2003). Analysis of the 30 surrounding words allowed for deeper insights to surface while exploring the ways podcast hosts or guests use a keyword to portray a specific meaning or message to their podcast listeners, mainly birthing people (Leech and Onwuegbuzie 2007). Once immersed in the data, some of the segments did not provide enough context for inclusion, exclusion, and coding criteria; I expanded the context from 30 words to the entire surrounding paragraph directly in MAXQDA (Bernard, Wutich, and Ryan 2017). Over two months, I read all KWIC segments for both podcasts (n=7,144) to determine which segments would be included and coded and which would be excluded from coding.

I included every unique segment where speakers discussed birthing people and care providers, others or themselves, and their roles, relationships, responsibilities in reproductive and birthing spaces. I excluded repetitive iterations to not double count a code for the same section of the conversation: since the KWIC method pulled every iteration of a word separately, many segments were repeated if the sentence(s) contained the same keyword more than once (e.g., woman uttered 3 times over 30 words) or if the segments contained more than one keyword (e.g., doctor and patient). and where the use of the keyword did not relate directly to pregnancy, birthing, or postpartum. The kinds of segments that were excluded did not relate directly to pregnancy, birthing, or postpartum and tended to be about someone other than the birthing person or care provider (e.g., mother used to describe the birthing person's mother), decision-making regarding studies and trials, and irrelevant descriptive language about the

keyword (e.g., the doctor was on vacation). I clearly defined categories of similar meanings or codes that were related to authority and value including perspectives on individuals, knowledge, interactions, and decision-making related to pregnancy, birth, and postpartum. I sorted each included segment into the following codes, allowing for double coding when applicable: birthing people making decisions; decisions being made for birthing people; providers and birthing people engaging in shared decision-making; birthing people and provider(s) working together when decisions are not being made; speaker values the birthing person's needs, desires, and knowledge; speaker values something other than the birthing person's needs, desires, and knowledge; person indicated by or referring to the keyword possesses knowledge; and person indicated by or referring to the keyword is the recipient of knowledge (Figure 1). Using MAXQDA automated word counts and manual code counts, I created keyword and code frequency count tables (Tables 2, 3) and two KWIC code frequency count tables (individuals and decision-making) which included all keywords and how they were coded across both podcasts to determine similarities and differences (Tables 4, 5).

A common critique of KWIC technique is that "it can be difficult to see patterns and connections in the resulting array of text" as this method visually presents data as visually aligned and stacked keywords and their context in grouped categories (Wattenberg and Viégas 2008). In addition to the KWIC frequency count technique, I conducted a critical discourse analysis. Since communication between care providers and their audience is always a socially situated dialogic process, this additional immersion allowed me to explore and describe the nuances of how meanings were situated and expanded upon in each passage through the discourse (Bhaktin 1982). For the discourse analysis I read entire transcripts but focused on the passages surrounding all coded segments. The following analytic questions guided a deeper thematic data analysis:

How and why are certain individuals making decisions?

How do speakers justify their opinions on who can make decisions?

What types of knowledge and knowledge systems are discussed?

Which forms of knowledge are elevated and how is this done?

Are speakers constructing actors as active or passive? How?

This analysis allowed me to compare across the two podcasts to examine how individuals situate authority and power through my own exploration of repetitions, metaphors, similarities and differences, and linguistic connectors within the speech text in places that had already been coded. Additionally, I listened to each selected podcast episode to explore nuances in speech and tone (e.g., pauses and changes in tone) in each coded passage. Through KWIC and critical discourse analyses, I compared the ways different types of care providers situated individuals and decision-making regarding pregnancy, birthing, and postpartum to organize themes from the resulting findings (Ryan and Bernard 2003). By tallying and examining the frequency counts and coded information, patterns and key differences emerged within conversations in across the two podcasts. I grouped and summarized these patterns and themes and gave shape to the meanings podcast speakers ascribed to authority, reproduction and birthing, birthing people, and care providers. I acknowledge that the meanings I ascribed to the data including what I found meaningful, the codes I created and defined, and the following results and discussion sections are fully entangled with my lived experiences as the descendant of Mexican immigrants, a full spectrum birth doula trained by a Black midwife [4], and the product of a hospital birth where my mother did not speak the same language as her medical team and did not feel empowered or safe.

RESULTS

Speaker make-up varied across the two podcast samples: *Birthful* host (doula) invited mothers, doctors, maternal specialists, midwives, doulas, and other care providers related to pregnancy, birthing,

[4] Trained by Sumayyah Franklin at Sumi's Touch School. Training included midwifery, doula, and traditional medicine approaches and techniques regarding the full spectrum of reproductive care: healing, pregnancy, abortion, miscarriage, childbirth, and postpartum care.

and postpartum while *The Ob/Gyn Podcast* hosts (doctors) invited doctors and maternal specialists. Although the transcripts were similar lengths and the number of KWIC segments pulled for each podcast were similar (*Birthful* 3930 total segments and *The Ob/Gyn Podcast* 3214 total segments), there were fewer coded KWIC segments for *The Ob/Gyn Podcast* (n=547) compared to *Birthful* podcast (n=986). This is likely due to higher exclusion of segments on *The Ob/Gyn Podcast* as more of the discussions were about recently published studies and less about interactions in birthing and reproduction spaces explicitly. However, this is itself is a key finding as what speakers choose to speak on and highlight in their episodes also subtly communicates an elevation of the importance of certain types of knowledge and information that is deemed worth sharing. Frequency count data and deeper discourse analysis revealed four main themes: (1) worth and importance, (2) provider roles in birthing spaces, (3) integral actors in reproduction and birthing decision-making, and (4) shaping legitimacy.

(1) WORTH AND IMPORTANCE

Speakers on both podcasts acknowledged that reproduction and birthing is a nuanced and multidimensional process, and overtly described valuing the birthing person's needs, desires, and knowledge. However, the expression of these needs, desires, and embodied knowledge as important and valuable happened much more frequently, more than double the rate, in the *Birthful* podcast compared to *The Ob/Gyn Podcast*. Providers on both podcasts highlighted the importance of other factors (e.g., risk management) as integral parts of reproduction, birthing, and decision-making, though *The Ob/Gyn Podcast* providers valued other factors over two times more than speakers on the *Birthful* podcast, which sometimes included birthing people themselves. Further exploration of coded segments revealed that speakers on both podcasts additionally valued evidence-based research, medical knowledge, statistics, guidelines, patient risk management, medically necessary intervention, fetal safety, and liability and legal restrictions and felt that these things were also worthy of consideration in birthing spaces. Given the higher number of segments coded as "speaker values something other than the birthing person's needs, desires, knowledge" in *The Ob/Gyn Podcast* providers mentioned many of these shared values more

frequently. Additionally, there were distinctions in other values across the two subsets of speakers that did not overlap. Providers on the *Birthful* podcast valued ancient midwifery knowledge and practices, cultural practices, Black/Indigenous/women of color (BIPOC) midwives, nonwestern healing practices like acupuncture, mental health, and spirituality in the birthing process. While providers on *The Ob/Gyn Podcast* valued cost and cost efficiency, standardization of assessment and diagnosis, and genetics when providing care. Valuing the "emotional well-being" of the birthing person only came up once in *The Ob/Gyn Podcast* data set (OB 20, 78).

Expanding on the two codes regarding value, the discourse analysis revealed differences in how providers elaborated on their specific position and how they responded to certain needs or desires. There were some examples where providers from *The Ob/Gyn Podcast,* which were all doctors, valued the birthing person and their needs, but with specific caveats or restrictions. For example, one doctor valued birthing people's desire for home birth, but only if they were identified as "low-risk" by their doctor; it seemed unsafe to "allow" for a desired home birth if a person was deemed "high-risk" (OB 4, 429). This doctor also went onto describe that a "home birth-like delivery is a very well-crafted sentiment" and that doctors and hospitals should strive to make hospital births more like home births. This language extended over a few passages and seemed to indicate a tolerance of desire for home birth only if delivery still happens at the hospital, under the purview of a doctor and/or medical team. This individual transcript only contained four coded segments for keyword "midwife/midwives" and did not mention "doulas" – both are known to provide home birth care; in fact, there was only one coded segment using keyword "doula" throughout all transcripts for *The Ob/Gyn Podcast.*

Terms like "low-risk" and "high-risk" came up many times in coded segments and surrounding paragraphs for both podcasts. Providers on *The Ob/Gyn Podcast* frequently referred to birthing people as low or high-risk individuals – this seemed to imply that the term was inextricably linked to the individuals themselves or part of them as people. Instead of discussing low versus high-risk in terms of individuals,

Birthful providers described low versus high-risk situations or risk factors and used phrases like "put you in a higher-risk pregnancy bracket" (Birthful 10, 50) or "high-risk pregnancy." One provider said "I don't view mothers as high-risk. They have risk elements they were given in some context" (Birthful 9, 116).

