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‘I WENT TO THE ONE GAME IN TOWN’: OBSTETRIC AND MATERNITY UNIT CLOSURES, DWINDLING BIRTH CHOICES, AND RESILIENCE IN RURAL APPALACHIA

DISSERTATION

A dissertation submitted in partial fulfillment of the
requirements for the degree of Doctor of Philosophy in the
College of Arts and Sciences
at the University of Kentucky

By
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Lexington, Kentucky
Director: Dr. Erin Koch, Associate Professor, Anthropology
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2022

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ABSTRACT OF DISSERTATION

‘I WENT TO THE ONE GAME IN TOWN': OBSTETRIC AND MATERNITY UNIT CLOSURES, DWINDLING BIRTH CHOICES, AND RESILIENCE IN RURAL APPALACHIA

Obstetric and maternity health services are being rapidly eliminated in the rural United States, making maternal care more difficult to access and causing negative birth outcomes. Service closures have a magnified impact in Appalachia due to histories of systemic regional and state policy practices which devalue the lives of people living rural areas, local economic marginalization, geographic barriers, and insufficient health infrastructures. This research investigates how women living in rural Appalachia navigate pregnancy and birth amidst constant care closures. The Sunflower Mountain Region is a seven-county area in rural Southern Appalachia. The region has experienced ongoing obstetric closures over the course of the past decade. The findings presented in this dissertation are based upon 15 months of a combination of remote and in-person ethnographic research with pregnant women, mothers, and health professionals in the Sunflower Mountain Region between 2019-2022. I conducted formal interviews, informal conversations, participant observation in local health and educational settings, and an online survey.

This dissertation questions the impacts of obstetric service closures on communities and individual women. The elimination of maternity services in the Sunflower Mountain Region has wide-reaching effects because the area is so interconnected with livelihoods, resources, and healthcare. Therefore, one obstetric closure impacts how other maternity care providers structure their care due to the changes in patient flow. I argue that the elimination of rural birthing services creates a ‘sacrifice zone’ where rural lives and health are sacrificed in the name of saving hospital systems money. When obstetric services are eliminated, risks to the health and wellbeing of pregnant women living in rural Appalachia increase and birth choices decrease. Fewer birth choices create disempowerment in pregnancy experiences. Pregnant women, mothers, and health professionals exhibit resilience in the face of health inequalities, but resilience can be exhausting and frustrating. This sheds light on cultural and political aspects of policymaking and implementation. I also explore the various marginalizing processes in the region and how intersectionality shapes birthing experiences. Additionally, because this research was conducted during the COVID-19 Pandemic, I document the novel challenges of pregnancy, birth, and postpartum during an unprecedented global crisis. I explore the intersections of rurality and pandemic, which creates a precarious healthcare and social environment. Ultimately, this research shows that eliminating birth choices is an act of disempowerment and highlights the way local professionals and women fill the gaps that the state creates in removing maternal healthcare.

KEYWORDS: Appalachia, Anthropology of Reproduction, Stratified Reproduction, Rural Healthcare, United States

Athanasia T. Beasley

04/04/2022

Date

‘I WENT TO THE ONE GAME IN TOWN’: OBSTETRIC AND MATERNITY UNIT CLOSURES, DWINDLING BIRTH CHOICES, AND RESILIENCE IN RURAL APPALACHIA

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CHAPTER 1. INTRODUCTION: RURAL HEALTH INEQUALITY AND REPRODUCTIVE INJUSTICE

On a warm breezy day in mid-June of 2019, I paced back and forth in the parking lot of Friendship Women's Health Center. The parking lot looks run down by age and use with large cracks in the pavement and faded parking space lines, but the actual building looks relatively new with large windows and a fresh, white paint job. The building is not very big, but then again, anything human-made looks small in comparison to the deep green mountains towering proudly in the background. The parking lot is full of cars, but it is quiet where I stand. There is only light traffic passing by on the main road and the only sense of movement around me is the breeze that picks up and ruffles my dress every few minutes. Despite the impressiveness of the mountains around me, I was looking down and incessantly checking my cell phone. I was waiting here to meet Meredith Jones[1], a midwife who has been working in this region for decades. Earlier in the week we had exchanged texts back and forth trying to arrange a time and place to meet. Her schedule was incredibly busy, unpredictable, and constantly changing, as it tends to be when you are in the business of delivering babies. I was leaving town the next day, so this was our last chance to meet up. She asked me to meet her at 1pm at the Women's Health Center where she works. Earlier in the day she contacted me again to warn me that this was a busy day, but I was happy to wait. It was nearly 3:00pm and I had not heard anything from her, so I decided to send a message and let her know that it was no problem that we could not connect and propose a phone meeting at a later date. After sending the text, I walked towards my car when my phone buzzed again. "Wait- are you

