How Are Babies Made?

Discourses of foetal "persons" and pregnant "mothers" in news media and health education texts

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Abstract

Adopting a social constructionist perspective this research asks *how are babies made?* This question destabilises the local reproductive context asking how foetuses and their mothers have come to matter. I have analysed "everyday" texts broadly circulated in this context addressing matters related to pregnancy. These include health education posters intended to communicate health information to pregnant women, and news media articles from daily newspapers throughout Aotearoa New Zealand. Using a discourse analytic method, I have identified a strong discursive practice of subjectifying foetuses as entities separate from pregnant women with distinct identities: foetal persons. While foetal subjects take various forms, the dominant construction is the "unborn baby," a vulnerable infant who must be protected from harm and emerges as the central subject of pregnancy.

The construction of pregnant subjects in these texts relates to the construction of foetal subjects. Pregnant women (and potentially pregnant women) are reduced to their bodies' reproductive role as "maternal environments," ones which pose risks to the foetus. However, they are also constructed as maternal subjects. As "mothers," pregnant women are individually responsible for ensuring the health and wellbeing of foetuses. The "good mother" *will of course do anything she can* for her "child" by self-regulating her potentially harmful behaviour. The "acquiescent mother" acquiesces to biomedical interventions on behalf of the foetus. Pregnant subjects who do not self-regulate their behaviour and acquiesce to biomedical interventions are "bad" maternal subjects who harm their "children."

The discourses of biomedicine (and biomedical sciences) and public health, particularly those of risk, emerge as dominant in constructing and naturalising of these reproductive subjects. I consider the implications of these subjects for social practices around reproduction, and for midwifery practice.

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The ideas presented in this thesis have been accumulated in my years both studying and practicing midwifery and were inspired by the women, whose journeys through this perhaps most complex and profound of human experiences, I have been lucky enough to share. However they are ideas which have been refined, developed and in many ways transformed through the process of undertaking this research. My thesis supervisors Dr Lesley Patterson and Dr Avril Bell have helped me enormously with this process and I have greatly appreciated their time, encouragement, feedback, and advice. I would also like to acknowledge Dr Jenny Coleman for her advice and encouragement at various points during this thesis. I would like to acknowledge the College of Humanities and Social Sciences at Massey University Wellington for the provision of a wonderful postgraduate workspace and resources, and the support of the administrative staff in both the college and the School of Sociology, Social Policy and Social Work, Fred and Jasmine. I have also greatly appreciated the financial support for this thesis provided in the form of a Massey Masterate Scholarship.

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List of Intertexts

Bodies, then, are not born: they are made

(Haraway,1989: 10)

Chapter One

Foetal Positions : An Introductory Context

> Perhaps no flesh is more over determined with cultural meaning than the female reproductive body.
>
> (Newman, 1996:2)

It is Wednesday morning, the 4th January 2006 and I have sat down with a coffee and the morning newspaper. My thesis proposal is due and I will spend the day writing. While I am interested in issues surrounding reproduction, and in particular reproductive rights, I fear that it has all been said already; that 'feminism' and 'reproduction' are old news.

I scan my eyes over the front page. I am greeted by the headline in bold: '***Abortion linked to mental problems***' (Robotham, 2006, January 4: 1). A new abortion controversy has been sparked by the findings of a scientific study led by a Dr David M Fergusson PhD at the Christchurch Medical School. A psychologist and epidemiologist, Fergusson has found that: 'having an abortion as a young woman increases the risk of developing mental health problems including depression, anxiety and substance abuse' (Robotham, 2006, January 4: 1). The subsequent debate rages in the popular media for most of January as I prepare to commence this thesis. Almost immediately the radio talkback phones ring hot; news segments and articles in magazines and newspapers appear; panels of "experts" are rolled out on current affairs shows; letters to the editor and letters to the editor about letters to the editor flourish. *Everyone*, it seems, wants their say; and *everyone*, it seems, has something different to say.

Unsurprisingly, the anti-abortion movement called Fergusson's study a victory: finally some scientific evidence that could be used to challenge Aotearoa New Zealand's already precarious legal access to abortion based on "mental health" grounds.[1] A.B. Patelesio from Wainuiomata wrote in a letter to the editor of the *Dominion Post* on January 9th, 2006:

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[1] The findings of this study were significant to the anti-abortion movement because women's "right" to access legal abortions in this country is still based on a legal "loophole" within the Crimes Act 1961 where

> A small victory for the unborn, or is it (Jan 4)? We thought we had won the battle over abortion when scientific evidence proved that, from the moment of conception, all the necessary elements that create a new human life are present. However, the abortion industry, Family Planning Association and successive governments closed ranks and the argument conveniently moved from a moral, or even legal one, to the right of a woman to choose. (2006, January 9: 6)

The medical advisor for New Zealand Family Planning Association was surprised by Fergusson's findings and called for more research, as did the chief executive of the Mental Health Foundation, who stressed the complexity of the causes of mental ill health. Members of the Abortion Supervisory Committee, who oversee abortion services in this country, dismissed the ways in which the findings were presented and emphasised the importance of context. Fergusson himself emphasised the "reliability" and "a-political" nature of his findings and distanced himself from either side of the abortion debate. The science should speak for itself he claimed. Politicians were strangely quiet. Consumers of abortion services were silent.

I suspect that many feminist activists and scholars observed this controversy over abortion with interest and concern. Many now take as "givens" the "wins" of several decades of feminist struggles to secure what I will broadly define as reproductive freedoms (access to safe and legal abortions; access to contraception; access to free and safe maternity care with a choice of birth place; type of maternity care and carer; and paid maternity leave). However this controversy demonstrates the on-going instabilities in these freedoms. These instabilities are reflected on a global scale. According to the World Health Organisation, 19 million women worldwide continue to experience an unsafe abortion each year, 68, 000 of whom die from resulting complications (World Health Organisation, 2005). Further, 1600 women and over 10, 000 newborns die every day due mostly to complications that could have been prevented during pregnancy or childbirth, 98 percent of whom are from the developing world (World Health Organisation, 2005). In the United States the "abortion war" continues unabated. At the

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abortion remains a crime unless, severe foetal abnormalities and pregnancies resulting from sexual assault aside, a woman can convince two biomedical experts that the 'continuance of the pregnancy would result in serious danger (not that normally attendant upon childbirth) to the life or the physical or mental health of the woman' (as cited in Simmons, 2005: 27).

legislative level reproductive rights are constantly challenged by the political right and much energy is consumed with trying to keep abortion legal. For many women abortions remain extremely difficult to access, and where services are available clinics have been the targets of violence by anti-abortion groups. The statistics of crimes relating to abortion practice in the United States are extraordinary:

> ...in the first half of the 1990s there were five murders, eleven attempted murders, six bombings, twenty-nine incidents of arson, 352 incidents of vandalism, thirty-eight incidents of assault and battery, 168 death threats, seventeen burglaries, 214 stalkings, 1674 hate mailings and phone calls, 7011 bomb threats, 8764 pickets, 252 clinic blockades, and 9315 arrests of anti-abortion protestors at U.S. clinics. (Casper, 1999: 103)

However, despite the serious physical threats to women in the reproductive context on a global level, attempts to control reproduction, at least in the west where the material gains have been greatest, have taken on a new locus. Increasingly centred is the struggle about what it *means* to make babies. Of particular concern for feminists has been the emergence of naturalised foetuses as social actors within the discursive landscape. It would seem that the meanings inscribed upon these public foetuses are now contributing to pervasive cultural understandings of reproduction as a conflict between two separate individuals with their own needs and rights: pregnant women and foetuses (Michaels & Morgan, 1999).

One needn't look far for evidence of these developments within our local context. Images of foetuses proliferate: "floating in space", they appear as separate entities from the pregnant women in whom they are located. They populate roadside billboards funded by the anti-abortion movement. They are on the front pages of newspapers and magazines announcing "exciting new developments" in reproductive technologies, in health education materials and in glossy coffee table books that show us "how life began." They are in movies, on advertisements, and are proudly displayed as baby's "first picture" following ultrasound examinations during pregnancy. However, foetuses are not only image; they also increasingly speak to us through the protests of anti-abortion activists, through public health messages imploring women to change their behaviours, and through the advice (or

imperatives) given to pregnant women from maternity carers (biomedical and midwifery) and concerned "others" - families, friends and "responsible citizens" (Squier, 1991).

At the same time, foetal physiology and medicine are rapidly growing areas of biomedical research and expertise, and there is now a constant stream of "new research evidence" tracing any number of health (and social) problems to foetal experiences in the "womb environment."[2] Because the knowledge claims of science and biomedicine continue to hold cultural authority as "neutral" and "objective," they rapidly become established as contemporary certainties, our reproductive reality, and thus more difficult to question and challenge. They also have major implications. In the January 4th article cited earlier, despite stressing the apolitical nature of his findings, Fergusson himself recognises the political implications of scientific knowledge projects in the local reproductive context, stating: 'The results could undermine the legal basis for access to abortion in jurisdictions where termination is legal only if continuing the pregnancy would threaten the woman's physical or mental health' (Robotham, 2006, January 4: 1). Of concern for feminist analyses of the reproductive context is the extent to which the meanings now gathering around, indeed constituting, reproductive bodies may support political agendas which threaten women's reproductive integrity and the reproductive freedoms gained thus far (Michaels & Morgan, 1999).[3]

As the struggle over reproduction has increasingly become one about what it *means* to make babies, the theoretical influences of poststructuralism have been very timely. With an emphasis on the ways in which meanings are constructed, poststructuralist perspectives and the analytical tools of social constructionism have been particularly useful for feminists' challenging the contemporary certainties that define and shape women's reproductive bodies, practices, and

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[2] These studies are making big news. One very regular presence in the local media has been 'super scientist' Professor Peter Gluckman, director of the University of Auckland's Liggins Institute, whose 'world first research is proving the foetal origins of subsequent growth and health' (Peter Gluckman – super scientist, 2004, December 18: B1-B3).

[3] 'Reproductive integrity' is a term borrowed from Michaels and Morgan (1999), which I use to refer to the notion of women's "wholeness" in their experiences of reproduction: being able to act according to their own beliefs, needs and values, as well as maintain their sense of bodily boundary.

experiences. Further, poststructuralist perspectives on power have helped to resolve some tensions for feminists' reproductive political strategies, which have been constructed around the notion of "A Woman's Right to Choose." Particularly challenging has been how to approach the reproductive context in a way that does not reduce women to passive victims of reproductive institutions, technologies and practices – for both anecdotal and research evidence tells us clearly that they are not – whilst being able to reveal and challenge the ways in which power works through the reproductive context.

Poststructuralist theory challenges the naturalness of rational unified selves, able to direct their own life trajectories, a notion of the individual that has been at the heart of "modern theory" and has been positioned as the actor in feminist political strategies. By contrast, from the poststructuralist perspective, individuals – their bodies, identities, practices and "choices" – are understood as constituted from the meanings produced by discourse. In other words, women *may* be agents making their own reproductive "choices" and negotiating their own reproductive experiences, identities and practices. However, they do so within a complex network of socially constructed meanings which may constrain, or render impossible, certain of those "choices." The abortion controversy cited earlier is an excellent example of this. The meanings produced about women's reproductive bodies by this "scientific study" potentially restrict women's "choice" to have an abortion through the communication (construction) of mental health risks.

Feminist analyses of the reproductive context that have adopted such perspectives can be described as 'deconstructive' in character. They seek to destabilise dominant reproductive meanings and knowledges, rejecting as they do any notion that making babies can ever be reduced to 'literalised and universalised women's body parts' (Haraway, 2000: 232). Armed with these analytical instruments, feminists have approached the reproductive context, or rather contexts, asking how (and why) babies (and mothers) have come to matter in the ways that they have. Yet while the intention is to destabilise, these reproductive knowledge projects are not only seeking to dismantle. They also seek to generate or to transform through knowledge projects characterised by what Haraway (2000:

235) calls *yearnings*: for freedom and justice for *all* humans, for the recognition of common commitments and of differences in all political projects, and for new ways in which to speak of, experience and practise reproducing.

Utilizing poststructuralist perspectives, and in particular the analytical instruments of social constructionism, I have sought to destabilise the local reproductive context. Following the advice of Smith (1987: 175-176), I have investigated how power operates by analysing textual materials that intersect with our immediate everyday lives. Thus I have sampled "everyday" texts within my local reproductive context - daily newspaper articles and health education posters addressing matters related to pregnancy to consider the following research questions:[4]

- How are reproductive bodies and the bodily experience of being pregnant discursively constituted?
- What reproductive subjects are produced as a result?
- How can we understand the relationships between the constitution of reproductive bodies and subjects, and social practices around reproduction?

To analyse the selected texts I developed a form of qualitative discourse analysis informed by the theoretical perspectives of feminist poststructuralism. This involved repeated deconstructive readings of the texts, noting patterns and recurring themes in terms of what was being said, about what, and by whom. In analysing these texts, I was interested in how reproductive bodies and the bodily experience of being pregnant was discursively constituted and constructed; the communities of practice or interests implicated in these constructions; and the reproductive subjects that were produced as a result. I was also interested in what the implications of these constructions may be for reproductive practice.

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[4] The newspaper articles are from daily newspapers throughout Aotearoa New Zealand and were sampled over a 10 month period from the 1st October 2005 until the 31st July 2006. The health education posters, which are frequently displayed in clinic rooms, hospitals, parent education centres and parent shows, were sampled in February/ March 2006 from Regional Public Health and were developed by both the Ministry of Health and non-governmental health advocacy organisations.

As a midwife, I act within the contested domain of reproduction that I am researching. Midwifery plays a major role in the provision of maternity care in Aotearoa New Zealand. Midwifery's location as a profession autonomous from biomedicine, and its articulation of a philosophical framework that asserts that midwives work in partnership with women, have been very significant to Aotearoa New Zealand's reproductive politics (Guilliland & Pairman, 1995). My experiences as a midwife have largely provided the impetus and focus for this research. However, they have also provided challenges. There is a tension for me here between the constructionist ontology that informs this research, and the 'real' women with whom I work. My concern is whether the analysis of reproductive bodies and subjects as social constructs necessarily entails the denial of the material bodies who reproduce. If it does, how can I, as a midwife, negotiate such a position? This tension will be considered at various points throughout this thesis.

Structure of Thesis

This thesis is in seven chapters. This first chapter provides the context within which the research inquiry is located. Chapter Two is a literature review, overviewing the theoretical foundations adopted for this research, and feminist reproductive studies that have already utilised this perspective to question *how babies are made*. Chapter Three locates this inquiry within wider epistemological debates about the status of knowledge produced by feminist poststructuralist and discourse analytic research, and provides a detailed account of the design and process of this research project. Chapters Four and Five present the findings of this research. Chapter Four presents an analysis of six health education posters developed to communicate pregnancy health information within Aotearoa New Zealand. Chapter Five presents the analysis of 35 daily newspaper articles related to pregnancy sampled over an eight month period.

In Chapters Four and Five I identify the strong discursive practice of subjectifying foetuses as entities with their own identities, separate, but also at great "risk" from, the pregnant women in which they are located. My findings also demonstrate the extent to which the construction of pregnant women relates to the

construction of foetuses. Pregnant women in these texts are reduced to their bodies' reproductive role as "maternal environments," environments potentially perilous to these foetal subjects. However, pregnant women are also constructed as "maternal" subjects. As "mothers" they are constructed as individually responsible for ensuring the health and wellbeing of these foetuses, both through their acquiescence to expert advice, surveillance, management and intervention; and through their own self-regulation of potentially "risky" behaviours.

Chapter Six provides a discussion of the research findings. I first provide a brief summary of my findings and discuss three of the specific strategies whereby the scientific, biomedical and public health knowledges about reproductive bodies in these texts are consolidated as certainties or "facts." Using Foucault's notion of *disciplinary power*, I then consider the potential implications of these constructions for reproductive practices. I argue that reproductive bodies and subjects in my local context are being *made* in ways that may result in the *discipline* of pregnancy through its construction as a "risky" process which requires expert surveillance, intervention, and self-regulation, in order to protect the foetus. However, I caution against theorising women as a monolithic category who are all subject to the exercise of disciplinary power in the same way, and whose responses will be uniform and universal. I recognise the limitations of this research and propose further research which may consider how women negotiate these dominant reproductive meanings in relation to their own lives and embodied experiences. Finally, I consider my own community of practice in relation to these findings and the extent to which midwifery is implicated in the *discipline* of pregnancy. Chapter Seven provides a brief summary of the thesis. In my concluding comment I reconsider the tension between the theorisation of mothers and babies as social constructs, and the "real" bodies encountered in my "everyday" midwifery practice.

Chapter Two

How Are Babies Made? : A Review of the Literature

> It turns out that addressing the question of where babies come from puts us at the centre of the action in the New World Order. With roots in local and international women's health movements as well as in various scholarly communities, since the early 1970s feminists have developed a rich toolkit for technoscience studies through their attention to the social-technical webs that constitute reproductive practice.
>
> (Haraway, 2000: 232)

Introduction

In this chapter I consider feminist inquiries into the reproductive context and the social-political meanings that constitute it. I first articulate the theoretical framework which underpins this research, discussing how postmodernism and poststruturalism have formed the "backcloth" to social constructionism (Burr, 1995: 12). I then explore how feminist poststructuralist inquiries into the reproductive context have utilized social constructionism to destabilize the ontology of reproductive embodiments and practices, asking instead how women's reproductive bodies and foetal bodies, through discourse and practice, have come to "matter" in the ways that they do. In particular, I examine how visualisation technologies and legal, biomedical and public health discourses have contributed to the construction of "foetal subjects" displayed within different discursive terrains. This literature review raises many issues, as well as conceptual frameworks, for my own investigation.

Social Constructionism and Feminist Poststructuralism

For several decades the founding assumptions of modern "western" social, political and cultural theory have been deeply challenged and destabilized by the intellectual and cultural movements of postmodernism and poststructuralism. In sweeping attacks on the 'falsely universalizing, over-generalising and over-ambitious' "grand" modern theories of social reform, such as liberal humanism, structural functionalism and Marxism, these newer intellectual movements have

sought to destabilize the Enlightenment beliefs that underpin them (Barrett & Phillips, 1992: 1).

At the heart of the Enlightenment were beliefs in the practices and values of science as ways of understanding the "truth" about the natural and the social worlds; in the unified rational thinking "self"; and in social and political progress (Pilcher & Whelehan, 2004: 109). In contrast, postmodernism and poststructuralism have critiqued these dominant modern knowledge forms, rejecting the authority of science and the notion of an ultimate "truth," and questioning of the inevitability and benefits of progress. Poststructuralism has also rejected the liberal humanist notion of the unified and rational self able to direct their own life trajectory, and the structuralist emphasis on social structures (such as patriarchy and capitalism) in determining social relations. Instead, poststructuralists have adopted a social constructionist perspective, shifting attention to the ways in which language, knowledge and power interact, shaping social relations and practices, and constructing our sense of our selves.

Burr (1995: 12) argues that the intellectual movements of postmodernism and poststructuralism have formed the cultural and intellectual "backcloth" against which the theoretical perspectives of social constructionism have taken shape. Burr (1995) identifies four key social constructionist concepts: a critical stance towards taken-for-granted knowledge; the historical and cultural specificity of all knowledge; knowledge is produced through social interaction, especially language and discourse; and constructions of knowledge have effects on social practices and vice versa.

In its critical stance towards our taken-for-granted ways of understanding the world, social constructionism calls into question the analytical categories, such as gender, that we use to give the world meaning, arguing that they are not the reflection of some naturally occurring reality. This perspective invites us to be critical of the Enlightenment idea that our observations of the world unproblematically yield its nature to us, and further to question whether objective, unbiased observation of the world is possible at all (Burr, 1995: 3). Rather, from a

social constructionist perspective, the ways in which we commonly understand the world, the categories and concepts we use, are considered to be historically and culturally specific. In other words, the knowledges we have of the world are artefacts of a particular society and culture. Attention must thus be turned away from trying to understand the true "nature" of *how things and people are*, to an examination of the historical and cultural practices which over time have stabilized to *make* things the way they are. Indeed, it is not enough to ask where knowledges come from; we also must ask *how* they are produced (Burr, 1995: 7).

Social constructionists take the perspective that knowledge is constructed as people interact together in the course of daily life. While social constructionists insist on the productive nature of all social interactions, they are specifically interested in the effects of language because of its centrality to interaction. From a social constructionist perspective, language is understood as more than a way of expressing ourselves; it is one of the ways by which the world becomes constructed (Burr, 1995: 7). Finally, these social constructions of the world are understood as consequential in that they generate or validate certain types of social practices and exclude others.

Like social constructionism, feminist poststructuralism has rejected the realist ontology of the Enlightenment. Many feminists have rejected the ability of liberal feminism's individualism, and the large-scale structural analyses of patriarchy and capitalism articulated by Marxist and radical feminists, to explain and challenge the operation of power in determining gender relations. Further, the poststructuralist rejection of essentialist theoretical categories has disrupted the very ability of feminists to speak for and of women as a unitary category. While there has been much debate and indeed concern that poststructuralism undermines the political potential of feminism, which has mobilised its strategies around women as a unitary category and the demand for their "rights" – those belonging to the rational unified "self," many feminists have joined sympathies with the poststructuralist critical project. A particular appeal of poststructuralist theory is that is has helped to resolve some major contradictions between feminism's theoretical and political projects, in particular between, on the one hand, the

theorisation of the large-scale social structures that oppress women, and, on the other, women as agents of change and choice (Weedon, 1997).

Feminist poststructuralism contributes a gender dimension to contemporary critiques of modern theory and the re-theorisation of social organisation and power. Feminist poststructuralists have contributed to the "linguistic turn" in social science by focusing on the ways in which language, knowledge and power interact to construct and reproduce gendered meanings and shape the ways we experience our selves, our bodies and the social and material worlds (Petersen & Lupton, 1996; Weedon, 1997: 21). Central to the explanatory framework of feminist poststructuralism are social constructionist perspectives, especially those concerning language and discourse, subjectivity, truth and power, and the body.

A major influence of poststructuralist theory has been the increasing interest in and emphasis on the role of language and discourse in social organization and notions of reality (Lupton, 2003; Mills, 1997; Weedon, 1997). Contrary to realist ontological perspectives, where language is conceptualised as an expressive, transparent medium or vehicle for communicating "real" things, poststructuralists see language as a system that has its own determining effect in the ways that individuals think and express themselves (Mills, 1997: 7). The structuralist linguist, Ferdinand de Saussure, was perhaps the first to intimate the semiotic concern that language constitutes social reality and that, 'neither social reality nor the "natural" world has fixed intrinsic meanings which language reflects or expresses' (Weedon, 1997: 22).

Poststructuralists have taken this concern with the constitutive effects of language further by viewing language not as an abstract system of meaning, as de Saussure argued, but rather one which always exists in historically and culturally specific discourses that are themselves the product of power relations (Weedon, 1997: 23). The poststructuralist concept of discourse can be understood as the marriage of:

> ...the structuralist semiotic concern with the form and structure of language and the ways in which meaning is established with an understanding that language does not exist in a social vacuum but is embedded in social and political settings and used for certain purposes. (Lupton, 2003: 20)

Discourses can be understood as patterned systems of figures of speech, concepts, values, symbols and statements which form in coherent ways to describe, categorise and give meaning to the social and physical worlds – indeed which construct all that we understand to be real (Lupton, 2003: 20). In this sense, discourses can be understood as *productive*: they are systematic ways of making sense of the world by inscribing and shaping power relations within all texts, including spoken interactions (Baxter, 2003: 7). Court and Court (1998: 128) describe discourses as gathering around people and objects and providing a competing range of ways of giving meaning to the material world, as well as a range of subject positions, or ways of being in the world.

The *effects* of discourses, or sets of discourses, can be detected because of the 'systematicity of the ideas, opinions, concepts, ways of thinking and behaving which are formed within a particular context,' and because of the effects of those ways of thinking and behaving for social practices. We can assume, for example, that there is a set of discourses implicated in the construction of feminine and masculine identities, because women and men behave within a certain range of parameters when defining themselves as gendered subjects (Mills, 1997: 16).

In terms of thinking about discourse as having *effects* or being *constructive* in the reproductive context, it is important to consider the notions of knowledge, truth and power which produce these *effects* (Mills, 1997: 16). Knowledge and truth, from a social constructionist perspective, are not things that exist outside of people and their interactions but are things that are produced or constructed through discourse (Weatherall, 2002: 79). In the contested area of reproduction, then, a significant question is: which knowledges come to receive the label of "truth" or "common sense" and which do not? From this perspective, official knowledge and practice, indeed truth, is the product of the discursive work people do to exclude certain knowledges and to stabilise or naturalise others as "true" within the context of discursive power relations. Thus, rather than existing in a social vacuum, discourses can be understood as in conflict over what constitutes "truth" and "authority" (Mills, 1997: 17).

In the analysis of discourses, the interest is thus not with *which* discourse is a true or accurate representation of the "real," but with the mechanics whereby a discourse is produced as the dominant official discourse, supported by social institution, while others are marginalized or dismissed (Mills, 1997: 17). Power is central to discussions of discourse, and conceptualizations of how it operates have been completely reworked. Rather than assuming power to be the monolithic property of some individuals who exercise it to violate the rights of those who do not have it, as argued by liberal feminists, or that power relations are determined by gendered economic relations and the state, as Marxist feminists have argued, power is understood as filtered through all social relations as an *effect* of discourse (Weatherall, 2002: 80). In other words, rather than being a repressive force, power is understood as *productive* and, as such, 'involves more subtle mechanisms of power/knowledge whereby we are "persuaded" to act and think in certain ways that are deemed appropriate for us' (Ryan, Carryer & Patterson, 2003: 49). Power produces possible forms of behaviour as well as restricting others. It is "everywhere," diffuse and invisible, often enforced as much by self-surveillance as by authority figures (Ryan, Carryer & Patterson, 2003: 49). Pilcher and Whelehan (2004: 115) argue that this poststructuralist analysis of power allows for a more nuanced interrogation of the relations of power for feminist inquiries into the reproductive context. The goal in the analysis of discourses from a feminist poststructuralist perspective becomes the identification of the particular interests that are served, and power relations that are supported, in textual practice.

One of the major *effects* of discourse/power from a poststructuralist perspective is the construction of subjectivity. Poststructuralism offers an "antidote" to liberal humanism's Enlightenment "self" (the rational and unified individual who produces and directs their own life trajectory), the very self who has been central in feminist reproductive political strategies in their demand for reproductive "choices" (Davies, 1991: 42). In its place the feminist poststructuralist perspective argues that the experience of being a person is fragmented and contradictory, constructed from the discourses around it. Bearing in mind the poststructuralist theory of power as productive, power is understood as producing possible forms

of self as well as restricting selves. In other words, power relations produce particular forms of subjectivity (and associated behaviour) through discourse rather than simply repressing them (Mills, 1997: 17). As Foucault explains:

> The individual is not to be conceived of as a sort of elementary nucleus... on which power comes to fasten...In fact, it is already one of the prime effects of power that certain bodies, certain gestures, certain discourses, certain desires, come to be identified and constituted as individuals. (1980 as cited in Mills, 1997: 19)

The feminist poststructuralist concept of subjectivity has major implications for how we understand agency. While in the liberal humanist model of the person, agency is understood as a "natural" feature of sane adult human beings who are able to act freely, making choices based on rational thought, from a poststructuralist perspective, people's "choices" are understood to be shaped by discourses, the influence of which they may not be aware of, because of their location within these discourses (Davies, 1991: 46). In other words, "choices" are not free, because it is the subject's positioning within particular discourses that constructs their "chosen" line of action. This is not because there are no other lines of action available, but because one has been subjectively constituted through one's placement within that discourse to *want* that line of action (Davies, 1991: 46). Davies (1991: 46) argues that by making clear the way in which a person is subjected by discourse, poststructuralist theory shows how agency is partial.

This notion that power is exercised through the construction of subjectivity has been very useful to feminist analyses of the reproductive context. From this perspective women can be understood as agents who, if able, will make their own reproductive "choices," and have their own individual reproductive experiences, whilst recognising that they do so within a complex network of discourses (the effects of power) which construct reproductive selves and may constrain, or render impossible, certain "choices."

The Body and Disciplinary Power

> The body is the inscribed surface of events (traced by language and dissolved by ideas), the locus of a dissociated self (adopting the illusion of a substantial unity), and a volume in perpetual disintegration.
>
> (Foucault, 1984 as cited in McNay, 1992: 15)

The concept of the body as a social construct is of central interest to this research. From this perspective, the body is not a biological given but is rather the product of certain kinds of knowledge, discourses and practices, which are historically and culturally specific and which are always part of a wider network of power relations (Gatens, 1991; Lupton, 2003; Weedon, 1997). Power, through discourse, constitutes particular kinds of bodies, empowering them to perform particular kinds of tasks, and thus constructing specific kinds of subjects (Gatens, 1991: 132).

From the social constructionist perspective there is thus 'no such thing as the "natural" or "pre-social" body; it is impossible to know the body outside of the meaning of its cultural significations' (McNay, 1992: 38). Indeed, as Haraway (1989: 10) argues, bodies have been thoroughly "denaturalised." Bodies are *made*: 'they are constructs of a world-changing kind', mediating as they do all our body experiences through both life and death (Haraway, 1989: 10). Butler (1993: 45) thus calls for 'a return to the notion of matter, not as site or surface, but as a process of materialization that stabilizes over time to produce the effect of boundary, fixity, and surface we call matter'. In other words, from a social constructionist perspective we no longer assume bodies to be natural entities but instead ask how they *come to matter* in the ways that they do – as the *effects* of discourses belonging to particular institutions and communities of practice.

If the body, including the reproductive body, is to be understood as the product of discourse, then science and biomedicine become important sites of analysis. This is because they are social institutions that have been, and continue to be, dominant in determining how we understand and practise around the body; indeed, in producing meanings that constitute the body, they have largely succeeded in excluding alternative portrayals of the body and how it functions (Lupton, 2003: 25). From a social constructionist perspective, the strongly held cultural notion that science and biomedicine produce 'naturally unfolding scientific knowledge (with its objectivity, rationality and empiricism)' is rejected (Lupton, 2003: 26). Instead, biomedical and scientific knowledges and categories for understanding the body, including biological "facts," medically nominated categories like "risk

factors" and "disease labels," and medical practices such as "screening" and "treatments," are understood as products of their social and political context (Harding, 1997: 147; Ryan, Carryer & Patterson, 2003: 40). Feminist analyses adopting such perspectives have set about the destabilisation of the "objective" knowledges and languages of science and biomedicine to reveal the gendered stereotypes and metaphors about women's bodies hidden within them (Blum, 1993; Bordo, 1990, 1993; Casper & Moore, 1995; Haraway, 1989, 2000; Martin, 1989, 1991, 1994, 1998, 1999; Moore & Clarke, 1995; Shildrick & Price, 1998; Stabile, 1994, 1998, 1999).

Foucault (1981) focused particular attention on the relationship between bodies as social constructs and what he termed the "bio-politics" of neo-liberal societies; that is, the ways in which state apparatuses or institutions such as biomedicine, public health, the education system and the law seek to control the population through the particularised construction of individual bodies and bodily behaviours, ensuring citizens remain productive, self-regulated and docile. Foucault named this operation of power through bodies as *disciplinary power*. For Foucault, the central strategy of disciplinary power, as exercised by institutions such as biomedicine, has been the 'observation, examination, measurement and the comparison of individuals against an established norm' to *produce* the boundaries through which people understand, regulate and experience their bodies (Lupton, 1997 as cited in Ryan, Carryer and Patterson, 2003: 49). Bodies which violate these "normal" boundaries are singled out as "at risk" and as requiring expert advice, surveillance, and self-regulation to bring them back to order, to *normalise* them. In this way individuals become engaged in the exercise of disciplinary power. Power is not a possession that people lack and can thus be given, but rather it is a technique that, in the surveillance, observation, and normalisation of our bodies, is woven through our lives and identities: it informs our behaviours, practices and choices (Ryan, 2005: 17).

Feminist social constructionist studies have argued that women's bodies and bodily processes, such as menstruation, childbirth and menopause, have been particularly subject to the disciplinary power of biomedicine and the biological

sciences, through their construction as deviant, faulty or risky and thus requiring both expert and self surveillance (Cartwright, 1998; Davis-Floyd, 2003; Harding, 1997; Howson, 2001; Lane, 1995; Lupton, 1999; Markens, 1996; Murphy-Lawless, 1998; Treichler, 1990). The communication of risk by biomedical experts is particularly powerful because of the assumed "scientific" and "neutral" character of their knowledge (Lupton, 1999). Cartwright (1998) argues that childbirth provides a good example of a reproductive process that has been constructed out of biomedical discourses of "risk" and "deviance," with major implications for women's childbirth behaviours, practices and "choices." From the perspective of these studies, risk discourses have helped to establish biomedical (obstetric) control over childbirth, because in order to be "safe" (in particular to ensure the safety of the foetus) women "choose" to birth in hospitals and acquiesce to careful technological surveillance, such as continuous heartbeat monitoring and obstetric management.