(2) PROVIDER ROLES IN BIRTHING SPACES

There was a marked distinction in how providers interpreted and communicated their own role in relation to the birthing person and in the birthing space. Care providers from both podcasts engaged in supportive roles during birthing and described themselves as "guiding" and "taking care" of birthing people. They expressed the genuine desire to support and help birthing people have what they believed were good outcomes. *Birthful* presenters/providers described their role as supporting and facilitating, but not taking the lead – this included the two speakers who were doctors. Mostly, there was a sense that they acknowledged their knowledge and training, but felt their duty was to inform, not decide or act. Common verbs associated with these roles were encourage, talk, connect, teach, caution, instruct, and champion. On the other hand, *The Ob/Gyn Podcast* providers positioned themselves as experts in medical knowledge with a duty to "safely deliver babies and keep women alive," which is innately more tied to decisions or action. Common verbs associated with these roles were assess, counsel, treat, direct, decide, allow, let, and diagnose.

The most used keywords to describe the birthing person on *The Ob/Gyn Podcast* were woman/women, patient, and people/person, while *Birthful* podcast speakers most used people/person, body, and mother/mom. It is important to note how providers described birthing people and how they positioned themselves and other providers in relation to them more generally, while decisions were not being made. Providers on both podcasts mentioned collaboration through conversations between the provider and birthing person during the birthing process, describing situations where they were "on the same team" or "wanted the same things." Typically, in these instances, the provider and birthing person would come up with next steps together or discuss alternatives to a provider recommendation that was not

wanted by the birthing person. However, the rate for segments coded for providers and birthing people working together when a decision was not being made formally (e.g., provider keeping the birthing person informed on new information during pregnancy or during very early stages of birthing) was over twice as high for the *Birthful* podcast compared to *The Ob/Gyn Podcast.* Coded segments and podcast audios signaled that *Birthful* podcast providers thought working together was a normal and integral part of their work.

Furthermore, providers on *The Ob/Gyn Podcast* had different responses to a birthing person not wanting to do what the provider recommended that did not include working together or discussing alternatives. Listening to podcast audios revealed a shift in tone each time providers in *The Ob/Gyn Podcast* described situations like these. Often, there was a sense of frustration, disappointment, or condescension in the tonality of the speech in these moments. One provider said, "What do I do for this woman who against my recommendation is going to try to have a vaginal delivery…we just document, well at the end of the day we're not going to not take care of her" (OB 17, 392). Another provider did not comprehend why birthing people want to keep their placenta for encapsulation if there is "little science or data behind it" and said he and his colleagues, "sometimes [we] joke around like how do you know it's even your own placenta?" While listening to the *Birthful* podcast, I did not pick up on that same sense of frustration, disappointment, or condescension when discussing birthing people disagreeing with a recommendation. Most of the time, providers – mostly midwives – communicated an easiness to the birthing person guiding their own experience; this might be linked to the birth plans, options, and alternatives discussed in advance and in much more depth than is typical with hospital providers. Those moments of frustration, disappointment, or condescension did arise among providers in *Birthful,* but they arose when discussing harm toward birthing people, negative outcomes, or general frustration with the medical model of care. One example of these changes in tone arose through one episode where a doctor referred to the severe lack of training for obstetricians that is more concerned with expediency,

economics, and medical legal concerns than acquiring a nuanced skillset and the birthing persons needs and desires (OB 8, 38).

(3) INTEGRAL ACTORS IN REPRODUCTION AND BIRTHING DECISION-MAKING

There were more instances of both birthing people making decisions and providers and birthing people engaging in shared decision-making regarding pregnancy, childbirth, and postpartum practices in the *Birthful* podcast compared to *The Ob/Gyn Podcast*. Shared decision-making only came up in three of the 20 transcripts for *The Ob/Gyn Podcast*, compared to nine of the 20 *Birthful* transcripts. Often, *Birthful* providers alluded to their belief that birthing people should have full decision-making authority in these spaces. One of the doctors on *Birthful* advocated for shared decision-making and told the audience what questions to ask their medical providers to make sure they are a good fit and that they are open to shared decision-making before birthing. However, he also shared his unique perspective as a medical provider: "What unfortunately happens on the other end, the provider or that group begins to label that person as being somewhat a high friction point, maybe recalcitrant, so they start almost marginalizing that individual" (Birthful 9, 40). Providers on both podcasts had a similar number of segments coded "decisions being made for birthing people," with *The Ob/Gyn Podcast* having a slightly higher rate. However, when segments were coded this way in the *Birthful* podcast, providers more often expressed that this is how things are or have been, but not how they should be. They expressed a critique in instances where a decision was being made for the birthing person by someone else, much more often than *The Ob/Gyn Podcast* providers – where this critique was only evident a few times. Furthermore, *The Ob/Gyn Podcast* providers instead justified their need to make decisions regarding birthing by alluding to some of the values addressed in the "worth and importance" theme section (e.g., safety of the fetus, patient risk management, and insurance restrictions) as valid reasons for external decision-making. Most segments coded for birthing people making decisions in *The Ob/Gyn Podcast* were in regard to decisions about getting pregnant, having an abortion, and the postpartum experience, but not about birthing.

There was a clear indication of the disparity that exists in decision-making and power and how that disparity seems to be exacerbated by the hospital setting. In most of the descriptions of birthing in a hospital setting, there was a hierarchy at play where many non-birthing individuals acted as decision-makers, mainly doctors and sometimes, but less frequently nurses and pediatricians. In less frequent occasions within *The Ob/Gyn Podcast,* birthing people made decisions alone or in tandem with providers. In addition to individuals like care providers and administrators, the "medical system" and "hospitals" emerged as decision-making agents. For example, a doctor said hospitals often "tell patients they can't have VBAC [vaginal birth after cesarean] there" (Birthful 8, 76), and others expressed how American College of Obstetricians and Gynecologists (ACOG) guidelines and recommendations sometimes "decide." Providers, mostly those on *The Ob/Gyn Podcast,* seemed to refer to these larger external structures in a casual way that implied that these "knowledgeable" external agents are normally involved in birthing decisions. There were only a few instances when doctors expressed frustration at the issues this caused in their personal decision-making processes for birthing, further reinforcing that medical providers, not external agents, should be making decisions. Only some providers, mostly in *Birthful* podcast, critiqued these larger systems having decision-making authority as a problem: yet another thing that at times has more power or say than the birthing people themselves. One provider expressed her disbelief and concern over the phenomenon where "we have humanized the hospitals and dehumanized the literal, actual Black birthing people" (Birthful 15, 37).

(4) SHAPING LEGITIMACY

All providers across both podcasts positioned themselves and other care providers as possessing valuable knowledge through training or education or their experience as providers. Thus, both sets of providers granted themselves legitimacy through their knowledge and training which gave them the capacity to provide care to birthing people. Similarly, they also all communicated that there were moments when care providers were the recipients of knowledge. There were differences regarding what occurred in the surrounding discourse when providers situated themselves or colleagues as the "learners."

For providers in *Birthful* they mostly learned through additional trainings or nonprofit work, but there were a few key instances where they expressed learning from birthing people or from midwives or doulas about different approaches to birthing and care support and care relations. In *The Ob/Gyn Podcast,* providers learned from their own aggregate experiences providing medical care for other birthing people, new scientific or medical research, ACOG guidelines, or other doctors, specialists, or experts in obstetrics which was always associated with people with degrees or credentials. Additionally, in this data set there was no conversation about providers learning from birthing people and only one segment about them learning from midwives. In this podcast, across various episodes, doctors also talked about being unsure of the legitimacy of non-OB care providers including nurses. One doctor said they could not be sure what kind of training or knowledge nurses, midwives, doulas, or even medical residents had because he perceived quality of training in the US as commensurate to the amount of funding the training hospital receives (OB 16, 146). They mentioned that this was difficult to manage and was often linked to feeling like they had to make decisions. This seemed to imply a hierarchical positioning, not only within professions but also within the kind of knowledge possessed by each type of care provider.