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[1] All names have been changed to protect identity. This is discussed more in Chapter 2.

still here right now?" Meredith hurriedly walked out of the building and towards me in the parking lot. "I'm so sorry today got so busy! I have a few minutes right now and I wanted to meet you." She was wearing dark blue scrubs and her light brown hair was tied back out of her face. Based on her hurried manner, flushed face, and wisps of hair frizzing out from her ponytail, I deduced that she probably ran out here between delivering babies. We talked very briefly and quickly with the looming knowledge that she had to return to work imminently. She explained how she studied anthropology in college and her honors thesis focused on birthing practices in different global contexts. I gushed my admiration and appreciation for her running out here just to see me and she looked squarely at me and earnestly responded: "I really wanted to meet you. I live what you study and it's such a huge issue. Can I give you a hug?"

What Meredith meant by "living what I study" is that she is a maternal health care provider in a place that has been seriously affected by maternity unit closures. Just a few years ago she lost her long-time position as a midwife at a different rural hospital and had to relocate to Friendship, where she is currently working as a midwife. Unfortunately, Meredith's experience is not unique. Rural hospitals in the United States are closing at a higher rate than ever before with 181 hospitals closing since 2005 and 138 of those closures occurring since 2010 (UNC Sheps Center for Rural Health). Beyond these general hospital closures, obstetric[2] services are currently being eliminated in the rural United States at an unprecedented rate. This trend marginalizes and causes negative birth outcomes such as increased infant and maternal mortality and injury for the 18 million American women of childbearing age living in rural America (NRHA 2021). Obstetric

[2] The branch of medicine concerned with pregnancy and childbirth.

closures also pose substantial challenges for healthcare providers who continue to practice in the area (Hung et al. 2017). The maternal mortality rate is comprised of pregnancy-related deaths which the CDC defines as “the death of a woman during pregnancy or within one year of the end of pregnancy from a pregnancy complication, a chain of events initiated by pregnancy, or the aggravation of an unrelated condition by the physiologic effects of pregnancy” (CDC 2019). The elimination of obstetric services can also impact infant mortality which is defined as the death of a child before their first birthday (CDC 2019). Even in cases where maternal or infant death does not occur, women and their children can experience injury from pregnancy and birth such as hemorrhage, anemia, infections, and other physiological injury (Mayo Clinic). Another aspect of negative birth outcomes includes mental health concerns. Postpartum depression and post traumatic stress from labor and birth can be exacerbated by a negative birthing experience (Ertan et al. 2021).

In this dissertation, I rely on the experiences, insights, stories, and work of people like Meredith Jones to show how pregnant women, mothers, and health professionals living in rural, Southern Appalachia navigate accessing obstetric healthcare amidst increasing care closures. The purple dots on the map in Figure 1 indicate the US hospitals that have lost obstetric services between 2005-2014 (McKay & Overberg 2017). More recent publications indicate obstetric services are continuing to be eliminated at a rapid rate (Kozhimannil et al. 2018). First and foremost, I aim to provide and discuss the more in-depth narratives and lived impacts behind some of those purple dots. Through participant observation, ethnographic interviews, and examination of regional, state, and national health policies, I explore the impacts of health service closures in rural America.

This research aims to delve into the challenges and unexpected consequences of obstetric closures and their impact on the community, but also the resourceful ways women navigate pregnancy and birth when faced with structural and economic barriers to maternity care.

Risk and Resilience

Throughout this dissertation, instances of risk and examples of resilience in response to adversity will be prevalent. Anthropologists have conducted extensive research and theorizing on the concepts of risk and resilience. This is not a dissertation that intends to fully explore these concepts, but they will appear throughout. "Risk" is defined as "elevated odds of undesirable outcomes" (Painter-Brick 433). That is how I use this term throughout the dissertation. For example, I discuss the *risk* of contracting a virus, *risk* of negative birth outcomes, *risk* of not making it to the hospital on time, and so on. It is important to note that risk is a concept that can sometimes be used in a reductionist way when used to oversimplify and overlook the complexity of everyday life (Painter-Brick 435). To avoid this, I will "situate risk in local worlds" (Painter-Brick 435) through ethnographic narratives and moments as opposed to talking about it in broader, structural terms. I find this to be more effective to accurately convey the ways risks are experienced in everyday life.

Resilience is "the ability to adapt" which is inherently difficult to measure (Painter-Brick 433). Resilience is a strength-based process which highlights the ways people react to challenges and difficulties. Risk and resilience are related, and I will weave them together in local worlds throughout this dissertation. Through discussions of resourcefulness and adaptation, I hope to highlight resilience in rural Appalachia on

individual and community levels to ethnographically show that obstetric closures and care shortages have impacts beyond a deficit framing of loss, risk, and hardship.