Also of interest from a Foucauldian perspective is the extent to which new public health strategies have been implicated in the *discipline* of bodies through attempts to change people's behaviours by emphasising the *risks* to health posed by every aspect of their "lifestyle".[5] These risk discourses, as part of the normalising strategies of public health, have contributed to the construction of a particular kind of *ideal* public health subject, the "healthy citizen" (Gastaldo, 1997; Hyde, 2005; Lupton, 1999, Petersen & Lupton, 1996; 2003; Ryan, Carryer & Patterson, 2003: 116). The "healthy citizen" is one who assumes individual responsibility to manage and self-regulate the risks posed by their lifestyle behaviours, not only to ensure their own health but the health of the nation. They voluntarily seek to maximise their health opportunities and minimise the risks to which they are exposed (Petersen & Lupton, 1996). They police or self-regulate their own behaviours and those of others and need only guidance and advice from "expert" knowledges to engage in activities that serve their best interests. Failure to perform these tasks and reduce health "risks," and thus ensure their status as a

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[5] New public health strategies are those which have been dominant since the mid 1970s. They are characterised by their focus on prevention rather than cure and tend to emphasise the "dangers" of 'lifestyle' behaviours for health.

"healthy citizen," may render individuals susceptible to moral judgement, blame and guilt for ill-health.

Health education materials, as a specific public health strategy, contribute to the exercise of disciplinary power in neo-liberal societies through their part in the communication (construction) of the responsibilities of "healthy citizens." Gastaldo (1997: 113) argues that while those who produce health education materials obviously possess the good intentions of preventing harm and promoting health, health education materials make a contribution to the exercise of bio-power because they communicate the "norms" of healthy behaviours and promote self-discipline for the achievement of good health.

Social constructionist perspectives on the body have been particularly useful for feminist analyses of the reproductive context. As I will demonstrate later in this chapter, these perspectives have enabled feminists to consider how the construction of reproductive bodies with particular meanings is an exercise of power, constituting the boundaries within which reproductive subjects can experience "their bodies" and "selves." However, some feminists have expressed concern that social constructionist approaches place so much emphasis on culture and the effects of language and discourse that the body as a real, physical entity almost completely disappears (Pilcher & Whelehan, 2004). Indeed, perspectives which deny the biological reality of lived bodies may prove self-defeating or even dangerous if they mean that women who menstruate, are pregnant, undergo childbirth, abortions or menopause are denied the 'sheer physicality and inevitable social consequences of these uniquely female physiological experiences, some of which are universal across cultures' (Lupton, 2003: 27). From my perspective as a midwife who daily experiences the profound physical and emotional labour required by women during childbirth, to deny that bodies are born in the assertion of their social construction is deeply troubling.

These concerns about the fate of "real" bodies and "real" body experiences in the face of poststructuralist and social constructionist perspectives on the body have been consolidated into the theoretical position of 'Critical Realism'. From the

critical realist perspective, as articulated by Williams (1999: 814), postmodernist or poststructuralist perspectives which deny the existence of a reality (including bodies) beyond discourse are an 'epistemic fallacy'. Williams (1999: 814) argues that the example of bodies in pain provides a powerful reminder of a pre-discursive realm and the 'limits of language and culture to "contain" or "capture"' some body experiences. Critical realism, while not necessarily rejecting all inquiries into the socially constructed aspects of bodily facts, attests to a reality beyond discourse, and thus to the existence of "real" bodies.

A major focus within the contested arena of childbirth politics over the past several decades has been debates about the meanings of labour "pain." From the perspective of some obstetric and anaesthetic experts, labour pain has tended to be represented as pathological, both distressing for women and stressful for the foetus, and thus needing to be countered with anaesthesia. For many women, developments in epidural anaesthesia in labour have been welcome. However, from the perspectives of the natural childbirth movement, and some feminists, midwives and women's health activists, epidurals have been seen as yet another method to consolidate biomedical control over women's life processes and, further, that labour pain has been *made painful* because of biomedical interventions during childbirth, such as confining women to hospital beds. They have instead articulated labour "pain" as a potentially positive and transformative experience, which can be supported by such measures as allowing the birthing woman free movement in labour, immersion in water, and continuous care from people with whom she has a relationship. Labour "pain" does not provide evidence of a pre-discursive bodily experience but rather can be understood as a contested construct. This is not to say that labour pain is not a real experience for women but instead that how they experience it and what they decide to do about it is deeply dependant on the meanings they, and others, ascribe to such an experience.

Thus, in response to critical realism, it would seem as though there are a range of available meanings to interpret all bodily "experiences," even "pain." Further, the body may well be a real material entity, but ultimately we can only know it

through the meanings that discourse makes available to us, and these are culturally and historically specific and the products of powerful and often contradictory interests. My interest in this research is whether the theoretical adoption of feminist poststructuralist perspectives *does* necessarily entail the rejection of the body and undermine the physical reality of women's work in birthing babies. The tension between theorising reproductive bodies as social constructs and the "real" bodies and bodily experiences I encounter in my midwifery practice will be considered, although perhaps not resolved, throughout this thesis.

Foetal Personhood and Maternal Bodies

> Bodies, then, are not born; they are made. (Haraway, 1989: 10)

The centrality of reproduction to all contested areas of social and political life has led feminists to ask relentlessly: *how are babies made?* (Haraway, 2000: 232). In conducting their inquiries, feminists have repeatedly challenged the reduction and "essentialising" of that question to women's universal and literal body parts and more specifically to their wombs. Rather, a number of feminists influenced by poststructuralism have argued that *making babies*, indeed all aspects of reproduction and reproductive embodiment, are constituted and contested through a complex web of discourses and practices, the products of some very powerful interests.

Of particular interest, indeed concern, for feminist inquiries into the reproductive context has been the increasing visibility of foetuses in all areas of social life and the central role they have come to play in reproductive politics. Such inquiry has paid particular attention to the discourses and practices implicated in the *production* of foetal subjects (or the social construction of foetuses as "persons") and the mechanisms by which "life before birth" has come to be understood culturally as the existence of a particular entity with a distinct identity (Michaels & Morgan, 1999: 5). Of central concern has been how the social and cultural construction of the foetus as an ontological given, with special "person-like" qualities, has had major implications for the pregnant bodies in which they are located. Ascribing foetal "personhood" has transformed social and reproductive

practices around pregnant bodies, and threatened women's reproductive autonomy and rights.

The first images of "foetal life" entered the public sphere with Lennart Nilsson's famous images of foetal development.[6] Since then, there has been a proliferation of foetuses in popular culture in various written and visual forms, including obstetric and paediatric journals, Hollywood movies, advertising, the popular media, and in the now commonplace display of ultrasound images as "baby's first picture" (Fox, 2000; Michaels and Morgan, 1999; Newman, 1996).[7] Two significant forces have been identified in the increasing proliferation of, and social interest in, foetuses. The first is the now routine practice of obstetric ultrasound scans in 'modern' maternity care. The second is the enthusiastic adoption and reproduction of foetal imagery as a key strategy by the anti-abortion movement. Such proliferation of foetal images has facilitated not only the construction of the personhood of foetuses, but also the erasure and negative representation of women's bodies. As Fox (2000: 173) argues: 'in a society dependent upon images, this evolving "politics of representation" has played a crucial role in erasing women's bodies'.

Beyond the forces of ultrasound technology and the anti-abortion movement, feminists have analysed the foetus as the site and result of multiple actors' work practices, including pregnant women themselves. I now briefly review some of the feminist analyses that have examined the ways in which foetuses have "come to matter" through their visualization, in anti-abortion, biomedical, public health and legal discourses, and in discourses constituting women who wish to be or are pregnant.

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[6] The photographic series was entitled 'Drama of Life Before Birth' and was published in *Life* magazine in 1965.

[7] Michaels and Morgan (1999: 1) note the irony that the privacy assured to women in regards to their reproductive choices and practices by *Roe v. Wade* - the 1973 U.S Supreme Court decision which legalized abortion on the grounds that women had a constitutional right to protection from state involvement in their personal matters - has been followed by increasing public fascination and involvement with foetuses.

The Visualized Foetus and the Disappearing "Mother"

Of particular interest and concern for a number of feminist scholars is the role of the now routine practice of obstetric ultrasound imaging in reconfiguring social concepts of reproduction through the proliferation of foetal imagery in popular culture (Balsamo, 1997; Duden, 1993; Hartouni, 1997, 1998, 1999; Howson, 2001; Lehner, 2003; Mitchell, 2001; Mitchell & Georges, 1998; Petcheskey, 2000; Stabile, 1994, 1998, 1999; Sturken & Cartwright, 2001; Taylor, 2004; Treichler, Cartwright & Penley, 1998; Weir, 1998; Woodward, 2000). Within biomedical discourse, visual technologies such as obstetric ultrasound have tended to be represented as "utilitarian apparatuses," or tools which are benign, neutral, and increasingly essential to biomedical practice and women's health. However, from a social constructionist perspective, biomedical "peering" technologies actively construct reality through the process of visualizing. As Hartouni argues:

> Peering technologies like ultrasound or fiber optics imaging do not simply turn the inside out, or render the opaque transparent, or extend our vision to reveal the elusive secrets of nature. Technologies themselves do not peer; they are instruments and relations that facilitate or obstruct, but above all, construct "peering," indeed, instruments and relations that do not simply uncover meaning, but inscribe and enforce it. (1998: 211)

These analyses are concerned with the constructive effects of routine ultrasound practice, in particular that ultrasound is performed in such a way that it not only assigns "person-like" qualities to the foetus, but also disrupts the notions of the foetus as contained "inside" the woman's body and of pregnancy as an "interior" experience (Lupton, 1999: 62). In their observation of ultrasound scans, Mitchell and Georges (1998: 108) noted that the sonographer's presentations of the foetal images during scans were passed through a "cultural sieve" whereby the foetus was inscribed with "baby-like" qualities and granted subjectivity, and often a voice. For example, sonographers described the foetus as "the baby," and foetal movements as particular kinds of "childlike" activities, such as "playing," "swimming," "dancing," and "waving" when talking to pregnant women (Mitchell & Georges, 1998: 108).

While certainly enhancing our medical knowledge of the foetus, technologies such as ultrasound scans have displaced other knowledges, particularly those of

pregnant women (Fox, 2000: 172). Indeed "seeing" the foetus through technology has reconfigured the embodied knowledge and experience of pregnancy by privileging the image of the foetus, the technological quickening, over the embodied quickening[8] (Howson, 2001: 99). Further, in actively mobilising an appeal to commonsense notions of the foetus as a living human being, these technologies have facilitated the construction of the foetus as a separate entity, literally a miniature baby (Fox, 2000: 173). The personification of the foetus in this way mesmerizes the viewer(s), including the woman, her family and the sonographer, resulting in their forgetting that the main embodied subject of ultrasound is actually the woman. Lehner describes her experience candidly:

> In other words: a sonogram takes a picture of me that I am not in. Even in the examining room I do not really exist. The moment when all eyes turn away from my belly, and toward the monitor, even I become a passive observer of an "Other", an "Other" which cannot be seen with the eye. For the foetus to be seen as an independent entity, the woman must drop out of the image. (2003: 547)

The foetal image on the screen, Lehner (2003: 547) is telling us, appears to exist independently of her body, as a medical "fact."

Mitchell and Georges (1998: 110) argue that when the distinction between the foetus inside a woman's body and the image seen on the ultrasound screen become blurred, so too do women's bodily boundaries. This loss of their bodily boundaries and bodily knowledge goes unnoticed by many women, as they become captivated by the visual image of their "baby," an image that is inscribed with cultural meanings (Mitchell & Georges, 1998: 110). The strange irony of biomedical "peering," as Hartouni (1998: 211) describes it, is that women are simultaneously both marginalized (or they completely disappear) whilst also being subjected to increased medical surveillance.

The Anti-Abortion Movement and Maternal-Foetal Conflict

Various analyses attest to the power of images in our visual culture and, in adopting a social constructionist perspective, emphasise that: 'Foetal figures not

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[8] This term refers to the physical sensation of foetal movements that usually occurs some weeks after the first routine ultrasound scan.

only proliferate in contemporary culture and reflect its changes, they also help construct it' (Squier, 1991: 18). Important for a number of feminist scholars is the process whereby this biomedical vision of the foetus as a separate entity has come to pervade broader society (Balsamo, 1997; Casper, 1994, 1999; Chavkin, 1992; Dubler, 1996; Fox, 2000; Hartouni, 1997, 1998, 1999; Michaels & Morgan, 1999; Michaels, 1999; Morgan, 1999; Petchesky, 2000; Rothman, 1989; Squier, 1991; Stabile, 1994, 1998, 1999). These scholars argue that the foetus as separate entity has become the site of multiple actors' work practices, including the antiabortion movement and public health strategies, and has been constructed in ways which have refigured social concepts about reproduction. Of particular concern is that these constructions have contributed to the notion of maternal-foetal conflict, positioning women's bodies not only as "passive hosts," but also as threatening or hostile to the *nation's* "unborn children."

Of all the communities of practice who have been implicated in the struggle over the symbolic meanings of foetuses, the anti-abortion movement is perhaps the most organized and is responsible for seizing the visual foetus as a political strategy. From an anti-abortion perspective, foetal photographs and ultrasound images have at last presented "scientific" evidence that developing foetuses are miniature humans, and thus that abortion constitutes the murder of an "unborn baby" and should be outlawed (Oaks, 2001: 141). Petchesky (2000) argues that from the mid-1980s a central strategy of the anti-abortion movement, recognizing the power of the visual foetus in a visually oriented culture, became the distribution and active construction of this visual foetus as a rights bearing subject: "the unborn child." This notion of "foetal rights" was a direct challenge to feminist strategies that have based their arguments for legalized abortion on "women's right" to choose whether or not they want to be pregnant. The visual foetus has become central to the anti-abortion movement's construction of the foetus' "right to life." Newman, for example, describes some of the anti-abortion movement's use of visual foetuses:

> To persuade, anti-abortion activists use paraphernalia like white infant coffins filled with bloody baby dolls, strollers carrying mock skeletons, jars represented as containing dead foetuses, slide shows and film footage of intrauterine foetal movement, aborted embryos, severed foetal limbs and entire foetuses, even dead newborns...demonstrators thrust plastic foetal models in the face of abortion clinic clients screaming, "Don't kill your baby," and fervently explain their mission: "We have to save the life of the pre-born human baby". (1996: 19)

Perhaps the most disturbing thing about how people have received foetal imagery is their apparent acceptance of the image itself as an accurate representation of a real foetus. Petchesky (2000: 174) argues that the 'curled-up profile, with its enlarged head and fin-like arms, suspended in its balloon of amniotic fluid, is by now so familiar that not even most feminists question its authenticity'. In her review of foetal imagery over the past thirty years, Petchesky (2000: 174) observes that in almost every picture the foetus is solitary, dangling in the air (or in its sac) with nothing to connect it to any life-support system, often even without an umbilical cord. The pregnant woman herself tends to be completely visually absent. Petcheskey (2000: 175) argues that from their beginning such photographs have represented the foetus as primary and autonomous, the woman as absent, or peripheral, and as such foetal imagery epitomizes the distortion inherent in all photographic images - their tendency to slice up reality into 'tiny bits wrenched out of real space and time.'

Feminist analyses emphasize that the success of the anti-abortion movement in establishing the personhood of the foetus has depended both on the visual erasure of women's bodies in dominant foetal imagery, and the subsequent construction of women as adversaries of their own pregnancies or foetuses. As Stabile (1998: 172) notes, in current representations the maternal space has, in effect, disappeared. What has emerged in its place is an environment that the foetus alone occupies. That is, 'in order for the embryo/foetus to emerge as autonomous – as a person, patient, or individual in its own right – all traces of a female body must disappear' (Stabile, 1994: 172).

A consequence of this erasure of women's bodies has been the social construction of maternal-foetal conflict and the attendant preoccupation with foetal protection

in legal, biomedical and public health discourses (Hartouni, 1998; Stabile, 1994). As Hartouni (1998: 213) notes, the ways in which we have come to understand the relationship between pregnant women and foetuses have been refashioned because of foetal imagery: 'The foetus floats free, a discrete and separate entity, outside of, unconnected to and, by virtue of its ostensible or virtual independence, in an adversarial relationship with the body and life upon which it is nevertheless inextricably dependent'. In this process of erasure, representations of the "maternal environment," once understood as benevolent and nurturing, have transformed this site into 'a hostile, infanticidal toxic waste dump, from which the autonomous "person" must be protected by the paternalistic arm of the government' (Stabile, 1994: 172). This increasingly pervasive cultural notion of pregnant women as separate from, and in conflict with, foetuses has had major implications for the material reality of women's lives. For Stabile (1998: 189) the process of naturalization in which the foetus has come to exist in an ideological and historical vacuum serves to divert attention away from material bodies and from questions regarding the economic situation of pregnant women. This free floating foetus 'exists in a nowhere land – it miraculously receives shelter and food. It exists in an environment somehow immune to racism, sexism, and economic violence – an environment without borders or boundaries' (Stabile, 1998: 189). Through the now prevalent rhetoric of "foetal protection" in public health, biomedical and legal discourse, the material needs of the female bodies that "house" foetuses, as well as the needs of their children and families, can be dismissed or overridden. As Stabile notes: 'While the foetus needs "protection" (a thinly disguised alibi for controlling women), it doesn't ask for capital' (1998: 189).

Nowhere can the implications for reproductive practice of the social construction of foetal "rights" and maternal-foetal separation and conflict be seen more clearly than in the prosecution of pregnant women for "foetal abuse." Feminist scholars have analysed the discourses implicated in an increasing number of "foetal abuse" cases in North America (Balsamo, 1997; Daniels, 1999; Dubler, 1996; Hubbard, 1994; Rothman, 1989; Stabile, 1999). Dubler (1996) reviews one such case, *Whitner v State*, in which a woman was convicted for criminal child neglect for

taking cocaine during her pregnancy, a conviction based on the legal recognition of foetuses as *persons* holding certain legal rights and privileges. Such cases demonstrate disturbing attempts to control the behaviour of pregnant women through the invocation of the language of foetal protection (Dubler, 1996: 938). Imposing this duty on the pregnant woman seems reasonable because of unarticulated social assumptions about the maternal role:

> These unarticulated assumptions draw upon a range of moral and social intuitions about how a pregnant woman should behave in order to deliver a healthy child. This transitive reasoning is possible through the equation of proper maternal behaviour with proper gestational behaviour. (Dubler, 1996: 939)

This collapse of maternal behaviour with gestational behaviour is a direct implication of the almost complete social naturalization of foetuses as "unborn babies" and the increasingly ambiguous ontological status of women in reproductive discourse as a result.

In Aotearoa New Zealand there are no precedents for prosecuting women for "foetal abuse" at present. However, as Daniels (1993 as cited in Balsamo, 1997: 100) warns: 'Political power may ultimately rest not on the technical precedent of legal rights, but on the symbols, images, and narratives used to represent women in this larger public culture'. The ways in which pregnant women and foetuses are discursively represented within "public culture," and the implications of these discourses for reproductive practice, is of central interest to this research.

Biomedicine, Public Health and Foetal Risk

As I have demonstrated, there has been much attention paid by feminist scholars to the role of biomedical visualization technologies and the work practices of those who operate them in the construction of reproductive reality and in particular of foetuses as "miniature babies," separate from the pregnant bodies that house them. I have also outlined how these constructions have been taken up and developed within anti-abortion discourse, producing the now dominant social constructions not only of the foetus as "unborn baby" but also of pregnant women as the potential antagonists to these foetuses. Feminists have analysed the prosecution of women for "foetal abuse," illustrating the extent to which these

constructions have become dominant and naturalised in ways that may be harmful to women.

However some feminists have expressed concern that feminist analyses have concentrated excessively on the role of reproductive technologies and foetal images in the construction of reproductive meanings (Shuttleworth, 1993/1994; Weir, 1996). They have challenged feminists to locate their analysis in a much more complex web of social institutions, knowledges and technologies that contribute to the *discipline*, or *governance*, of reproduction. As Weir argues:

> ...the keying of investigation to government rather than to technologies in the narrow sense moves the beginning point of inquiry away from critical and reactive commentaries on technical innovations to a very thick description of the administrative and discursive construction of pregnancy. (1996: 389)

This interest in governance widens analysis beyond reproductive visualising technologies and identifies how other discourses and practices are implicated in the ongoing construction and naturalisation of reproductive subjects, focusing in particular on the disciplinary power of biomedicine and public health (Casper, 1994, 1999; Ginsburg & Rapp, 1999; Golden, 2005; Lupton, 1999; Markens, Browner & Press, 1997; Oaks, 2000, 2001; Petersen & Lupton, 1996; Rapp, 1990; Shuttleworth, 1993/1994).

Biomedical and public health discourses around reproduction, in particular those of risk and the healthy citizen, have been influenced by, and contribute to, the anti-abortion movement's constructions of foetuses as subjects and of maternal-foetal conflict, and are a new locus of control of pregnant bodies. As Oaks argues:

> ...the construction of the foetal person as a subject has coincided with increased attention to how pregnant women's practices, such as cigarette smoking, alcohol consumption, and drug use, negatively affect foetal health. Framing pregnancy as a potential conflict (in which a woman's rights, needs, or desires clash with those of her foetus) has opened the so-called maternal-foetal relationship to public surveillance, regulation, and intervention. (2000: 64)

Indeed, biomedical and public health discourses of risk and the healthy citizen, while having consequences for all people, have affected women in particularly significant ways because of the gendered social expectation that they will assume

responsibility not only for their own health but also for that of their families, and in particular their children (Petersen & Lupton, 1996: 76). Through the visualisation and construction of foetal subjects as described above, women's "good healthy citizen" responsibilities for the care of their children and their children's health have now stretched back to before their birth, indeed to before conception (Lupton, 1999: 62). The construction of the foetus as an individual separate from the pregnant woman, and the construction of women as "maternal environments" that are potentially hostile to foetuses, has brought the health and wellbeing of the foetus increasingly into focus (Lupton, 1999: 62). The "risks" posed to foetuses have been the subject of much epidemiological and clinical research that has tended to represent the foetus as fragile and highly vulnerable, and its development susceptible to a multitude of threats (Lupton, 1999: 63).

As the public health emphasis on individual responsibility for self-control and self-monitoring has extended into another body (that of the foetus), the pregnant woman has become both doubly at risk and doubly responsible for two bodies (Lupton, 1999: 63). As a result, pregnant women have become caught in a complex network of discourses and practices aimed at the surveillance and regulation of their bodies in order to protect the foetus (Lupton, 1999; Shuttleworth, 1993/ 1994). Evidence for this can be seen in the expert advice which encourages pregnant women to police their bodies to ensure that the health of their foetus is not compromised by their own actions (Lupton, 1999: 64). Lupton (1999: 66) argues that one of the implications is that women who fail to heed expert advice are frequently portrayed in the popular media as "monster mothers" who risk harming their children's health through their selfish behaviours. The question for further analysis, suggests Oaks (2000: 65), is this: what positions on foetal health may feminists hold in the face of the expanding recognition of, and concern for, foetal persons within biomedical and public health discourse, or, indeed, in broader public culture? Oaks asks:

> Do arguments that pregnant women ought to change some practices to benefit their babies-to-be undermine a belief in women's moral and legal rights to choose how to treat their bodies? Are there ways to discuss foetal health without buttressing the antiabortion movement's constructions of foetal personhood and foetal rights? (2000: 65)

"This Is My Baby": The Lived Experience

Theorising the foetus as a social construct has forced feminist analyses to consider *all* of the ways in which foetuses have *come to matter*, including the meanings inscribed by women themselves, despite how this may complicate feminist reproductive politics. The concern of the feminist reproductive scholars discussed above has been that the social construction of foetal subjects as "persons" has resulted in a double bind for women, with major implications for their reproductive integrity, indeed for their reproductive "freedoms." On the one hand, in part due to the power of the visual in western culture, women are now routinely erased from the reproductive picture in the process of foetal visualization and the social fascination with foetuses that has followed. On the other, it now seems that women are positioned as solely responsible for the wellbeing of foetal persons as "unborn children" (Michaels & Morgan, 1999: 4). However, feminist critiques of the implications of foetal personhood for women's reproductive integrity are complicated by the significant place foetuses have come to hold in the 'private imaginary of women who are or wish to be pregnant' (Michaels & Morgan, 1999: 2).

Despite the temptation to theorize women as the passive victims of foetal personification and the reproductive technologies responsible for their visualization, such a position has been deeply complicated by those women who have actively asserted the personhood of foetuses as a way of making visible their long-ignored experiences of pregnancy loss (Layne, 1999, 2003). Likewise, many women who are, want to be, or have been pregnant are interpellated by the social construction of foetuses as persons (Lehner, 2003; Rothman, 1989; Young, 1984). As Petchesky (2000) notes, despite there being some "truth" to the claim that women are victims of the technological control of their reproductive processes, evidence suggests that many women form very real connections with the technologically mediated foetus and, indeed, generate demand for visual technologies. A number of studies have analysed women's encounters with ultrasound technologies and the technologically mediated foetus, identifying the multitude of ways in which women make sense of and relate to foetuses (Browner & Press, 1996; Casper, 1999; Markens, Browner & Press, 1997; Markens,

Browner & Preloran, 2003; Mitchell, 2001; Weir, 1998). For example, in Mitchell's study of ultrasound practice, a number of women used ultrasound's projection of the foetus as a way of stimulating or engaging their partner's interest in their pregnancy:

> I want him to know that this is a baby. It's not going to go away. He just can't get it yet. I guess it's a physical thing. Men don't have all the changes in their body...The ultrasound changes that. It's like a slap in the face for him! ...Now he's got to get serious about us and this baby. (2001: 151)

The problem for feminists' reproductive politics, argues Layne (1999: 163), has been the fear that to acknowledge the presence of foetuses and the meanings they hold for women would mean conceding to the anti-abortion movement the ontological stability of foetuses as "unborn babies," undermining the gains made in women's reproductive freedoms in the process. However, the response of many feminists – to reject or ignore foetuses – has frequently meant the denial of the lived experiences of many women, including feminists themselves. In fact feminists' silence about the real emotional meanings of the foetus for women has at times actually fed powerfully into the conservative construction of women as callous and uncaring toward, indeed in conflict with, the foetus (Bordo, 1993; Rothman, 1989). Ginsberg and Rapp (1999) and Lehner (2003) are feminist scholars who have sought to challenge feminist politics around foetuses through an examination of their own personal encounters and emotional engagement with the foetal person, as shaped by the experience of ultrasound and prenatal diagnosis. Following an ultrasound that diagnosed foetal abnormalities, Lehner decided to terminate her pregnancy, and she raises these questions for feminist analyses:

> I am mourning, and I can't say for whom, or even what. Does the loss of a foetus constitute a death, and if so, who dies? How can the foetus die if it hasn't been born? How do I properly mourn an image? (2003: 545)

Lehner's (2003) interest is in the meaning of the foetal image of obstetric ultrasound imaging for women and how this image is mourned in the context of pregnancy loss or termination for foetal abnormalities. Lehner argues:

> I do not argue here that the foetus of the sonogram is, simply, the right wing icon: the unborn child. Instead I wish to complicate the political silence of the feminist left on the complexity of the foetus as image and as infant. It is not enough to say "a foetus is nothing more than an image" and be done with it. This statement ignores the very history of genre convention upon which sonograms build their claims to medical fact. Images ARE real, insofar as they offer pleasure, cause pain, and incite viewers to action. (Lehner, 2003: 548)

Conclusion

As demonstrated in this literature review, a large number of feminist analyses have adopted a social constructionist perspective to examine the reproductive context, focusing in particular on the social construction of foetal subjects and their implications for the pregnant bodies in which they are located.

The task for feminist analysts (myself included), faced with the complexities of the reproductive context and the multiple meanings ascribed to foetal and pregnant bodies, is to retain our commitment to theoretical positions, such as the social constructionist perspective adopted here, that allow us to be supple and flexible in our analyses of all of the ways that "babies" come to matter (Casper, 1999; Michaels & Morgan, 1999). This means rejecting any temptation to present foetuses, 'armed with ultrasound machines, surgical instruments, prenatal testing procedures, intrauterine cameras', as the enemy, and pregnant women as their passive victims (Michaels & Morgan, 1999: 6). But neither need we, nor *can* we, abandon our reproductive struggles. Rather, from the social constructionist perspective, we can recognise women as agents who negotiate their own meanings about foetuses and make their own choices about reproductive technologies, abortion and self-care in pregnancy whilst understanding that they do so within the larger gendered web of social discourses about reproduction and mothering. Our greatest foe thus becomes those communities of practice or powerful interests, a number of which have been identified here, which seek to stabilise and normalise particular reproductive and foetal meanings that may be hostile to women's reproductive integrity and their broadly defined reproductive freedoms (Michaels and Morgan, 1999: 6). As we sit at our analytical keyboards contemplating the reproductive context, our goal should thus be to "destabilise" any particular foetal ontology and reproductive "truth," in the hope that we may

free up the spaces in which women, as agents, can define and experience reproduction.

This research simultaneously *borrows* from, and, I hope, *contributes* to, feminist analyses of contemporary reproductive contexts. It utilizes social constructionism as "a speculum": an instrument to "widen" or open up reproduction in Aotearoa New Zealand, rejecting the notion of the bodies and practices involved in this reproductive context as natural or universal (Haraway, 2000: 235). I question the ways in which the bodies of pregnant women and foetuses have "come to matter" within this local context. In particular I examine discursive strategies and power, asking whose interests have been served or favoured in the stabilization and naturalization of these particular reproductive meanings as *the way things are*, as our reproductive "reality." However, my interest here is not only in questioning *how and why babies are made* in these particular ways, but also in the implications for reproductive practices and women's embodied experiences. Further, to reject this reproductive reality as just that – "reality" – and instead to examine it as a construct of discourse and practice, opens up the possibility for resistance in the articulation of counter discourses and practices.

In the next chapter will I outline and discuss my development of a method of qualitative discourse analysis specific to this task. I begin with a discussion of the epistemological and methodological principles that have informed my approach to discourse analysis, explaining why it is well-suited to social constructionist research. I then outline the design and practice of the research, including the research questions, selection of data, the process of analysis, and a discussion of the validity of my findings.

Chapter Three

"You Only Have Nine Months to Grow the Perfect Baby": Methodology and Research Design

> The text enters the laboratory, so to speak, carrying the threads and shreds of the relations it is organised by and organises.
>
> (Smith, 1990: 3-4)

> The decision to use discourse analysis entails a radical epistemological shift...discourse analysts do not regard texts as vehicles to find out about some other reality assumed to lie beyond or behind language. Instead they are interested in the text in its own right, and therefore ask different questions.
>
> (Gill, 2000: 188)

Introduction

Having reviewed the literature on foetal and maternal subjects, the purpose of this chapter is to enter the research "laboratory" and provide a detailed account of the practice of qualitative discourse analysis in this research project. The literature suggests that to explain this kind of research it is not enough to simply describe the procedure of analysis, or what I *did* as the researcher. It is also necessary to refer to the wider epistemological debates about the status of knowledge produced by such research (Burr, 1995; Fairclough, 1992; Gill, 1995, 2000; Parker, 1992; Potter & Wetherell, 1987; Taylor, 2001). I begin this chapter with a discussion of the epistemological and methodological principles that have informed my approach to discourse analysis.

I then outline the design and practice of the research, including the research questions, selection of data, the process of analysis and a discussion of the validity of my findings. I explain how I negotiated the confusing array of discourse analysis "types" and developed a method of analysis specific to my particular research questions and texts. In explaining the process of analysis I also discuss the tension between doing discourse analysis and articulating what the process of analysis actually involves.

Feminist Poststructuralist Discourse Analysis

This research was designed with two broad concerns in mind, one substantive, the other methodological. The substantive concern was the use of a social constructionist perspective, as has been adopted from within feminism poststructuralism, to destabilise the ontology of reproductive bodies and selves, and explore the ways in which women's reproductive bodies and subjectivities have been socially constructed in my local context. There are a number of feminist theorists who have used this social constructionist approach in their inquiry into the reproductive context and the social-political meanings which constitute it, developing, as they have, a rich "toolkit" for inquiries of this kind. The methodological concern was with the design of a discourse analytic research inquiry informed by feminist poststructuralism and specifically social constructionism.

As was demonstrated in Chapter Two, the challenges of postmodernism and poststructuralism have had a destabilising effect on the founding assumptions of modern western theory through their "sweeping attack" on the falsely universalising tendencies of modernist theorising about the social world (Barrett & Phillips, 1992: 1). Whilst there has been much debate (and ambivalence) within feminism regarding the compatibility between feminist theoretical and political projects and these poststructuralist perspectives, poststructuralism has had a profound impact. This has had major implications, not only for the focus of research, but also for feminist research practices, including the discourse analytic method adopted and developed here.