Both podcast providers also acknowledged that birthing people possess knowledge regarding birthing whether innately or through educating themselves on the subject. However, providers in *The Ob/Gyn Podcast* more often claimed that birthing people were recipients of knowledge compared to the number of times they claimed that birthing people had their own valuable knowledge, while it was about the same for *Birthful* providers. There was also a subtle difference in the type of birthing people who possessed credible, trustworthy knowledge (associated with decision-making authority) and those who were only cast as recipients of knowledge or were portrayed as needing knowledge. In the *Birthful* podcast, many providers alluded to the innate or natural knowledge of the birthing person and/or that of their body to perform birthing, to know when to push, and to know when something is wrong, while this only came up in one episode transcript for *The Ob/Gyn Podcast*. A doctor in this same podcast explicitly stated their belief that birthing people simply cannot possess the capacity or framework to comprehend

such complicated medical subjects, at least not enough to have informed consent (OB 20, 214). Here, they were alluding to the number of years of medical and educational training that a doctor or specialist receives, or the number of years spent on research studies that birthing people do not possess. The guest doctor in the episode pushed back against this idea and suggested that although they might be an expert in the subject, birthing people are experts in themselves. Providers in both podcasts, though more often in *The Ob/Gyn Podcast*, referred to the "well informed/well educated" birthing person and associated them with more successful experiences and outcomes.

DISCUSSION

Though I have my own opinions on reproductive and birthing justice, the goal of this analysis was not to take a side or state that there is a definitive, best way to birth. It certainly was not a conversation about whether it is better to birth at home or in a hospital, with a doctor or a midwife, and with or without use of medical interventions or medical technologies. Instead, this analysis aimed to pay close attention to the ways in which providers discuss authority and power and construct themselves and birthing people, particularly in neutral encounters. These interfaces are where birthing people often engage as they seek answers to their questions and guidance for their reproductive and birthing experiences. What is being produced by these interactions and discourse? Are podcast hosts reinforcing or challenging certain "birther" and "provider" roles and expectations? Is the product supportive of the human rights effort to allow people to make decisions about themselves and their own bodies under every circumstance, including birth? Or do the outcomes of interaction reify that there are justifiable claims to certain bodies and restrictions to this human right?

For better or worse, formal care providers like doctors, nurses, midwives, and doulas and other individuals or institutions as agents recruited by the dominant discourse of reproduction are constructed as having the responsibility and unique knowledge and skillset to take care of birthing people and, at times, have the potential to reduce harm in terms of maternal and neonatal mortality (House of Representatives

2019). I say at times because it would be a severe injustice not to mention that this is not always the case; for example, in the US maternal mortality has increased in disproportionate ways in the past few years, but we will get into this more throughout the discussion. We as individuals are socialized from birth and learn social cues and significance from an early age, always picking up information from other people and language all around us. Ideas we see portrayed in a movie or social media post, words we read in books and news, and the direct and indirect messages we hear in our daily encounters and interactions with others inform the roles we feel we have been assigned to perform and the meanings we give them (Bhaktin 1982; Ram 2015). Thus, the four main themes in the findings are connected to other theory, findings, and implications; more broadly these themes also allude to complex processes of identity formation, agency, and the ethics of care. Reproductive justice underpins this study and as an activist scholar, I recognize the complexity of the different perspectives that exist regarding birthing and what is right and safe, while demanding respect and full autonomy for birthing people.[5]

(1) WORTH AND IMPORTANCE

In this first theme, different care providers across both podcasts all valued many important dimensions of reproduction and birthing including evidence-based research, medical and scientific knowledge, data and statistics gathered by scientists and researchers, guidelines put forth by medical experts and specialists, processes for patient risk management, medically necessary interventions, safety of the birthing person and fetus, and questions of liability enforced by the legal system. However, providers on the *Birthful* podcast expressed valuing birthing people and their needs, desires, and knowledge more than twice as many times as doctors on *The Ob/Gyn Podcast*. By ascribing importance and value to birthing people and the things they deem necessary and important for themselves and their families, care providers positively influence and shape societal perceptions of birthing people and those needs and desires. Moments of social encounter, as Barth theorizes, are where humans create meaning

[5] Full autonomy in reference to the definition of birth justice: the right to give birth with whom, where, when, and how birthing people choose (Ross and Solinger 2017).

about themselves, their place in society, and their relation to others (Barth 1998). In other words, encounter and language directly influence our understandings and perceptions of social organization and our place in social orders; in turn, we perform our designated social role and reinforce ideas about those roles to others. Furthermore, when doctors on *The Ob/Gyn Podcast* expressed valuing birthing people and their needs, desires, and knowledge they also openly communicated specific caveats or restrictions to listeners. I argue that stating that you respect and value a birthing person's desire to have a low intervention home birth but then stating that your solution to this desire is to make hospital births more like home births is contradictory and patronizing. It forces different ways of birthing into the medicalized way of birthing, implying that the medicalized way is preferred and somehow better (Silliman et al. 2004; Ehrenreich and English 2010).

More importantly these findings signal to birthing people that their needs and desires come secondary to the needs and desires of medical care providers and in subtle ways, this might also communicate a devaluing of home birth and those involved in home birth, including birthing people and care providers. Furthermore, this use of language also communicates certain values ascribed to modern medical birthing practices and historically traditional birthing practices. Beyond shared values, there was a stark difference in what *Birthful* providers valued (e.g., spirituality) compared to what *The Ob/Gyn Podcast* providers valued (e.g., assessment and diagnosis). This difference can be situated in the conversation about modernity versus traditionalism as the things doctors on *The Ob/Gyn Podcast* valued strictly aligned with ideals of modernity like science and the positivist worldview of the existence of absolute truth (Oakley 1979; Knudson-Martin and Silverstein 2002a; Goldbort 2006a; Callister, Beckstrand, and Corbett 2010a; Iseke 2013). The diverse speakers on the *Birthful* podcast placed value on a much wider spectrum of things across these two supposed binary oppositions, recognizing the importance of dimensions across both modernity and traditionalism. These encounters have deep implications on the agency and mental health of birthing people. Moreover, the words providers choose to deploy have the capacity to devalue certain worldviews and ways of existing that do not satisfy the status

quo. It is also important to note the ways race and gender constructs are associated with certain knowledge and worldviews and what political intentions surface when we consider the overt and subtle ways of valuing modern birthing practices more than others (Crenshaw 1991). Every birthing person is unique in a multitude of ways and has their own needs, desires, and knowledge and specific attitudes and beliefs around reproduction and birthing.[6] Individual agency and the authority to make decisions for oneself should be taken seriously as birthing people often have well informed and valid reasons to seek specific kinds of birthing and care (Martin 2001; Jackson, Schmied, and Dahlen 2013; Ross and Solinger 2017).

(2) PROVIDER ROLES IN BIRTHING SPACES

Key findings in this theme include how providers across the two podcasts position themselves and their roles in birthing spaces differently, how they refer to birthing people differently, and how they think about collaboration and partnership between birthing people and care providers differently. Doctors on *The Ob/Gyn Podcast* used verbs for their own actions (e.g., allow and let) in relation to birthing people and birthing that are innately linked to decision-making or being in charge. This links back to our definition of power, if the care provider can explicitly make decisions on their own and enforce obedience or tell birthing people what to do in birthing contexts, they are assumed to wield authority. Furthermore, these doctors also referred to birthing people as "patients" and "woman/women" much more frequently than speakers on the *Birthful* podcast. The use of language in these two topics create the set of requirements that exacerbate the unequal power dynamic evident in the doctor-patient relationship (Brannon 2016; Vargas et al. 2021). By positioning birthing people as a patient, providers construct them as someone who is sick: a subject to be treated and saved we undermine people's capacity and human right to make decisions about their own bodies and health. Brannon also discusses the gendered roles

[6] According to the United Nations and the US Centers for Disease Control and Prevention, there are approximately 10,687 people born each day in the US, meaning that thousands of birthing people give birth here every single day (National Center for Health Statistics 2021).

evident among expectations in doctor-patient interactions and how these influence the behavior of both providers and birthing people in these situations. Though more people are starting to see this relationship as a collaboration, the traditional conceptualization of this dynamic includes the "subordinate patient and the controlling practitioner where the patient role is more compatible with the stereotypically feminine than the stereotypically masculine role whereas the provider role is more consistent with traditional masculinity (Brannon 2016)." These expectations are still evident in this podcast analysis where providers on *The Ob/Gyn Podcast* referred to working together with their patients at half the rate that *Birthful* providers did. This, along with the change in tonality marked my frustration and tension that arose in moments when providers discussed disagreement about decision-making in birthing spaces, indicates a sharp contrast in the two approaches to care provision.