Again, this dissertation does not intend to fully focus on these two complex concepts. But many ethnographic examples will illustrate how obstetric closures increase the risks women experience when they are seeking pregnancy and labor care in rural Appalachia. Additionally, several stories prove the resilience of women and healthcare providers in this community in the face of these challenges. Risk and resilience are aspects of people's lives that provide more insight on lived experiences of service cuts and closures in rural areas. Throughout the ethnographic narratives in this dissertation, risk is closely connected to disempowerment. Risk is often produced in places where people are disempowered. Resilience, which is often understood as a positive reaction to risk, can be empowering. But this is not necessarily always the case. I hope to illustrate how resilience can be positive and empowering, but also exhausting and frustrating.

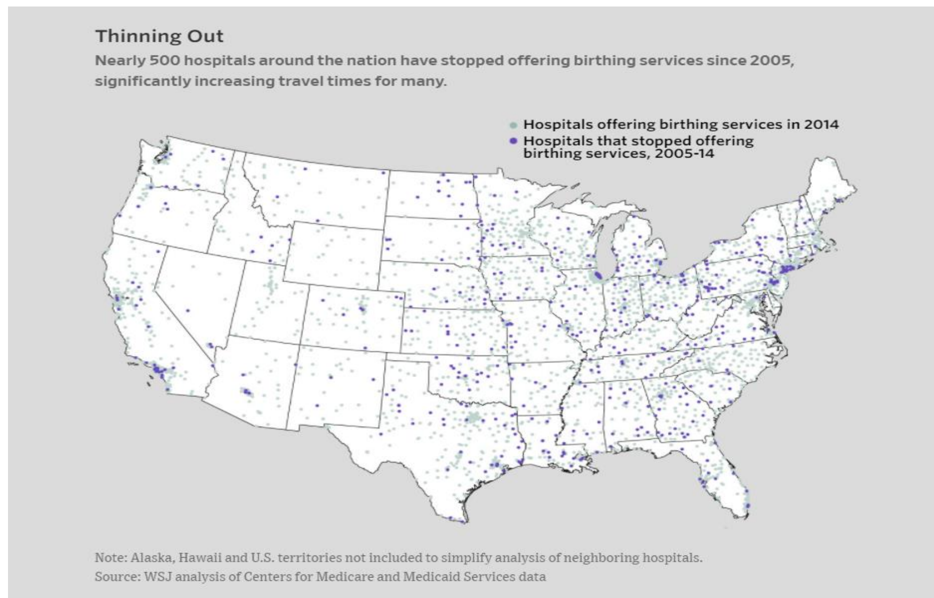

Figure 1.1: Figure from Wall Street Journal analysis of Centers for Medicare and Medicaid Services Data showing hospitals that stopped offering birthing services (the purple dots) between 2005-2014.

Rural Maternal Health in The United States

If you type the phrase, “rural maternal health USA” into a Google search bar, you will be greeted with pages and pages of links to journalistic, blog, public health, social science, and popular news articles. Some of the titles include: “When a rural maternity unit closes, alternatives are hard to come by” (Engel-Smith 2020); “Mountain Maternity Wards Closing, WNC Women’s Lives on the Line” (Pearson & Taylor 2017); “Why Are Obstetric Units in Rural Hospitals Closing Their Doors?” (Hung 2016), and “Rural Mothers, Babies at Risk When Hospitals Cut Obstetric Services (Galvin 2019).” In 2017, a public health team from the University of Minnesota published a systematic review of US hospitals and concluded that 9% of all rural counties in the US lost obstetric services in the decade between 2004-2014 (Hung et al. 2017). Additionally, 45% of all rural counties had no obstetric services at all during the study period (2017). While rural clinic

closures have been a topic of conversation throughout US history, the Hung et al. study provided clear data and visual figures[3] to illuminate the crisis and subsequently raise the volume of the conversation on rural obstetric care. This research is widely cited in news articles and academic articles alike. It has prompted other researchers to delve further into the reasonings behind these excessive closures. For example, document the places women receive maternity care (Kozhimannil et al. 2018), understand what kind of risks this carries (Lewis et al. 2019), and even begin to study the health outcomes because of the closures (Malouf et al. 2021). Doctors, nurses, policymakers, and public health professionals all use the data provided by Hung et al. 2017 to explore questions on the impacts and causes of obstetric closures. Upon reading these articles and analyses, my own series of questions emerged. How do these closures impact everyday life for pregnant women living in rural areas? How do they navigate this new challenge? Pregnancy experiences extend far before and after the actual moment of birth. Women need support and some level of healthcare during the nine months of pregnancy leading up to birth and the period of time after birth in experiencing postpartum life and new parenthood. Therefore, maternal healthcare and support is necessary for an extended time surrounding pregnancy and birth. The elimination of obstetric services and subsequent resource scarcity in rural areas has an impact on health outcomes, but also on how women experience their time in pregnancy, birth, and postpartum. The ethnographic data in this dissertation provides situated responses to the following question: How does a lack of proximate care and waning resources contribute to issues during this entire phase of life for women living in rural areas?