While there has long been much concern within feminism to challenge the androcentric biases of the positivist social science paradigm, the aim until recently had been to develop a "successor science," one that would lead to a more integrated and inclusive knowledge than the analytically oriented and "masculine" form of knowledge dominant in academia (Leatherby, 2003: 44). There has been significant debate within feminism about the form that this successor science should take, yet the notion that "truth" exists independently of the knower and thus could be found through "good" social science practices remained

unchallenged.[9] However, Poststructuralism and its insistence on the historical and cultural specificity of knowledge has seen claims of a universal social world that exists independently of the knower rejected. Rather, all knowledge, including that produced as research, is understood as rooted in the values and interests of particular groups. Thus, there are no universal theories or "truths" to be encountered in social inquiry, only partial or situated knowledges that are constructed in the specifics of time and place (Leatherby, 2003; Pilcher & Whelehan, 2004).

The aim of feminist research such as that undertaken here thus ceases to be the establishment of the feminist truth, but rather becomes the *deconstruction* of "truth" (Leatherby, 2003: 51). By rejecting the possibility of a "feminist truth," feminist research has become increasingly focused on the constructive effects of discourse and the discursive procedures whereby human beings gain an understanding of their common world. In the reproductive context, for example, the aim of feminist inquiry has become to deconstruct or destabilise the taken-for-granted assumptions about *how things are*. These inquiries seek to identify and examine the presence and effects of discourses that construct reproductive knowledges, practices and subjects, and to present alternative accounts that challenge and question.

The shift in focus to the constructive effects of discourse has led to a "flurry" of research activity, all of which can be broadly gathered under the label of discourse analysis. While discourse analysis is certainly not the only research method informed by poststructualist principles, and the very term remains relatively contested because of its use within diverse disciplinary locations, it has been embraced by researchers located within these theoretical perspectives (Coupland, 2003; Grace, Potts, Gavey & Vares, 2006; Lupton & Mclean, 1998; Malacrida, 2002; Markens, 1996; Redwood, 1999; Tulloch & Tulloch, 2003; Wetherell & Preistley, 2001).

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[9] This debate has largely been between feminist empiricists and those arguing for a feminist standpoint epistemology (Leatherby, 2003)

Poststructuralist discourse analysis takes as its focus of inquiry the constructive effects of discourse within texts. Texts are the focus of discourse analytic research because all discourses are considered to be textual (expressed in texts), and also inter-textual (drawing upon other texts and their discourses to achieve meaning) (Lupton, 2003: 20). Burr (1995: 166) argues that discourse analysis can be understood as deconstructive in that it attempts to take apart texts and see how they are constructed out of discourses to present particular images of people and their practices. In analysing the functions or effects of discourses within texts, the discourse analyst may be interested in the identification of which discourses are privileged and thus become dominant in a given context and the power implications of this. The researcher may be concerned to identify the subject positions offered by different discourses, and the identity and political implications of these (Burr, 1995: 166).

In developing a method of discourse analysis, some important methodological considerations about the relationship between researcher and researched are required. Acknowledgement of the researcher's *own* involvement in the research process, and the results that are produced, is required (Burr, 1995; Casper, 1999; Clarke & Montini, 1993; Fox, 1995; Frankenberg, 1993; Grace, 1998; Haraway 2000; Layne, 1999; Olesen & Clarke, 1999). Fox (1995) suggests that this may be achieved by inserting into the research the researcher's own self as the *intertext*. Intertextuality is a concept that coheres well with poststructuralist perspectives on language and knowledge, asserting that all texts, including the research text, are social practices and are thus subject to deconstructive reading. As Fox argues:

> Social science texts, like any others, are to be read and re-read, not as representations (accurate or flawed) of the social world, but as contested claims to speak "the truth" about the world, constituted in the play of disciplines of the social. (1995: 2)

By accepting the challenges of intertextuality, the researcher acknowledges the impossibility of producing a research text that presents a transparent mediation of knowledge of the social world. Rather, the researcher locates themselves as part of the social being explored. Fox (1995: 5) suggests that one way this may be achieved is by disrupting the linear "official" research text with the "other voices" that have informed the researcher's relationship to the research. This may include

the researcher's own "voice," as well as relevant texts that are not "officially" under analysis but with which the researcher has engaged during the process of research.

As a "reproductive body," a midwife, and a feminist involved both in feminism's theoretical and political projects, I am deeply embedded within the contested political, cultural and social context of reproduction in contemporary western society, and this research is shaped in significant ways by my own social positioning. I will thus heed the advice of Fox (1995) and place myself "at risk" in this research by using my own story as intertext, locating, as I do, this research as a discourse within the contested reproductive context. I have also included as intertext some of the visual and textual representations of pregnant women's and foetal bodies that I have encountered during this research process and which have gradually accumulated on the pinboard above my desk. Having developed a dubious reputation as the "foetus researcher" among my family, friends and colleagues, I was regularly the recipient of "texts" which had been thoughtfully collected for my interest, including newspaper and magazine articles and pictures, shows recorded from television, books and videos found in libraries and second-hand book stores, and pamphlets and posters from parent shows and waiting rooms, all of which are implicated in the representation of "the foetal experience." While these texts are not "officially" included in my sample under analysis, they are very much part of my engagement with the reproductive context through this research, and I thus include four of the texts here as intertext. These intertexts precede Chapter Four, Chapter Five, Chapter Six and Chapter Seven.

Intertext

> The universe, somebody said, and I know now it is true, is made of stories, not particles; they are the wave functions of our existence. If they constitute the event horizon of our particular black hole they are also our only means of escape.
>
> (Brink, 1996 as cited in Kirkham, 1997: 183)

I could argue that the act of my mother "giving birth" to her second baby in a small maternity unit at the end of summer 1979 was my first introduction to the reproductive context. However it is probably more accurate to say my actual engagement with the contested domain of reproductive politics came a little while after. It did however have a somewhat premature beginning. Raised for several

years as a child in a fundamentalist Christian community in Australia, active in the anti-abortion movement, I became a very young actor in the "abortion wars," participating in anti-abortion demonstrations as one of the many young faces that have so often been used to front adult issues. As I have already argued, the assertion of the "right to life" of the "unborn" was at the core of this movement's strategy, and at eight years old I was already well acquainted visually with this "unborn baby," through posters of foetal images, and as a voice from the "inside" (our school choir recorded a song in which the foetus pleads for life). Our departure after some years from this community, and my eventual involvement in feminist activism in my teens, radically shifted my position in this "war," but I have been left with a very real sense of the bitter struggle for meanings around which it has been constructed.

I have continued to be an actor in the politics of reproduction, becoming involved in feminist women's health projects that have been active in asserting women's right to "choose" what happens to their reproductive bodies. Eventually I studied midwifery, which I considered to be a feminist profession. I have encountered many complexities in my midwifery practice that have deeply challenged my feminist politics about reproductive "rights" and "choice" and that provided the impetus for this research. It would probably be fair to say in hindsight, though I would have bitterly disputed such a claim at the time, that as a young "feminist" graduate midwife I approached the reproductive context with a great deal of naivety, or at least simplicity. Informed by my feminist politics, I believed that women had been the passive victims of biomedicine, that ominous institution of patriarchal control, which had pathologised and medicalised women's healthy life processes including pregnancy and childbirth, subjecting women to unnecessary and often appalling interventions, and undermining their right to "choose" how and where they gave birth. Reproductive technologies, in my understanding, were the instruments used by biomedical doctors to enforce this biomedical power. Armed with the Midwifery Partnership Model,[10] *I was convinced that as an independent midwife I had the ability, indeed the responsibility, to "save" women from oppressive biomedical and technological control of the childbirth process.*

The reality of course was a reproductive context far messier and more complex than my feminist politics and professional framework could account for. Rather than being passive victims of the power of biomedical and technological practices who required my rescue efforts, I found that many women felt very positive about their "choices" for biomedical screening and biomedically managed pregnancies and births, and accepted or approached with much enthusiasm what they needed to do to be safe and give their child the best start in life. Indeed as I sat through many of my clients' home video recordings of their ultrasound scans and gazed at the blurry images of foetuses given names, identities, and "things" by the fifth month of pregnancy; supported women through the grief of pregnancy loss; debriefed women following highly medicalised births about which they felt very

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[10] The professional framework for midwifery in Aotearoa New Zealand, the keys principles of which are: equality, shared responsibility and empowerment, and informed choice and consent (Guilliland and Pairman, 1995).

positive; and reflected on my own participation as a midwife, I started to question my conceptualisations of power in the reproductive context. Whilst it became increasingly difficult to conceive of women as passive victims of biomedical control, neither could I accept the notion of women as agents capable of making "free choices." It was very clear that many of these supposed "choices" were, within the local reproductive context, actually imperatives. I was very aware that power relations were deeply embedded in the western reproductive context at every level and in every interaction, but they did not operate as I had understood them.

Research Design and Process

As articulated in Chapter One, my interest in this research is captured by the following questions:

Research Questions

- How are reproductive bodies and the bodily experience of being pregnant discursively constituted?
- What reproductive subjects are produced as a result?
- How can we understand the relationships between the constitution of reproductive bodies and subjects, and social practices around reproduction?

There are two phases to the research practice demonstrated here: the selection and management of the data and the actual process of analysis. I will argue the importance of both phases to successful discourse analytic research. I will conclude this section with a discussion about the validity of the findings produced by this kind of research.

Selecting the Data

A major consideration in the design of a research project that would best enable me to identify the discourses implicated in the construction of reproductive bodies and subjects concerned the objects of analysis. The research literature locates the examination of texts as central to discourse analytic research (Lupton, 2003; Mills, 1997; Potter & Wetherell, 1987; Prior, 2004, 2004; Taylor, 2001; Van Dijk, 1988, 1991). Lupton (2003: 21) argues that any communication is considered a

text worthy of study for the identification of discourses and may include textbooks, hospital records, self-help manuals, novels, television programmes, popular and professional newspaper and magazine articles, and of course transcripts of interviews.

Smith (1987: 175-176) argues that the best way to understand how power operates is to begin with textual materials that intersect with our immediate everyday lives. I decided that I needed a sample of texts about pregnancy that could be considered to be "everyday" by their nature and that were also broadly circulated throughout my local context. I made the decision to sample my first set of texts from the mass media. The appeal of mass media texts was their wide distribution and my anecdotal awareness that reproductive issues had been receiving media attention. This choice of text was also informed by the emphasis within the feminist literature on the role of the mass media in the construction of meanings about women's bodies (Bordo, 1993; Kaplan, 1992; Martin, 1989, 1994, 1998, 1999; Shuttleworth, 1990,1993/1994). As Martin (1999: 97) argues, while the concepts of the body and health that constitute the social imagination are learned and developed in multiple and diverse ways in families, organisations, communities, and institutions, they are significantly developed 'in relation to (influencing and being influenced by) the vast and heterogeneous contents of popular media'.

Having decided to analyse mass media texts, and given the broad range of texts that would be appropriate and interesting, including women's and parenting magazines, television shows and radio, I needed to make some decisions about what kind of media text I would sample. After considering a number of possibilities I decided on "news" texts. My definition of what constitutes news was informed by van Dijk (1988), who has developed a methodology for the discourse analysis of news. Van Dijk (1988) offers a conceptual framework of the everyday notion of news that I have applied in the selection of my texts. Van Dijk (1988: 4) defines "news" as 'a news item or news report, i.e., a text or discourse on radio, on TV or in the newspaper, in which new information is given about recent events'.

Because the conceptual framework for what may constitute news was so broad, like van Dijk (1991) and Lupton and Mclean (1998), I decided to restrict my sample further by concentrating only on printed news; that is, news articles published in daily newspapers. Again, the decision to restrict my sample to printed news articles was partly due to the desire to keep my sample to a manageable size – meaning I could also analyse other types of texts – and because of the recognition that daily newspaper news continues to play a crucial role in mass communication as one of the most accessed sources of news (van Dijk, 1988: 4).

My decisions about what constituted newspaper news also requires some further clarification. Again drawing on van Dijk's (1988: 5) method, I made a distinction between news articles and feature articles 'that present new information on recent events', which I included in my sample, and all the other types of texts that may be found in a daily newspaper, including advertisements, opinion pieces, letters to the editor, editorials, reviews and all texts that have a programmatic nature, which were excluded. The purpose of this was to analyse what might be described as "genuine" news, informed by 'news values' of objectivity and factual reporting (van Dijk, 1988: 5).

I commenced my sampling of newspaper articles from daily newspapers from the beginning of the month in which I developed the proposal for this research and concluded sampling at the end of the month prior to when I was ready to begin analysis. This gave me a ten-month sample from the 1st October 2005 to the 31st July 2006. I sourced my articles through Newstext Plus, a full text database of New Zealand daily newspapers, using *pregnancy* as my search term and excluding opinion pieces and letters to the editor. I also made the decision to exclude articles and features with a main focus on abortion because I wanted to focus on the discourses implicated in the communication and construction of "normal pregnancy" as a life-course event. My final sample consisted of 35 articles and features on a variety of topics related to pregnancy, including: teen pregnancies; HIV screening in pregnancy; foetal surgery; fortification of bread with folic acid to prevent birth defects; Down's syndrome screening; smoking and alcohol effects

in pregnancy; "new research" on foetal health; and announcements about developments in reproductive technologies. I sourced the original copies of these texts from Massey University Library and National Library of New Zealand. The texts were numbered in chronological order and each individual text was numbered line by line to help me manage the data.

Health education materials targeting pregnant women provided the second sample of texts. As a midwife I had personally distributed to pregnant women a large number of health education materials addressing a broad range of lifestyle behaviours and other factors which may be "risky" to health in pregnancy. As demonstrated in Chapter Two, there has been much discussion in the literature about the role of the discourses of new public health strategies, including health education materials, in the construction of western cultural meanings about health and bodies, especially in relation to risk. These analyses have argued that such constructions have had specific implications for reproductive women (Gastaldo, 1997; Hyde, 2005; Petersen, 1997; Petersen & Lupton, 1996; Ryan, 2005, 2005; Ryan, Carryer & Patterson, 2003). Considering my research questions, health education texts thus provided a significant site for the analysis of discourses constituting the bodies and behaviours of pregnancy, and the implications of these for social practices around reproduction.

Also of interest in the analysis of health education materials was the potential for interesting comparisons between the discourses operating in these intentionally pedagogical health texts and those operating in purportedly objective "news" media texts. While I *expected* to encounter only dominant health discourses in the educational texts, I was interested in whether media texts, because of their context, would have competing discourses operating, both dominant discourses and exceptions or resistant discourses. Another key difference between these different texts that made them interesting for comparison was the target audience. While the health education materials are addressed specifically to pregnant (or reproductive) women, the newspaper articles address a general reader.

A large number of health education materials are produced by non-governmental health advocacy organisations and the governmental health agency, the Ministry of Health, including pamphlets, videos/DVDs, posters, television advertisements and books. Thus, I decided I would need to restrict my sample of these texts. I decided on posters because, being largely visual, they are a different kind of text from newspaper articles, and in my practice as a midwife I was aware that they were well-distributed in places frequented by pregnant women and their families and whanau, including the maternity wards of hospitals, clinic waiting and consultation rooms, parent shows, and antenatal classrooms. To sample these texts, I visited my local *Health Ed*, the regional distribution centre for free health education materials developed by the Ministry of Health and non-governmental health advocacy organisations. I visited twice in February and March, 2006, to ensure the set of posters I sampled was representative of those available to pregnancy health care providers at this time. On both visits the same six posters addressing pregnancy were available, and these became my sample. This sample included four posters concerned with alcohol consumption in pregnancy, one on smoking in pregnancy and one on HIV screening in pregnancy[11] (See the images in Chapter Four). Each poster was assigned a letter of the alphabet for purposes of identification during the analysis stage.

My final sample of texts for analysis was, therefore, 35 newspaper articles published over a period of ten months from October 2005, and six health education posters currently available at my local regional health resource distribution centre in February and March 2006.

The Process of Analysis

Having reviewed the literature, developed my research questions, and sampled my data, I was now ready to commence analysis and thus produce my research findings – or was I? As a researcher new to the field of discourse analysis, and

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[11] I do note that the four posters on alcohol in pregnancy were produced by the same agency, The Alcohol Advisory Council of New Zealand, and from their appearance they seem to have been produced at different times. However, for the purposes of my sampling criteria I have not made a distinction between these because they are all still currently available for distribution, and in my anecdotal experience they continue to be displayed in locations where pregnant women might encounter them.

despite being well versed in the theoretical concepts involved, actually sitting down to *analyse* my data proved intimidating. There is much agreement in the research literature that unlike other research methods that may be followed "recipe style," guidelines for doing discourse analysis necessarily fall short of step-by-step instructions (Burr, 1995: 163; Fairclough, 1992; Gill, 2000; Parker, 1992; Potter & Wetherell, 1987; Taylor, 2001). This is largely due to two factors: the many different understandings of, and approaches to, discourse and discourse analysis as an interdisciplinary practice (Fairclough, 1992: 225); and because by its nature discourse analysis is an interpretative practice that does not lend itself to procedural description (Burr, 1995: 163; Gill, 2000: 177). As Potter and Wetherell describe:

> Analysis of discourse is like riding a bicycle compared to conducting experiments or analysing survey data which resemble baking cakes from a recipe. There is no mechanical procedure for producing findings from an archive of transcript. There is no obvious parallel to the well-controlled experimental design and test of statistical significance... Just as with bike riding, it is not easy to convey the analytic process in abstract. (1987: 168)

However, despite these difficulties, Taylor (2001: 41) argues that in order to justify its findings, any reflexive research practice, including discourse analysis, needs to be able to articulate a coherent method of analysis. Describing what happened enables readers to assess the research, which acts as a form of evaluation. Leavy (2000) frames this as a commitment to validity and authenticity in specifically *feminist* research practice because she considers that this is more likely to be scrutinised.

The method of analysis I developed for my sampled texts was 'learnt by doing' (Gill, 2000: 177). It is only in hindsight that I can clearly articulate the various stages it involved. In the discussion that follows, I will make reference to the suggestions in the research literature that guided the stages of my analysis. In my description of this method, I will assume that the texts under analysis were predominantly those in print, but in my discussion of the analysis of the visual images that concludes this section it will be apparent that the same method of discourse analysis applies to both print and visual texts, with only minor variations applying to the latter.

Stage One: Repeated critical and deconstructive readings of the texts

The research literature emphasises repeated, careful, critical reading of the texts as the central task of analysis that seeks to identify discourses (Burr, 1995; Fairclough, 1992; Gill, 2000; Potter & Wetherell, 1987; Taylor, 2001). As Gill (2000: 188) describes: 'Discourse analysis is a careful, close reading that moves between text and context to examine the content, organization and functions of discourse'. In the act of critically reading the texts, the discourse analyser is attempting to move away from the individual idiosyncrasies and specific views expressed in each text, to focus on the social processes at play (Grace, 1995: 74).

Burr (1995: 165) describes this task as 'deconstructive reading'. The analyst attempts to dissect texts to see how they are constructed in such a way as to create and stabilise particular meanings about people and their actions (Burr, 1995: 165). This involves revealing the "hidden" assumptions and internal contradictions in the texts, and making the absent or repressed meanings present for the reader (Burr, 1995: 165). It may seem obvious, but deconstructive reading also involves the identification of the discourses that operate in the text. Burr states that this is where

> ...prevailing discourses of, say, gender, sexuality, disability and so on are examined and their identity and power implications brought to the fore. This might involve identifying the subject positions offered by different discourses, and the identity and political implications of these. (1995: 166)

Graham's (1990 as cited in Reinharz, 1992: 149) method of feminist intertextual deconstruction demonstrates how deconstructive reading can be applied to multiple texts, as in my sample. Graham's (1990 as cited in Reinharz, 1992: 149) method follows a similar process to that articulated by Burr (1995) but looks between as well as within texts for these features. This would enable me to examine how my different types of texts dealt with similar "issues."

The reading process of discourse analysis is thus a critical interrogation of the text(s) whereby the analyst is constantly asking: why am I reading this passage in this way and what features produce this reading? (Potter & Wetherell, 1987: 168). Burr's (1995) and Graham's (1990 as cited in Reinharz, 1992: 149) explanation of deconstructive reading was particularly informative for my approach to analysis

because, considering my research questions, I too was wanting to "break the surface" of these different types of texts and identify discourses, the subject positions offered by these discourses, and the political implications of these for reproductive practice.

Stage Two: Identifying and noting patterns/ recurring key words and themes

When I first sat down to critically read or deconstruct my sampled texts, I was convinced that there was nothing there. This is commonly the case with discourse analytic research, which requires a certain blind faith from the researcher that there *is* something there, even when this is not immediately obvious to them (Burr, 1995: 168; Potter & Wetherell, 1987: 175; Taylor, 2001: 38). However, in the act of repeatedly reading and re-reading the texts, changes in my understanding started to take place, and even small pieces of text started to produce findings (Potter & Wetherell, 1987: 175). As Potter and Wetherell state:

> The initial reaction is often that it all makes perfect, consistent sense, and that there is no phenomenon to be researched. However in the later stages of analysis the same discourse can seem so fragmented and contradictory that it is difficult to see how it could ever be taken as sensible in the first place. (1987: 175)

As I noticed patterns in the texts, I noted them down in a blank notebook and continued searching. I noted patterns in terms of both *variability* (relating to differences in the content and form of accounts) and *consistency* (relating to the identification of features shared by accounts) (Potter & Wetherell, 1987: 168). The sorts of shared features I identified and noted were similar to those articulated by Burr (1995) and included: repetitions in who was speaking; recurrent themes in what was being said; coherent sets of statements or phrases that appeared to address pregnancy in similar ways; the use of metaphors in the description of topics related to pregnancy; and the repetition of words and, in particular, names for things, which seemed loaded with meaning. In looking specifically at metaphors, I was interested in what images and associations they imported and in any apparent contradictions in their use. I was also interested in which speakers, which ways of thinking and speaking, and which images were excluded, denied or repressed in these texts. In other words, I was interested in repetitions, not only of what was present, but also of what was absent in these texts.

This level of analysis involved working through the data over a fairly long period of time, noting every detail of these features and continuing to search. Potter and Wetherell describe this process as the opposite of reading for the gist:

> If you read an article or book the usual goal is to produce a simple, unitary summary, and to ignore the nuance, contradictions and areas of vagueness. However, the discourse analyst is concerned with the detail of passages of discourse, however fragmented and contradictory, and with what is actually said or written, not some general idea about what was intended. (1987: 168)

I very quickly identified a large number of possible patterns in the data and it is important to note here that the next stage of analysis necessarily involved privileging some at the expense of others. As Taylor (2001: 39) argues: 'Discourse data are "rich," which means that it is probably impossible to reach a point where the data are exhausted, with nothing more to find in them because the analysis is complete'.

Stage Three: Returning to the data and continuing to search; indexing the recurring themes

As my analysis progressed through the first few texts, I found I was generating a large quantity of observational notes and decided I would need some way of managing my analysis. I thus developed a simple index, which was a structured and numbered list of the features listed above, so that where I found another example of an already noted feature I could mark it in the text with the number from the index. This index was also dynamic rather than exhaustive, meaning I could continue adding to it as I encountered new features in the texts. However, this did mean going back over the already indexed texts and adjusting the indexing.

My method of indexing was adapted from Ritchie, Spencer and O'Connor's (2003) method of qualitative data management, which they refer to as 'framework'. Ritchie et al. (2003) suggest that the recurring themes and other features noted when critically and closely reading the data can be arranged in the form of a conceptual framework or index. These themes and other features can then 'be sorted and grouped under a smaller number of broader, higher order categories or "main themes" and placed within an overall framework' (Ritchie et

al., 2003: 221). Once the index was devised, numbers were assigned to differentiate the individual categories and then used to index the data so that the location of each theme or feature within the text could be identified (Ritchie et al., 2003: 221).

This is not to infer, however, that this type of textual analysis is tidy or easily captured in separate categories, and in many instances in my analysis, especially in relation to particularly significant or dense sections of the texts, themes tended to occur in close proximity or completely overlap. As Burr (1995: 168) notes of her analysis, often the same word or phrase appeared as a potential component of multiple themes or discourses.[12] Thus, in my findings chapter, the same pieces of text may be employed in reference to different discourses.

Stage Four: Mapping these themes visually and identifying relationships between them

Having completed the indexing, I now had a number of continually recurring "ways of talking" or, in Grace's words, 'gravitational fields' (1998: 117). My next step was to map these features out visually or diagrammatically on large sheets of paper and try a number of different ways of representing the relationships between them. What emerged in this process was a number of discourses, some quite contradictory, others overlapping, located around two reproductive bodies, the pregnant woman and the foetus. When these discourses were arranged around the reproductive bodies that they were constructing, they could be read together, and various subject positions related to these "bodies" emerged. Having arranged the discourses visually around each of the reproductive bodies, it was possible to identify their shared features, and the dominant discourses and subjects became apparent. As also suggested by Grace (1995; 1998), by reading this visual diagram, the discourses and subjects that I had identified could be read together as a summary or structure for how the dominant discourses worked together to constitute these reproductive bodies and subjects and the relationships between them.

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[12] Burr (1995: 168) argues that this is one way in which discourse analysis is different from content analysis, where words or phrases may only occupy one coding category.

Stage Five: Finding examples

I then returned to the data for examples of the discourses and subjects. This was a relatively straightforward process because of my indexing. I used these examples in the production of my findings to demonstrate how the discourses at work in these texts were implicated in the constitution of reproductive bodies and subjects.

Stage Six: Noting exceptions

In returning to the data for examples, I also noted the few sites in the texts where there were resistances or exceptions to the discourses and subjects identified in Stage Four. It is significant to note that there were very few moments of resistance or exceptions in my analysis, even in the media texts where I might have expected many more. This says much about the dominance of these reproductive discourses and also worked as a form of evaluation of my process of analysis. As Gill (2000: 187) argues, deviant case analysis is a significant aspect of the discourse analyst's ability to check the reliability and validity of their analyses. By examining in detail aspects of the texts that seem to contradict the pattern identified, the analyst may consider whether the pattern is sufficiently disrupted to render it unworkable (Gill, 2000: 187). Potter and Wetherell (1987: 170) contend that cases that lie outside the explanatory framework of a theory are almost always more informative than those that lie within it. They argue:

> If there is clearly some special feature of the exceptions which marks them off from the standard examples and thereby determines their exceptions, the explanatory scope of our scheme is confirmed. If there are no special features which plausibly explain difference, the exclusive nature of our scheme must be questioned. (Potter & Wetherell, 1987: 170)

I have thus taken seriously the role of exceptions in my analysis, however minor they might seem, and conclude chapters Four and Five, which present my findings, by identifying these exceptions.

Visual Texts

While the process of analysis outlined above refers largely to the analysis of texts in print, my sample of texts also included visual images. The visual images were both photographs used in the newspaper texts and the various types of images, diagrams, photographs and cartoons used to communicate information on the

health education posters. In this section I will attend specifically to the features of my analysis of visual images, arguing as I do that for the most part the two processes of analysis are very similar because they each involve asking the same types of questions about the function or effects of discourses.

For the discourse analysis of my visual images I developed a method that combined Burr's (1995) 'deconstructive reading' and Pearce's (1999) method for the discourse analysis of advertising images. As with the analysis of texts in print, the research literature emphasises that although there is no "right" way to interpret images, it is vital for the reliability and validity of the research that the researcher be able to articulate the various stages involved in the analysis. The three stages involved in the analysis of my visual images are described below. Although they are articulated somewhat differently, they do not differ in any significant respect from the stages described above in the analysis of texts in print. It is also noteworthy that my analysis of the visual images was conducted in conjunction with my analysis of print, for the simple reason that the visual images in my sample were always juxtaposed, and therefore operating in discursive mediation with, printed text. For example, the photographs used in the newspaper texts were accompanied by captions, and a combination of visual image and print was employed on the posters.

Stage One: Critical deconstructive "reading" of the visual text

'Deconstructive reading' is suited to visual texts as much as those in print (Burr, 1995). In approaching the critical or deconstructive "readings" of these images I was concerned to identify similar features to those in the analysis of the print texts. These included noting variations and consistencies in the use of visual images and their accompanying text across the sample, including repetitions in the choice of images, in who was shown, who was speaking, in what they were saying, and in the use of metaphors. It also involved contemplating the constituent parts of each individual image. This included the settings; the objects; the appearance of people present in the posters, including their facial expression, gender, and apparent social class, status and race; the use of colour and focus; the size, choice and placement of print; the relationship between who was speaking in

print and visual representation; and the visual emphasis on different parts of the print. I also considered the complete package of meaning contained within the text and its underlying principles and attitudes (Pearce, 1999: 79). This deconstructive or critical reading also involved attention to whom and what is absent or repressed in the images.

As I read or considered each text individually, I listed these various features. This was done fairly systematically, which meant I approached each text in a similar way, starting first with my overall impression of what the text was "saying" and then considering the various parts of the image in the order listed above. As I did this I started to notice various recurring features in the texts, and noted these, but continued my critical "readings" until all six posters were analysed in this way.

The next two stages of analysis only apply to the health education texts because the critical "reading" of the media photographs was integrated into my process of analysis for the texts in print, as discussed above.

Stage Two: Identification of discourses and subjects

As with the analysis of the texts in print, I then mapped these recurring features and themes out visually and noted how they also tended to cluster around two reproductive bodies, the pregnant woman and the foetus/baby. Read together as clusters it was possible to see how they were implicated in the construction of dominant subject positions. This stage of analysis was the same as that for the analysis of texts in print.

Stage Three: Considering any exceptions to the dominant discourses and subjects in the sample

Finally, to evaluate my analysis I revisited the posters to consider any elements in the texts which may have been exceptions to the dominant discourses and subjects I had identified.

Statement of Validity

While discourse analytic research involves a great deal of what Burr (1995: 171) calls intuitive or subjective reading, and does not make claims to objectivity for validity, there are still several ways in which I might make a claim as to the reliability and validity of my findings (Burr, 1995; Gill, 2000; Potter & Wetherell, 1987; Taylor, 2001). These are: adherence to the sampling criteria, clear explanation of the process of analysis, deviant case analysis, coherence and fruitfulness.

One of the most common failings of discourse analytic research is the failure of the researcher to give an account of how the analyses were actually performed (Burr, 1995: 167; Leavy, 2000: 9). Despite my confession that it was difficult to do so, providing a detailed account of my method here, including my treatment of deviant cases, functions as a claim to validity. A set of analytic claims should also give coherence to a body of discourse by demonstrating how the discourses fit together and how the discursive structure produces effects and functions (Potter & Wetherell, 1987: 170). Potter and Wetherell warn:

> If there are loose ends, features of the discourse evident in the data base which do not fit the explanation, we are less likely to regard the analysis as complete and trustworthy. If the explanation covers both the broad pattern, and accounts for many of the micro-sequences, then we will take it more seriously. (1987: 170)

My final claim to validity is based on Potter and Wetherell's (1987: 171) notion of fruitfulness: 'the scope of an analytic scheme to make sense of new kinds of discourse and to generate novel explanations'. In other words, is my analysis relevant and useful to the reproductive context? My claim, perhaps unsurprisingly, is that it is. In the late stages of writing up this research I had the opportunity to present my findings to a large group of my midwifery colleagues. While it was truly intimidating to present these findings to my peers, it was also a validating experience that reassured me that this research offers a critical perspective on the reproductive context that may have implications for professional reproductive practice and lead to further research and discussion.

Conclusion

In this chapter I have provided a detailed account of the method of qualitative discourse analysis developed for this research. I began this chapter with a discussion of the epistemological and methodological principles that have informed my approach to discourse analysis, demonstrating that it is a method of research well suited to the theoretical perspectives of social constructionism. I then outlined the design and practice of the research, including the research questions, selection of data, the process of analysis and a discussion about the validity of my findings, demonstrating how I negotiated the confusing array of discourse analysis "types" and developed a method of analysis specific to my particular research questions and texts. The next two chapters present the findings of my analysis as outlined above. Chapter Four presents the analysis of the six health education posters. Chapter Five presents the analysis of the 35 newspaper articles. In Chapter Six I discuss these findings in relation to women's reproductive practices and to the professional practice of midwifery.