(3) INTEGRAL ACTORS IN REPRODUCTION AND BIRTHING DECISION-MAKING

This theme was of particular importance to how authority and power take shape in moments of decision-making, especially given the vast literature on how women's involvement, or lack of involvement in decision-making, can have significant impacts on birth experiences, care satisfaction, and postpartum mental health (Goldbort 2006a; Jackson, Schmied, and Dahlen 2013; Nieuwenhuijze et al. 2014; Wang et al. 2021a). Whether providers on the *Birthful* podcast alluded to how things are currently or their desire for how birthing should be, they discussed birthing people making decisions much more often compared to providers on the other podcast. On the other hand, the doctors on *The Ob/Gyn Podcast* spoke much more frequently about other care providers, agents, or entities making decisions for birthing people. These nuances in what speakers choose to highlight is important because it sets the tone for narratives of reproduction. If birthing people are tuning into social media accounts and podcasts to receive education and knowledge and inform their reproductive and birthing experiences, the messages they are hearing shape their ideas about who has authority and power in these spaces before they even go into labor.

One important anecdote by a doctor on an episode of *Birthful* chose to remark his experience as a medical provider and convey the unfortunate fact that when birthing people try to assert authority and agency with their medical care providers (e.g., doctors and nurses) or gain some sense of control over their experiences, they are labeled as problematic and uncooperative. He specifically uses the work "recalcitrant" which describes someone "having an obstinately uncooperative attitude toward authority or discipline." His choice of word elucidates where medical providers place authority in birthing spaces, even today, and if a birthing person is recalcitrant then they must be uncooperative toward medical providers who are then imbued with authority. We cannot overlook the growing body of research that overtly calls out abuses of authority in childbirth experiences, many of which are justified through the need for safe childbirth or in response to a birthing person's "uncooperative and problematic" behaviors and attitudes (Pickles and Herring 2020; Vargas et al. 2021). Though, birthing people have different perspectives on how involved they would like to be in birthing spaces (Nieuwenhuijze et al. 2014), providers expressing their desires to collaborate on decision-making or transfer decision-making authority to the birthing person construe birthing people as active and agentive actors while resistance to collaboration or justifying the need for others to make decisions for the birthing person may be interpreted as construing birthing people passive and disempowered subjects.

(4) SHAPING LEGITIMACY

Lastly, this theme about legitimacy is central to the reproductive justice movement and efforts to challenge the legitimacy of certain actors. The doctors on *The Ob/Gyn Podcast* only situated themselves as learners or recipients of knowledge when they had something to learn from their own aggregate experiences providing medical care for other birthing people, new scientific or medical research, ACOG guidelines, or other doctors, specialists, or experts in obstetrics. The people they learned from were always individuals with formal training, degrees, or credentials. As Mies and Ehnrenreich and English posit, the decentering and delegitimization of women healers and midwives was a strategic effort to place authority and power in other hands, always away from women and always away from lay healers who

"practiced magic" in healing (Mies 1986; Ehrenreich and English 2010). Following this theory and critique of medicine, it makes sense that in this randomized subset of data, those doctors never once mentioned learning from a birthing person and their innate or learned knowledge and mentioned learning from a midwife only once throughout all 20 episodes. This type of language does not inspire messages of equality or partnership and may very well reinforce the idea that the "modern woman" or the "good mother" should trust her doctor entirely (Oakley 1979; Goldbort 2006a). On the contrary, when listeners tune into the *Birthful* podcast and hear more often that care providers learn from birthing people and their knowledge they might receive a much different message that they possess valuable knowledge that is worth sharing they might be more likely to engage with their care providers in meaningful ways and feel good about all that they have to contribute in birthing and parenting spaces (Wang et al. 2021a; Beck 2020).

Moreover, *The Ob/Gyn Podcast* providers situated birthing people as recipients of knowledge more often than they situated them as possessing their own credible and trustworthy knowledge. This is directly linked to authority and decision-making because in reproduction and birthing narratives, safety and harm reduction are key topics of discussion. Safety has been constructed as entirely enmeshed with knowledge: the more training you have the better suited you are to practice safe medicine and keep people alive (Brannon 2016; Backes and Scrimshaw 2020). Thus, how much you know and that what you know is also positively or negatively associated with individuals and knowledge in the dominant discourse of reproduction. As Skalník argues in Anthropology of Power, "it seems that personalities may give authority to institutions and roles rather than the other way around" (Skalník 2003). Podcast hosts as personalities have an immense reach especially with the explosive, recent and projected growth in the podcast industry (Ruby 2023; Rephonic 2023). Who and what they grant and do not grant value and legitimacy to may not only give authority to certain roles and institutions, but it may convey to a wider audience a message about social order and power in decision-making in reproduction and birthing. Whether they reify or challenge the dominant discourse's historical attempts to achieve domination and

control can make the difference in reproductive justice and social change. Finally, one of *The Ob/Gyn Podcast* anecdotes illustrated in this theme of legitimacy regarding informed consent gives us a peak into the type of birthing person, if any, that might be granted legitimacy, authority, and thus decision-making power. The doctor says that he does not believe informed consent with patients can be achieved particularly in the case of breastfeeding with HIV, as he mentions that birthing people do not possess the level of training and education and years dedicated to research that specialists undergo. Through his language, tone, and the rest of his conversation he signals a single caveat to this belief, perhaps he might believe that if you are a medical provider with as many years of training, education, and research as the specialist then you can have informed consent with your care provider. This example highlights the problem that we run into when care providers idealize the "well-educated or well-informed" birthing person. Who is this elusive person? What do they look and sound like? Notions of identity and social status and personal implicit biases have a severe impact on the ways care providers perceive and treat birthing people. In my previous work in Peru, hospital care providers – both obstetricians and midwives – considered women who were "less educated" and "less prepared for birth" to be much more difficult to work with; these characteristics were often linked to class and indigeneity. I would be remiss not to mention (again) the harmful ways in which individuals' bodily autonomy and jurisdiction is constantly contested by "poverty, racism, environmental degradation, sexism, homophobia, and injustice in the US" (Crenshaw 1991; Silliman et al. 2004; Apfel 2016; Ross and Solinger 2017).

REPRODUCTIVE JUSTICE AND AGENCY

One of the main feminist critiques against the problematic narrative of "choice" in birthing is that it masks subtle forms of coercive medicine. By asserting that birthing health care is "choice-based," we ignore the fact that choice is not equitably accessible and overlook intersections of multiple identities that affect health care quality and health outcomes (Roberts 1997; Apfel 2016). Some of the providers in these podcasts actively contributed to spaces of true choice and decision-making, while others did not. In this way, providers' conversations communicate to birthers that birthing is not a space of true autonomy. In

support of the achievement of radical well-being, we as care providers, scholars, and activists must push back against narratives that situate capitalist and oppressive modes of relating to one another, especially in terms of reproduction. The two themes about value and decision-making show significant moments where this educational material subtly, and not so subtly, place more importance on things other than the birthing person and their needs and thus justify an external claim on the reproductive body. Solinger and Ross discuss coercive medicine and state that "no nonpregnant person can be compelled to undergo any medical procedure for the benefit of another person. Denying [them] the right of bodily integrity and effacing the decision-making authority that [they] would have legally possessed had [they] not been pregnant" (Ross and Solinger 2017). Where does a birthing person's agency begin and end? Some individuals have even been subjected to court orders forcing them to have cesarean births (Silliman et al. 2004). This gets into the political aspects of how power and authority is used in this setting to further oppress certain individuals, mainly women, trans, and nonconforming folks and imbricates the same legal and political systems in place to further marginalize these and BIPOC communities.