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[3] See Figure 1.2.

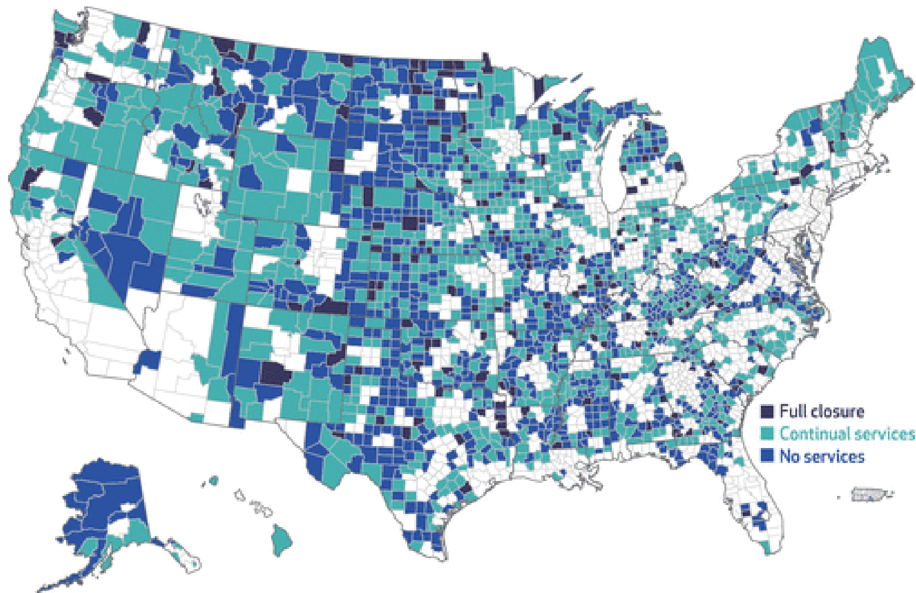

Figure 1.2: Hung et al. 2017 image of obstetric closures in the United States.

Aims of This Project

Between June 2019- September 2021, I collected ethnographic data through a hybrid approach using remote and in-person methods. The principal objective of this project was to examine how living in a rural area in the United States affects women's pregnancy and birth experiences, especially amidst increasing closures of obstetric and birthing facilities. For the purposes of this dissertation and my own life, I use the term "rural" in a way that parallels the basic definition of a place with fewer than 500 people per square mile or fewer than 2,500 people total (USDA 2021). But I also aim to push back at the implicit ways the rural United States is constantly defined through negative stereotypes in mass media, public health, and policy that I discuss further in this dissertation. Interestingly, the US Census Bureau does not even define rural. Instead, "They consider 'rural' to include all people, housing, and territory that are not within an

urban area. Any area that is not urban is rural" (HRSA 2021). Rurality is multifaceted and dynamic and varies greatly depending upon context. While it is impossible to pin down one stagnant definition, rurality does deserve to be central and not an afterthought: a position it often seems to be relegated to based on cultural discussions, mass media, policy, and definitions such as the one by the Census Bureau. "Rural" is central in this dissertation.

Based on my preliminary fieldwork and research, it was clear that service closures have a magnified impact on rural mountainous areas located in the US South and Appalachia due to histories of marginalization, local demographics and economics, geographic barriers, and insufficient health infrastructures (Douthit et al. 2015). Some of the most potent barriers that women in the Southern Appalachian community that I worked in were a lack of transportation in rural areas, the complication of accessing resources for financial support, and a general dearth of birthing resources. These barriers become even more pronounced when proximate places to actually deliver a baby are shut down. I explore how women living in this context navigate these barriers to access maternity care.

Secondly, I aim to acknowledge and explore the challenges and inequalities rural women experience without contributing to and reproducing the rural reductionist narrative which focuses solely on the deficits of rurality making the region out to be a barren place of nothingness (Blanchette & LaFlamme 2019). This narrative is especially relevant in discussions of Appalachia[4] which tends to be a region that is assumed to be homogenous, backwards, and isolated (Billings et al. 1999). To push beyond this deficit

[4] Thoroughly discussed in Chapter 2.

framing, I also question and explore the social supports, connections, and solidarity that health professionals and pregnant women rely on to help navigate a maternal healthcare desert.