Smokey Sue Smokes for Two ™
'Smokey Sue may look like a toy, but the message it sends is deadly serious. As Sue smokes, tars and nicotine pass through the water around a life-like model of a seven month foetus. The darkened water is a grim reminder of the pollutants reaching and affecting the developing body. Includes: five reusable tubes and convenient carrying case. Size: 14" x 6" x 6-1/2". Required but not included: cigarettes. Recommended filterless for quicker results.'
(Sargent-Welch, 2007)

Chapter Four

Discourse Analysis Findings: Health Education Texts

Introduction

'Smokey Sue Smokes for Two™', the public health resource illustrated on the previous page, is available worldwide from a number of anti-smoking advocacy organisations. The model has been designed for health educators or health professionals working with pregnant women to demonstrate what happens to their developing foetus when they smoke. The assumption behind this health education strategy, argues Oaks (2001: 160), is that 'women will associate the lifelike foetus floating in brown, polluted amniotic fluid with what really happens when they smoke and then determine to quit or to never start smoking'. The doll's educational power lies in this imaginative leap, which, while succeeding in shocking smokers, does not impart biologically accurate information (Oaks, 2001: 160).

As outlined in Chapter Two, feminists have argued that the increasing proliferation of foetuses in both visual and textual form has been central to the social construction of reproductive bodies. In particular, they have contributed to the construction of "life before birth" as a separate entity with its own identity – a foetal person. This foetus is increasingly being established as a social actor who lives beyond the boundaries of a pregnant woman's body (Oaks, 2001: 140). As a result, women's own status in reproductive discourse has become increasingly unstable, resulting both in the reduction of the pregnant woman to a "container" or "maternal environment," and in pregnant women's physical disappearance from the reproductive picture.

The contemporary construction of foetal and pregnant subjects has led to the notion that the pregnant woman and foetus are in a relationship characterised by conflicting needs and rights. It is through these constructions that the behaviour of the pregnant woman has increasingly come under scrutiny as placing the foetus, now the central subject of pregnancy, at risk of harm. 'Smokey Sue Smokes for

Two™' provides a stark visual confirmation of the arguments of many of the analyses reviewed in Chapter Two. From a social constructionist perspective, public health resources such as 'Smokey Sue' can be understood as both the product of, and also productive of, such constructions.

The findings presented here are an analysis of six health education posters addressing topics related to pregnancy, including smoking, alcohol consumption and pregnant women who are HIV positive. I first provide critical descriptions of my analysis of each poster, demonstrating how pregnant and foetal bodies and subjectivities are being discursively constructed. My key findings here reflect the feminist analyses reviewed in Chapter Two. Through both its visual and textual construction in these posters, the foetus emerges as the vulnerable "unborn baby," the ontologically secure and central subject of public health discourse about pregnancy. Pregnant women on the other hand occupy an ambiguous ontological status in these posters. They are simultaneously reduced to their reproductive bodies, as vessels for these foetal "persons," as well as to "maternal" subjects with the moral and medical imperative to guard foetal health from the risks posed by their own bodies and behaviours. There are no exceptions to these dominant subject positions in this sample of posters. In concluding this chapter I provide a brief discussion about the possible reasons for this, suggesting that it is most likely due to the type of text under analysis.

Critical Descriptions

Poster A

This poster asks women who are pregnant to consider whether they may be at risk of being HIV positive. The visual image is of an unsmiling, even worried-looking baby. The poster is wide and thin and the baby is at the end. A long band of red runs across the poster narrowing as it reaches the baby. It appears to symbolise the danger the baby faces by exposure to infectious blood. The background is black, emphasising the drama of the red. The "maternal" body is absent here, except perhaps as the vector: the red line which flows towards the baby may symbolise the risk the pregnant woman poses to the "unborn baby" in the passage of the infectious blood through the umbilical cord in utero, or as the foetus passes

PREGNANT? Worried about HIV and AIDS? A mother with HIV can pass the virus to her baby during pregnancy, at birth, or through breastfeeding.
"....the good news is....treatment is available to reduce the risk of baby getting HIV."
If you think you could be at risk of HIV talk to your doctor, midwife or specialist as soon as possible.

Poster A

through the birth canal during birth. With the visual absence of the pregnant woman, the baby emerges as the single focus of concern in this poster, an entity separate, but also "at risk," from its mother. While the pregnant woman is visually reduced in this poster to the risk that she poses to her "baby," the text addresses her directly as a maternal subject. "Mothers," the text informs us, can pass HIV to their "babies" during pregnancy, birth and breastfeeding; and thus the pregnant "mother" must act urgently to protect her "vulnerable child." The "good" maternal subject in this poster must recognise the "risk" she poses to her "baby" and *seek biomedical help*. This involves communicating with health professionals *as soon as possible* and acquiescing to biomedical treatment. She will *of course* do this to protect her "baby," because that is what any "good" mother would do. She is reassured that if she does this, the risks she poses to her baby can be reduced. Biomedical "experts" here mitigate the risks posed by the pregnant woman to the "baby."

The construction of the foetus as "baby," and the pregnant woman as "mother" to this baby, is thus achieved both visually and textually. The pregnant woman who views this poster is prompted towards the recognition of her foetus as *already* a vulnerable, worried "baby" at risk, regardless of the gestation of her pregnancy, wanted or unwanted. She is thus *already* a "mother." These subjects, "mother" and "baby," are being constructed in ways that suggest that they are formed and stable from embryo to breastfeeding baby, rather than liminal and in development. This works to reduce or even completely disregard the physical and emotional work of pregnancy and childbirth in 'bringing a child forth' (Squier, 1991). In the overwhelming focus, visually and textually, on the foetus/baby's health, the pregnant woman's health, and in particular the importance for her health of HIV testing and treatment, goes unmentioned. Her separation from her foetus/baby is complete.

Poster B

This poster addresses smoking in pregnancy. Here the text is at the top of the poster and introduces the visual image, a photograph. It is a direct quote from the


"Who am I to give this child a bad start in life, fill his lungs with all that crap that goes into cigarettes?
I'll give him a choice.
So I stopped smoking - it was real hard."

Poster B

woman pictured, and one line of the text has been highlighted for emphasis. It reads:

> *"Who am I to give this child a bad start in life, fill his lungs with all that crap that goes into cigarettes?*
>
> *I'll give him a choice.*
>
> *So I stopped smoking – it was real hard."*

Below the text sits a mature-looking Maori woman, alone on a couch, holding a large, sleeping baby boy in her lap. There are immediate visual references to the Madonna and Christ child here. The woman holds the hand of the baby boy, who lies in the foreground while she looks soberly off to the side of the camera, rather than making direct eye contact. She is not smiling and is dressed plainly. A wedding ring is visible on her left hand, which holds the baby on her lap. She sits in a living room, which appears tidy but which does not leave the viewer with an impression of affluence.

Unlike the "mothers" who will be described in Posters C, D and F, this poster both visually and textually represents the "good" mother who understands and can articulate that she is secondary to her child. This "good" mother does not prioritise her own desires or "choices," but has allocated this "right to choose" to her child, who is the central focus. She is self-sacrificing and nurturing, and she understands the full gravity of her role and individual responsibility as a "mother" throughout the reproductive process, especially in regards to her (born or unborn) "child's" health. Unlike the "babies" in Posters A and C, this child sleeps peacefully; confident that his mother is "doing everything she can" to protect his wellbeing and health. There is the suggestion that his contentment and apparent healthiness are related to her "good" behaviour. She has followed advice and ensured a "good" outcome: a healthy baby. The mother's agency is demonstrated by her acquiescence to health advice in respect to the effects of smoking on her foetus/child and by her successful efforts to change her behaviour, even though

> *"it was real hard."*

It seems that the extent to which she is the "good" mother here is in direct relation to the extent to which she accepts her marginality, and so she asks:

"Who am I to give this child a bad start in life...?"

The only possible response to this question, confirmed by the woman's own "self-denial," is that she is, of course, not any(body).

The emphasis on the words *"I'll give him a choice"* is also a significant textual strategy. This highlighted statement makes a direct intertextual and contextual reference to social debates about abortion and contraception, where feminist and women's health activists have mobilised around the notions of "we demand choice" and "a woman's right to choose" in defending or insisting upon access to contraception as well as legal and safe abortion services. This feminist position has become etched in social reproductive debates in the past 30 years as "pro-choice." In this poster, the "good mother" has surrendered her "right to choose" and, instead, realising the centrality of her child and thus her own marginality, has assigned "the right to choose" to her child, or, more specifically, to her son. The rights-bearing subject who emerges here is not the reproducing woman, but the child, born or unborn. The discursive strategies operating in this text confirm women's necessary guilt if they prioritise their own choices over those of others, especially their children, as I will find "bad mothers" doing in Posters C and D.

This poster can also be subjected to both gender and cultural-critical readings. Reproduction and parenting emerge from this poster as deeply gendered social practices. The woman sits alone with the baby, who notably is male, questioning who *she* is to *give this child a bad start in life*. Although we can deduce from the wedding ring on her finger that perhaps she has a partner, and we know it is a biological necessity that someone else has contributed to "making" this baby at some point, this woman is alone in considering her responsibilities and care for this child. The "father," through his full visual and textual absence, has been let "off the hook" in terms of his own responsibilities for reproductive and child health. Acquiescence to biomedical advice and behavioural change is thus a gendered practice in the reproductive context. Women are expected to follow biomedical advice for their "baby's health," while men and "others" are not.

However, in this image it is not just fathers who escape being visually implicated as responsible for their children's health; so also, it seems, do Pakeha women. The only women photographically present in these posters are those who appear to be of Maori and Pacific Island descent, groups who are thus being targeted as "at risk." As I discussed in Chapter Two, "risk categories," which may inform the decision to target particular groups with public health messages, can also be understood as social constructs.[13]

Poster C

The focus of this poster is alcohol consumption in pregnancy. The visual image is a cartoon of an infant lying on a bed inside a pink circle, which resembles "the womb," on the outside of a woman's body. The "infant" on the bed is chubby and pink and has blond hair. But something is very wrong with this "baby." It is lying on its stomach with its head over the edge of the bed. Its face is green and it has a blue tongue, which is hanging out. Its eyes are drooping and its arm dangles down.. The "baby" is sick. On the wall of this "uterine bedroom" is a calendar with the months crossed off. This "sick baby" is counting down the days until it can "get out of there." The pregnant woman's body is off to the side of the poster and has no head or feet, but prominently represented are her large hands holding a drink, which, we are to assume, is alcoholic. Her knees are pointing towards each other as though she is unsteady on her feet. She has pink-painted fingernails on droopy hands and wears a bold-patterned dress. The central focus of her body is the large pink "womb," which floats on the outside of her abdomen and "houses" the foetal subject. The bold black text that accompanies this image reads:

YOU HIT THE BOOZE AND THE BOOZE HITS BABY!

The foetal "baby," in his/her *own* little "womb bedroom," is located in the centre of the poster and is constructed as fragile, sick, and "trapped inside." The centring of the "baby" in this way has relied upon the decentring of the pregnant woman. While we are shown the full physical form of the foetal person, the pregnant

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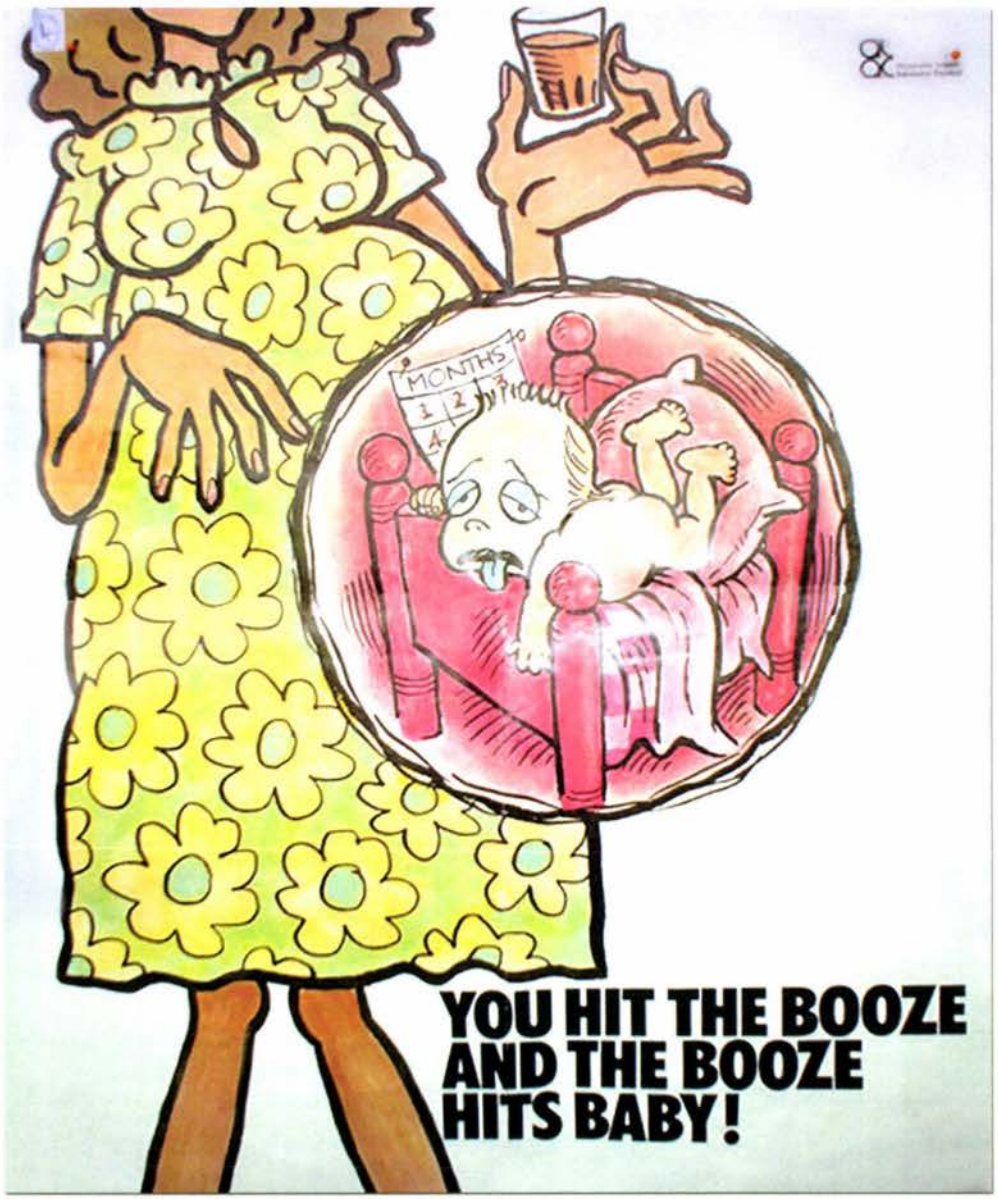
[13] Drawing on my experience as a midwife, I think that it is likely that the targeting of Maori and Pacific Island women in these posters may, at least in part, be informed by what I would consider to be widespread racism within biomedical and public health institutions. This is a possible site for further research.



Poster C

woman is headless and footless. Visually this woman is objectified as a physical environment for the foetus, rather than being granted the status of a subject-in-herself.[14] Further, this "environment" is portrayed as toxic or poisonous for the "baby."

However, there is a contradiction operating here. While the pregnant woman is visually objectified as the "baby's home," textually she is granted subjectivity, but *only* as a mother. "Mothers," we are being told, who drink alcohol while pregnant are abusing their babies, a notion that is closely related to the anti-abortion movement's argument that women who have abortions are killing their "unborn babies." In this way, the poster portrays an adversarial relationship between the pregnant woman and the foetus, or, even further, an abusive relationship. This "mother" is oblivious to the harm she is inflicting upon her "baby" and does not realise that this baby is desperate to "get out of her womb." "Good" maternal subjectivity is dependant upon the pregnant woman prioritising her foetus's interests, indeed her foetus's life, over her own. This "mother" is failing to fulfil this role. As reviewed in Chapter Two, a number of feminist analyses have expressed concern that such coding of foetal persons as vulnerable agents in need of, if not demanding, vigilant protection, and pregnant women as their "mothers," informs the legal trend of prosecuting women for foetal harm. While there is not a culture of legal prosecution for "foetal abuse" in this country, women may be subject to moral judgement for their behaviour while pregnant on the grounds that they are "mothers" who are abusing their children.

Poster D

The visual image in this poster is of an enlarged foetal photograph, the product of obstetric ultrasound imaging. This foetus floats over a blue background and there is no visual evidence of a woman's body. A light shines down on this giant foetus,

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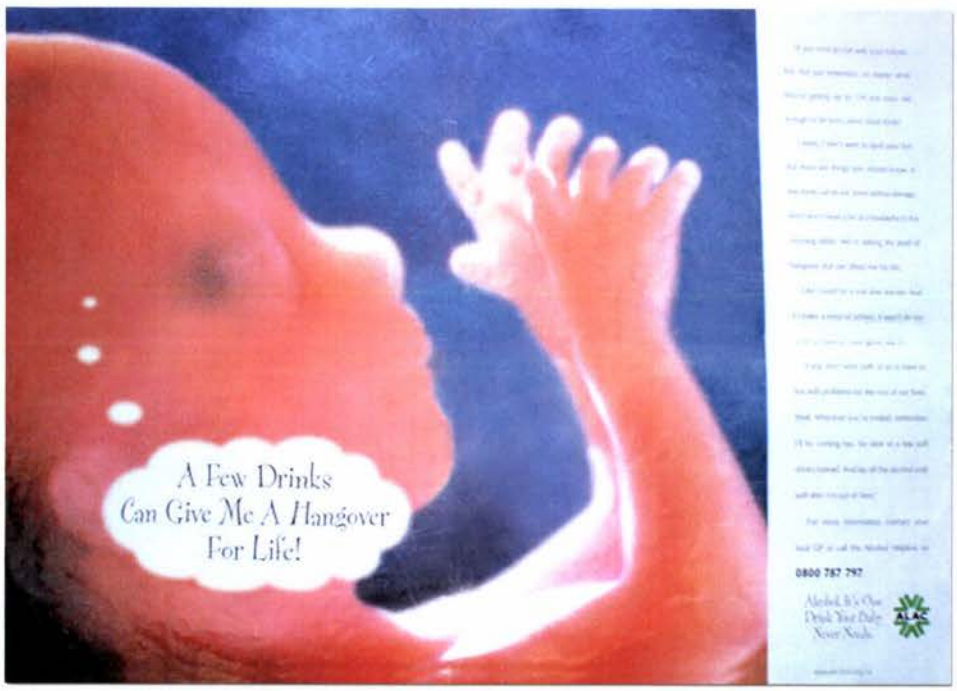
[14] Klein (1993) argues that the objectification of women through their visual representation as fragmented bodies is typical of images of women in the visual media in our culture and is inseparable from social constructions of gender and sexuality.


A Few Drinks
Can Give Me A Hangover
For Life!
0800 787 797
Alcohol. It's One
Drink You Only
Need Needs.
ALAC

Poster D

revealing the fragility of its translucent skin. There are "thought bubbles" floating out of the foetal head, which end in the statement:

A Few Drinks Can Give Me A Hangover For Life!

This image continues the strong discursive practice of subjectifying the visualised foetus. There are visual references to anti-abortion movement imagery in the representation of this fragile, yet "larger than life," foetus. The meanings that have accrued around and inscribed visualised foetuses, the product of multiple communities of practice, but perhaps most prolifically the anti-abortion movement, inform our reading of this foetus as a person, the "unborn baby" no less. Visually, both the size and centrality of the foetus, and the total physical absence of the pregnant woman's body, down to the colour of the background, which is more oceanic than uterine, confirm this "child's" elevated status in public health discourse on pregnancy. In her visual absence, the pregnant woman is not the main embodied subject of pregnancy here, but rather, as the foetus tells us, she is a site of "risks" which may threaten foetal wellbeing and the future health of the child.

These risks are articulated by the foetus, who addresses the "mother" directly:

> *If you **must** go out with your friends, fine. But just remember, no matter what they're getting up to, I'm not even old enough to be born, never mind drink! I mean, I don't want to spoil your fun, but **there are things you should know**. A few drinks can do me some serious damage. And I don't mean a bit of a headache in the morning either. We're talking the kind of hangover that can affect me for life. Like I could be a real slow learner. And if I make a mess of school, it won't do my career prospects much good, will it? **If you don't want both of us to have to live with problems for the rest of our lives, think.** Wherever you're invited, remember I'll be coming too. So stick to a few soft drinks instead. And lay off the alcohol until well after I'm out of here.* [Emphases added.]

Here the giant fragile foetus has not only gained an identity as a separate entity, but also speaks "from the womb." Further, the foetus has assumed a parental role of authority and addresses, almost admonishes, the maternal "child." The woman is being instructed by this foetal "parent" about how she should behave while pregnant, and what may be the consequences of her actions, in a manner

reminiscent of a parent speaking to their teenage child. This reversal of roles further helps to achieve the visual foetus's central and elevated status, and the reduction and marginality of the pregnant woman.

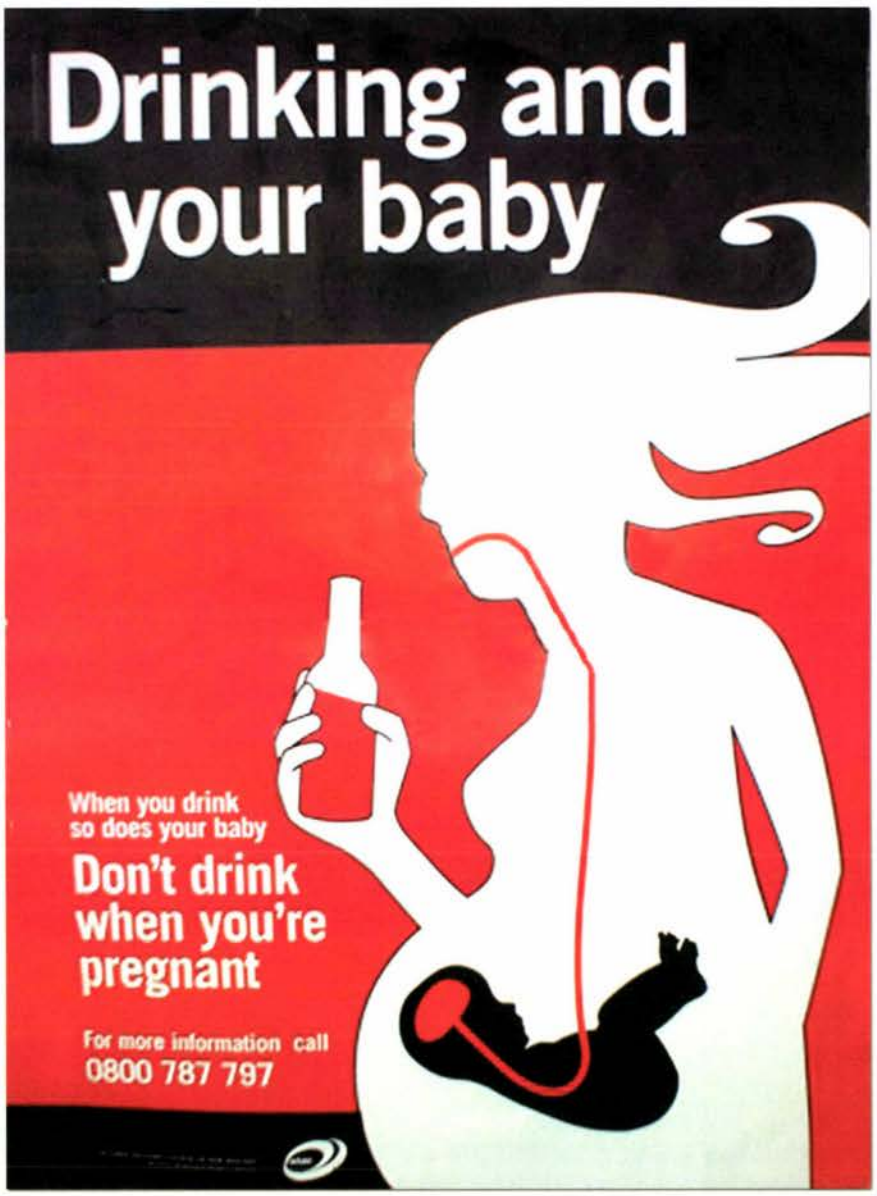
Textually, the pregnant woman here is constructed as a "maternal subject," instructed by her foetus about "good" maternal behaviour. It seems that ideally the "good" pregnant "mother" should keep her socialising to a minimum and thus prioritise her foetus over "fun":

> *'If you* ***must*** *go out with your friends, fine. . . . I mean, I don't want to spoil your fun, but there are things you should know.'* [Emphasis added.]

She needs to accept individual responsibility while pregnant for the long-term health and wellbeing of her child, to the extent that even her child's future educational and employment successes will be determined while she is pregnant. It is also noteworthy that the mother's (self) interest is invoked in the text here as an incentive for her "good behaviour." The foetus reminds her that if it is harmed, the "mother" will also have to *live with the problems* for the rest of her life. Again, reproduction and child-raising here are deeply gendered practices, for which it seems women, as "healthy citizens," are individually responsible.

Poster E

The topic of this poster is also alcohol consumption in pregnancy. Visually, this poster gives a bold impression, and the use of contrasting colours, red, white and black, portray a sense of urgency or importance. A cultural reading is also possible here, given that the colours used are those of the Tino Rangitiratanga flag, perhaps targeting Maori women as an "at risk" group. The visual image of this poster is presented as a scientific diagram, demonstrating to the viewer the passage of alcohol from the mouth of the pregnant woman to the developing brain of the foetus, the stark "reality" of which should perhaps "shock" women into avoiding alcohol consumption while pregnant. However, as Oak (2001: 160) notes of 'Smokey Sue', this "diagram" is not biologically accurate, but rather relies on an 'imaginative leap'.


Drinking and your baby
When you drink so does your baby
Don't drink when you're pregnant
For more information call 0800 787 797

Poster E

In this visual image, the pregnant body is a black outline on a red background, with empty white space where the body should be. The maternal subject has literally been cut out of the image. She is the container for her foetus. Inside her empty white shell lies the solid black form of the "baby." The outline of the woman lifts to her mouth a bottle half-full of red liquid. The red liquid, like the "dangerous blood" in Poster A, passes through her organless body and goes straight through the "baby's" abdomen and into the brain, which is also red. There are no "insides" in the diagram of the woman. The "baby" floats in her empty space, without the boundaries of the uterus and the placenta that feeds it, without, in fact, any physical support or nurturance from the pregnant woman at all. Their physical relationship in this diagram is completely reduced to the harm the pregnant woman may do to the "developing baby" by what she consumes.

The solid black form of this "threatened baby" has visually become the central focus of the poster. Like Posters A, C and D, the process of centring this "baby" as the focus of this health message for the pregnant woman has, at least in part, been achieved by "disappearing" the pregnant woman. The diagram, while reducing the pregnant woman's physical contribution to the gestation of the foetus, and elevating the physical presence of the foetus, simultaneously renders the pregnant body a container for the foetus and the foetus's biggest threat.

The construction of the foetus as "baby," a separate entity who is the focus of the health message because it is "at risk," is further confirmed textually. The large white text on the black background at the top of the poster reads:

> *Drinking and your baby*

while the text in the bottom left hand corner, which is white on a red background, elaborates:

> *When you drink so does your baby*
> *Don't drink when you're pregnant*

Although visually the woman has been reduced to a maternal environment, the subjectification of the foetus as "baby" also renders her a "maternal" subject who

must follow this public health imperative to protect her "baby." She has no choice here; she is a "mother" and as such she has individual responsibility for her "baby."

Poster F

In some ways this poster is an anomaly when "read" alongside the rest of the sample. This is because it does not visually represent a foetus or baby in order to convey the dangers of alcohol consumption in pregnancy, and also because it visually represents women as full social subjects. In fact, at first glance it appears to be a very positive image of three smiling women standing together in a kitchen, each holding a glass of champagne. They are turned towards each other and seem to be enjoying each other's company, perhaps celebrating something. However, the woman in the foreground is visibly pregnant, perhaps even in the last weeks or days of her pregnancy, and she is lifting the glass of champagne to her mouth. The large text above the women's heads reads:

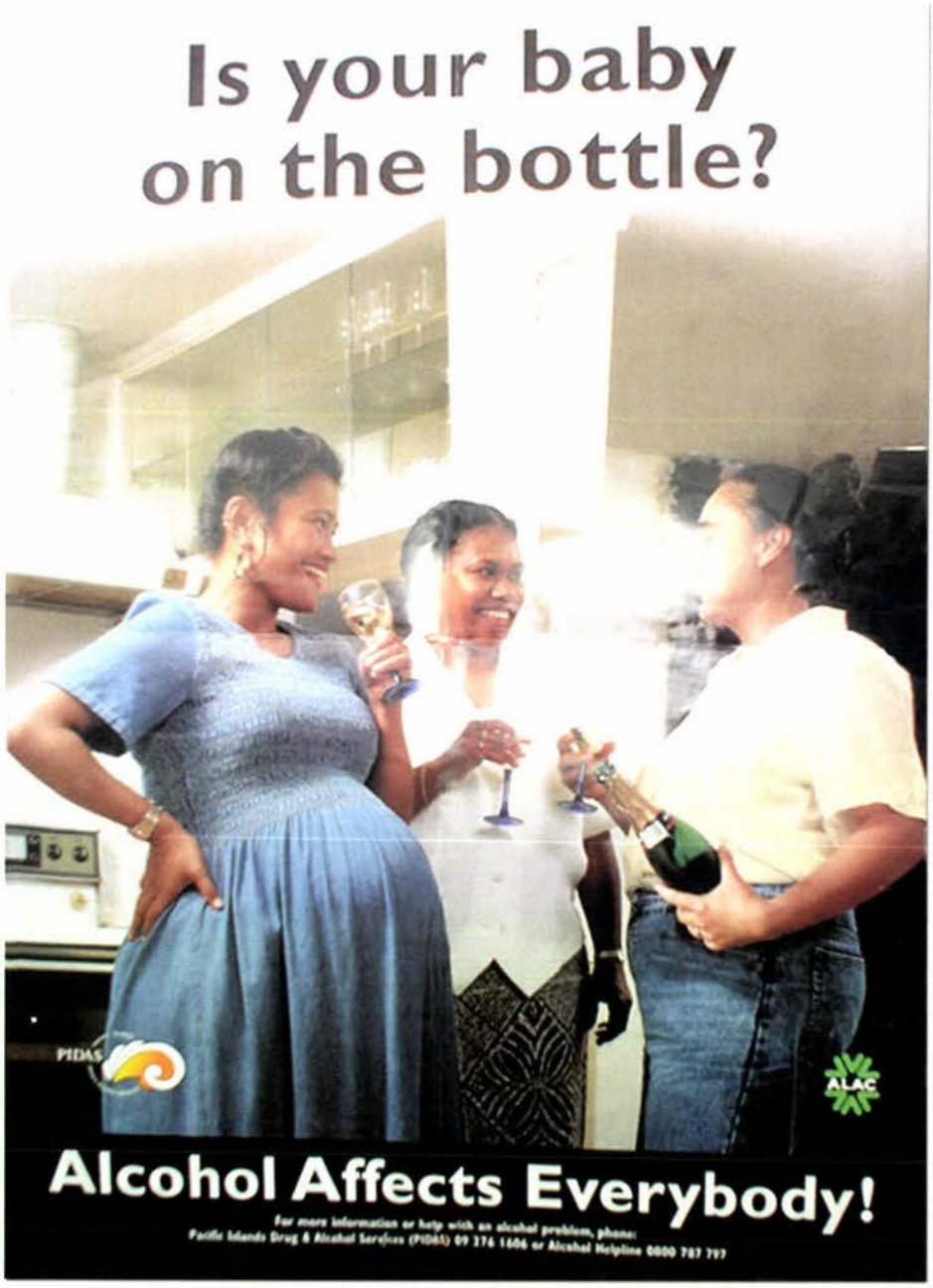
Is your baby on the bottle?

and below:

Alcohol Affects Everybody!

By prompting the viewer textually to question the pregnant woman about her "baby," we come to view the pregnant body before us as itself the sign of a baby, one which is "housed" within the pregnant woman and is at risk from her behaviours. When we identify the pregnant woman as the "home" for this baby, the pregnant woman's behaviour comes under surveillance despite how positive this image is and how

happy the women appear. We "read" this woman as a "mother" and as such evaluate her behaviour, asking whether she is doing something that may harm her "baby." As a "mother" she should be prioritising her foetal "baby's" interests over her own. This means focusing her attention on the risks of her behaviour for her foetal "child" and self-regulating her behaviour accordingly.


Is your baby
on the bottle?
PIDAS
ALAC
Alcohol Affects Everybody!
For more information or help with an alcohol problem, phone:
Pacific Islands Drug & Alcohol Services (PIDAS) 09 276 1606 or Alcohol Helpline 0800 787 797

Poster F

Unlike the woman in Poster B, who sits alone and speaks to us of her sacrifice for her child, this woman has not prioritised her "baby's" health and changed her behaviour. She does not yet realise her responsibilities as the "good mother." By showing the pregnant woman drinking in a social context and then questioning her about her behaviour – *Is your baby on the bottle?* – the viewers of the poster are also perhaps being informed about their responsibilities when they see a pregnant woman behaving "inappropriately." When we identify bad "maternal" behaviour, should we also approach pregnant women and question them about their baby's wellbeing? It seems likely that we are being reminded here about everyone's responsibility to protect "foetal" children by intervening on their behalf where a pregnant woman's behaviour may be "threatening." While the text tells us that alcohol affects *everybody*, this is perhaps more a reference to the "baby" we can't see than a destabilisation of the concept of "at risk" groups, because again it is only Maori and Pacific Island women who are visually present, not pakeha women, nor others.