Birth is a deeply personal, physiological, and transformative process that, along with the birthing person, has been made subject to the medical industrial complex. We cannot deny the harm that is caused, directly and indirectly, by this project of subjectification of the birthing person through acts of obstetric violence, neglect, discrimination, lack of consent, and criminalization at the hands of care providers and institutions (Silliman et al. 2004; Ehrenreich and English 2010; Apfel 2016; Ross and Solinger 2017; Begley et al. 2019; Vargas et al. 2021; Martin 2001). Various scholars point to specific historical instances of this harm on birthing people, specifically BIPOC and poor individuals, in the US including state-mandated public health policy, forced sterilization and use of unsafe contraceptives, medicalization of childbirth and decreased agency during birthing, forced health interventions, welfare reform, coercive family planning programs and policy, charging birthing people with murder when they reject medical advice, and increased custody cases and forcibly removed children into the foster care system (Ginsburg and Rapp 1995a; Silliman et al. 2004; Ross and Solinger 2017; López-Espino 2022). We must critically

examine the historical, political, and social situating of reproduction and recognize the ways that race, class, sexuality, and gender exacerbate a desire to shift authority and power to someone other than the birthing person. In the call to empower birthing people we must recognize, that at every step of the way there are projects, both new and ongoing, that seek to dissuade people that they have the right and capacity to birth and parent in a way that best supports them and their families.

ETHICS OF CARE

It is one thing to say a birthing person should be empowered to make their own decisions and choices about how their birthing experience will go, but how are providers putting this into action? Hospitals, states, and other institutions have the authority to make decisions on large scales and in the individual reproductive lives of people; this shows how the abstract can have concrete and sometimes harmful effects on individuals especially regarding reproduction. Ethics of care focuses on the fundamental dependence of each individual and is wrapped up in consent and bodily autonomy. Yet, all themes revealed a reinforcing of certain kinds of hierarchical relationships of individuals and of the knowledge they possess. There is an inherent disconnect and disagreement between the needs and goals of the system and the need for birthing people to have full autonomy over their bodies in birthing spaces and spaces of care. Essentially, doctors are trained to find a problem and fix it and they take an oath to do no harm and 'keep people alive' and it is intrinsically tied to their profession and the social roles they must perform as doctors. This inadvertently clashes with birthing people/parents human right to bodily autonomy and the agency and autonomy they should be granted in decision-making related to their bodies and their families. Seemingly, these worldviews and what they need to accomplish contradict each other. Povinelli discussion of authenticity except when it undoes someone else gets to the issue we see here. What happens when your way of existing begins to encroach on mine? There are "irresolvable obligations" to the law and to morals (Povinelli 2002). There is clear tension here that needs to be worked through.

However, I argue that there is something missing from the list of justifiable exceptions to everyone's right to full bodily autonomy, by going back to the Hippocratic oath which vows to do no harm. Providers in the two podcasts all agreed on one thing: they all wanted 'successful outcomes.' What if we dare to expand the current definition of successful outcomes, refusing for the bare minimum of survival to count as success, and create a radical alterity of togetherness and care work and support between providers and birthing people? Midwives and doulas have been cultivating these spaces for centuries; the narrative of medicalized childbirth tried to silence them for a while there recently, but they came back stronger than ever (Ehrenreich and English 2010; Silliman et al. 2004; Ross and Solinger 2017). Providers all talk about short term success: the birth with no major negative health outcomes to the mother or child. Yet, postpartum mental health and wellness often gets overlooked and underappreciated for its importance and impact. A few of the key risk factors identified globally for postpartum depression (PPD)[7] are strained close relationships, stressful life events, prior history of depression, low social support, and unexpected birth outcomes (Goldbort 2006b; Wang et al. 2021b; Wong and Fisher 2009). Many qualitative studies revealed a major risk factor that quantitative studies were unable to capture – women felt that they were not living up to cultural standards of what it means to be a "good mother" (Goldbort 2006b; Knudson-Martin and Silverstein 2002b; Callister, Beckstrand, and Corbett 2010b; Oakley 1979). By reinforcing a lack of knowledge and thus authority over reproduction and a hierarchy of power that potentially renders birthing people as passive actors to whom birth is happening, we are failing the future parents that we are so desperately seeking to provide care for.

IDENTITY: MATERNAL LEGITIMACY VERSUS ILLEGITIMACY

The final point in the shaping legitimacy theme is the key source of inquiry here. The medical profession has been criticized for its treatment of female patients, especially in the ways that it constructs

[7] PPD is formally known as "Major Depressive Disorder (MDD) with Peripartum Onset" as defined in the most recent 5th edition text revision of the American Psychiatric Association (APA) *Diagnostic and Statistical Manual of Mental Disorders*, DSM-V-TR (Segre and Davis 2013).

"female patients" as incapable of participating in decisions concerning their own health and treatment (Brannon 2016). It is essential to question and critique what providers mean when they associate education with success. Do they mean educated people are more expressive of their needs during birthing or do they mean, like Oakley posits, that they trust their doctors and medicine, so they are less expressive? For each provider this may be different however this is especially critical because, as was alluded to throughout the findings section, birthing people who express their knowledge, needs, desires, and expertise in their own bodies to medical providers are often labeled as problematic or uncooperative. For individuals in the reproductive justice sphere this may not come as a surprise, but women of color and primarily Black women, have symptoms and complaints dismissed, are misdiagnosed, and are labeled as uncooperative more often than others (Moyer 2022). This is attained through the continued project of legitimizing certain bodies and delegitimizing others. The reproductive control of certain bodies both upholds and utilizes social constructions of "difference" to serve as a weaponized tool of oppression that seeks to advance colonial and patriarchal, hegemonic agendas (Davis 2015; Ginsburg and Rapp 1995b; Silliman et al. 2004; Ross and Solinger 2017).

This extends throughout the entire spectrum of reproduction – from pregnancy to childbirth to parenting. Providers' reference to the smart, educated birthing person reinforces an archetype of the successful birthing person – the ideal feminine woman and mother – who is then granted legitimacy and is constructed as someone capable of making decisions for themselves and their children. What about the pregnant person, birthing person, or parent who is constructed as uneducated or unfit? Mechanisms of power and authority, including language, serve certain hegemonic agendas which maintain social injustice (Farnell and Graham 1998). Roberts discussion of "incurable immorality," the idea that Black women transfer deviant lifestyles that lead their children to a life of poverty, delinquency, and despair, constructs them as subjects to be "monitored and restrained" (Roberts 1997).[8] In the same way we should pay

[8] "Incurable immorality" was coined by Herbert G. Gutman in The Black Family in Slavery and Freedom, 1750–1925 (New York: Pantheon, 1976), p. 541

special attention to the ways that decision-making in birthing is made portrayed as something that needs to be earned by some and something given as a human right to others. Constructions of the unfit Black and Latine mothers along with other myths and stereotypes of native women, Asian and Pacific Islander women, trans, and non-binary birthing are what underlies maternal legitimacy versus illegitimacy which translates to authority and power over one's own body and children (Martin 2001; Silliman et al. 2004; Ross and Solinger 2017; López-Espino 2021; 2022).

CONCLUSION

This research elucidates the subtle and overt ways in which care providers reproduce the narrative that the birthing person is a passive agent to whom birth happens at the hands of more capable experts and justifies the need for others to make decisions for birthing people. I argue that reifying this narrative causes direct harm by overlooking the importance of bodily autonomy and agency on postpartum mental health. Simultaneously, there is a competing narrative in which providers recognize the historical oppression on certain groups and value reproduction and postpartum mental health. This narrative instead seeks to create active agents where birthing people and their needs, desires, and knowledge are valued, and they are fully empowered to make reproductive and birthing decisions for themselves and their families. These findings have deep implications for the politics of reproduction, health care, and current and future birthing. As Apfel and other scholars and activists assert, reproduction has always been a site of resistance. A feminist ontology asserts that power differences shape the lived experiences of people and their meanings and recognizes that gender is one of many variables that intersect and produce differences in power among sets of people. Thus, this work calls for a "decentered nonauthoritarian approach to all human relationships and thinking about those relationships" and serves as a reminder that all knowledge is historically informed and socially produced (Gailey 1998). Consequently, it is possible to change our understanding of what is important and why.