The final aim of this project is to understand more fully the less obvious and unintended domino effect consequences of obstetric unit closures in rural areas. Through this data, I discuss how these outcomes connect to wider trends in pregnancy experiences constructed by biomedical and state institutions. I hope to clearly trace how the decisions made by policymakers and hospital executives have an impact on individual women. I explore how cutting obstetrics programs shifts the risk from institutions onto women's bodies.

Obstetrics, Gynecology and Midwifery: Problematic Births of Maternity Care

The central question of this dissertation asks how women living in rural Appalachia navigate accessing obstetric care despite increasing structural barriers. Even this question holds the assumption that obstetric care is desirable: people want and need to access these services, and it is inconvenient and dangerous not to be able to do so. To interrogate this assumption that my own research question makes, I contextualize the violent and oppressive histories of obstetrics, the surgical field dedicated to medicalized care during pregnancy and labor, gynecology, the medical field more generally focused on reproductive health[5], and midwifery, a more women-centered, empowering, traditional field of health care during pregnancy, birth, and postpartum.

[5] Obstetrics and Gynecology are often grouped together, hence OBGYN.

The earliest recorded births were all attended by women[6]. From goddesses attending ancient births in mythology to midwives in the bible, it is very clear that women in the community, mothers, and female friends had the role of assisting birth (Carr 2012). Surgeons and Physicians were only called in at last resort in the case of major emergency (Carr 2012). In fact, for men to attend births was considered offensive as they were a negative presence and violated femininity and modesty during birth (Carr 2012). Around the 18th century, instances of obstructed labor, when the baby cannot exit the pelvis because it is being blocked, were becoming a substantial issue largely because many women had abnormally shaped pelvis bones due to having rickets in their own childhoods (Carr 2012). This incited the invention and use of forceps during birth to pull the baby from the pelvis, which opened the door for more medical intervention and ultimately led to male physicians (as all physicians at the time were men) getting involved in processes of childbirth (Carr 2012). By the end of the 18th century, male medical providers began training in obstetrics and conjectured that with their knowledge of anatomy they could "improve" childbirth (Rooks 2012). These changes originated in Europe but the United States followed suit shortly after (Carr 2012).

Prior to physicians being the primary attendants of birth in the surgical field of obstetrics, midwifery was the norm. The history of midwifery in the US can help explain the low rates of midwife-led births today. Between 1910 and 1912 when midwifery was still popular but obstetrics as a medical, professional field was gaining momentum, a few reports were published concluding that obstetricians were not experienced or well trained

[6] My purpose here is not to provide a comprehensive historical account of midwifery but instead to focus on the roots of the profession as a social role and approach to birth in order to contextualize the landscape of maternal healthcare I explore in this dissertation.

(Rooks 2012). To fix this problem, the reports recommended that all births be moved to the hospital and midwifery be discontinued so obstetricians could get more practice delivering babies (Rooks 2012). In 1915, prominent and well-respected obstetrician Dr. Joseph DeLee wrote that birth is a pathological process that damages mothers and babies and therefore must be treated as such (Rooks 2012). He concluded that midwives have no place in the birth process (Rooks 2012). Dr. DeLee also suggested and outlined a series of intense interventions (using tools, anesthesia, and sedatives) to assist with birth which then became common (Rooks 2012). A process called "Twilight birth," in which the woman was given a series of sedatives so she can be unconscious during birth, became popular at this time as a status symbol for upper-class women (Rooks 2012). Dr. DeLee and other well respected medical professionals headed a smear campaign of midwifery insisting that it was barbaric, outdated, and dangerous. Much of this slander was racist and sexist in nature. Physicians clearly asserted that women could not assist in childbirth as effectively as men (Hughes & Bernstein 2018) and obstetricians and gynecologists often performed invasive pelvic exams and procedures without consent to punish women who they suspected to be sex workers (Horwitz 2019). Obstetricians explained that the women who midwives were primarily working with (typically poor women) needed to go to charity hospitals instead of delivering at home so they could increase training for obstetricians (Rooks 2012). Researcher Judith Rooks writes, "Midwives attended approximately half of all births in 1900, but less than 15 percent by 1935. By the early 1930s most practicing midwives were black or poor-white granny midwives working in the south. Where midwifery declined, the incidence of mother and infant deaths from childbearing or birth injuries generally increased. A scholar who conducted an intensive