Summary of Findings

Foetal and pregnant bodies are being constructed in similar ways across this sample of posters. All of these posters participate in various ways in subjectifying the foetus. The foetus/baby in these posters has both visually and textually become the central focus of pregnancy and the public health message, while the pregnant woman has been decentred, or marginalised. These constructions support the pedagogical function of these posters in communicating public health messages/imperatives about appropriate "maternal" behaviour in pregnancy. Pregnant women here, in order to fulfil their responsibilities as "healthy citizens," and as "mothers," must assume individual responsibility for managing risks to health – not those posed to their own health, but those posed to that of another "citizen," the foetus.

The foetuses in these posters are "unborn babies," separate entities with distinct identities; they are autonomous, thinking and speaking subjects with rights. This subjectification is achieved in several ways. Visually, foetuses are either

represented as autonomous individuals separate from the pregnant woman, as in Posters C, D and E; or, as in Posters A and B, they are represented through the use of photographs of actual babies, eliding the difference in our visual imagination between foetuses and born babies altogether. Textually, we are told clearly that what we see are babies, as in Poster D where the pregnant woman is informed: 'Alcohol. It's one drink your baby never needs'. However, more than "unborn babies" who might appeal to "maternal instinct," the communication of the public health imperative here seems to rely on the construction of these "babies" as vulnerable or fragile individuals who require *urgent* maternal care and/or external intervention to ensure their protection. Risk is a major discourse implicated in the construction of foetal subjects as "vulnerable babies" in these posters. The visual communication of risk is evident in Poster C where the sick "baby" lies in its womb bedroom, as it is also by the image in Poster A of the worried baby at the end of the channel of infectious red "blood." Risks are also communicated as indisputable "facts" by the authoritative experts who speak textually in these posters: 'You hit the booze and the booze hits the baby' (Poster C) and 'Pregnant? Worried about HIV and AIDS? A mother with HIV can pass the virus to her baby during pregnancy, at birth, or through breastfeeding' (Poster A). Through their visual and textual construction in these posters, the foetus as an "unborn baby," albeit a vulnerable one, is ontologically secure and is the central subject of pregnancy and public health discourse.

Pregnant women, on the other hand, occupy an ambiguous ontological status in these posters. The centring of the foetal subject means that the pregnant woman is no longer the main embodied subject of pregnancy in these posters. Her marginality is constituted in two different ways across this sample. In Posters A, C, D and E, where the foetus or baby is visually the central subject, the pregnant woman is either completely absent visually, or she is reduced to her body's reproductive role as a "maternal environment" for the foetal subject, an environment that is, moreover, potentially hazardous. However, textually in these posters the pregnant woman is constructed as a maternal subject who is responsible for the care and protection of the vulnerable foetal subject. As a maternal subject, the pregnant woman *must* heed the imperative to self-regulate

her "risky" behaviour, or, as in Poster A, acquiesce to biomedical screening and treatment in order to protect her "child" from the hazards posed by her own body. In this way the pregnant woman comes to participate in her own objectification.

Posters B and F work in a different way in their construction of the pregnant "mother." In these posters, the women are photographically present and central as full subjects, in that they are thinking, speaking, social actors. However, we are prompted both visually and textually towards recognition of them as a certain kind of subject with socially prescribed behaviours: "mothers." As maternal subjects, these women are the focus of a moral gaze whereby their behaviour is under surveillance and is evaluated. The woman in Poster B is the "good mother" who sits alone on a couch at home holding her sleeping baby boy and looks soberly off to the side of the camera. She wears a wedding ring, dresses sensibly, and her home is tidy. Accepting her own marginality, she *puts her child first*, is nurturing and has self-regulated her behaviour because she understands her moral responsibilities as a "mother." In this image we are told that changing one's behaviours, for example quitting smoking, is an act of "maternal love" and care for one's "baby." This is the only location in these posters where the woman herself speaks to the viewer – to tell us of her sacrifice. In this way she is the most complete female subject of all the posters and acts as an example for other "mothers." However, it seems that the cost of being a "good mother" here is the woman's isolation. Unlike the woman in Poster F, this woman does not have a social life.

Poster F is the only site where the pregnant woman is shown in her social context without a visual representation of the foetus/baby, and in this way she is also an exception. She is in the centre of the image and stands turned towards her friends, smiling, with a glass of champagne. Like the woman in Poster B, she is a full subject. However, given the prominence of her pregnant abdomen, and the text which questions her about her baby, we are also prompted to read her as a certain type of subject, a "mother." When we read her as a "mother" we determine that there is something wrong with her behaviour. While the subjectivity of the "good mother" in poster B is determined by her primary and essential relationship with

her child, whom she prioritises over anything else, this relationship is disrupted in Poster F. A binary operates here: the "bad" pregnant mother prioritises herself, and social time, ahead her "child." She fails to comprehend her "maternal" responsibility for her foetus's life-long wellbeing and achievements, articulated, as we have seen, in the peremptory speech of the foetus in Poster D. The actions of "bad mothers" directly result in foetal harm and as such these mothers are the adversaries of their foetuses.

This construction of "bad" mothers in these posters echoes the analyses in Chapter Two of the instances in North America where women have been prosecuted for foetal abuse. While at present there is no such legal culture in Aotearoa New Zealand, these posters perhaps signpost a broader public culture that may endorse resentment toward women who behave in ways other than those socially prescribed for pregnant "mothers" (See Daniels, 1993 as cited in Balsamo, 1997: 100). It also seems likely, considering the women targeted as "at risk" in these posters, that such social anxiety about appropriate maternal behaviour is more easily projected onto those pregnant women who are neither white nor middle-class.

The fact that the pregnant women in these posters are largely represented outside of their social contexts and alone in the reproductive process is also significant to my analysis. The women here do not have visible partners, families, or other children. In fact there is not one reference to the "father-to-be," or the potential impact of his behaviours, in any of the posters. Where the pregnant woman is contextualised as being in relationship with other people, as in poster F, this social context is used to inform our moral judgement of inappropriate maternal behaviour. Otherwise, women are individual actors here, in sole relationship with their foetuses. In these posters, reproduction, as well as the "healthy citizen's" responsibilities for children, are deeply gendered practices.

Exceptions

Part of the analytical scheme for the discourse analysis of these posters was the identification of any exceptions to the dominant discourses and subjects identified

during the analysis. As Gill (2000: 187) argues, deviant case analysis is a significant aspect of the discourse analyst's ability to check the reliability and validity of their analyses. The discourse analyst must consider if there are any exceptions significant enough to disrupt the patterns identified and thus undermine the analysis (Gill, 2000). On the other hand, Potter and Wetherell (1987) warn that the discourse analyst should be suspicious of their explanatory framework if there are no exceptions to their analysis. The exceptions, in fact, do much to confirm the validity of the explanatory framework (Potter and Wetherell, 1987).

In analysing these posters for exceptions, I have not encountered any aspects that would undermine my analysis, and thus, as suggested by Gill (2000), this works as a form of validation for my explanatory scheme. Nonetheless, in heeding the warning of Potter and Wetherell (1987) I must also problematise this lack of exceptions. One possible explanation is the small size of the sample. However, because the sample included all the posters that were available for distribution, it should be fairly representative of those produced. The lack of exceptions to my explanatory scheme is most likely due to the type of text under analysis. As texts designed to communicate a public health message, they are intentionally pedagogical by nature; this means that it is perhaps unsurprising to encounter only dominant public health and biomedical discourses about pregnancy and foetal health in their analysis. Of significant interest, then, is whether the media texts analysed in the next chapter will offer a wider range of competing reproductive meanings because of the news values inherent in "objective" reporting.

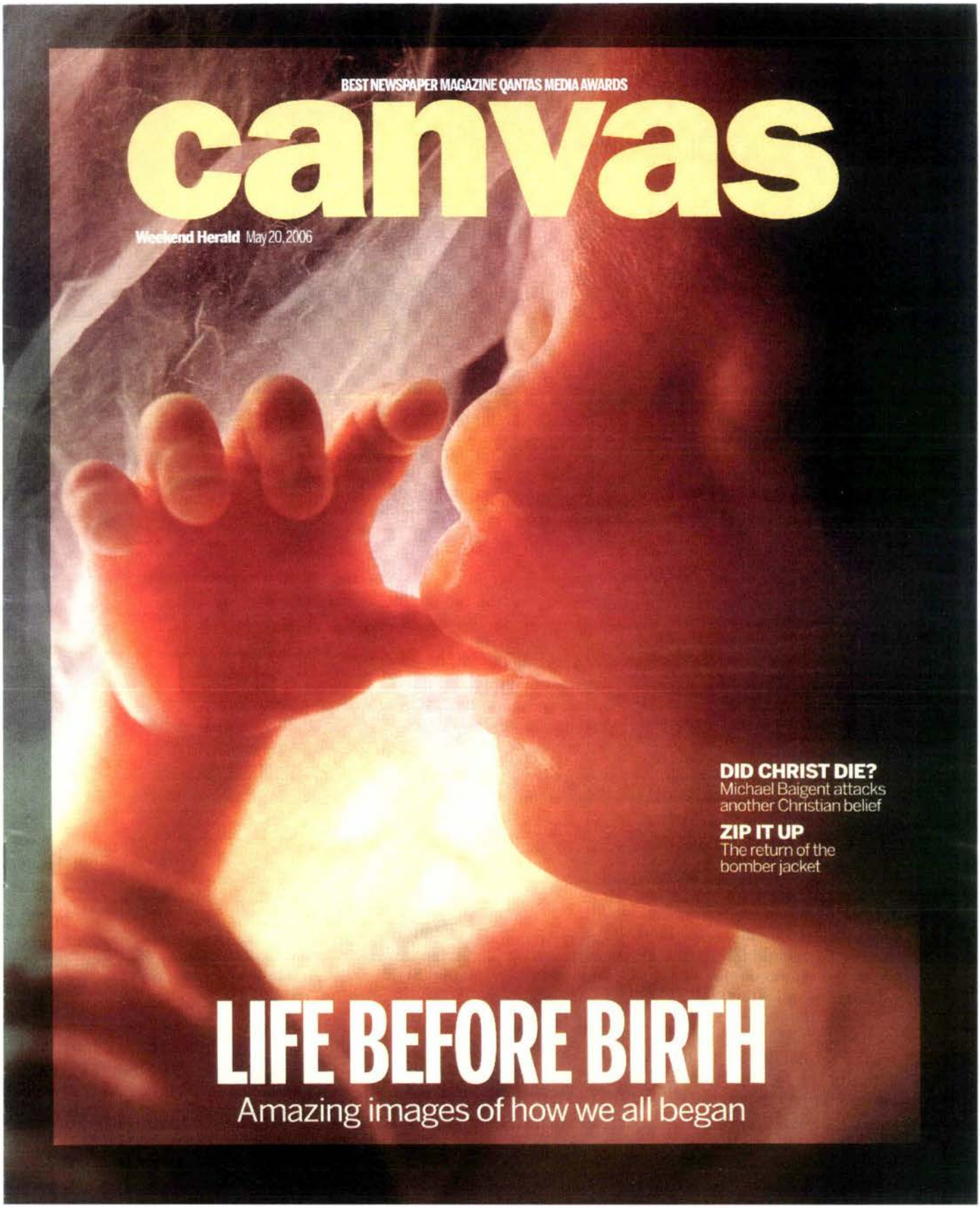
Conclusion

As discussed in Chapter Two, feminist analyses of the reproductive context have been concerned with the implications of the increasingly public presence of foetuses. Of particular interest, indeed concern, for these analysts has been the ontological enhancement of foetuses achieved by their presence as a regular, almost unremarkable feature of the public landscape, and the simultaneous devaluation of the pregnant bodies in which they are located. In this chapter I have analysed six posters developed to communicate health information to

pregnant women. The foetuses in these posters are constructed both visually and textually as entities separate, but also at risk from, the pregnant women in which they are located. They are vulnerable "unborn babies" and have emerged from my analysis as ontologically secure in, and indeed the central subject of, public health discourse about pregnancy.

Pregnant women, on the other hand, occupy an ambiguous ontological status in these posters. The construction and centring of foetal subjects relies on the reduction of pregnant women's subjectivity. Pregnant women are simultaneously reduced to their reproductive bodies as vessels for these foetal "persons" and are also "maternal" subjects with the moral and medical imperative to guard foetal health from the risks posed by their own bodies and behaviours. As the recipients of behavioural imperatives communicated in these posters, pregnant women are being persuaded to change their behaviour on behalf of their "baby's" life and health in order to fulfil the social expectation of them as mothers. The pregnant subject as "good mother" emerges from this analysis as self-sacrificing, compliant with medical advice about how to care for her "unborn child," and in primary and exclusive relationship with her "unborn child." The "bad pregnant mother" interrupts this relationship by prioritising social contact with others and "fun" over her "child," and is thus responsible for its harm.

Another site where foetuses have become increasingly visible is in the mass media. The image on the following page is just one of many foetuses that have populated, both as image and text, the mass media during the course of this year long research project. In the next chapter I present my analysis of 35 newspaper articles reporting on topics related to pregnancy, sampled according to my description in Chapter Three.


BEST NEWSPAPER MAGAZINE QANTAS MEDIA AWARDS
canvas
Weekend Herald May 20, 2006
DID CHRIST DIE?
Michael Baigent attacks another Christian belief
ZIP IT UP
The return of the bomber jacket
LIFE BEFORE BIRTH
Amazing images of how we all began

Chapter Five

Discourse Analysis Findings: News Media Texts

Introduction

This chapter presents an analysis of 35 newspaper news and feature articles on topics related to pregnancy, sampled by the process described in Chapter Three. These articles reported on a wide range of issues relating to pregnancy, including teen pregnancies; the introduction of universal screening programmes for pregnant women, including those testing for HIV and diabetes; the risks of foetal surgery; the fortification of bread with folic acid to prevent birth defects; improving Down's Syndrome screening tests; smoking and alcohol consumption while pregnant; "new research" linking pregnancy behaviours with long term health problems for the foetus; and announcements about new reproductive technologies.

The findings presented here demonstrate the construction of two dominant subject positions in these articles – foetal "persons" and pregnant "mothers" – largely the product of public health and biomedical discourse, with its emphasis on "new scientific research" and technological development. As with the health education posters analysed in Chapter Four, these articles demonstrate a strong discursive practice of subjectifying the foetus as an entity separate from the pregnant woman, with its own identity, needs and rights. There are two dominant constructions of foetal subjects in these articles. The foetus as "unborn baby" is a vulnerable infant who must be protected from harm and who emerges as the central subject of pregnancy. The foetus as "future citizen" is projected beyond baby and childhood. This foetus is the future adult whose health is "at risk" while it is in the womb. However, foetal subjectivity is also disrupted in these articles. The "designer baby" is a foetus whose subjectivity is liminal. Biomedical "experts" both assert the subjectivity of this foetus as "patient," for whose welfare they are very concerned, and disrupt this subjectivity if it interferes with the development of their technologies and practices. Finally, the "fatal positions" are

those foetuses who are not assigned subjectivity because they have "flaws" that biomedical "experts" cannot resolve.

Also mirroring the analysis of the health education posters, the bodies and subjectivities of pregnant women in these articles are constructed in ways that correspond with the construction of foetuses as outlined above. Pregnant women are simultaneously reduced to their reproductive bodies as the "maternal environment," one which may be perilous to the foetus, as well as being constructed (or constricted) as maternal subjects responsible for ensuring the health (and future health) of foetal "persons" through their self-regulatory behaviour and their acquiescence to biomedical interventions. The "good mother" is a maternal subject who will *of course do anything she can* to ensure the health and wellbeing of her "baby" as long as she is educated about the "risks" posed by her behaviours. She self-regulates these behaviours, accepting individual responsibility for her "child's" health, both now and in the future. The "acquiescent mother" is a passive construction of the maternal subject who accepts and acquiesces to biomedical or public health interventions "done to her" in the name of the foetus. As the site where biomedicine "treats" the foetal patient, the pregnant woman's own health is of marginal interest or not of interest at all. Finally, pregnant maternal subjects who do not self-regulate their behaviour or acquiesce to biomedical management of their bodies, performed in the foetus's name, are the "(m)Others." These are "bad" maternal subjects who are responsible for harming their "children" and thus also society. While these constructions are particularly dominant in these articles, in concluding this chapter I call attention to some minor exceptions to the dominant reproductive subject positions identified in my analysis.

How Babies Are Made

A major feature of these articles is the construction of foetal subjects as entities separate from pregnant woman, with distinct identities: foetal "persons." The foetal subject positions of "unborn baby" and "future citizen" are the most dominant in these texts and in many instances they *overlap*, so that talk of

foetuses may simultaneously draw on the different subject positions available. The major discourse implicated in the construction of these foetal subjects, and administered by an "expert" who is almost always *biomedical*, is that of risk, and, more specifically, that of the foetal subject who is at risk of harm from the pregnant body and "maternal" behaviours. The discourse of risk works to construct foetal subjects as vulnerable and threatened, requiring external intervention and management, as well as pregnant women's self-regulation, to reduce risks posed by pregnant bodies and behaviours. It is the biomedical "expert" who speaks for, or on behalf of, this threatened foetus, imploring individual women to change their behaviour and/or urging society to *do something* to protect foetal health. This is not only because the foetus is a "child" but also because it is the "future citizen." This helps to establish the biomedical "expert" as central to the reproductive process and in a primary, protective relationship with the foetus. However, biomedical "experts" in these articles also hold the authority to disrupt foetal subjectivity. If it interferes with the development of their work practices or technologies, or if their technologies are unable to resolve "flaws" in the foetus, the foetus becomes a "non-person" and ceases to be of concern for biomedicine. I will now elaborate on the construction of these foetal subjects and non-subjects using excerpts from the news media articles of my sample.

The "Unborn Child": The foetus as baby

The foetus as "unborn baby" or "child" is a dominant subject position in these texts and is discursively constituted both visually and textually. As the "unborn baby," the foetus is described as an autonomous person, an individual separate from the pregnant woman, with its own rights and needs regardless of its gestational age. Indeed, the personhood of the "unborn baby" is established, in a number of these articles, in advance of its conception. As "babies," the foetuses in these articles are vulnerable individuals whose health and wellbeing is a central focus. Article One demonstrates the personification of the foetus as an "unborn child" through the work practices of researchers. The article reports that the researchers, through their technological work instruments – obstetric ultrasound – were able to prompt and then capture on film what was "obviously" the "unborn

baby" crying. Here the "unborn baby" is inscribed as an emotional being, independent from, but vulnerable to, the pregnant woman. The pregnant woman is present in this article as a bodily boundary through which researchers can interact with this "baby":

> *The lungs inflate; there are gasps, breath-holding and then a long release of breath. The bottom lip even quivers. The only thing missing is the noise. New research shows unborn babies as young as 28 weeks gestation appear to cry in the womb. Researchers used an ultrasound scan to record the response of a foetus when a 90 - decibel noise was played through a small loudspeaker against the abdomen of a pregnant woman.*

The foetus in Article Eight is also a vulnerable "baby in the womb":

> *It's always an anxious time - the first few months of pregnancy. Wondering whether to tell anyone, if there will be problems. But for Nelson mum Lee-Anne Milne it was doubly scary* - ***she knew it was likely baby Ella-Marie would need a blood transfusion in the womb before she even took a breath****, just to give her a chance at survival.* [8] [Emphasis added.]

Risk is a major discourse implicated in the construction of these vulnerable "unborn children." The health and wellbeing of this "unborn child" is an overwhelming concern for biomedical experts, health authorities, community health activists and organisations who speak on behalf of the foetus in communicating these risks to pregnant women. The following excerpts demonstrate the construction of the foetus as the *vulnerable* individual, the "unborn baby" whose right to health and wellbeing is threatened by the pregnant woman:

> *"While* ***it is obviously better for a baby to be completely nicotine-free****, at least with a nicotine replacement therapy, nicotine is all they will be getting. Having a mother who smokes* ***is far worse for the health of the unborn child*** *than having a mother who is on a nicotine replacement product" she said.* [5] [Emphases added.]
>
> *"Alcohol is known to be one of the main causes of brain damage in the* ***unborn baby****."* [32] [Emphasis added.]
>
> *Food borne illnesses also pose dangers to the* ***unborn child*** *...*[34] [Emphasis added.]
>
> *...folic acid or folate, is a form of vitamin B now known to be critical in preventing* ***babies in the womb*** *developing neural tube defects such as spina bifida.* [6] [Emphasis added.]

> *But what about a child's first home, the womb? There is still inside-smoking in this home for 18,000* ***unborn children*** *each year in New Zealand.* [14] [Emphasis added.]
>
> *A lack of planning means women might inadvertently put their unborn children in danger or miss out on some of the nutrients they need.* [34]

As these excerpts demonstrate, the construction of the foetus as "baby" is so naturalised that there is very little distinction made between the "unborn baby" and the infant or child who has already been born. In Article Five, for example, the health professional refers to the foetus as both "baby" and "unborn baby" when discussing smoking in pregnancy. By collapsing the distinction between foetuses and babies who have been born, the boundaries of the pregnant body become ontologically unstable, and women's physical and emotional labour in the growth of the foetus and the act of childbirth, which "brings the foetus forth," is reduced or completely erased (Squier, 1991). Another site where this is apparent is in the articles that address the proposed universal screening of pregnant women for HIV. In all of these articles, transmission of HIV is described as 'mother-to-child transmission' [15, 16, 17, 18], or 'maternally acquired HIV' [19, 30], regardless of the point in pregnancy, childbirth or the postnatal period where the transmission may have occurred.

As well as these textual constructions, the "unborn child" is also represented visually in Article Three, which explores the debates around foetal surgery in the United States. A large visual image of a foetus floating in space, similar to those used both within anti-abortion materials and public health resources such as Poster D, dominates this article. This foetal image is located in the centre of the text and contains no visual reference to the woman's body in which it is located. The foetus is bathed in a hazy glow, revealing its translucency, indeed its fragility. Yet the image also speaks of the foetus as a separate entity, the main embodied subject of pregnancy in this article. It is simultaneously an independent and a vulnerable being. The feminist analyses reviewed in Chapter Two were particularly concerned with the constructive effects of such foetal images (the product of biomedical visualising technologies) in establishing the ontological stability of foetuses as "persons" and disappearing the pregnant bodies on whom these foetuses depend.

The "Future Citizen": The foetus as healthy member of society

Here the concern with the health of the "unborn baby" is extended far beyond pregnancy, and even infancy, to become a concern with the health of the future adult. The following excerpts demonstrate the notion that the foetus is a "future citizen," whose life-long health is almost solely determined by the pregnant woman and her behaviours while this citizen is "in the womb," or even before its "arrival" in the womb. If the pregnant woman is understood as individually responsible for the health of these "future citizens," then she is individually responsible for the health of society. Harming the "future citizen" here represents a social cost in the sense that the foetus will not grow into a "healthy," contributing member of society:

> *Researchers have found links between small birth weight and increased risks of heart disease, diabetes, lung disease and hypertension in adulthood. Ironically, a woman who diets before or during pregnancy can set her child up for future obesity because her foetus is preparing for a world with little food. "They are just predisposed to becoming obese and, as they get old, diabetes."* [34]
>
> *An adverse environment in the womb also seems to set the stage for later adult health problems.* [23]
>
> *Thin babies are more likely to become obese later in life, and have a higher risk of heart attack, stroke and diabetes.* [23]
>
> *New Zealand researchers - particularly at Auckland University's Liggins Institute- are helping to establish how nutrition in the womb influences health throughout life.* [34]
>
> *An affected person may require support on a life-long basis and have difficulty functioning as an independent adult...There is emerging evidence that alcohol exposure before birth may contribute to later development of diabetes- a worrying connection considering the current rates of alcohol consumption in pregnancy in New Zealand.* [11]
>
> *"Any improvement in child health can have a huge impact on a limited number of people in adulthood," Health Ministry child health chief advisor Pat Tuohy said...There has also been research linking babies that were small for their gestational age to higher hospitalisation and death rates from heart disease.* [21]
>
> *Babies with spina bifida – in which one or more vertebrae fail to develop completely – usually survive but require extensive medical and surgical care and most suffer lifelong moderate or severe disabilities.* [28]

> *An Auckland University study has found one in five first-time mothers will suffer pre-eclampsia or have premature or underweight babies. Nationally, 200 babies die each year as a result. Neonatal care for babies born very prematurely costs $1000 a day, and some have life-long complications including developmental delays and hearing and sight problems.* [24]

Article Fourteen charts the "risks" of pregnant women's smoking behaviours on the "future citizen," from pregnancy to adulthood. The assumption here, as in the excerpts above, is that the life trajectory of the foetus, including health outcomes, is determined while it is in "the womb" and is thus the responsibility of the pregnant woman:

> *However, these disadvantages follow a child throughout life. They show as increased risk, in pregnancy, of miscarriage, prematurity, still birth; **in infancy, of sudden infant death; frequent and severe illnesses, learning problems; in childhood, of glue ear, asthma, meningococcal disease and, in adulthood, of heart disease, stroke and diabetes.*** [14] [Emphasis added.]

Related to the construction of the foetus as the "future citizen," whose lifelong health is being determined by the pregnant woman while "in the womb," is the notion that these foetal "future citizens" are the "nation's children" on whose behalf there is a social responsibility to intervene. Intervention is made either by encouraging "concerned citizens" to educate pregnant women on the risks their behaviours pose to their "children," or, assuming that the pregnant woman is unable to manage these risks, through the introduction of population-wide public health initiatives. The discourse operating here is that if the risks to these "unborn children" can be reduced, then the health of the nation is more secure. In Article Eleven, the reader is encouraged to identify and educate pregnant women, and especially "at risk" pregnant women, about the dangers of alcohol for foetal health:

> *In the absence of warning labelling in New Zealand, the best thing you can do is to help pregnant women to avoid alcohol by being able to understand and explain the reasons why this is important. Young women are particularly at risk from drinking alcohol.*

In Articles Fifteen, Seventeen and Thirty, the construction of the "nation's children" is particularly strong. The focus of these articles is "New Zealand's children," the national resource who are "at risk" from the transmission of HIV

from pregnant women. There is an urgency to intervene on their behalf by introducing universal screening for HIV in pregnancy and thus reduce our "third world statistics." The discourse operating here is that *surely we can do more for our nation's children*, by better protecting them from the HIV-positive "mother." With such a strong focus on the nation's "children," the pregnant woman's own health in relation to her HIV status goes unmentioned in these articles:

> *HIV screening for pregnant women will start later this month, following a record year for HIV diagnosis rates. New Zealand posted the highest diagnosis rate in its recorded history last year, with 183 cases.* ***Six were babies infected through mother-to-child transmission, a rate which one health professional said put the country on a par with the Third World.*** *Health Minister Pete Hodgson announced yesterday that Waikato District Health Board would be the first to begin rolling out the universal programme, from March 20.* [15] [Emphasis added.]
>
> ***Six New Zealand children*** *were infected with HIV from their mothers last year, strengthing the case for screening pregnant women for the virus.* [17] [Emphasis added.]
>
> *A Christchurch GP is angry over a delay in starting routine HIV testing for pregnant women, saying several babies will needlessly contract the virus as a result...Until a national roll-out is complete, two or three babies a year will be born with HIV, Smith said. "It's an avoidable tragedy."* [30]
>
> *Compulsory HIV screening for pregnant Counties Manakau women will be implemented in the next three years...The move follows the release of AIDS and HIV statistics last week that showed six children were diagnosed with HIV through mother-to-child transmission last year.* [18]

In the excerpts above we can start to see the extent to which biomedicine is implicated in the construction of the foetus as "unborn baby" and "future citizen." Biomedical "experts" are very closely aligned with the care and protection of the "unborn baby" to ensure its health and future health, and as such the foetus is the subject of biomedical research. In Article One, "experts," with the help of their technological instruments, reveal the "emotional life" of the "unborn baby" to the pregnant woman, indeed to society. It is as though the biomedical expert or researcher is being constructed as the one in a primary relationship to the "unborn," rather than the pregnant woman. This analysis supports the argument of Mitchell and Georges (1998) that through ultrasound examinations in early pregnancy many women now experience what they term a "technological quickening": a technologically-mediated experience of their "baby" a number of

weeks before they first feel their baby move inside them. This not only puts the social reality of the "baby" and "mothering" in "fast-forward," but it also establishes biomedical experts and their technologies as the mediators of the foetal experience (Mitchell and Georges, 1998).

The excerpt from Article Thirty above demonstrates how biomedical experts emerge in these articles as passionate advocates for "babies," born and unborn. The doctor in Article Thirty insists that something be done to protect the health of "babies" from infectious pregnant women and finds it *deplorable* that universal screening for HIV is being introduced slowly. Such a dominant focus on the health and wellbeing of "unborn babies" by biomedical experts in these articles seems to rely strongly on the neglect of pregnant women's wellbeing. The source of anger for the doctor in Article Thirty is the *slow* introduction of universal HIV screening, despite the reasons given for the gradual introduction, which include ensuring that health providers are trained to be able to appropriately counsel pregnant women if they receive a positive result, as well as the need to develop information materials and systems for dealing with false positive results. While these measures are intended to reduce the impact on pregnant women of a positive HIV test result, it is foetal wellbeing that is the overwhelming focus for this doctor, and thus the delays caused by the development of such measures are not only unacceptable: they are "deplorable." A major feature of this sample of texts is the prioritisation of foetal wellbeing over the wellbeing of pregnant women, which can only be achieved through their construction as separate entities, one of which must be prioritised over the other.

The "Designer Baby": The foetus as biomedical patient

Biomedicine's interaction with the foetus extends beyond advocacy for the vulnerable "unborn" and the technological role in "showing us into the womb." In these articles the foetus is also the "designer baby," the patient who is the subject of biomedical procedures and the site of the development of biomedical technologies. Like the "unborn baby" and "future citizen," the construction of the "designer baby" also depends upon its separation from the pregnant woman. As the subject of biomedical interventions where its health is threatened "in the

womb," the "designer baby" is constructed as a "biomedical miracle," the creator of which is the biomedical expert. Article Eight, for example, begins with the statement:

> *Blood transfusions in the womb have* ***given*** *a Nelson mother a precious gift – a healthy baby.* [Emphasis added.]

This is also evident in this excerpt from Article Three:

> *If the procedure worked, they said, it was possible they could save the healthy baby.* ***"It blows my mind we were able to do this. It was a godsend,"*** *says the 31-year-old medical clerk from Bend, Oregon. She now has a healthy three-year-old son, Thomas.* [Emphasis added.]