Moreover, if meanings are formed through the encounter of individuals, it is critical that we examine the outcomes and products of these spaces and their discourse. Social media is only one of the many spaces of encounter between care providers and people who can birth and is likely one of the more neutral spaces of interaction compared to other interactions between the two. How language is used in all social contexts is key to understanding the meanings people ascribe to themselves and others. Specifically, for people with wombs, both direct and indirect interactions with laws, institutional policy, and care providers inform their own roles in relation to others, thereby shaping and informing identity and agency. By analyzing two podcasts which aimed to educate their audiences, we identified some of the ways different providers locate authority and power, whether intentionally or unintentionally. I argue that the meanings providers communicate about birthing people and decision-making in birthing and the potentially harmful roles and relationships they may reproduce, reify, or refuse likely translate into the type of care they provide in reproductive and birthing spaces. Certainly, the discourse birthing people engage in informs the conscious and unconscious ways they think about themselves and their bodies and impact their birthing and parenting experiences. It is of critical importance to further explore a continued lack of equitable autonomy and birth justice as it has severe implications for marginalized communities, postpartum mental health, and the health and wellness of future generations.

APPENDIX

Figure 1 – Codes and Definitions

Birthing people (BP) making decisions: a decision(s) regarding fertility, pregnancy, birthing, and postpartum practices and experiences is(are) made by the birthing person.

a decision(s) regarding fertility, pregnancy, birthing, and postpartum practices and experiences is(are) made by someone/something other than the birthing person.

Decisions being made for birthing people: a decision(s) regarding fertility, pregnancy, birthing, and postpartum practices and experiences is(are) made by someone/something other than the birthing person.

Shared decision making: a decision(s) regarding fertility, pregnancy, birthing, and postpartum practices and experiences is(are) made by the collaboration of someone/something other than the birthing person, typically but not necessarily care providers, and the birthing person.

Working together when decisions are not being made: care provider(s) and birthing person are collaborating and working together during fertility, pregnancy, birthing, and postpartum, but a decision is not being made.

Speaker values the birthing person's needs, desires, and knowledge: person speaking expresses the value of a birthing person and their body, lived experience, needs, desires, and knowledge in the birthing space.

Speaker values something other than the birthing person's needs, desires, and knowledge: person speaking expresses the value of anything other than a birthing person and their body, lived experience, needs, desires, and knowledge in the birthing space.

Has knowledge: Person indicated by or referring to the keyword possesses knowledge or is expressing knowledge.

Recipient of knowledge: Person indicated by or referring to the keyword does not have knowledge, needs knowledge, or is receiving knowledge from someone or something else.

Table 1 - Keywords

Indicators of individuals	Indicators of "decision making"
advocate patient woman/women mother/mom human person/people body provider surgeon OB/obstetrician doctor nurse midwife/midwives doula expert specialist individual	decision/decide choice/choose in charge require convince pressure power control authority desire prefer wish want need best better necessary important effective success

Table 2 – Keyword count[9] by podcast

Keyword (individuals)	# of keyword in Ob/Gyn[10]	# of keyword in Birthful[11]	Keyword (decision-making)	# of keyword in Ob/Gyn	# of keyword in Birthful
advocate	*	*	decision/decide	71	89
patient	91	12	choice/choose	16	64
woman/women	583	128	in charge	*	2
mother/mom	26	90	require	23	23
human	*	*	convince	*	*
person/people	370	492	pressure	*	*
body	22	210	power	12	48
provider	12	113	control	40	47
surgeon	12	1	authority	*	*
OB/obstetrician	29	17	desire	*	*
doctor	30	78	prefer	1	13
nurse	27	31	wish	5	19
midwife/midwives	44	152	want	267	294
doula	1	312	need	125	241
expert	4	4	best	42	68
specialist	*	4	better	95	74
individual	17	22	necessary	7	7
-			important	98	94
-			effective	13	2
-			success	18	8

* zero occurrences in coded segments

[9] Number of times keyword occurred in each podcast. This number was not converted to frequency as the total words in each data sample was well over 100,000 words and the percentages are all below 1.
[10] 135,457 words in *The Ob/Gyn Podcast* sample data.
[11] 126,845 words in *Birthful* sample data.

Table 3 – Code frequency count by podcast

	# of segments (rate%)[12]	
Code	**Birthful**	**The Ob/Gyn Podcast**
BP making decisions	124 (12.6%)	51 (9.3%)
Decisions being made for BP	100 (10.1%)	73 (13.4%)
Shared decision-making	42 (4.3%)	10 (1.8%)
Values BP	221 (22.4%)	47 (8.6%)
Values something other than BP	131 (13.3%)	202 (36%)
Working together	174 (17.7%)	46 (8.4%)
BP has knowledge	146 (14.8%)	64 (11.7%)
BP is recipient of knowledge	47 (4.8%)	52 (9.5%)
Total (number of codes)	985	547

[12] Rates shown in percentage and calculated by dividing the number of instances of the code by the total number of codes for that podcast and multiplying by 100.

Table 4 – KWIC indicators of individuals code frequency

Keyword	Code	Frequency[13] of code in Birthful	Frequency of code in OB/GYN
body	BP making decisions	6.1%	42.9%
	Decisions being made for BP	3.8%	7.1%
	Providers & BP engaging in shared decision making	1.5%	-
	Has knowledge	21.4%	7.1%
	Recipient of knowledge	2.3%	7.1%
	Values BP	42%	14.3%
	Values something else	9.9%	21.4%
	Working together	13%	-
doctor	BP making decisions	2.7%	6.3%
	Decisions being made for BP	32.4%	12.5%
	Providers & BP engaging in shared decision making	2.7%	-
	Has knowledge	24.3%	37.5%
	Recipient of knowledge	5.4%	-
	Values BP	-	3.1%
	Values something else	13.5%	31.3%
	Working together	18.9%	9.4%
doula	BP making decisions	18.5%	-
	Decisions being made for BP	3.7%	-
	Providers & BP engaging in shared decision making	6.2%	-
	Has knowledge	19.8%	100.00%
	Recipient of knowledge	6.2%	-
	Values BP	9.9%	-
	Values something else	11.1%	-
	Working together	24.7%	-
expert	Has knowledge	75%	100%
	Values BP	25%	-
individual	Values BP	100%	-
midwife	BP making decisions	10%	-
	Decisions being made for BP	2.5%	-

[13] Frequency or rates shown in percentage and calculated by dividing the number of instances of the code for each keyword by the total number of coded segments for that keyword and multiplying by 100.

	Providers & BP engaging in shared decision making	7.5%	-
	Has knowledge	30%	-
	Recipient of knowledge	2.5%	-
	Values BP	10%	-
	Values something else	2.5%	100%
	Working together	35%	-
mother/mom	BP making decisions	14%	9.1%
	Decisions being made for BP	7%	9.1%
	Providers & BP engaging in shared decision making	14%	-
	Has knowledge	9.3%	-
	Recipient of knowledge	4.7%	18.2%
	Values BP	16.3%	-
	Values something else	14%	54.6%
	Working together	20.9%	9.1%
nurse	BP making decisions	8.3%	-
	Decisions being made for BP	16.7%	14.3%
	Has knowledge	25%	28.6%
	Recipient of knowledge	-	21.4%
	Values BP	4.2%	7.1%
	Values something else	8.3%	21.4%
	Working together	37.5%	7.1%
obstetrician/OB	BP making decisions	4.2%	-
	Decisions being made for BP	12.5%	12.5%
	Providers & BP engaging in shared decision making	8.3%	-
	Has knowledge	33.3%	31.3%
	Recipient of knowledge	8.3%	12.5%
	Values something else	20.8%	43.8%
	Working together	12.5%	-
patient	BP making decisions	33.3%	14.9%
	Decisions being made for BP	-	6.8%
	Providers & BP engaging in shared decision making	-	4.1%
	Has knowledge	8.3%	5.4%
	Recipient of knowledge	8.3%	14.9%
	Values BP	8.3%	5.4%