study concluded that the 41 percent increase in infant mortality due to birth injuries between 1915 and 1929 was due to obstetrical interference in birth" (Rooks 2012). Contrary to obstetrics, midwifery is not a surgical field. Anthropologist Barbara Katz Rothman explains that midwifery is feminist praxis because "Midwifery works with the labor of women to transform, to create, the birth experience to meet the needs of women. It is a social, political activity, dialectically linking biology and society" (Rothman 1989: 117). This is opposed to obstetrics, in which the job of the physician is to separate the mother and child "so they can 'recover,' so that the woman can 'return to normal,' and the baby can be 'managed' separately. These ideologies of technology and patriarchy focus the vision and the work of obstetrics" (Rothman 1989: 117). Understanding the differences in these two fields and how obstetrics was established as the primary way for women to seek assistance during birth is necessary to much of this dissertation and I will explore the tensions between the two throughout.

It is important to note that obstetrics and gynecology have roots in intense racism. In her book *Medical Bondage, Race, Gender, and The Origins of American Gynecology,* historian Deirdre Cooper Owens explains that the constitutional banning of the African slave trade posed issues for US slave owners who were facing their desire to grow the system of slavery without the transatlantic trade (Owens 2017). A solution to this issue was to ensure that enslaved women were having many children that survived because slavery was passed from mother to child (Owens 2017). In concurrence with the newness of obstetrics this created a culture of manipulative, unconsented, abhorrent medical gynecological experimentation. John Marion Sims, who is known as the "father of American gynecology" for being the first to perform intricate gynecological repairs and

procedures, relied on a group of about 10 enslaved women who he himself owned (Owens 2017). He trained these women to be his medical team who he also experimented on without anesthesia or consent because he believed that Black women could not feel pain as intensely as white women (Owens 2017). Therefore, obstetrics and gynecology were really founded on the unconsented, free labor and bodies of Black, enslaved women in the United States. These oppressive roots are brutal, and the legacy of this racism remains today and expresses itself through massive inequalities in birth outcomes. For example, the pregnancy-related mortality rate for white women in the United States is 12.7 per 100,000 live births (Artiga et al. 2020). American Indian and Alaskan Native (AIAN) women have a rate more than double that of white women at 29.7 per 100,000 live births. The rate for Black women is 40.8 per 100,000 live births (2020). Even in California, the state with the lowest maternal mortality rate in the US, the mortality rate for Black women is three times higher than that of white women (2020).

Like Gynecology, Obstetrics, and so many critical mechanisms in the United States, midwifery can also be attributed to the labor and expertise of Black women. Many enslaved women were forcibly brought to the US and began practicing midwifery in rural communities and continued this practice for many decades through the 20th century (Rook 2012). As I mentioned, there was a lot of concern over the high infant and maternal mortality rates in the 20th century. Physicians and public health officials claimed this was because of untrained midwives while data on puerperal fever collected by Ignaz

Semmelweis[7] shows it was mostly because of the inadequate practices of poorly trained obstetricians (Carr 2012). Physicians and hospitals blamed the high rates on midwives because this was during the era where physicians realized they could become involved in and profit from delivering babies. To shift public trust from midwives to doctors in hospitals and thereby initiate obstetrics as a major medical field, midwives had to be discredited (Carr 2012). The distrust between physicians and midwives that is still prevalent today was sowed at the genesis of obstetrics due to these slanderous rumors about midwifery. Congress passed the Sheppard-Towner Act in 1921 to provide federal funding to train and license midwives, especially Black midwives in the South who represented the largest population of unregulated birth attendants (Tobbell 2021). The funding was used to implement midwifery training for these midwives (Tobbell 2021). The training was provided by public health nurses who knew less and had less experience than the Black midwives who they were training and licensing (Tobbell 2021). Not only did the more knowledgeable Black midwives have to endure this training, but they also had to submit to being overseen by these public health nurses which was frustrating and discouraging for Black midwives who were using generational knowledge and were experts in this field (Tobbell 2021). Obstetricians and policymakers continued to slander Black midwives although it is very well documented that midwives consistently had better birth outcomes than physicians (Tobbell 2021). This outcry prompted more surveillance on midwifery and ultimately led to the dissipation of traditional Black

[7] Semmelweis conducted data collection in a teaching hospital in Vienna and found that women would die in Unit 1 of the hospital but not in Unit 2. Unit 1 was attended by physicians and their students and Unit 2 was attended by midwives.

midwifery (Tobbell 2021). Even though this surveillance put pressure on the field, Black midwives continued to provide critical care to rural families who had very little access to formalized obstetric care (Tobbell 2021). Midwifery has a unique place in Appalachia because residents of rural mountain regions continued to rely on midwives after the shift to obstetrics (Scott 1982).