However, the construction of the "designer baby" is perhaps most explicit in Article Ten, where biomedical "experts" can be read as the "creators of life," centrally located in the reproductive process:

> *NZ 'designer baby' test mother six weeks pregnant*
>
> *The first woman to undergo in New Zealand a controversial "designer baby" test used overseas is on the way to having a child. Dr Richard Fisher, of Auckland fertility clinic Fertility Associates, said three patients were undergoing the testing, which is used with in-vitro fertilisation (IVF). One, a 39-year-old is six weeks pregnant after five years of recurrent miscarriages. "She's very excited," Dr Fisher said. "But she's been through many pregnancies before and a couple of IVF cycles as well.*
>
> *"All current monitoring suggests the pregnancy is progressing normally".*

Nonetheless, unlike the "unborn baby" and "future citizen" who are full subjects in these articles, the subjectivity of the "designer baby" can be disrupted if it interferes with the work practices of biomedicine and science. For biomedical experts to be the "creators" of the "designer baby" they also require foetuses to be the site of experiment so that their technologies and work practices can be developed. Thus, in some of these articles, unlike pregnant women who *must* always ensure foetal wellbeing, biomedical experts hold the authority to risk foetal wellbeing so that biomedical knowledge can be developed. It is interesting to note the frequent use of 'foetus' instead of 'baby' where these articles are discussing the development of biomedical practices. In Article Three, a feature on the increasing use of foetal surgery in the United States, the "designer baby's" liminal subjectivity, in the face of biomedical "development," is apparent:

> *Physicians recently have begun operating on foetal heart defects, an experimental procedure generally considered to be at the leading edge of foetal surgeries. Russell Jennings, director of Harvard's Advanced Foetal Care Centre, said that outcomes of about 60 heart surgeries performed at the hospital were encouraging but ambiguous. About 5 per cent to 8 per cent of the foetuses died. Though some surgeries resulted in normal hearts, others yielded only partial improvements. Doctors cannot be sure what the outcomes would have been if no surgery was undertaken. "There are still more questions than answers," Dr Jennings said. "But we believe this will eventually prove to be effective in many cases."* [3]
>
> *Edmund Yang, director of Vanderbilt University's Foetal Diagnosis and Therapy Centre in Nashville, says he is confident that many foetal surgeries offered today will* ***eventually*** *be proved safe and effective.* [3] [Emphasis added.]
>
> *Many also maintain that this is the way medicine works: a small number of patients must agree to undergo experimental procedures so doctors can learn and improve their techniques.* [3]

These excerpts demonstrate instances where, in the hands of biomedical experts, foetal loss is justifiable. Unlike Article Thirty, where foetal harm is deplorable and nothing should be spared in efforts to reduce its incidence, in Article Three some foetal harm or loss is a reasonable outcome of the development of biomedical technologies and practices. However, at any point, biomedical experts may reassert the subjectivity of the foetus as "child" to construct their technologies and practices as moral imperatives for women who should do what they can to help their children by acquiescing to biomedical treatment of their foetuses:

> *Dr Harrison acknowledges that critics of foetal surgery have some valid concerns. Nonetheless, he says the procedures represent one of the most promising areas of medicine today: "The fact is, by the time a child is born, the die has been cast. With this, we're starting to change that."* [3]

Fatal Positions: Foetal others

With the "unborn child" and "future citizen" I have demonstrated a strong discursive practice of subjectifying the foetus in these articles. The "designer baby" demonstrated how biomedical experts hold the authority to disrupt this subjectivity if it interferes with their work practices, yet also to reassert foetal subjectivity to justify these practices. The "foetal others" are those foetuses to whom personhood or patienthood status is not extended at all, and thus whose

protection *at all costs* is not ensured, nor is it a priority. These are foetal "others" that have significant abnormalities that biomedical expertise is, so far, unable to "correct." Here the only concern of the biomedical expert is that neither the physical presence of these foetuses, nor the screening tests used to detect these foetuses, are allowed to endanger the wellbeing of the "healthy unborn child." This excerpt from Article Three demonstrates biomedical work practice around foetuses who not are not "persons":

> *Andrea Merkord was three months' pregnant when she received devastating news. Doctors told her that two of her triplets were sharing one heart and would not survive. If they did, the third foetus would probably die too. So Mrs Merkord did not hesitate when doctors at the University of California, San Francisco, proposed experimental surgery to try to save one of her babies' lives. They would insert a small needle into her womb and use a laser to separate the two endangered foetuses from the healthy one. If the procedure worked, they said, it was possible they could save the healthy baby. "It blows my mind we were able to do this. It was a godsend," says the 31-year-old medical clerk from Bend, Oregon. She now has a healthy three-year-old son, Thomas.*

The narrative trajectory of this passage demonstrates how foetuses are being constructed in different, indeed contradictory ways, and thus the ontological instability of foetal "persons" when confronted by biomedicine. Here, while there are three foetuses at risk, biomedicine can separate two foetuses, who are non-subjects, from one baby and end up with one healthy child who lives. The biomedical experts design or "save" this one baby; it is their miracle. The terminated foetuses are not babies in this text because biomedicine could not correct their abnormalities. The personhood of the foetus therefore emerges as directly related to its chances, as evaluated by biomedicine, of being born a "normal" child.

A binary between normal "babies" and abnormal "foetuses" also operates in Articles Four and Twenty Five. In these articles, biomedical "experts" are very concerned that screening for foetuses with Down's Syndrome is putting "healthy babies" at risk. It is clear here that while there is much biomedical concern for the wellbeing and "survival" of healthy unborn babies, the biomedical interest in foetuses with Down's Syndrome is their *detection*, in order to give parents the "choice" about whether or not to continue these pregnancies. The statistics

provided in these articles suggest that most women will not continue these pregnancies:

> *Test puts unborn **babies** 'at risk'*
>
> *...More normal pregnancies may be adversely affected by amniocentesis than the numbers of Down syndrome **foetuses** detected.* [25] [Emphases added]

Summary of Findings

This section has elucidated the discourses implicated in the construction of foetal subject positions in these texts. There are two dominant though overlapping foetal subjects that have emerged from my analysis of these texts – the foetus as "unborn child" and "future citizen." These are constructed as entities separate from pregnant bodies and are individuals with needs and rights. In other words, they are granted full status as persons in these texts. The third foetus has liminal subjectivity. The subjectivity of the "designer baby" can be asserted and disrupted by biomedical experts as suits their work practices. The fourth foetus constructed here is the non-subject. It has not been assigned subjectivity because it is flawed.

The "Unborn Child": This is the foetus as baby, the central subject of pregnancy. It is an entity separate from the pregnant woman in whom it is located and has the characteristics and status of full personhood. The health and wellbeing of these "unborn children" is "at risk" and of major concern.

The "Future Citizen": Here the foetus is projected beyond baby and childhood and is the "Future Citizen." The health of this "at risk" foetus is a concern for society because it is the nation's child. Society must intervene on its behalf and thus this foetus is the subject of large-scale public health initiatives and biomedical interventions.

The "Designer Baby": Here the foetus is constructed in conflicting ways within biomedical discourse. It is both a "patient" and a site of experiment for the development of biomedical technologies and practices. As a "patient," the foetus is under intense biomedical gaze. Overwhelming biomedical and scientific concern with pregnancy in these articles is focused on the protection

and care of this "patient," who must be saved at all costs through biomedical intervention. Yet the foetus is also the site of biomedical and scientific experiment in these articles and in various locations the subjectivity of the foetus as "unborn baby" or "patient" is disrupted in order to justify biomedical and scientific work practices that may harm foetuses.

Fatal Positions: The foetal "others" are those foetuses that are not assigned personhood or patienthood status and thus are *non* subjects. This is because these foetuses are flawed; they have abnormalities that biomedicine cannot "correct" and thus their harm or demise is justifiable, especially if "healthy" "unborn babies" can be saved as a result. What emerges here is that only particular "kinds" of foetuses are constructed as "persons."

How Mothers Are Made

The strong discursive practice of subjectifying the foetus, demonstrated above, has major consequences for pregnant subjects in these texts. While for the most part foetuses are being constructed as separate entities with distinct identities – and are thereby becoming the central if not sole focus of biomedical, public health, and indeed more generalised social concern with reproduction – the status and physical presence of pregnant women is reduced or marginalised.

This is achieved in two ways. Firstly, pregnant women in these texts are being reduced to their body's reproductive role as the maternal environment, at best passive hosts and at worst hostile to foetal life. Secondly, simultaneously and rather contradictorily, they are also being constructed as maternal subjects expected to exercise agency in performing their "maternal" duties towards foetuses. As the maternal subject, the pregnant woman in these articles is *already* a "mother" to her "unborn child," an agent with the moral imperative to perform her maternal duties well by being willing to do whatever she needs to in order to protect her "baby." However, while the maternal subject may exercise some agency here in "choosing" biomedical interventions and changing her behaviour, her choices are confined to those prescribed socially as appropriate for a mother,

and if she exercises agency outside of this prescription she becomes a "bad" mother.

As with the foetal subjects described above, "risk" is a major discourse implicated in communicating appropriate "maternal" behaviour in order to protect "vulnerable" and "threatened" foetuses, and it contributes to the contradictory construction of pregnant women. While her body and behaviours are the source of risk for the foetal subject, as "mother" she is called upon to reduce or eliminate this risk by self-regulating her behaviour and acquiescing to biomedical advice, screening and intervention.

The Pregnant Body as the "Maternal Environment"

The "Child's First Home"

The pregnant woman is constructed in these articles in ways that tend to reduce her to her body's reproductive role as the "maternal environment" that the foetal subject occupies, a notion captured particularly clearly in this excerpt from Article Fifteen:

> *But what about a child's* ***first home, the womb?*** *There is still inside-smoking in this home for 18,000 unborn children a year in New Zealand...****A smokefree first home (pregnancy)*** *is the single most important way to protect against preventable health problems for children.* [Emphases added.]

While this is perhaps the most explicit example of this construction, there is evidence elsewhere in this sample. In two of the articles addressing the introduction of routine HIV screening in pregnancy [15, 18], the reduction of the pregnant woman to her reproductive role *and* her infectious disease, can be seen in her description as an 'HIV pregnancy':

> *If detected early, an HIV pregnancy may result in a healthy HIV-free child. Between eight and 18 women a year may be found to be HIV positive," said Mr Hodgson.* [15]

In Article Eight, which reports the life-saving treatment of a baby through intrauterine blood transfusions, the pregnant woman is described as 'the womb', the location that the foetal subject, in this case the "designer baby," occupies:

> ***While still in the womb Lucy became anaemic**, limiting the blood's ability to carry oxygen to the organs and tissues and putting her at risk. At 32 weeks, her body began to swell up. Doctors decided she would need an intrauterine transfusion to replace the destroyed red blood cells.* [Emphasis added.]

This is also the case in Articles Two and Five:

> *The health forum about pregnancy and smoking in Auckland yesterday was told that each year 18,000 babies were exposed to poisonous tobacco chemicals* ***while in the womb.*** [5] [Emphasis added.]
>
> ***In-womb** anxiety find.* [2] [Emphasis added.]

As demonstrated above, the construction of the foetal subject as "unborn baby" is particularly evident in Article One (see pp. 75-6). This is so significantly achieved here because of the almost complete reduction of the pregnant woman to the status of "maternal environment," or womb, as well as biomedical test site:

> *New research shows unborn babies as young as 28 weeks' gestation* ***appear to cry in the womb**. Researchers used an ultrasound scan to record the response of a foetus when **a 90-decibel noise was played through a small loudspeaker against the abdomen of a pregnant woman.*** [Emphases added.]

The "Perilous Body": Pregnant bodies as the risk environment

The excerpts above demonstrate how the pregnant woman is being constructed as an environment which the foetal subject occupies. However, the subjectification of the foetus as a *vulnerable* individual depends upon the construction of the pregnant body, beyond that of passive host, to an environment that may be hostile to foetal life. The pregnant body described here is a "maternal environment," but it is also a risky body that may threaten foetal health and wellbeing and thus the future health of the woman's children and society. Initial evidence for this claim can be seen above in the extent to which the "experts" emphasise the importance of preparing the pregnant body for the foetus. It is "experts" in these articles, for the most part biomedical, who hold the knowledge of, and thus the cultural authority to communicate, the risks to foetal subjects posed by the "perilous

body." This communication takes the form of the findings of "new scientific research." In Article Seven, the biomedical expert's research has identified a number of "risks" posed to "(unborn) babies'" health, not only by pregnant women's behaviours, such as smoking or drinking alcohol, but also by the very nature of their bodies' size and age:

> *Teen pregnancies a gamble*
>
> *Teenage pregnancies gamble with babies' health, Auckland scientist Professor Peter Gluckman said in Nelson yesterday. Evolutionary biological research suggested that nature "gamble" on the life of a first child, so the first-born children of teenage mothers faced poor health and survival odds, he said...Professor Gluckman's lecture focused on research that suggested even simple things could affect the outcome of pregnancy...Inappropriate diet,* ***being underweight,*** *smoking or using alcohol or drugs around the time of conception* ***could markedly increase the likelihood of the child having a wide range of common health problems****...The risk to the child also increased when the mother had her first child at 35 or older, he said – another increasingly common social trend.* [7] [Emphases added.]

This excerpt from Article Five demonstrates not only the construction of the pregnant woman as a womb, but furthermore one that is toxic or hazardous for the "baby":

> *The health forum about pregnancy and smoking in Auckland yesterday was told that each year 18,000 babies* ***were exposed to poisonous tobacco chemicals while in the womb.*** [5] [Emphasis added.]

Likewise, in these two excerpts the pregnant body is one that is hazardous for foetuses:

> *Sullivan said it was known that some genetic markers for leukaemia could be traced to birth, suggesting they developed during pregnancy. Exposure of the developing foetus to various agents was already known to cause major developmental abnormalities.* [13]
>
> *Experts are calling for all pregnant women to be tested for diabetes as increasing rates of the condition put more babies at risk of dying or suffering severe abnormalities.* [12]

The emotional state of pregnant women, especially those experiencing stress, is also considered to be perilous to the "unborn child" and "future citizen" in these following excerpts. Indeed, in Article Twenty Three, "new research" compares the

hazardous effects on the foetus of women who smoke while pregnant with the effects of stress:

> *Preliminary results from a long-term study of 7000 pregnant women in Amsterdam showed those who worked 32 hours a week or more in high-stress jobs had children with a significantly lower than normal birth weight- on average 150g, the same as that caused by smoking during pregnancy. Thin babies are more likely to become obese later in life, and have a higher risk of heart attack, stroke and diabetes. Stressed mothers were more likely to have babies who cried excessively, and they were more at risk of developing pre-eclampsia, which affects up to 4% of pregnancies.*

The findings of scientific research, as they are reported in these articles, are very authoritative in communicating reproductive "risks," with biomedical "experts" citing "scientific evidence" to support their claim that pregnant women's stress can harm the foetus and cause long-term future health problems:

> *Dr Peter Gluckman, of University of Auckland's Liggins Institute, said studies on earthquakes and the World Trade Center bombing had shown episodes of acute stress during pregnancy could have* ***life-long effects*** *on the foetus, especially if they occurred early in the pregnancy. "What these things do is change the pattern of genes."* [23] [Emphasis added.]
>
> *'Children whose mothers were particularly stressed during pregnancy may be more vulnerable to anxiety, research suggests. A Bristol University team has found that anxiety in late pregnancy was linked to higher cortisol levels in children aged 10. The study involved 74 children, whose saliva samples were analysed three times a day'.* [2]

It seems in these excerpts that we are expected to accept the findings of "new scientific research" as "proof" or "facts," despite how ambiguous the explanations of this research may be.

Finally, while all pregnant women's bodies may pose threats to the foetus, some pose *more* threats. The biomedical "expert" in Article Seven is specifically concerned with the risks to foetal health from pregnant bodies that are not deemed to be the "ideal" age, being either "older" or "too young" (see p. 88). The biomedical expert argues:

> *The risk to the child also increased when the mother had her first child at 35 or older, he said - another increasingly common social trend.*

The "risks" that older pregnant bodies pose are also adverted to by the biomedical expert in Article Twenty One:

> *Dr Tuohy said that during the past 20 years there had been a sustained drop in the number of babies born small for their gestational age - often a marker of poor nutrition or smoking. However, that improvement had been largely cancelled out by an increase in pre-term births, partly due to older mothers and an increase in the use of fertility treatments, resulting in multiple births.*

While the use of research "evidence" and "expert" opinion is a powerful strategy for communicating risk in these articles, Article Twenty Four uses the individual experience of a celebrity to communicate the "risks" to older women contemplating pregnancy:

> *Gofton, who was 41 when Jean-Luc was born, recommends older women take it easy during pregnancy and have weekly blood pressure and urine texts..."If you have to work, plan not to put your body under stress, especially older mothers -* ***our bodies are not meant to carry babies****."* [Emphasis added.]

There is also much concern at the risks posed to foetuses by young pregnant bodies in these articles. In Article Thirty Five, this concern is articulated in terms of the dominant social discourse on the "socio-economic risks" for children of teenage pregnancies:

> *Gaynor Duff, Christchurch regional manager of Family Works, said reducing teen pregnancies should be a government priority because they often had serious social consequences such as increased risks of abuse and neglect, social isolation, poor bonding with their children and poverty.* [35]

The concern in Articles Seven, Twenty Nine and Thirty Four, on the other hand, is articulated in terms of the risks posed by the actual youth of the pregnant bodies, a far more disturbing construction. In these articles, the "experts" claim that it is the bodies of teenage women that threaten the "unborn baby's" health, rather than just their social behaviours:

> *Teenage pregnancies gamble with babies' health, Auckland scientist Professor Peter Gluckman said in Nelson yesterday. Evolutionary biological research suggested that nature "gambled" on the life of a first child, so the first-born children of teenage mothers faced poor health and survival odds, he said...*[7]

> *"The importance of teenage birthrate is twofold. Children born to very young mothers can have a high range of health problems. They start at a health disadvantage"* [29]
>
> *In mature women, the body tends to prioritise the foetus, giving it the nutrition it needs first. "There's kind of a hierarchy of importance." In pregnant teenagers, there is more of a balance between mother and child.* [34]

Interestingly, in Article Thirty Four, the mature body is constructed as one that will be protective of the foetus – as long as it is not *too* mature, Article Twenty Two tells us. The construction of the "perilous body" leaves the bodies of pregnant women in a fine balance. They must not be too old, nor too young; they must not be too large, nor too small; they must be prepared pregnancy and remain calm and passive throughout. Even so, their bodies may still pose "risks" to the foetus.

The "Wom(b)an": All women of reproductive age are potentially pregnant

While the pregnant body is being constructed as a potentially hazardous "maternal environment," there is another construct operating in these articles: the notion that all women of reproductive age are potential "wombs." In other words, potentially fertile women are *always* a "maternal environment." The implication of course is that, as they are always potentially pregnant, women should consider themselves "pregnant" at all times and behave accordingly. Women who could be "at risk of an unplanned pregnancy," as Article Eleven states, are being advised to stop drinking alcohol and smoking, take folic acid supplements, maintain a healthy weight, eat healthily and be screened, not primarily for their own health, but to protect any "baby" that they may conceive:

> *Pregnancy a possibility? Then it is imperative you increase the folic acid in your diet now to prevent the likelihood of your baby being stillborn or born with a lifelong disability.* [6]
>
> *Take care with alcohol in the festive season. If you are pregnant, planning pregnancy or are at risk of an unplanned pregnancy, avoid drinking alcohol. You might think this is a tough message, but it is a necessary one. We do not know what level of alcohol consumption, if any, is safe during pregnancy and there is increasing evidence about how alcohol can damage a developing baby.* [11]

Inappropriate diet, being underweight, smoking or using alcohol or drugs around the time of conception could markedly increase the likelihood of the child having a wide range of common health problems. [7]

'Doctor wants more pre-conception care'

More effort is needed to improve the health of women before they become pregnant, says New Zealand Medical Association deputy chairman Don Simmers. Speaking at the first of the Christchurch School of Medicine's mid-winter dialogues, Simmers said pre-conception healthcare was "a forgotten area of maternity care". [26]

New Zealand researchers- particularly at Auckland University's Liggins Institute- are helping to establish how nutrition in the womb influences health throughout life. Dr Coad says ***it is not only what women eat during pregnancy but also what they eat beforehand that have impacts. "If they are crash dieting or bingeing or just eating very badly, it might have knock-on consequences."*** [34] [Emphasis added.]

Just as the "father-to-be" is almost completely absent from discussions about responsibility for foetal health, there is no reference in these excerpts to the concept of a "pre-fertiliser," or the idea that men should ensure that their sperm are healthy at all times.

The Pregnant Self as the "Maternal Subject"

The "Good Mother"

Pregnant women in these articles, while being reduced to their bodies' reproductive role as the "maternal environment," are also constructed as "maternal" subjects who are individually responsible for the care of the "unborn child" and "future citizen." As I will demonstrate here, this involves the "good mother" and "acquiescent mother" self-regulating their "threatening" behaviours and acquiescing to biomedical screening, interventions and management on behalf of the foetus.

This next set of examples demonstrate the construction in these articles of the pregnant woman as a "mother" who *will of course do anything she can to ensure the health and wellbeing of her "baby,"* as long as she is educated about "the risks" posed by her behaviours. In order to be a "good mother," the pregnant woman must exercise agency by accepting her individual responsibility for preparing her body, the "maternal environment," for pregnancy. Once pregnant,

she must prioritise her "unborn baby" by adjusting, indeed self-regulating, the behaviours that may be "threatening" to the foetus, including her diet, work hours and lifestyle choices. The care of the "unborn" in these articles emerges as a highly gendered practice. While there is this intense emphasis on the role that pregnant "mothers" have in determining their "unborn child's" health and future health, the roles that others ("fathers-to-be," family, friends and social networks) may play is almost completely absent in these texts. In the entire sample of articles, there is only a single reference to the potential implications for foetal health of the behaviour of those with whom the pregnant woman shares her life, and even here there is no direct reference to the "father-to-be":

> *Smoking in a child's first home is a double whammy for the child: first-hand smoke from the mother and* ***second-hand smoke from people who smoke around her****.* [14] [Emphasis added.]

A dominant discourse in this sample of articles is the need for the pregnant "mother" to *prepare* her body for the foetal subject. Women are being urged to plan and prepare for pregnancy in order to provide the ideal environment for foetal subjects, one that will best promote foetal health and wellbeing and thus a healthier future society:

> *Pregnancy a possibility? Then* ***it is imperative*** *you increase the folic acid in your diet now to prevent the likelihood of your baby being stillborn or born with a lifelong disability. Brenda Hynes, national clinical advisor on nursing for the Plunket Society said that folic acid, or folate, is a form of vitamin B now known to be critical in preventing babies in the womb developing neural tube defects such as spina bifida. "Women* ***must have*** *enough folic acid in their diet for at least a month before they get pregnant- it is too late to increase folic acid intake after becoming pregnant, although adequate intake of folic acid continues to be important during the first three months of pregnancy."* [6] [Emphases added.]
>
> *Doctor wants more pre-conception care*
>
> *...It included helping women avoid unwanted or unplanned pregnancies, testing for diabetes and sexually transmitted diseases, encouraging women planning to get pregnant not to smoke, drink alcohol or use illicit drugs, and to take folic acid.* [26]

Once pregnant, women should continue to take folic acid; ideally be financially secure; must not drink alcohol, smoke or take drugs; be very mindful of their nutritional requirements and food safety; avoid potential pollutants or toxins;

reduce their work hours and avoid stressful events; monitor their weight gain; and "take it easy":

> *Sullivan said mothers-to-be* ***should be cautious and avoid*** *exposure to chemicals, drugs, smoking and alcohol during pregnancy.* [13] [Emphasis added.]

If they can't stop smoking, then *the least they can do* is use nicotine patches:

> *Pregnant heavy smokers* ***should consider*** *using gum or patches* ***if they cannot give up*** *the habit, according to a leading obstetrician...*[5] [Emphases added.]
>
> *"Alcohol is known to be one of the main causes of brain damage in the unborn baby." Pregnant women and those planning to become pregnant* ***should stop*** *drinking altogether, she said.* [32] [Emphasis added.]
>
> *Tis the season to be jolly, but* ***it's not a good idea*** *to partake in some Christmas spirit if you're pregnant or want to be.* ***Take care*** *with alcohol in the festive season if you are pregnant, planning pregnancy or are at risk of an unplanned pregnancy,* ***avoid d****rinking alcohol. You might think this is a tough message, but it is a* ***necessary*** *one.* [11] [Emphases added.]

The pregnant "good mother" should also reduce her hours at work and avoid stressful situations:

> *'Pregnant women urged to halve work hours jobs'*
>
> *Auckland researchers are investigating the risks to pregnant women from high-stress jobs. A Dutch study has concluded such women, particularly those with longer hours,* ***should halve*** *their time at work...Social health professor Gouke Bonsel, who set up the Amsterdam Born Children and their Development research, says pregnant women in high-stress jobs who want to be on the safe side* ***should work*** *no more than 24 hours, or three days, a week.* [23] [Emphases added.]
>
> *I tire of women saying, 'I'm going to work right to the end.' You are growing another human being. If you have to work,* ***plan not to*** *put your body under stress."* [24] [Emphasis added.]

Finally, the maternal subject needs to be very careful about what she eats and how she prepares it. She needs to consider her nutrition regardless of morning sickness, and be very careful to avoid potentially dangerous foods. In Article Thirty Four, the headline reminds women that they are individually responsible for determining their "child's" wellbeing and health through what they eat while pregnant:

> *They are what you eat.*

> *Food bourne illnesses* ***also pose dangers to the unborn child****. A raft of foods -everything from cream to sushi - can contain harmful bacteria. Pregnant women* ***need to take extra care*** *with food safety and are advised to avoid prepared foods, wash fruit and vegetables well, cook food thoroughly and not eat raw eggs, meats or fish.* [34] [Emphases added.]
>
> *Women with a healthy weight* ***should gain*** *between 11.5 and 16 kilograms during pregnancy, according to the Health Ministry guidelines. But the requirements vary - thinner women* ***may need to*** *gain more weight and obese women,* ***much less****.* [34] [Emphases added.]
>
> *Vegetarian women are not likely to cause problems for their foetuses,* ***as long as they are careful to have a balanced diet****. "A lot of women who are vegetarian are a little bit more nutritionally aware anyway," Dr Coad says. Nutrients that vegetarians and vegans* ***need to pay particular attention to*** *are protein, iron, zinc, calcium, vitamin A, vitamin B12 and the fatty acids usually found in eggs, meat and fish.* [34] [Emphases added.]

As demonstrated by the words to which I have added emphasis, the advice from health professionals for pregnant "mothers" in these articles tends to take the form of imperatives much like those used in the public health posters analysed in Chapter Four, all of which are linked to the notion that this is a high risk situation for the foetus. Women are being told that this is what they *should* or *must do* for their children while they are pregnant – if they are to be "good mothers."

The "Acquiescent Mother"

The "good mother" demonstrated above is an active social agent who must fulfil her responsibilities as a maternal subject by changing or self-regulating her behaviour in order to properly care for the "unborn child." The "acquiescent mother," by contrast, is the passive recipient of biomedical or public health monitoring and interventions on behalf of the foetus in order to protect her "child." There are three ways in which the subject position of the "acquiescent mother" is constructed in these articles. First, she is completely accepting of biomedical screening technologies and monitoring, aimed at detecting "risks" to the foetus. Second, she is the site of biomedical management and treatment of the foetal patient; in fact, she is very grateful for these interventions. Finally, her own health in relation to biomedical attention to pregnancy is either not mentioned at all, or, if it is mentioned, it tends to be an afterthought.

The maternal subject here is expected to acquiesce to biomedical screening and monitoring, including antenatal checks, blood tests, and ultrasound scanning for abnormalities. A number of the articles address the introduction of universal screening programmes aimed at reducing the risks to foetal health across the population [4, 6, 12, 15, 16, 17, 18, 19, 25 and 30]. The two tests with which these articles are predominantly concerned are the introduction of universal HIV screening and diabetes testing for all pregnant women. In both cases it is biomedical "experts" who are calling for the introduction of universal testing, because "babies" have been harmed by the failure to screen these perilous pregnant bodies. The passive grammatical constructions used in the following excerpts represent screening and testing as something that is going *to be done* to the pregnant woman, regardless of her thoughts and feelings about such tests:

> *Call to test mums for diabetes*
>
> *Experts are calling* ***for all pregnant women to be tested*** *for diabetes as increasing rates of the condition put more babies at risk of dying or suffering severe abnormalities...Diabetes experts in New Zealand and Australia have joined forces to call for* ***screening of all pregnant women*** *after a random Australian study showed dramatic reductions in abnormalities and deaths amongst those babies whose mothers were tested and treated for diabetes during pregnancy. The College of Midwives* ***recommends women*** *with recognised risk factors* ***be tested****, including those with a family history of diabetes, those who are non-European, and those who are overweight or obese.* [12] [Emphases added.]
>
> *Record HIV year prompts screening at pregnancy*
>
> *HIV* ***screening for pregnant women*** *will start later this month, following a record year for HIV diagnosis rates...HIV screening will be incorporated into existing tests for pregnant women between eight and 14 weeks, which include screening for rubella, syphilis and hepatitis B.* [15] [Emphasis added.]
>
> *Health Ministry public health senior advisor Doug Lush said infection in the six children could have been avoided* ***if the mothers had been tested*** *for HIV before they gave birth. "It is a problem and so I think the decision to introduce screening is the correct decision, given these six potentially preventable cases."* [17] [Emphasis added.]

In the case of universal screening of HIV in pregnant women, which is a contested proposal with enormous implications for pregnant women, their families and communities, the space for open discussion about the benefits and consequences of testing during pregnancy is limited by the subject positions that are made

available. Maternal subjects, we are being told, will do anything they can to reduce the risks to their child, by acquiescing to biomedical screening and subsequent interventions, regardless of the consequences for themselves. In this way, the "choice" for biomedical screening is informed by the moral imperative of "good mothering." As the "angry" GP states in Article Thirty, in response to the slow introduction of universal HIV testing:

> ***"People take very little in the way of invitation*** *to safeguard the well-being of their child. I can't understand why we don't just get on with it and tick the box," he said.* [30] [Emphasis added.]

For this GP, the issue is *simple*: "children" are at risk and any *normal* person would want to protect them. There should thus be no question that all pregnant women be tested for HIV in pregnancy. The opening sentence of Article Eighteen is quite revealing of the biomedical discourse operating here:

> ***Compulsory*** *HIV screening for pregnant Counties Manukau women will be implemented in the next three years.* [Emphasis added.]

While this is erroneous reporting, because at the present time women will be able to opt-out of HIV screening if they choose, such a statement signals potentially disturbing implications of the reproductive subjects being constructed here. Is the foetal subject becoming such an ontologically secure construction, and the pregnant woman such an ontologically unstable one, that before long such screening on behalf of the foetus will be *compulsory* for pregnant women? This possibility echoes the concerns of other feminist analyses that biomedical and legal discourses of foetal protection are increasingly combining to threaten women's reproductive integrity and their basic rights as autonomous individuals.

The demand for acquiescence to biomedical screening also extends to biomedical management and interventions where risks to foetal health have been identified, regardless of whether these interventions may themselves pose risks for pregnant women's own health and wellbeing. In fact, the "acquiescent mother" is one who is very grateful for these biomedical interventions, which here include procedures and surgery to correct foetal abnormalities, intensive biomedical management of pregnant women who are HIV-positive, and public health measures such as the mandatory fortification of bread with folic acid to ensure women have adequate levels when they conceive:

> *All that is needed to prevent 70% of neural tube defects (NTDs), a range of conditions that includes spina bifida, is for a mother to boost her body's levels of folate, a B vitamin, in the months before and after conception. And the best way to do that, says Thurston, is to put folic acid into all the nation's flour. That way mothers with planned and unplanned pregnancies* ***are captured.*** [33] [Emphasis added.]

If a pregnant woman receives a positive HIV diagnosis, she must completely acquiesce to biomedical management in order to feel confident that she has done everything she can to "protect" her child from harm:

> *There is a 25 to 30 percent chance that an HIV-positive mother will pass the infection on to her baby, but this can be reduced to less than 1 per cent if HIV is detected in pregnancy and* ***the mother takes antiviral drugs, has a caesarean birth and bottle-feeds****...Twenty-one babies have been infected at birth by HIV-positive mothers in the past 13 years. These children will suffer serious health problems and will probably die in their 20s.* [16] [Emphasis added.]

In the case of foetal surgery, the benefits of which are debated in Article Three, *doing everything she can* may mean putting her own health, indeed her own life, at risk:

> *In 2000, a Florida woman died while undergoing a procedure to reverse a complication involving her twin foetuses. The incidence was the first known maternal death during foetal surgery in the US. The surgeon who did the surgery believes the woman died from an amniotic fluid embolism after fluid leaked into her body and sent her into shock; both foetuses also died.* [3]

However, the biomedical "expert," a foetal surgeon, justifies these "risks" by reminding the reader that the central subject of pregnancy is the vulnerable "unborn child"/ "future citizen," whose future is fixed by the time it is born:

> *Dr Harrison acknowledges that critics of foetal surgery have some valid concerns. Nonetheless, he says the procedures represent one of the most promising areas of medicine today: "The fact is, by the time a child is born, the die has been cast. With this, we're starting to change that."* [3]

The obvious dangers posed to women are countered by the only speaker in Article Three who is not a biomedical "expert," a woman who has undergone foetal surgery and is very grateful for biomedical intervention. She states:

> *"It blows my mind that we were able to do this. It was a godsend," says the 31-year-old medical clerk from Bend, Oregon. She now has a healthy three year old son, Thomas.* [3]

There are no instances in Article Three, or in any of the articles in this sample, of women reported as being critical of the biomedical management of their pregnancies, or of any biomedical interventions.

While foetal health is an overwhelming focus for biomedical experts in these articles, the pregnant woman's own health has remained of marginal interest. In the majority of the articles, there is no reference made to women's health at all. Where it is referenced, it tends to be an afterthought or is represented as an extra bonus for the pregnant women who has prioritised foetal health by acquiescing to biomedical advice to change her threatening behaviours. This excerpt from Article Thirty Four captures this "afterthought" inclusion of pregnant women's health into the reproductive picture. Here, the expert, who has focused throughout this fairly long feature article on all the ways in which pregnancy diet and nutritional behaviours determine the future health of the foetus, is quoted at the end of the article with this offhand reference to pregnant women's own health:

> *If it all seems like a hassle, Dr Coad points out that measures that encourage foetal health - such as eating nutritious foods and reducing caffeine and alcohol consumption - are good for women too.* ***"They will probably feel better for it anyway."*** [34] [Emphasis added.]