	Values something else	41.7%	25.7%
	Working together	-	23%
people/person	BP making decisions	21.2%	15.1%
	Decisions being made for BP	5.3%	12.3%
	Providers & BP engaging in shared decision making	2.3%	1.4%
	Has knowledge	6.1%	11%
	Recipient of knowledge	15.9%	13.7%
	Values BP	15.9%	11%
	Values something else	9.8%	32.9%
	Working together	22.7%	2.7%
provider	BP making decisions	4.8%	-
	Decisions being made for BP	17.5%	13.3%
	Providers & BP engaging in shared decision making	7.9%	-
	Has knowledge	9.5%	33.3%
	Recipient of knowledge	3.2%	6.7%
	Values BP	3.2%	13.3%
	Values something else	14.3%	13.3%
	Working together	39.7%	20%
specialist	Has knowledge	50%	-
	Values science	25%	-
	Working together	25%	-
surgeon	Has knowledge	-	50%
	Values BP	-	50%
	Values something else	100%	-
woman/women	BP making decisions	11.6%	8.3%
	Decisions being made for BP	20.9%	19.8%
	Providers & BP engaging in shared decision making	-	1.9%
	Has knowledge	14%	4.5%
	Recipient of knowledge	-	7.6%
	Values BP	14%	14%
	Values something else	25.6%	35%
	Working together	4.7%	8.9%

Table 5 – KWIC indicators of decision-making code frequency

Keyword	Code	Frequency of code in Birthful	Frequency of code in OB/GYN
best	BP making decisions	18.2%	-
	Has knowledge	27.3%	28.6%
	Values BP	36.4%	14.3%
	Values something else	18.2%	57.1%
better	BP making decisions	13.3%	-
	Decisions being made for BP	6.7%	5.3%
	Has knowledge	26.7%	10.5%
	Recipient of knowledge	-	21.1%
	Speakers\Values BP	13.3%	-
	Values something else	40%	57.9%
	Working together	-	5.3%
choice	BP making decisions	33.3%	-
	Decisions being made for BP	14.3%	-
	Providers & BP engaging in shared decision making	4.8%	-
	Values BP	19%	-
	Values something else	9.5%	100%
	Working together	19%	-
choose	BP making decisions	44.4%	100%
	Decisions being made for BP	11.1%	-
	Providers & BP engaging in shared decision making	11.1%	-
	Has knowledge	22.2%	-
	Working together	11.1%	-
control	BP making decisions	14.3%	-
	Decisions being made for BP	28.6%	-
	Providers & BP engaging in shared decision making	14.3%	-
	Has knowledge	7.1%	-
	Recipient of knowledge	7.1%	-
	Values BP	21.4%	-
	Values something else	-	100%
	Working together	7.1%	-
decide	BP making decisions	50%	25%

	Decisions being made for BP	-	25%
	Providers & BP engaging in shared decision making	27.8%	-
	Has knowledge	-	25%
	Values BP	11.1%	25%
	Values something else	5.6%	-
	Working together	5.6%	-
decision	BP making decisions	39.1%	18.2%
	Decisions being made for BP	21.7%	63.6%
	Providers & BP engaging in shared decision making	17.4%	9.1%
	Has knowledge	8.7%	-
	Values BP	4.3%	-
	Values something else	-	9.1%
	Working together	8.7%	-
effective	Values something else	-	100%
important	Has knowledge	23.1%	-
	Values BP	46.2%	4.8%
	Values something else	23.1%	95.2%
	Working together	7.7%	-
in charge	Decisions being made for BP	50%	-
	Has knowledge	50%	-
necessary	Decisions being made for BP	-	100%
	Has knowledge	25%	-
	Values something else	75%	-
need	BP making decisions	9.5%	-
	Decisions being made for BP	7.1%	10.5%
	Providers & BP engaging in shared decision making	1.2%	5.3%
	Has knowledge	3.6%	5.3%
	Recipient of knowledge	2.4%	21.1%
	Values BP	40.5%	-
	Values something else	22.6%	36.8%
	Working together	13.1%	21.1%
power	BP making decisions	4.8%	-
	Decisions being made for BP	19%	-

	Has knowledge	9.5%	-
	Recipient of knowledge	4.8%	-
	Values BP	42.9%	100%
	Values something else	14.3%	-
	Working together	4.8%	-
prefer	Has knowledge	16.7%	-
	Values BP	16.7%	-
	Values something else	33.3%	100%
	Working together	33.3%	-
require	Decisions being made for BP	33.3%	33.3%
	Has knowledge	33.3%	33.3%
	Values something else	33.3%	33.3%
success	Values something else	-	100%
want	BP making decisions	8.3%	20%
	Decisions being made for BP	9.5%	13.3%
	Providers & BP engaging in shared decision making	1.2%	6.7%
	Has knowledge	10.7%	13.3%
	Recipient of knowledge	1.2%	13.3%
	Values BP	48.8%	6.7%
	Values something else	6%	26.7%
	Working together	14.3%	-
wish	Decisions being made for BP	50%	-
	Has knowledge	16.7%	-
	Recipient of knowledge	16.7%	-
	Values BP	16.7%	-

BIBLIOGRAPHY

Apfel, Alana. 2016. *Birth Work as Care Work: Stories from Activist Birth Communities*.

Backes, Emily P., and Susan C. Scrimshaw. 2020. "Maternal and Newborn Care in the United States." In *Birth Settings in America: Outcomes, Quality, Access, and Choice*. National Academies Press (US). https://doi.org/10.17226/25636.

Barth, Fredrik. 1998. *Ethnic Groups and Boundaries: The Social Organization of Culture Difference*. Waveland Press, Inc.

Beck, Cheryl T. 2020. "Mother-Infant Interaction During Postpartum Depression: A Metaphor Analysis." https://doi.org/10.1177/0844562119897756.

Begley, Keith, Deirdre Daly, Sunita Panda, and Cecily Begley. 2019. "Shared Decision-Making in Maternity Care: Acknowledging and Overcoming Epistemic Defeaters." *Journal of Evaluation in Clinical Practice* 25 (6): 1113–20. https://doi.org/10.1111/JEP.13243.

Bernard, H. Russell, Amber Wutich, and Gery W. Ryan. 2017. *Analyzing Qualitative Data: Systematic Approaches*. Second Edition. Sage Publications.

Bhaktin, M.M. 1982. *The Dialogic Imagination: Four Essays*. University of Texas Press Slavic Series.

Booker, Cory. 2022. "Booker, Warren, Casey, Moore Introduce Mamas First Act to Combat Maternal Mortality Crisis." 2022. https://www.booker.senate.gov/news/press/booker-warren-casey-moore-introduce-mamas-first-act-to-combat-maternal-mortality-crisis.

Brannon, Linda. 2016. *Gender: Psychological Perspectives.* Taylor & Francis.

California Department of Healthcare Services. 2023. "Doula Services as a Medi-Cal Benefit." https://www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx.

Callister, Lynn Clark, Renea L. Beckstrand, and Cheryl Corbett. 2010a. "Postpartum Depression and Culture: Pesado Corazon." *MCN The American Journal of Maternal/Child Nursing* 35 (5): 254–61. https://doi.org/10.1097/NMC.0B013E3181E597BF.

Cheater, Angela. 1999. *The Anthropology of Power: Empowerment and Disempowerment in Changing Structures*. Routledge.

Crenshaw, Kimberlé Williams. 1991. "Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color." *The Public Nature of Private Violence: Women and the Discovery of Abuse*, February, 1241–99. https://doi.org/10.2307/1229039.

Davis, Georgiann. 2015. *Contesting Intersex: The Dubious Diagnosis*. *New York University Press*. https://doi.org/10.1177/00943061166645241.

Ehrenreich, Barbara, and Deirdre English. 2010. *Witches, Midwives & Nurses*. Second Edition. The Feminist Press.

Farnell, Brenda, and Laura R Graham. 1998. "Discourse-Centered Methods." In *Handbook of Methods in Cultural Anthropology*, 411–57.

Fathalla, Mahmoud F. 1995. “The Impact of Reproductive Subordination on Women’s Health.” *The American University Law Review* 44: 1179–89.