Tensions in Midwifery Care

Clearly, obstetrics and midwifery were at odds and physicians and obstetricians worked to denounce midwives. Yet there were also substantial divides within the field of midwifery. In 1923, Mary Breckinridge founded the Frontier Nursing Service (FNS) in Wendover, Kentucky which trains midwives to assist births in rural areas (Buchanan 2000). The Frontier Nursing Service trained almost 25% of all midwives in the US and was the institution that brought nurse-midwife training to the United States (Buchanan 2000). Mary Breckinridge was a generationally wealthy white supremacist and eugenicist (Niles & Drew 2020). She believed that Appalachians were the "purest" Americans and needed to be protected from mixing with any other populations (Niles & Drew 2020). The Frontier Nursing Service did not admit a single Black nurse until after Breckinridge's death in 1965, and the FNS also did not serve any of the Black population living in Appalachia (Niles & Drew 2020). Prior to the FNS, birth in Appalachia and across the US South was traditionally overseen by African American midwives. But the entirely white nurse force of the FNS continued to denounce Black midwives and slander their professions to uplift their own credentials (2020). Ultimately, these traditional midwives of Appalachia and the South (who were mostly Black women who learned their midwifery skills from their own mothers) were prohibited from continuing to

oversee births (Buchanan 2000).[8] Yet unregulated Appalachian midwives of all races attended births into the 1950s due to the vast rural areas with little access to care.

An Ironic Switch

It is clear from this history that midwifery was built upon the expertise, innovation, and commitment of Black and poor (often in the rural South) women in the United States. Yet midwives today are overwhelmingly white women (American Midwifery Certification Board 2021).[9] Additionally, while midwifery use in the US has been surging since the 2010s, it is often viewed as a practice for upper-middle class women, as high intervention birth (like Twilight Birth) once was (Pergament 2012). Many insurance providers do not cover midwifery, and Medicaid only recently began fully covering these services (CMS 2020). Additionally, there is a national and global shortage of birthing centers and midwives (World Health Organization 2021). Midwifery laws and regulations vary widely within the United States because they are governed by local laws.

Looking globally, most pregnant women work primarily with midwives and only see obstetricians in cases of emergency (United Nations 2021). The US is very unique in this regard. For every 100 births in the US, only 10-12 will be attended by a midwife (Niles & Drew 2020). Ultimately, midwifery is an ancient practice that has been beaten out of the US cultural and medical fabric through intense, systematic racism and sexism and the emergence of the dominance of Western biomedicine. The cultural shift and

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[8] These are the roots and systemic exclusion that is responsible for the fact that 90% of midwives today are White. (American Midwifery Certification Board)

[9] This is discussed further in Chapter 3.

negative stigma attached to midwifery in the early 20th century persists today. Understanding the context of midwifery and maternity care is critical to the framing of this dissertation as midwifery and obstetrics are juxtaposed uniquely due to services closures in the region at the center of this research[10]. The specific histories of obstetrics and midwifery in the US are critical to understand as they play a substantial role in this dissertation and problem overall. Another necessity to the groundwork of this issue is how reproduction more broadly is a key arena to understanding and viewing social inequality.

Midwifery in a Global Context

In this dissertation I discuss the benefits of midwifery care in rural Appalachia. Based on my own position and research, I represent midwifery through a very specific, North American lens. Based on my ethnographic work and experience, midwives often act as supportive advocates of pregnant women. But anthropologists who study the role of midwives throughout the world have noted that this is not always the case and midwives and other traditional birth attendants are not always empowering or supportive for pregnant women. For example, Elyse Ona Singer's ethnographic exploration of maternity units in Mexico City shows how midwives contribute to "reproductive governance" (Morgan and Roberts 2012). This means that the midwives working in this context "transmit a suite of values about personal responsibility and self-regulation through the use of birth control" which contributes to restrictive population policies and feeds into stereotypes and negative treatment of lower-income women (Ona Singer 2016:

[10] Discussed in detail in Chapter 3.

453). Additionally, anthropologist Sara Price's ethnographic research in rural India shows how traditional birth attendants can be harsh, unforgiving and authoritative during birth which leaves pregnant women feeling scared and unsupported (Price 2014). It is important to acknowledge that the role of midwives in the context of this particular dissertation is not reflective of every global situation.

The Anthropology of It All

I use a variety of anthropological theoretical frameworks and concepts throughout this dissertation. I explain them in detail when I use them in each of my ethnographic chapters. For the purpose of this introductory chapter, I give overviews of the anthropological scholarship which builds the groundwork for this project. Anthropologists who discuss the cultural and political motivations of healthcare, embodiment of inequalities, feminist ethnography, and dispelling cultural myths and pervasive stereotypes have been seminal in my own understanding and framing of this project. In the following sections I will summarize some of this work through a closer look at the anthropology of reproduction and ethnographies of North America.