(m)Others

Given the overwhelming emphasis placed on pregnant women's individual responsibility for determining the health and future health of the foetus, foetal harm becomes understood as the failure of the pregnant woman to fulfil her "maternal" responsibilities. The "(m)others" are those women *who haven't got the message* and have harmed, or who may harm, foetal health through their behaviour. They are "bad" maternal subjects and serve as a warning to other women about what will happen if they do not heed the risks being communicated. In these excerpts the harm caused to the foetus by women's failure to plan for their pregnancies is emphasised:

But Dr Coad says many New Zealand women do not actively prepare for pregnancy. "It's quite typical in Westernised cultures, where people don't want to get too ready." A lack of planning means women might inadvertently put their unborn children in danger or miss out on some of the nutrients they need. For instance, the importance of getting enough folic acid during pregnancy is well-known, "but most women don't start till they've had their pregnancy confirmed." [34]

Women in the early stages of pregnancy, or thinking about conceiving, are already advised to take folic acid supplements. But half of all pregnancies are unplanned, and by the time many realise they are pregnant it is too late. [20]

"Frighteningly, the most important time is right around conception." Women who were unaware or unprepared for their pregnancy might not behave in ways that led to an optimum outcome for their child, he said. Inappropriate diet, being underweight, smoking or using alcohol or drugs around the time of conception could markedly increase the likelihood of the child having a wide range of common health problems. [7]

The nutritional "expert" in Article Thirty Four explains the scientific "facts" about how pregnant women's poor nutritional behaviours harm foetuses. We can see here the gendered nature of scientific "fact" as it operates in the reproductive context. In this excerpt, women and "future citizens" are removed from any socio-economic and political context, the realities of which are known to be major determinants for health. Rather, we are told that the life-long health of a person may be determined, not just during, but also prior to, pregnancy, through women's risky behaviour towards their children and thus the hostile nature of their womb. The foetus and pregnant women are in conflict here:

> *Ironically,* ***a woman who diets before or during pregnancy can set her child up for future obesity because her foetus is preparing for a world with little food. "They are just predisposed to becoming obese and, as they get old, diabetes."*** [34] [Emphasis added.]

Women's lifestyle behaviours have also harmed the foetus, in this these excerpts due to the pollution of the "womb environment":

> *The health forum about pregnancy and smoking in Auckland yesterday was told that each year 18, 000 babies were exposed to poisonous tobacco chemicals while in the womb.* [8]
>
> *Dr Coad says that alcohol consumption continues to be a concern, especially as many women do not plan their pregnancies. An Otago University study issued this month found 20 per cent of the mothers and pregnant women surveyed had binged on alcohol at some point during their pregnancy. But most had not realised they were pregnant.* [34]

As in Article Thirty Four above, Article Thirty Two reports a recent study that found pregnant women are continuing to drink alcohol while pregnant and are thus failing to heed public health messages. This is "bad" maternal behaviour for pregnant women who should be protecting their "babies" health:

> *Researcher Sheryl Parackal said the survey showed the no-alcohol message was not getting through to women. "Alcohol is known to be one of the main causes of brain damage in the unborn baby." Pregnant women and those planning to become pregnant* ***should stop drinking altogether****, she said.* [34] [Emphasis added]

In Article Nine, the coroner uses the case of a baby's death to remind women of the threats to their babies' health and life when they smoke during pregnancy:

> *The death of an 8-month-old baby in Invercargill this year was* ***a warning to mothers who smoke during pregnancy not to*** *sleep with their babies, coroner Trevor Savage said in the Invercargill Coroner's Court yesterday.* [9] [Emphasis added.]

This is despite the particular details of the case, where the cause of the baby's death was unable to be determined:

> *But smoking during pregnancy may result in a reduced arousal response in situations where rebreathing carbon dioxide has resulted in a lack of oxygen, he said. Sudden Infant Death Syndrome (SIDS) or cot death was often linked to mothers who smoke during pregnancy and share a bed with their children, Mr Savage said. However, the exact cause of death in this case could not be determined and the death was found to be a sudden unexpected death in infancy.*

It appears that despite this finding, there is still a moral lesson here for women about appropriate "maternal" behaviour and a reminder about their individual responsibility for their babies.

Summary of Findings

This section demonstrates the discourses implicated in the construction of pregnant bodies and subjects in these articles in ways which correlate with the construction of foetal subjectivity summarised above. The pregnant woman in these articles is constructed out of sometimes contradictory discourses. They simultaneously reduce her to her body, by emphasising her reproductive role as the "maternal environment," and construct (and constrict) her as a maternal subject. There is a double bind here for women. On one hand, her body, as

"vessel" for the foetal subject, is being constructed as deeply threatening, yet she is also this "child's mother" and as such she *naturally* will do *whatever she can* to ensure its protection. This demonstrates her "maternal" love and that she is the "good mother-to-be." For the most part, she is out of context, and her primary relationship and focus is her "unborn baby."

The pregnant body as maternal environment

The "Child's First Home": The pregnant woman has been reduced to her body's reproductive role, which is the "maternal environment." She has reduced subjectivity and is represented as a foetal container or vessel. Pregnancy should be planned so that the "maternal environment" is prepared to house the foetus.

The "Perilous Body": While the pregnant woman's body is a vessel for the foetus, it is also a risky body which threatens foetal health and wellbeing. All aspects of the pregnant woman's life may pose threats to foetal, and thus social health, including her lifestyle, work, emotional state and diet.

The "Wom(b)an": All women of reproductive age are potentially the "child's first home" and/or the "perilous mother." Women should thus ideally always behave as though they have the potential to be pregnant.

The pregnant self as maternal subject

The "Good Mother": The pregnant woman is already a "mother" to her "unborn child" or "baby" and will *of course do anything she can* to ensure the health and wellbeing of her "baby," as long as she is educated about "the risks" posed by her behaviours. The pregnant woman accepts her marginality in the reproductive process and exercises agency only insofar as she accepts individual responsibility for foetal health and a good outcome from pregnancy, which is a healthy child. To demonstrate that she is a "good mother," she is expected to adjust, indeed self-regulate her behaviour, thus reducing the risks that her perilous body pose to the "unborn baby."

The "Acquiescent Mother": Unlike the "good mother," who is an active social agent trying to fulfil her responsibilities as a maternal subject by changing or self-regulating her behaviour, here maternal subjectivity also requires women to be acquiescent to, or passive objects of, biomedical or public health interventions on behalf of the foetus. The pregnant body becomes the subject of large-scale public health initiatives, aimed at reducing the risks to the "unborn child" across the population. As the site where biomedicine "treats" the foetal patient, the pregnant woman's own health is of marginal interest or is of no interest at all.

(m)Others: The "good mother" and "acquiescent mother" have fulfilled their maternal responsibilities towards the foetus and thus are "good" maternal subjects. The other "mothers" are those women who "haven't got the message" about their responsibilities as maternal subjects and have harmed foetal health through their behaviour. They are the "bad" maternal subjects and serve as a warning to other women about what will happen if they do not heed the risks and comply with biomedical advice, screening and intervention.

Exceptions

As with the analysis of the health education posters in Chapter Four, an important final stage of the analysis of these daily newspaper articles is a review of any exceptions to the reproductive bodies and subjects identified. As I argued in Chapter Three, a consideration of exceptions to the explanatory framework enabled me to evaluate whether there were any significant enough to disrupt my analysis. However, I also recognised the identification of some exceptions as an important way of confirming my explanation of the dominant discourses and subject positions. As Potter and Wetherell (1987) warn, the discourse analyser should be suspicious if there are no exceptions to their analysis. In my analysis of the health education posters I did not identify any exceptions. My justification for this was the size of the sample under analysis and the type of text being analysed. Public health resources, I argued, are intentionally pedagogical and so, perhaps unsurprisingly, the discourses and subjects operating in these texts are only those which reflect the dominant public health and biomedical paradigms.

In my analysis of newspaper articles and feature articles, my expectation, because of the news value of "objective" reporting of *all sides of the story*, was that I would find a far more complex situation, a real play between dominant and resistant discourses in the construction of reproductive bodies. This, however, was not the case. While there are several exceptions to the explanatory framework, which I will detail below, their positioning within the articles and their brevity did much to marginalise their impact in challenging the dominant discourses and subject. One of the most striking features of the analysis of the media articles for me was the overwhelming dominance of scientific, biomedical and public health discourses within these media texts and the almost complete absence of any challenges to their meanings. If this sample can be taken as reflective of society, then the institutions of science and biomedicine remain incredibly powerful social institutions in the construction of women's bodies, despite the several decades of feminist challenges to their meanings. The small number of exceptions encountered was as follows:

Exception one

> *He suggested that testing by invasive methods - such as amniocentesis after screening with age and/or ultrasound - meant that "more* ***unaffected pregnancies*** *are likely to be being lost* ***than abnormal ones*** *detected. This must surely be an unsustainable and undesirable situation.* [4] [Emphases added.]

In this excerpt from Article Four, repeated in Article Twenty Five on the same topic, the foetus is not treated as an individual separate from the pregnant woman. Here, rather than describing the "contents of the womb" as a separate entity, an "unborn baby" or even a foetus, it is an "unaffected" or "abnormal" pregnancy. The foetus and pregnant woman remain a single entity in this description. However, there are points within the same articles at which the foetus is also subjectified. For example, the headline to Article Twenty Five reads *Tests put unborn babies "at risk."*

Exception Two

> *Fisher said he believed the 63-year-old British woman currently carrying an egg-donated foetus was too old. "**However, I do have to ask if it were a male becoming a father at the same age, would there be the same controversy**," he said. Health risks increased with the age of the mother and if a woman over 45 wanted to carry a donated egg the clinic would do a full assessment.* [22] [Emphasis added.]

As demonstrated, the reproductive bodies and subjects constructed in these articles are deeply gendered. Women as "mothers" are constructed as individually responsible for the health of children, indeed the health of society, yet their bodies are constructed as hazardous to foetuses. Men, on the other hand, are almost entirely "let off the hook" for reproductive responsibility. This brief excerpt from Article Twenty Two, which reports on the potential risks of "older" pregnant "mothers," is the only reference throughout this sample where the gendered nature of biomedical discourse around reproduction is articulated. Again, it is a brief exception, and the article promptly continues its gendered discourse.

Exception Three

> *Maternity Services Consumer Council co-ordinator Lynda Williams, whose organisation opposed routine testing, said she believed it was a waste of money. If HIV testing was done in pregnancy, it was essential GPs and midwives were trained in pre-test counselling because **it was a life-changing diagnosis**. "**If woman don't understand that they're having it and get a positive result, then the fallout is huge. Women have a completely different reaction to being told their iron stores are low**," she said.* [30] [Emphasis added.]

This excerpt from Article Thirty is notably the *only* location in this sample where there is any suggestion that the push by biomedical experts for the routine screening of pregnant women for HIV may have negative consequences for pregnant women. While there are a number of articles on the introduction of routine HIV tests, this is the sole reference to the potential consequences of a positive HIV test for pregnant women; indeed it is the sole effort to report any comment from a consumer organisation. It is placed at the end of this article, which carries the headline *Doctor deplores HIV test delay*. The comment by Lynda Williams is not a central point within the article; it is more like an afterthought. The notion that reducing the "risks" to "babies" might need to be

weighed up in relation to how universal HIV screening will affect pregnant women's lives remains an extremely marginal discourse in these articles.

Exception Four

> *Tackling inequality would also reduce infant mortality rates, said Simmers. "**Poor socio-economic (status) has more influence on the outcome of maternity care than any other issue**," he said.* [26] [Emphasis added.]

The dominant constructions of foetal and pregnant subjects demonstrated above rely for the most part on the removal of pregnant women from their socio-economic and political contexts. Women tend to be constructed as lone individuals in these articles, solely responsible for the wellbeing of foetal persons through their behaviours. They are neither in relationships with other people, nor in contexts that, at least in part, may determine *their* wellbeing, let alone the wellbeing of their pregnancies. This is the only clear acknowledgement in these articles that the socio-economic status of women may be a major influence on the outcome of pregnancy.

Conclusion

In this chapter I have analysed 35 news media articles relating to pregnancy. Like the health education posters analysed in Chapter Four, I have identified dominant constructions of foetal and maternal subjects in these articles. The subjectification of the foetus as an entity separate from the pregnant woman, with its own identity, needs and rights, remains a dominant construction. These foetal subjects are the central focus of "expert" concern with pregnancy in these articles, and they are largely the product of biomedical (including biomedical science) and public health discourses of risk. Foetal subjects here are both the vulnerable "unborn baby," who is "at risk" now, and the "future citizen," whose life-long health and wellbeing is "at risk."

The construction of pregnant women in these articles correlates with the construction of foetal subjects. Again, reflecting the findings in the analysis of the health education posters, pregnant women (or potentially pregnant women) are reduced to their bodies' reproductive role as the "maternal environment" for the

foetus, an environment that they are told is potentially perilous to foetal health. Yet they are also constructed as maternal subjects who must do *everything they can* to protect their "baby" and the "future citizen" from harm. This means self-regulating their behaviour as the "good mother" and acquiescing to biomedical interventions on behalf of the foetus. The extent to which pregnant women are "good" or "bad" "mothers" depends on the extent to which they conform to these prescribed behaviours. However, the bodies of some pregnant women (for example those who are old or young) are so threatening that foetuses are "at risk" regardless of the extent to which pregnant women fulfil their responsibilities as "good" maternal subjects.

Unlike the health education posters, there are foetuses in these articles who are not assigned subjectivity. While pregnant "mothers" must *always* ensure the wellbeing of foetal subjects, biomedical "experts" hold the authority to disrupt foetal subjectivity if it interferes with the development of their work practices or technologies, as with the "designer baby," or if biomedical work practices and technologies are unable to resolve "flaws" in the foetus. These foetal non-subjects do much to demonstrate the authority over reproductive meanings held by biomedical "experts" in these texts.

In the next chapter I discuss the findings of my analyses of both the health education posters and the news media articles, and explore the possible implications of these constructions for reproductive practice.

A woman's right to know about:

The medical evidence indicating there could be links between abortion and breast cancer.

Both of NZ's leading breast cancer organisations (like their overseas counterparts) maintain that there is no conclusive evidence of any link between abortion and breast cancer, and therefore it is not mentioned as a risk factor.

It is a controversial issue in medicine. For example, 29 credible studies since 1957 suggest that there could be a link. Other studies report finding no such evidence.

Fortunately, the Internet enables you to check out the available evidence for, or against, any link - and decide for yourself.

Before listing useful websites, here are the comments of one breast cancer specialist:

Dr Angela Lanfranchi visited New Zealand after a lecture tour of Australia. She is Vice President of the Breast Cancer Prevention Institute in New York and clinical assistant professor of surgery at the Robert Wood Johnson School of Medicine in New Jersey. Her comments are based on her experience:

"When I first heard of the link between abortion and breast cancer, I thought it was a pro-life fantasy. However, out of curiosity I changed the intake form in my office and started asking my breast cancer patients for their complete reproductive history. I found a third of my 30-year old breast cancer patients had had abortions and yet no history of breast cancer in the family. I continued to see more and more young women with a history of abortion developing breast cancer. Despite the denials, the science and data are medically accurate. Understanding the physiology of the breast is essential."

29

credible studies indicate a link.

Dr Lanfranchi also suggests that in her opinion:

"Medically, breast cancer is one of the most seccessfully treated cancers if found with screening before it becomes invasive, or when the tumour is small and localised to the breast. If after eight to 10 years, an abortion causes a cancer cell to form screening may find a curable one centimeter cancer. Although mammograms can find calcifications in young 'dense' breasts, they are less revealing in young women. Therefore, screening with ultrasound or MRI can reveal cancers not seen on mammogram."

Please note: most miscarriages, due to the lack of estrogen, do not increase the risk of breast cancer. These websites provide comprehensive information to help you research the issue. Visit:

www.abortionbreastcancer.ca

www.abortionbreastcancer.com www.bcpinstitute.org www.cireserach.org

Visit our website: **www.voiceforlife.org.nz**

voice for life

Voice for life
Private bag 12-286
Thorndon WELLINGTON 6144

Chapter Six

Reproducing Matters: Discussion of Research Findings

> On closer examination, the medical "facts" of the pregnant body are discourses that change over time and space. Like all bodies, the pregnant body is subject to specific disciplinary regimes.
>
> (Longhurst, 2001: 64)

It is Sunday morning, early in January 2007. I have sat down with my coffee and the *Sunday Star Times*. *Another* day of writing. I open the magazine section and yet again I am reminded of the relevance of my research. I take my coffee upstairs and start to write. *Voice for Life*, a collaboration of various actors involved in Aotearoa New Zealand's anti-abortion and conservative "family value's" movements has placed an advertisement in the paper, informing us of latest scientific "evidence" that abortion may be linked to breast cancer.

Last year, it was mental health problems. A couple of weeks back, in another newspaper, "new research" linked cancer to foetal experiences in the womb (King, 2006, December 12: 2). It seems that more quickly than we can destabilise reproductive meanings, they are forming. Proving especially powerful and prolific are those that claim the reproductive "truth" through biomedical and scientific "evidence." The task to "destabilise," to refuse to let the constructions of reproductive bodies become ontological givens, remains crucial.

This chapter provides a discussion of reproductive meanings as I have encountered them in this research. In analysing the samples of health education and news media texts in my local context, I was interested in how reproductive bodies and the bodily experience of being pregnant were discursively constituted in these texts, and the kinds of reproductive subjects produced. The findings from the discourse analysis of these two sets of text are strikingly similar. In neither text do the dominant constructions (for the most part the *product* of scientific, biomedical and public health "expert" discourse) face any significant challenge or resistance. While this is perhaps unsurprising in relation to the health education posters, the similar lack of resistance to scientific and biomedical meanings within the media texts, and the similarity in their construction of reproductive bodies and

subjects, are significant findings.[15] Indeed, "news" functions in these articles as a vehicle for the communication of biomedical imperatives in a similar way to intentionally pedagogical health education materials. This illustrates the cultural authority of science and biomedicine to establish their knowledges as contemporary certainties that are thus less likely to be questioned or challenged: they become our reproductive "truth."

However, these findings also bring into question the role of the "news" media in the social construction of reproduction. Rather than being a neutral vehicle for delivering news, the news media here emerges as also deeply implicated in the reproductive context. My findings closely reflect those of Daniels (1999) and Oaks (2000), that while media coverage of men's reproductive health studies tended not to represent men as fully responsible for foetal harm, and raised uncertainties about scientific knowledge claims, scientific evidence of women's reproductive health was often presented as factual and certain, and women to blame for foetal ill-health. In my sample of news media articles, men are almost completely absent from reproductive discourse, while scientific "evidence" is provided in a number of articles of women's sole responsibility for determining (and harming) foetal health and the future health of the foetus. "Scientific evidence" is intended to change women's behaviours in the interests of foetal wellbeing, and we are given very little discursive space to question or evaluate the science, and, indeed, are expected to accept it as "fact."

I begin this chapter by discussing the dominant reproductive bodies and subjects as I have encountered them in the health education and media texts, demonstrating as I do several ways in which the discourses of science, biomedicine and public health strategies work to stabilise or naturalise these particular constructions as our reproductive "reality." I then consider in closer detail the potential relationship between this "reality" and social practices around reproduction. Of particular interest is whether the reproductive bodies and subjects in my local

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[15] As Gastaldo (1997) has argued, outlined in Chapter Two, it has already been well established that public health strategies are implicated in the power relations of reproduction (by asserting dominant meanings about reproductive bodies and their behaviours).

context are being made in ways which may subject them to the exercise of disciplinary power, as "risky" bodies that threaten "babies'" wellbeing.

I then revisit the question of women's agency to signal the need for further research that is able to consider how pregnant and reproductive-age women negotiate these meanings in relation to their own embodied experiences. Finally, I consider the findings in relation to a specific community of practice invested in the reproductive context – midwifery. I discuss the relationship between midwifery and the "expert" discourses involved in the construction of dominant reproductive meanings that may contribute to the *discipline* of pregnancy.

Making Babies *and* Mothers

The strong discursive practice of subjectifying the foetus is a central finding in my analysis of both the health education posters and news media articles. In both types of text, the dominant construction of the foetus is as an individual, separate from the pregnant woman, with its own set of interests, needs and rights. This is an unsurprising finding considering the feminist analyses reviewed in Chapter Two. As Duden, a feminist historian who has traced the historical and cultural construction of foetuses as separate entities from pregnant women in the West, argues:

> This history... has now led us to the epoch of foetal dominance. Its visible appearance has colonised discourse, vision, and I would argue, the experience of the potentially or actually pregnant woman. Surreptitiously, a new ideogram, demanding a new set of attitudes, has emerged and become universally accepted. This is "life." (1993: 9)

While the construction of foetal subjects takes various forms in these texts, they share the notion that they are "at risk." The foetus as **"unborn baby"** is a dominant construction in both the health education and media texts and supports the pedagogical function of these texts (whether this function is intentional or not) by appealing to pregnant women as "mothers." The "unborn baby" is a vulnerable individual "at risk" from the pregnant, or potentially pregnant, "mother" – both her body and behaviours. As such, the "unborn baby" emerges as the central subject of pregnancy and the focus of biomedical and public health research and

interventions. The notion that the foetus is "at risk" is also extended to the **"future citizen,"** whose *future* health and wellbeing is "at risk" while it is "in the womb." As the foetus in Poster D tells its mother:

> *I don't want to spoil your fun, but there are things you should know. A few drinks can do me some serious damage...We're talking the kind of hangover that can affect me for life...*

The **"designer baby"** is the foetus who is "at risk" but can be "saved" by the development of new biomedical work practices and technologies. As the biomedical expert states at the end of Article Three in regards to foetal surgery: *'The fact is, by the time a child is born, the die has been cast. With this we're starting to change that'.*

The construction of foetal subjects in these texts correlates to the construction of pregnant women. In order for the foetus to emerge as the central, embodied, reproductive subject, pregnant women in these texts are simultaneously reduced to their body's reproductive role as a "maternal environment" and are constructed (or constricted) to their role as "mothers." As maternal subjects, pregnant women are inscribed with the expectation, indeed the moral imperative, that they will conform to certain socially prescribed "maternal" behaviours in the care of foetal "persons," including the self-regulation of their behaviours and their unquestioned acquiescence to biomedical interventions. Maternal subjects are, for the most part, not in context. They are not in relationships with other people. Indeed, it would appear that they reproduce alone. Neither would it seem that they negotiate their pregnancies in the context of complex lives shaped by forces such as politics, socio-economic status, culture and gender, not to mention their own individual desires and experiences. Their own health and wellbeing is neither of interest, nor is it significant – except as it may be harmful to these foetal subjects. They are in a primary relationship with their "unborn child" for whom they are individually responsible.

These findings lend support to the feminist concerns reviewed in Chapter Two, that the social organisation of reproduction in the West has unfolded in a way that now routinely erases women from the picture (literally, as is the case in some of the visual images of foetuses in both samples) and naturalises the presence of

foetuses. It is almost as though, argue Michaels and Morgan (1999: 4), as foetuses in their "maternal environments" are naturalised, women seem to vanish altogether, except as the recipients of biomedical and public health imperatives regarding their behaviours. The ambiguous ontological status that women occupy in these texts, and in reproductive discourse in general, has major consequences. In my samples of texts it takes the form of a double bind for women. On the one hand, the foetuses here are attributed special person-like qualities as vulnerable little babies for whom women are being told they are individually responsible. On the other, it is these maternal bodies that pose risks to the foetus. They are adversaries to the "babies" they are supposed to protect and care for as "mothers."

Risk discourses are central to the construction of foetal "babies" *and* pregnant "mothers" in these texts. Foetuses are subjectified as separate entities "at risk," while pregnant women become both the sites of these "risks" and those solely responsible for the reduction of these "risks." The mobilisation of risk discourse is the *effect*, for the most part, of the dominant "expert" knowledges of science, biomedicine and public health, *and*, as argued above, how they are communicated within these different kinds of texts. The dominance of scientific, biomedical and public health meanings relies on our acceptance of these "expert" knowledges as "certainties" or "facts." I will now discuss three of the specific strategies of knowledge production in these texts, which work to present these specific social realities about reproductive bodies as "certainties" or "facts": appeals to "expertise," references to evidence in the form of "new scientific research," and the use of technology.

Appeals to expertise

The cultural authority held by biomedical and scientific "expertise" is a powerful factor in supporting "truth claims" in these texts. As Lupton notes in her own analysis of the construction of pregnancy as "risky":

> *Contemporary knowledges and discourses on risk emerge from both expert and lay sites, but it is the experts who hold most sway because of the assumed "scientific" and "neutral" character of their knowledges. Expert knowledge on pregnancy has proliferated throughout the century, with the recent emergence of such specialities focused on the foetus as foetal medicine and genetic counselling. (1999: 63)*

"Experts" on pregnancy and foetal health – doctors, specialists, professors, scientists, researchers, public health professionals, coroners, and representatives from the Ministry of Health – occupy a central position in the majority of the media articles, and many stories are structured around them. Article Twenty Six, *'Doctor wants more pre-conception care'*; Article Thirty, *'Doctor deplores HIV test delay'*; and Article Twelve, *'Call to test mums for diabetes'*, each demonstrate the central role played by the "expert," who, in these articles, emerges as a moral force in the development of biomedical care of foetuses. Indeed in almost all of the texts, the media articles *and* health education posters, the "expert" is the speaker.

In the few instances where reproducing women themselves speak directly in either sample of texts, it is generally in support of the expert knowledges that structure these texts. For example, the woman in Poster B tells us she has stopped smoking: *'Who am I to give this child a bad start in life, fill his lungs with all that crap that goes into cigarettes?'* Likewise, in Article Twenty Two, *'Older mums on the increase in NZ'*, the article is structured around the concerns of a fertility expert and is supported by the comments of an "older mother" who *'would caution all women to think carefully'* about delaying motherhood.

The overwhelming concern of the "experts" in these texts is the communication of the "risks" pregnant bodies and behaviours may pose to foetal "babies." Furthermore, the ways in which these "risks" are communicated helps to consolidate them as "facts." The communication of "risks" as requiring "urgent" attention because foetal "babies" are being harmed is a significant feature of these texts. This can be seen particularly clearly in the headlines of several of the news media articles: *'Pregnant women urged to halve work hours jobs'* (Article 23); *'Down's test revamp urged'* (Article 4); and *'Switch urged on birth defect plan'* (Article 31). By communicating "risks" as requiring "urgent" attention, there is little space created for questioning these "risks" or for consideration of how they may be reduced without compromising women's reproductive integrity. Rather, the "expert" discourse becomes dominant, because *we must act now and follow the advice we are being given* to prevent harm to "babies."

The "experts" in the media articles are also represented as engaged in a "struggle" or "fight" against the "risks" to foetal life posed by pregnant bodies (Murphy-Lawless, 1998: 32). For example, the headlines of Articles Twenty Four and Twenty Seven read: *'Battling a pregnancy peril'* and *'Folate in bread to fight birth defects'*. Article Twelve, *'Call to test mums for diabetes'*, begins with the following announcement:

> *Experts are calling for all pregnant women to be tested for diabetes as increasing rates of the condition put more babies at risk of dying or suffering severe abnormalities...* ***Diabetes experts have joined forces*** *to call for screening of all pregnant women...* [Emphasis added.]

This helps to construct "experts" as the defenders or caretakers of these foetal "unborn babies" and as acting in their best interests. Their intentions are thus not to be questioned. In the health education posters analysed in Chapter Four, the "risks," largely articulated by the "invisible experts," are established as "facts" through their communication as health imperatives that are indisputable and incontrovertible:

> *A mother with HIV can pass the virus to her baby during pregnancy, at birth, or through breastfeeding. If you think you could be at risk of HIV talk to your doctor, midwife or specialist as soon as possible.* [Poster A]
>
> *When you drink so does your baby. Don't drink when you're pregnant.* [Poster E]
>
> *When you hit the booze the booze hits the baby.* [Poster C]

"New Scientific Research"

References to evidence in the form of "new scientific research" are a powerful strategy for consolidating the scientific, biomedical and public health knowledges about reproductive bodies as "facts" in the media articles. "Experts" in these articles refer to the findings of "new scientific research" to provide "evidence" of the "risks" posed to foetuses by a whole range of women's behaviours, during *and* before pregnancy. As I have demonstrated in Chapter Five, these studies construct pregnant women as primarily and individually responsible for the outcome of pregnancy and the health (and future health) of the foetus/baby. This renders invisible or inconsequential the host of other factors that we know will shape that outcome, including socio-economic status, male genetic contribution, and the environments in which women live and work. In other words, "new scientific

research" seems to be providing us with "evidence" of deeply gendered responsibilities for reproducing.

Further, the "experts" in several of the media articles refer to "new scientific research" that appears to be providing "evidence" that it is not only the behaviours of women before or during pregnancy that pose risks to the health of the foetus (risks that women *may* be able to reduce through acquiescence and strict self-regulation), but also that such risks are posed by the *actual bodies* of some women. For example, in Article Seven, *'Teen pregnancies a gamble - academic'*, the expert refers to 'evolutionary biological research' which seems to provide evidence that it is the bodies of teenage women, merely because they are young, that threatens the health and wellbeing of the foetal "baby":

> *Teenage pregnancies gamble with babies' health, Auckland scientist Professor Peter Gluckman said in Nelson yesterday. Evolutionary biological research suggested that nature "gambled" on the life of a first child, so the first-born children of teenage mothers faced poor health and survival odds, he said.*

The article concludes by also implicating "older" women in these "body risks": 'The risk to the child also increased when the mother had her first child at 35 or older, he said - another increasingly common social trend'. Studies such as the one referenced by the expert here construct gendered meanings of pregnant women as the antagonists of foetuses and as individually responsible for the outcome of pregnancy. Further, if these studies are to be taken to their "natural" conclusion, they construct a reproductive context in which anything less than the "ideal pregnant body" should not, perhaps, be making babies at all.

Technology

Finally, technology plays an important role in consolidating biomedical and scientific "facts" about reproduction. In Poster D and Article Three, for example, obstetric visualising technologies have facilitated the production of images of foetuses that seemingly "float in space." The technological visualisation of the foetus as separate from the pregnant bodies in which they are located has been profoundly significant in the construction of foetal subjects as separate entities – as "miniature babies."

Visualising technologies also function in the texts as the medium through which researchers and medical professionals can interact with the foetus, requiring only passive acquiescence from the pregnant woman. Again, this constructs "experts" as the authorities of "foetal reality." This can be seen particularly clearly in a number of the newspaper articles. In Article Ten, *'NZ "designer baby" test mother six weeks pregnant'*, for example, the biomedical expert states confidently: *'All current monitoring suggests the pregnancy is progressing normally'*. Here the health and wellbeing of the foetus, the "designer baby," is determined by biomedical monitoring instruments over which this expert has complete authority. The pregnant woman's own embodied experience of her foetus is invisible.

In their analysis of the antenatal care encounter between doctors and pregnant women, Browner and Press (1996) found that reproductive technologies were crucial in establishing biomedical authority and in disrupting the authority of women's embodied knowledge about their pregnancies. The technologies of prenatal testing, such as ultrasound or other diagnostic procedures, are almost never refused by women because refusal could be construed as a lack of care or responsibility on behalf of the pregnant woman. They argue that the "scientific" information offered by these technologies 'occupies a uniquely privileged spot. Information produced by science marshals inherent respect, even when it may have no apparent use' (Browner & Press, 1996: 152). In Article Two, researchers are reported as having recorded visual images of the "unborn baby crying in the womb." This is a good example of "scientific" information produced by technology that may be authoritative in constructing meanings about foetuses as vulnerable "unborn babies," despite its suspect usefulness.

My findings demonstrate the extent to which the "expert" discourses of science, biomedicine and public health continue to hold the cultural authority to construct and normalise particular kinds of reproductive bodies and subjects, despite several decades of challenges to their gendered meanings. Because these constructs rapidly become established as contemporary certainties or "facts," they are difficult to question or challenge. They become our reproductive reality. In this next section I will explore the potential implications of these constructions in

closer detail by considering my third research question: *How can we understand the relationships between the constitution of reproductive bodies and subjects, and social practices around reproduction?*

Disciplining Pregnancy

Ironically, perhaps, considering that reproducing in the West may now look safer for *both* women *and* babies than it ever has been, the emergent meanings about reproductive bodies are rendering pregnancy under increasing scrutiny for the "risks" it may pose to foetal life. By positioning reproductive women as the adversaries of their foetuses, these meanings work to construct the former as individually and solely responsible for the outcome of pregnancy, including the lifelong future health of any children they have. It appears from my findings that this construction of reproductive meanings is contributing to the *discipline* of pregnancy, requiring both external "policing" (expert advice, surveillance, intervention and management) and "self-policing" (the self-regulation of "risky" behaviours) to ensure the health and wellbeing of the foetus *and* of society. Pregnant women *will of course do whatever they can,* we are told in these texts, because they are *mothers who want to protect their children from harm.* In this way we can see how power is woven through the reproductive context, constructing reproductive subjects and identities in ways that shape women's reproductive behaviours, practices and choices.