Federici, Silvia. 2004. *Caliban and the Witch: Women, the Body and Primitive Accumulation*. Autonomedia.

Foucault, Michel. 1969. *The Archaeology of Knowledge*. Editions Gallimard.

Gailey, Christine Ward. 1998. “Feminist Methods.” In *Handbook of Methods in Cultural Anthropology*, 203–33.

Germond-Duret, Celine. 2015. “Tradition and Modernity: An Obsolete Dichotomy? Reflection on Binary Thinking and Indigenous Peoples.” https://doi.org/10.1080/01436597.2015.1135396.

Ginsburg, Faye D, and Rayna Rapp. 1995a. *Conceiving the New World Order: The Global Politics of Reproduction - Google Books*. University of California Press.

Goffman, Erving. 1956. *The Presentation of Self in Everyday Life*. University of Edinburgh.

Goldbort, Joanne. 2006a. “Transcultural Analysis of Postpartum Depression : MCN: The American Journal of Maternal/Child Nursing.” The American Journal of Maternal/Child Nursing. March 2006. https://journals.lww.com/mcnjournal/Abstract/2006/03000/Transcultural_Analysis_of_Postpartum_Depression.12.aspx.

Health Partners. 2023. “Midwife vs OB-GYN: What’s the Difference? .” 2023. https://www.healthpartners.com/blog/midwife-vs-obgyn-whats-the-difference/.

House of Representatives. 2019. “Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.” *Better Data and Better Outcomes: Reducing Maternal Mortality in the U.S.: Hearing before the Subcommittee on Health of the Committee on Energy and Commerce: House of Representatives, One Hundred Fifteenth Congress, Second Session* . https://heinonline.org/HOL/Page?handle=hein.cbhear/fdsysavhz0001&id=1&div=&collection=congrec.

Iseke, Judy. 2013. “Spirituality as Decolonizing: Elders Albert Desjarlais, George McDermott, and Tom McCallum Share Understandings of Life in Healing Practices.” *Decolonization: Indigeneity, Education & Society* 2 (1): 35–54. https://canvas.ucsd.edu/courses/32052/files/5914471?module_item_id=1150020.

Jackson, Melanie, Virginia Schmied, and Hannah Dahlen. 2013. “Birthing Outside the System: In Pursuit of the Best and Safest.” *Women and Birth* 26 (October): S17–18. https://doi.org/10.1016/J.WOMBI.2013.08.271.

Kanaaneh, Rhoda Ann. 2002. *Birthing the Nation : Strategies of Palestinian Women in Israel*. University of California Press. https://www.ucpress.edu/book/9780520229440/birthing-the-nation.

Knudson-Martin, Carmen, and Rachelle Silverstein. 2002a. “Suffering in Silence: A Qualitative Meta-Data-Analysis of Postpartum Depression.”

Leech, Nancy L, and Anthony J Onwuegbuzie. 2007. “An Array of Qualitative Data Analysis Tools: A Call for Data Analysis Triangulation.” *School Psychology Quarterly*. Educational Publishing Foundation. https://doi.org/10.1037/1045-3830.22.4.557.

López-Espino, Jessica. 2021. “Raciolinguistic Ideologies of Spanish Speakers in a California Child Welfare Court.” *Metalinguistic Communities*, 205–23. https://doi.org/10.1007/978-3-030-76900-0_10.

———. 2022. “Finding Excuses, Determining Risk: Latinx Parent Experiences in a California Child Welfare Court.”

Martin, Emily. 2001. *The Woman in the Body: A Cultural Analysis of Reproduction*. Beacon Press.

Mies, Maria. 1986. *Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour*. Zed Books.

Moyer, Melinda W. 2022. “Women Are Calling Out ‘Medical Gaslighting.’” *New York Times*.

National Center for Health Statistics. 2021. “Births and Natality.” Centers for Disease Control and Prevention. 2021. https://www.cdc.gov/nchs/fastats/births.htm.

Nieuwenhuijze, Marianne J, Lisa Kane Low, Irene Korstjens, and Toine Lagro-Janssen. 2014. “The Role of Maternity Care Providers in Promoting Shared Decision Making Regarding Birthing Positions During the Second Stage of Labor.” *J Midwifery Womens Health* 59: 277–85. https://doi.org/10.1111/jmwh.12187.

Oakley, Ann. 1979. A Case of Maternity: Paradigms of Women as Maternity Cases on JSTOR, 4 607–31.

Ortner, Sherry B. 1974. “Is Female to Male as Nature Is to Culture?” In *Women, Culture, and Society*. Stanford University Press.

Pickles, Camilla, and Jonathan Herring. 2020. *Women’s Birthing Bodies and the Law: Unauthorised Intimate Examinations, Power and Vulnerability*. Bloomsbury Publishing, PLC.

Povinelli, Elizabeth A. 2002. *The Cunning of Recognition: Indigenous Alterities and the Making of Australian Multiculturalism*.

Ram, Kalpana. 2015. “Moods and Method: Heidegger and Merleau-Ponty on Emotion and Understanding.” In *Phenomenology in Anthropology*, 29. Indiana University Press.

Rephonic. 2023. “Tap into the Power of Podcasting.” 2023. https://rephonic.com/.

Roberts, Dorothy. 1997. *Killing the Black Body: Race, Reproduction, and the Meaning of Liberty*. Pantheon Books. https://doi.org/10.1086/384248.

Ross, Loretta, and Rickie Solinger. 2017. *Reproductive Justice: An Introduction*. University of California Press. https://doi.org/10.1525/9780520963207.

Ruby, Daniel. 2023. “41+ Podcast Statistics For 2023 (Listeners & Market Size).” Demand Sage. 2023. https://www.demandsage.com/podcast-statistics/.

Ryan, Gery W, and H. Russell Bernard. 2003. “Techniques to Identify Themes.” *Field Methods* 15 (1): 85–109. https://doi.org/10.1177/1525822X02239569.

Sabin, Janice A. 2020. “How We Fail Black Patients in Pain.” Association of American Medical Colleges. 2020. https://www.aamc.org/news-insights/how-we-fail-black-patients-pain.

Segre, Lisa S, and Wendy N Davis. 2013. “Postpartum Depression and Perinatal Mood Disorders in the DSM.”

Silliman, Jael, Marlene Gerber Fried, Loretta Ross, and Elena R Gutiérrez. 2004. *Undivided Rights: Women of Color Organizing for Reproductive Justice*. South End Press.

Skalník, Peter. 2003. “Authority versus Power: A View from Social Anthropology.” *The Anthropology of Power: Empowerment and Disempowerment in Changing Structures*, January, 161–72. https://doi.org/10.4324/9780203427057-18/AUTHORITY-VERSUS-POWER.

Vargas, Brianna, Paola Louzado-Feliciano, Nicole Santos, Shannon Fuller, Sopiko Jimsheleishvili, Ángela Quiñones, and Holly H. Martin. 2021. “An Exploration of Patient-Provider Dynamics and Childbirth Experiences in Rural and Urban Peru: A Qualitative Study.” *BMC Pregnancy and Childbirth 2021 21:1* 21 (1): 1–15. https://doi.org/10.1186/S12884-021-03586-Y.

Wang, Ziyi, Jiaye Liu, Huan Shuai, Zhongxiang Cai, Xia Fu, Yang Liu, Xiong Xiao, Wenhao Zhang, Elise Krabbendam, Shuo Liu, Zhongchun Liu, Zhihui Li, and Bing Xiang Yang. 2021a. “Mapping Global Prevalence of Depression among Postpartum Women.” *Translational Psychiatry 2021 11:1* 11 (1): 1–13. https://doi.org/10.1038/s41398-021-01663-6.

Wattenberg, Martin, and Fernanda B Viégas. 2008. “The Word Tree, an Interactive Visual Concordance.”

Wong, Josephine, and Jane Fisher. 2009. “The Role of Traditional Confinement Practices in Determining Postpartum Depression in Women in Chinese Cultures: A Systematic Review of the English Language Evidence.” *Journal of Affective Disorders* 116 (3): 161–69. https://doi.org/10.1016/J.JAD.2008.11.002.

World Health Organization. 2023. “Safe Childbirth.” 2023. https://www.who.int/teams/integrated-health-services/patient-safety/research/safe-childbirth.