The construction of pregnancy as requiring external "policing," through expert advice, surveillance, management, and intervention, is evident in both the health education posters and the media texts. Indeed, "experts'" efforts to contain and control the "risks" posed by pregnant bodies and behaviours to the health and wellbeing of foetuses dominate most of the texts analysed. This can be seen particularly clearly in my analysis of the "acquiescent mother." For example, calls for the introduction of universal screening of pregnant women for such things as HIV, diabetes, pre-eclampsia, and Down's Syndrome, are particularly dominant in the media texts. These demonstrate how "risk" meanings position all pregnant women as requiring surveillance, followed by intensive biomedical management of her pregnancy if a woman is found to be at "high risk." The moral obligation to

acquiesce to these forms of biomedical interventions works through pregnant women's construction as "maternal" subjects who are individually responsible for the provision of "parental" care to foetuses: both "unborn babies" and societies' "future citizens."

Moral obligation acts as a form of *discipline* of pregnancy by constructing boundaries around women's "choices" for biomedical screening and intervention. However, there may be the potential for another troubling outcome related to these reproductive meanings, where "choices" – even ones that are obliged – may be threatened. The discourses operating through the texts related to HIV screening in pregnancy indicate a construction of a reproductive context in which foetal subjects are so central, and pregnant subjects so marginal, that the surveillance and biomedical management of women's reproductive bodies could feasibly become *compulsory*.

Beyond surveillance and biomedical management, there are other ways in which the meanings operating in these texts may be contributing to the policing of pregnancy. Particularly interesting to me are the ways in which "concerned citizens" are being encouraged to intervene on behalf of the foetus by informing or educating pregnant women about the risks of their behaviour when they are deemed to be behaving "inappropriately." For example, as discussed in Chapter Four, the design of Poster F positions the viewer as the *observer* of the pregnant woman's "bad" behaviour. When questioned about her behaviour (*'Is your baby on the bottle?'*), the pregnant woman is reminded about her responsibilities to her "baby," while the observer is reminded of their responsibilities to monitor and question pregnant women.

Pregnancy is also constructed in these texts as the site of wide-scale public health interventions. A number of the media articles report on the proposed introduction of a law making it compulsory to fortify bread with folic acid.[16] In these articles, pregnant women are *failing to manage the risks to the foetus because they are not*

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[16] Folic Acid is a supplement women are encouraged to take one month before and for the first three months of pregnancy to reduce the incidence of neural tube defects in the developing foetus.

planning and preparing for their pregnancies, and thus the government, through legislation (supported by biomedical experts and disability groups), must intervene on behalf of the foetus. Again, intervention is an imperative here because *babies are being harmed* by pregnant bodies and their behaviours.

As I have demonstrated, the construction of pregnant women's subjectivity as "mothers" in these texts appears to morally oblige them to acquiesce to the biomedical surveillance and management of their pregnancies. This construction is used to justify interventions when pregnant women's "maternal" conduct is in question. However, my analysis of both the health education and media texts, and in particular the "good mother" in Chapter Five, demonstrates that the construction of pregnant women as "mothers" also morally obliges them to govern themselves. In these texts this involves self-regulating their behaviours that may be "risky," making "choices" that are "best for baby," and generally conducting themselves while pregnant in ways deemed socially acceptable for mothers. This means putting their "unborn children" before themselves, *as any good mother would*, and privileging their relationship with their "child" above all others.

Because pregnant women are constructed as individually responsible for pregnancy, and are "mothers" who should be protecting their children by doing *everything they can* to *reduce the risks*, "failure" to self-regulate their behaviours according to biomedical advice and to conform to these socially prescribed "maternal" behaviours leaves women vulnerable to blame, guilt and even punishment for the future ill-health (or death) of the foetus. This can be seen in Article Nine *'Babies' death a warning'*, where the first sentence of the articles reads:

> *The death of an 8-month-old baby in Invercargill this year was a warning to mothers who smoke during pregnancy not to sleep with their babies, coroner Trevor Savage said in the Invercargill Coroner's Court yesterday.*

In this article, the death of the baby is used as a moral lesson for mothers about their behaviour during pregnancy, even though the details provided of this case indicate that there were a number of other potential contributing factors to the

baby's death, including overcrowding of the house the family was living in, *both* parents being smokers, and alcohol consumption. Given the reproductive meanings identified in this study, it does seem likely that, as was the concern of Daniels (1993 as cited in Balsamo, 1997: 100), we may be witnessing the evolution of a public culture that endorses resentment toward pregnant women in favour of the foetus, and which endorses subtle (or not so subtle) forms of coercion against those who transgress the boundaries of what we deem "acceptable behaviour for mothers." My findings also confirm the analyses of Lupton (1999) and Petersen and Lupton (1996) (reviewed in Chapter Two), where the construction of the "healthy citizen," which shapes the experiences of all subjects within contemporary neo-liberal societies, has particular implications for women through the construction of gendered meanings about their role in reproduction.

The Agency Question

> Although feminist scholarship has focused needed attention at the dangers of a foetal rights discourse for women's reproductive freedom in particular and women's rights in general, there has been little empirical work that examines women's embodied experience of pregnancy with regard to the light it could cast on the issue of maternal-fetal conflict.
>
> (Markens, Browner & Press, 1997: 352)

I have used the notion of *disciplinary power* here as a way to understand how power may be operating within my local reproductive context, without assuming that women are either passive victims to biomedical control over their reproductive bodies *or* that they are autonomous, responsible, unified and rational individuals who may move freely through the reproductive context and reproductive decision-making. My own midwifery experiences, and the history of feminist reproductive struggles, have made it clear that neither position can explain women's "reproductive realities." Rather, as I have demonstrated above, reproductive bodies and subjects are being *brought to matter* in ways that are rendering pregnancy a bodily state that requires both external "policing" *and* self "policing" to ensure the wellbeing of the foetus. The notion of *disciplinary power* has thus provided me with a way of understanding how women may be implicated in reproductive power relations, because from this perspective their "decisions"

(about preparation for pregnancy, self-care in pregnancy, lifestyle choices while pregnant, and decisions about their engagement with reproductive technologies such as foetal medical interventions and screening tests) are not made "freely," but rather are subject to dominant social discourses such as those which operate in these texts. These dominant discourses construct pregnant women as "mothers" and shape the boundaries of their reproductive experiences, behaviours and practices.

Returning to the agency question, my concern here is the danger of presenting women as a monolithic category who are all *subjected* in the same way in the reproductive context. "Mothers'" reproductive experiences and practices are not uniform in response to *disciplinary power*. Indeed, it is clear from my findings that women are *not* all subjected in the same way in these texts: risk discourses have concentrated around particular kinds of pregnant bodies: the old, the young and the "brown." Likewise, my midwifery experience and my reading of the feminist scholarship reviewed in Chapter Two suggest that women make sense of, and act upon, reproductive and especially foetal meanings by pursuing diverse reproductive strategies (Casper, 1999).

In research on diet in pregnancy, Markens, Browner and Press (1997: 366) found that women were far from uniform and unreflective social actors as they negotiated their dietary choices in pregnancy. However, they also caution that the fact that most pregnant women in their study modified their diets in at least some way for the foetus indicated the degree to which they were influenced by biomedical meanings and accepted individual responsibility for foetal wellbeing. They note:

> The high degree of accommodation we found is significant in as much as it indicates the extent to which women's reproductive behaviour during pregnancy is already subject to much control, by others and by themselves. Still, our findings suggest that the woman-foetus relationship is complex...pregnant women actively negotiate a complex web of intersecting demands. They are accountable to and influenced by biomedical proscriptions and related discourses of maternal responsibility. At the same time they attend to their own desires for a healthy baby, as well as their own health and perceptions of what will enhance their well-being, which may or may not be in conflict with biomedical notions. Finally, their dietary strategies are pursued within the constraints of time, money, and an accustomed life-style. (Markens, et al, 1997: 366)

Considering analyses such as Markens et al. (1997), it becomes clear that my research tells only part of the story. While I have demonstrated how reproductive bodies and subjects are constituted in ways that *may* contribute to the discipline of pregnancy and undermine women's reproductive integrity, this is not the "end of the story." Further research is necessary, not only capable of considering the extent to which women are subject to the meanings revealed here, but also how pregnant women negotiate these meanings in relation to their own desires, priorities, embodied experiences, and social and cultural contexts.

This returns me to a consideration of the task of feminist analyses of the reproductive context, as articulated at the end of Chapter Two. Faced with the complexities of the reproductive context, and the multiple meanings ascribed to reproduction and foetuses, our task must be to retain our commitment to theoretical positions, such as social constructionism, which allow us to be flexible in our analyses of all the ways in which *babies are made*. We must also continue with our efforts at destabilising dominant reproductive meanings that threaten to become (or have become) our reproductive "truth," especially those that are proving hostile to women's reproductive integrity and the reproductive freedoms gained thus far (Casper, 1999; Michaels & Morgan, 1999). For, in the face of reproductive developments such as foetal medicine and science, which increasingly provide us with the "facts" of foetal life (and harm), the urgency for fluid definitions of reproductive bodies is greater than ever (Murphy-Lawless, 1998: 253). The task has become, argues Murphy-Lawless (1998: 253), to secure agency for women, not in the sense of the rational individual, but agency 'to determine different levels and types of decisions with our bodies at different

points in our reproductive lives, and the different selves which are invoked, like the contracepting self, the menstruating self, the pregnant self'. While women may have already been disciplined (and subjected) by the meanings of science, biomedicine and public health when they encounter reproduction, by continuing to *destabilise* we may give women the flexibility to safeguard their own interests and meanings (Murphy- Lawless, 1998: 254).

Maternity Care(taking)

In describing her own project to destabilise reproductive meanings, Duden (1993: 110) confesses that her motivation was drawn from her curiosity as to whether she could experience herself and her body in ways other than through these contemporary reproductive certainties, to 'ruefully smile at this phantom' of foetal life and in the process reclaim her own autonomous aliveness. My interest here is the relationship between these findings and my own community of practice, midwifery. In particular I am interested in the extent to which midwifery may be implicated in, or resistant to, these socially constructed reproductive meanings. I will also propose that midwifery takes as one of its tasks a consideration of the possibilities for the reconfiguration of the dominant reproductive bodies and subjectivities encountered in this research, through its own discourses and practices.

Midwifery is a professional practice deeply embedded within my local reproductive context; however its professional "expertise" is marginal in the texts I have analysed. While scientific, biomedical and public health "expertise" is very dominant in all of the media texts analysed, midwifery "expert" comment is only present in two of the media articles, and in both articles these comments largely work to consolidate the biomedical "expert" opinion. For example, in Article Fifteen, *'Record HIV year prompts screening at pregnancy'*, there is the following midwifery response:

> *College of Midwives chief executive officer Karen Guilliland said midwives and other health professionals have been offering the HIV-test based on whether they believe a woman may be at risk of contracting the disease. "I am confident that the inclusion of HIV testing to be offered to pregnant women as a part of the blood tests available should have little effect on what is required of our midwives." Mrs Guilliland says it will remain the woman's choice whether she takes the HIV test, which is the situation in New Zealand for the suite of antenatal blood tests available.*

While the midwifery "expert" in this text emphasises that it is women's choice whether or not they have an HIV test, as I have demonstrated, these "choices" are unlikely to be made freely, given the dominant construction of these tests as an *imperative* to protect "babies." This is a construction left unchallenged by the midwifery "expert" in this article. Where there are references to midwifery practice in these texts it tends to be positioned alongside biomedicine as part of the *professional care* of pregnancy. For example, in Poster A, pregnant women are questioned about their risk of being HIV positive, and are then offered the following advice:

> *If you think you could be at risk of HIV talk to your doctor, midwife or specialist as soon as possible.*

It is certainly *not* the case that midwifery discourse or practice operates in these texts in any way that challenges the dominant and gendered reproductive meanings of science, biomedicine and public health.

I find this interesting. In the context of childbirth politics in this country over the past two decades, midwifery has positioned itself as a strong counter-practice to dominant biomedical models of childbirth. During the late 1970s, 1980s and early 1990s, the midwifery profession was involved in struggles alongside the feminist women's health, homebirth and natural childbirth movements in challenging biomedical control of childbirth and in demanding more women-centred, less interventionist, midwifery-led maternity services. A central strategy in these struggles, and echoing the call for other reproductive "choices," was the demand for "informed choice" rather than "routine practice" from maternity carers, together with the assertion that childbirth was a natural healthy life event.

In many respects, by the early 1990s huge gains had been made. Midwifery was secured as an autonomous profession, government funded to provide free, continuous, primary maternity care to women in either hospitals or women's homes throughout their pregnancies, births and the postnatal period. The philosophical framework articulated by midwifery at this time asserted that midwives and women work in partnership, sharing their mutual knowledges throughout women's childbirth experiences (Guilliland & Pairman, 1995). This was an enormous challenge to the dominance of biomedicine in the reproductive context of this country, and huge changes were expected over the following decade, including a significant shift towards homebirth and a reduction in the incidence of major biomedical interventions such as caesarean sections and the use of epidural anaesthesia. However, almost the opposite has occurred. Homebirth statistics are difficult to determine, but there is a general perception that they have not increased, and the rates of all biomedical childbirth interventions continue to rise. Like other reproductive "choices," it seems that securing "choices" in childbirth has not meant that women would want to (or feel able to) embrace them.

As with reproductive politics in general, feminist engagement in childbirth politics has shifted from the struggle to secure material "choices" to the struggle to destabilise meanings about women's birthing bodies (Cartwright, 1998; Davis-Floyd, 2003; Murphy-Lawless, 1998; Triechler, 1990). Much attention has been paid to the ways in which childbirth, like pregnancy, has been *disciplined* through its social construction as "risky" for "babies" and thus a process that requires intensive "expert" surveillance, management and intervention in order to be "safe." The midwifery profession has been drawn into these constructions, increasingly represented in the popular media as a professional practice that threatens both "babies" and "mothers" during childbirth. I have noted the following headlines over the past year: 'Midwife walks free after death' (2007, April 22: 2); 'Banned after baby deaths – now midwife wants her job back' (Meylan, 2005, November 6: 3); 'Midwife failed mother whose baby died in womb' (2005, November 2: 11); 'Midwife with five complaints against her fights to be reinstated' (Meylan, 2005, November 6: 3); and 'Government to end

midwife monopoly' (Bennets, 2006, January 27: A3). Indeed, I suspect that a study, parallel to this, that asked '*how are midwives made?*' may encounter dominant biomedical meanings of risk also deeply implicated in attempts to undermine autonomous midwifery practice.

However, in the texts I have analysed which focus on pregnancy, midwifery is neither a strong counter-discourse, nor practice, nor is it constructed as deeply threatening to foetuses or pregnant women. Rather, as I have demonstrated, the ways in which midwifery is constructed in these texts have done much to marginalise its expert discourses (significant given that the majority of pregnancy care is provided by midwives in this country) and have located it as part of the *professional care of pregnancy*.

In an attempt to account for midwifery's location in these texts, I have considered two possibilities. It is possible that in order for biomedicine to emerge as the "caretakers" of the foetus (a construction which is central to the consolidation of scientific and biomedical knowledges in these texts), not only must pregnant women be marginalised, but perhaps so too must any other community of practice which may lay some claim to foetal meanings. However, considering the literature, it may also be possible that midwifery has done much to position itself in the *discipline* of pregnancy through the assertion of counter-discourses which may have in fact fed powerfully into dominant biomedical constructions (Lupton, 2003; Shuttleworth, 1993/1994). In the dominant biomedical discourses analysed here, self-regulation, along with full acquiescence to biomedical surveillance and management, is crucial for pregnant women to ensure they have *done everything they can* to ensure the health (and future health) of the foetus. The literature suggests that, while intended to demedicalise childbirth, the discourses of midwifery and the natural childbirth movement have also emphasised the need for women to actively prepare and self-regulate their bodies during (and before) pregnancy, but in this case to ensure a "natural" birth.

Shuttleworth (1993/ 1994: 38) argues that the 'call to return to the "natural,"' to hold technology at bay, and for women to take control of their bodies, which has

underpinned much of the recent struggles to challenge biomedical control of childbirth, has represented a very double-edged weapon. While in many respects these challenges have been very welcome, offering a force for the resistance of biomedical and technological control, they also may work to reinstate some troubling notions about women's place within nature, in particular that they are "natural" mothers. Lupton (2003: 161) argues that:

> ...the natural childbirth movement has been criticised for drawing a distinction between "natural" and "artificial" childbirth, and for championing the view of women as simple, instinctive, close to nature, while men are seen as rational and scientific.

The implication is that women who do not achieve a "natural" birth are likely to feel that they have failed to prepare their bodies appropriately during pregnancy and thus have failed as "mothers" (Shuttleworth, 1993/ 1994: 38).

The relative silence of midwifery in the texts I have reviewed, and its positioning alongside biomedicine when it does appear, may be because, in many ways, the dominant discourses operating in these texts are not at odds with midwifery's own discourse on pregnancy, even though the intended outcomes are different. This may also signal the need for further analysis of "everyday" texts within my local context, such as pregnancy handbooks intended to assist women to achieve a "natural" pregnancy and birth, which represent more clearly the perspectives of the natural childbirth movement and midwifery professional practice and may demonstrate if, or how, *they* are implicated in the *discipline* of pregnancy.

In concluding this discussion, the question remains of how power may be challenged as it is encountered in analyses such as these, dispersed as it is through all social relations as the effect of discourse. In Chapter Two, I argued that the act of exposing power relations as they operate through discourses in particular contexts, such as reproduction, is itself a form of challenge, rendering those discourses fragile and thus vulnerable, for their strength lies in our acceptance that they are truths (Foucault, 1981; Pilcher & Whelehan, 2004). However, contemplating the role of my own community of practice, I am curious about the possibilities for actively setting about the task of reconfiguring or transforming meanings as they are encountered in poststructuralist analyses. Davies et al (2006:

89) describes the process of transformation as first making visible the silent discourses that constitute meanings and subjects, and then 'inserting new ways of thinking and being into the disciplines and professions through which we are monitored and through which, and in relation to which, we go on becoming subjects'. This involves both a decomposition, *and* a fractured, messy recomposition of thought and body, where meanings are reassembled in an "unthinkable" way (Davies et al, 2006: 90). The challenge of the poststructuralist transformative project is thus twofold: to adopt these instruments which enable us to destabilise, to see *what we are now*; and, as a response to what we find, to 'develop strategies (conceptual and practical) for making a radical break with current forms of domination, for imagining a new kind of subject' (Davies et al, 2006: 90).

My proposal for midwifery then, being a community of practice that has committed itself both philosophically and politically to being a woman-centred counter-practice to biomedical dominance (and which now faces its own struggle to survive dominant meanings that are hostile to its autonomy and this vision) is to urgently engage in this process of transformation. This will involve questioning ourselves about what *we* lose when we allow, *or* contribute to, the reduction of women to their reproductive bodies and roles and their exposure to relentless surveillance and moral judgement when pregnant. This will also involve questioning what we lose when we allow women to carry the burden of blame and guilt for reproductive outcomes we know are frequently out of their, and our, "hands." This will require discussion about the various kinds of strategies, both conceptual and practical, that may enable us to imagine, generate *and* practice different kinds of reproductive meanings, ones which enable us to simultaneously value foetal health and life, as it is meaningful for women, whilst also maintaining and asserting women's reproductive integrity, and the absolute necessity of their reproductive freedom.


EXPECTANT AND
NEW PARENTS
CAR PARK

Chapter Seven

Are Babies Born or Made? : Concluding Remarks

13/05/06: 0400

In to see Jane, as light on. Birthed at 2300hrs. Reports is unable to sleep but is getting some rest. Reports lochia remains moderate. Observations taken, remain stable. Fundus, firm and central, 1cm below umbilicus. Jane reports she has decided to name her baby Rosie and is wondering if she can see her. Baby retrieved from cool store, remains in good condition. Dressed in small baby clothes Jane has chosen and wrapped in blanket. Taken to Jane for a cuddle. Jane coping well although emotional at times. Lengthy discussion about her decision to terminate for foetal cardiac abnormalities and the normal features of a 25 week gestation foetus. Footprints taken and given to Jane for keepsake. Plan discussed for today. Jane's family coming in to ward to see baby and for goodbyes this morning and then for postmortum - paperwork completed for this. Would like baby cremated. Jane to spread ashes over rosebush at home. Offered sleeping medication – declined. To leave Jane with baby for a time, will call when ready to return baby to cool storage.

20/11/06: 0600

Contractions continue to be strong, long and regular 1: 3 minutes. Nina working so hard but pushing well with contractions, good sight of foetal head seen at the peak of each contraction, appears to be advancing well. Draining clear liquor and small amounts blood stained mucus show. Foetal heart tones heard intermittently after each contraction, 145bpm, reassuring. Nina on hands and knees beside bed, well supported by partner. Sips of water.

20/11/06: 0615

Birth of live infant female up into Nina's arms, assisted by partner. Mum and baby covered with warm wraps. Baby girl is well perfused and breathing spontaneously. Nina and Tony thrilled. Nina assisted onto bed cuddling baby skin-to-skin. Latched to breast with minimal assistance and suckling well. Placenta birthed by controlled cord traction following administration of Syntocinon 5units IM. Nina's vaginal blood loss heavy though acceptable, fundus firm and central at umbilicus. Given toast and milo. Nina exhausted but very happy to meet her baby.

This thesis is about meanings, and who has the power to make them. As I have demonstrated throughout this thesis, meanings about reproductive bodies are

neither "natural" nor "universal." Rather, they are social constructs; indeed, as Haraway (1989: 10) describes: 'they are constructs of a world changing kind'. They form the boundaries of bodies that reproduce, they mediate the experiences of those bodies, and they encourage us to behave in certain ways. As the intertext that precedes this chapter demonstrates, it would seem that they even have the power to direct traffic.

Haraway's (1989:10) assertion – 'Bodies, then, are not born; they are made' – was used at the start of this thesis to signpost my adoption of the theoretical perspectives of feminist poststructuralism and social constructionism to question *how babies are made*. In Chapter Two, I outlined the principles and key concepts which inform these perspectives, paying particular attention to the theorisation of selves and bodies as social constructs, the *effects* of discourse and power. I then took a "rummage" through the toolkit of analyses produced by those feminist scholars who have already adopted these perspectives and have set about the analysis of the contested domain of reproduction. Their task has been *destabilising* in nature, dislodging our reproductive "truths" and the ontology of reproductive embodiments and selves, and examining the discourses implicated in their construction in particular ways. This has necessarily involved attention to the institutions and communities of practice, some of which hold much social power, through which these discourses operate and whose interests are served in the stabilisation of these particular meanings. This research has borrowed from and sought to contribute to this toolkit by asking *how babies are made* within my local reproductive context, one in which I am deeply invested as a midwife. I have developed a form of discourse analysis informed by the theoretical perspectives of feminist poststructuralism and social constructionism and have analysed "everyday" local texts that address matters relating to pregnancy.

My findings have reflected those analyses of the reproductive context reviewed in Chapter Two. I have encountered a strong discursive practice of subjectifiying the foetus as an entity with its own identity, separate, but also at great "risk" from, the pregnant woman in which it is located. The dominant construction here is of the foetus as an "unborn baby," the vulnerable individual who has become the central

focus of "expert" attention in pregnancy. My findings have also demonstrated the extent to which the construction of foetuses in this way has relied on the construction of pregnant women in some troubling ways. Pregnant women in these texts are reduced to their bodies as maternal "environments," environments that are potentially perilous to these foetal "babies" and are constructed as "maternal" subjects. As these "maternal" subjects, pregnant women hold individual responsibility for ensuring the health and wellbeing of these foetuses, both through their acquiescence to expert advice, surveillance, management and intervention; and through their own self-regulation of potentially "risky" behaviours. These constructions that have emerged from my analysis are largely the product of the knowledges of science, biomedicine and public health.

In Chapter Six, I first discussed three of the specific strategies whereby the knowledges of science, biomedicine and public health achieve the status of "fact" in these texts. Using the notion of *disciplinary power*, I have then provided a discussion of how these constructs may be contributing to the *discipline* of pregnancy in my local reproductive context, and thus its control. I have argued that through these constructed meanings, pregnancy is subjected to the exercise of disciplinary power, as a bodily state that requires policing, both by experts and by individual women, to ensure the health and wellbeing of the foetus. These constructions work to form boundaries around women's reproductive behaviours, practices and "choices."

I have also argued that my findings may signal the evolution of a broader public culture, which may be becoming increasingly hostile to reproductive women in the interests of "the foetus," with potentially significant implications for women's reproductive integrity and their reproductive freedoms. However, despite these findings I have cautioned against the danger here of theorising women as a monolithic category who are all subjectified in the same way, and whose responses to these constructions are likely to be uniform and universal. I have recognised the limitations of this research focus and have suggested that a further research project may be necessary, one which can consider how individual women

negotiate the meanings encountered here in the context of their own lives and embodied experiences.

Finally, I brought the discussion back to my own community of practice, midwifery, and considered the extent to which it is implicated in these constructions and thus the *discipline* of pregnancy. Although over the past several decades midwifery has located itself as a counter-discourse and practice to biomedical dominance within my local reproductive context, there has been concern expressed that these counter discourses have produced *effects* which may indeed be contributing to the *discipline* of pregnancy. I have suggested that the analysis of texts informed by the midwifery perspective, such as pregnancy guides, would be useful in exploring these concerns further. However, despite the extent to which midwifery may be implicated in the *discipline* of pregnancy, I have also, anecdotally, noted midwifery's own vulnerability to the contestation of meanings within the reproductive context. I have suggested that to fulfil the philosophical vision of midwifery as a professional practice in partnership with women, and to ensure our survival as an autonomous profession, it may be necessary to engage in efforts to transform reproductive meanings as we encounter them in analyses such as this.

Despite the usefulness of the theoretical perspectives of poststructuralism and social constructionism in rendering visible the discourses at work in *making babies*, their adoption has created some challenges. The excerpts from the midwifery case notes that preface this chapter are fictionalised accounts that represent some of my practice experiences as a midwife in the busy women's hospital where I have continued to work while undertaking this thesis. They are experiences that have provided me with potent reminders about the many different kinds of experiences women have as they move through the reproductive context, and the multiple meanings they ascribe to such experiences. In concluding my thesis I have used these excerpts to assert the materiality of the reproductive bodies with whom I work. The tension between my adoption of poststructuralist and social constructionist theoretical perspectives for this research and these real bodies has been woven throughout this thesis. While in many respects Haraway's

(1989: 10) assertion that *bodies are made* is entirely reflective of the theoretical perspective I have adopted for this research, I have resisted the notion that to adopt such a perspective has meant a denial of real bodies, and the real work involved in birthing them. The bodies I come into contact with as a midwife experience the discomforts of pregnancy: they labour, they give birth, they bleed, produce breastmilk, have afterpains, and undergo a host of other *real* body experiences.

I have instead taken the position that while *making babies* is very real, the meanings that we ascribe to these real experiences, and the real bodies involved, both pregnant and foetal, are not "real." They are not reproductive "truths" based on objective and unbiased observation of the world; nor are they "natural" or universal phenomena that link all women in a shared experience, and to the "natural" world. Rather, as I have demonstrated, *making babies* is a deeply social experience. It is an experience subject to the influence of dominant institutions whose knowledges hold much cultural authority for their objectivity, and remain deeply gendered. It is an experience that has been constructed in such a way as to implicate women themselves in its control, through the limitation of the ways in which it can *be* experienced. And it is an experience that will always hold different meanings for different women at different times. Analyses such as this one can thus be considered as instruments that we may use to *destabilise* reproductive meanings where they threaten to *stabilise* and thus to become our reproductive "truth." These instruments are important. By destabilising meanings that are hostile, we can do much to ensure our reproductive integrity and the reproductive freedoms we have gained thus far.

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Appendix One

List of Texts

Health Education Posters

[A] Ministry of Health. (n.d.). *Pregnant? Worried about HIV and Aids?* [Poster]. Wellington: Author

[B] Ministry of Health. (n.d.). *I'll give him a choice* [Poster]. Wellington: Author

[C] Alcohol Advisory Council of New Zealand. (n.d.). *You hit the booze and the booze hits the baby!* [Poster]. Wellington: Author

[D] Alcohol Advisory Council of New Zealand. (n.d.). *A few drinks can give me a hangover for life!* [Poster]. Wellington: Author

[E] Alcohol Advisory Council of New Zealand. (n.d.). *Drinking and your baby* [Poster]. Wellington: Author

[F] Alcohol Advisory Council of New Zealand & Pacific Islands Drug & Alcohol Services Trust. (n.d.). *Is your baby on the bottle?* [Poster]. Wellington: Author

Newspaper Articles

[1] Macdonald, N. (2005, October 3). Babies spied shedding in-vitro tears. *The Dominion Post*, p. 9.

[2] In-womb anxiety find. (2005, October 3). *The Dominion Post*, p. 5.

[3] Costello, D. (2005, October 3). Great medical advance, or a big risk? *The Dominion Post*, p. B4.

[4] Down's test revamp urged. (2005, October 4). *The New Zealand Herald*, p. A5.

[5] Diaz, B. (2005, October 14). Babies might do better on nicotine gum. *The Dominion Post*, p. 4.

[6] Folic Acid intake helps prevent birth defects. (2005, October 28). *Waikato Times*, p. 11.

[7] Challis, E. (2005, October 29). Teen pregnancies a gamble- academic. *The Nelson Mail*, p. 2.

[8] Macdonald, N. (2005, November 14). The chance for a normal life. *The Dominion Post*, p. 8.

[9] Baby's death a warning. (2005, November 26). *The Southland Times*, p. 5.

[10] NZ "designer baby" test mother six weeks pregnant. (2005, December 10). *The New Zealand Herald*, p. 10.

[11] Kitson, K. (2005, December 21). Booze babies. *Manawatu Standard*, p. 15.

[12] Hayman, K. 92005, November 160. Call to test mums for diabetes. *The Press*, p. 4.

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[14] Protecting children from smoking. (2006, February 9). *The Press*, p. 10.

[15] Record HIV year prompts screening at pregnancy. (2006, March 10). *The New Zealand Herald*, p. A4.

[16] Taylor, G. (2006, March 10). Waikato leads way in HIV-baby testing. *Waikato Times*, p. 3.

[17] Test can prevent infected babies. (2006, March 8). *The Dominion Post*, p. 4.

[18] Toli, C. (2006, March 14). Three year wait for HIV tests. *Manukau Courier*, p. 1.

[19] Taylor, G. (2006, March 20). Waikato couple welcome HIV tests. *Waikato Times*, p. 1.

[20] Martin, Y. (2006, April, 12). Fortified bread new hope for children. *The Press*, p. 17.

[21] Macdonald, N. (2006. May 8). Bigger babies means healthier grown-ups. *The Dominion Post*, p. 5.

[22] Older mums on the increase in NZ. (2006, May 11). *The Press*, A4.

[23] Dann, J. (2006, May 21). Pregnant women urged to halve work hours jobs. *Sunday Star Times*, p. 9.

[24] Dann, J. (2006, 21 May). Battling a pregnancy peril. *Sunday Star Times*, p. 9.

[25] Tests put unborn babies "at risk". (2006, June 9). *The New Zealand Herald*, p. A1.

[26] Hayman, K. (2006, June 19). Doctor wants more pre-conception care. *The Press*, p. A2.

[27] Andrew, K. (2006, June 27). Folate in bread to fight birth defects. *The Dominion Post*, p. 6.

[28] NZ Closer to having folate in bread. (2006, July 3). *The New Zealand Herald*, p. A2.

[29] Taylor, G. (2006, July 3). Waikato teenage birth rate shame. *Waikato Times*, p. 1.

[30] Davis, J. (2006, July 4). Doctor deplores HIV text delay. *The Press*, p. 4.

[31] Rankin, J. (2006, July 6). Switch urged on birth defect plan. *Manawatu Standard*, p. 3.

[32] Palmer, R. (2006, July 23). Pregnant women okay with tipple. *The Dominion Post*, p. 3.

[33] Dudding, A. (2006, July 23). Recipe to prevent disability "flawed". *Sunday Star Times*, p. 7.

[34] Palmer, R. (2006, July 24). They are what you eat. *The Dominion Post*, p. A4.

[35] Thomas, K. (2006, July 22). Concern over teen mothers. *The Press*, p. A7.

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[2] Front Cover. (2006, May 20). *The Weekend Herald Canvas Magazine*, p. 1.

[3] "Voice for life" Advertisement. (2007, January 7). *Sunday Star Times Summertimes Magazine*, p. 2.

[4] Parker, N. (2007). *Directing Traffic* [photograph]. Wellington: Author.