Understanding Reproduction

As childbirth educator Gayle Peterson writes, "As a woman lives, so shall she give birth, so shall she die; in a like manner and style to her own individual approach to life" (Peterson 1984: 3). This quote shows how many factors contribute to the moment of birth and the maintenance of health in and beyond that moment. Childbirth involves financial components, interpersonal interaction with medical personnel, power relations, confrontation of patriarchal systems, questions of accessibility, and cultural choices.

These are all areas in which inequalities become clear, so pregnancy outcomes can illustrate the depth of disparities in society.

Although pregnancy and birth are significant on both global and local scales, reproduction was not always a topic of social science investigation (Rapp 2001). Anthropologist Brigette Jordan's groundbreaking 1978 book *Birth in Four Cultures* concretely explored how birth is culturally and socially bound. She writes that birth is "everywhere the same, it is also everywhere different in that each culture has produced a birthing system that is strikingly dissimilar from the others" (Jordan 1993:1). Jordan compares birthing practices in the United States, Sweden, Holland, and Yucatan. Jordan's book cemented the anthropology of birth as a meaningful topic of study, and she credits Margaret Mead as "the only other anthropologist I know of who had a vision of what an anthropology of birth can be" (1993: xi). Emily Martin's *The Woman in the Body: A Cultural Analysis of Reproduction* (1987) was also integral for placing birth in social and cultural theorist's purview. Martin closely examines medical metaphors of the female body as a machine that malfunctions to result in the failure of menstruation, painful labor in birth, and atrophy and death during menopause. Martin is interested in how women live and experience their bodies in the context of these metaphors which becomes very relevant during pregnancy and birth.

Birth in Four Cultures and *The Woman in the Body* created momentum for feminist anthropologists to delve into various aspects of reproduction and ultimately establish the field as critical to social theory. Rayna Rapp discusses this progression in the 2001 article, "Gender, Body, Biomedicine: How Some Feminist Concerns Dragged Reproduction to the Center of Social Theory." Rapp reviews medical anthropological

approaches to reproduction as a site of power and cultural expression. Rapp ultimately concludes that many theorists have worked to move reproduction from "invisibly central" in social lives to the focus of much anthropological work (2001: 7). A notable issue within the literature is the overwhelming representation of reproductive concerns of white, middle-class women, like me. Additionally, most of the authors are White women themselves, also like me. This limitation to emerging scholarship on reproduction produced a misrepresentation of birth experiences which were skewed based on race and class. As Lynn Bolles (2013), Leith Mullings (2005), and Audre Lorde (1983) have identified, white western feminism obscures other epistemologies and overrides and marginalizes knowledge produced which represents diverse experiences.

One of the most crucial tools of the anthropology of reproduction is the concept of "stratified reproduction" (Colen 1995). Anthropologist Shellee Colen's (1995) fundamental research with West Indian childcare workers and their white employers in New York City resulted in the forever relevant framework which holds that based on various axes of identity, different women are either encouraged or discouraged, supported or unsupported, valued or devalued during reproduction (Colen 1995: 89). Colen summarizes the process and continuation of stratified reproduction:

> Examining the cultural construction of parenting and childcare for West Indian workers and their US-born employers illustrates some of the many ways in which reproduction is stratified. Although parenthood and reproductive labor are central in the lives of both West Indian childcare workers and their employers, they are valued and experienced differently. Both groups are caught in the squeeze of reproduction- both try 'to do the best for' their children, sharing similar

> aspirations for them, while maintaining different notions about children and appropriate childcare. However, in a transnational system in which households have vastly disparate access to resources (according to class, race/ethnicity, gender, and place in a global economy), inequalities (themselves historically structured by social, economic, and political forces) shape and stratify experiences of reproduction for workers and employers. Moreover, this very stratification tends to reproduce itself by reinforcing the inequalities on which it is based. (1995: 97)

This theoretical concept runs through all studies of reproduction at population and individual levels. I employ this framework in my research to contextualize and understand how birth experiences and messaging are not random but are systematically cultivated based on social inequality and stratification.

Through a lens of stratified reproduction to understand inequalities in pregnancy, birth, and mothering, anthropologists have evaluated the intentions and effectiveness of reproductive policy that has unequal effects on different populations (Ostrach 2015; Rivkin-Fish 2004; Singer 2016). Additionally, several anthropologists have investigated how populations, communities, and bodies are subject to state control through health policy (Aganost 1991; Das 1995; Wendland 2007). A key example of this is Susan Greenhalgh's 2003 book investigating how high-power policymakers engineered China's one child policy and the impacts on social control they imposed. Beyond policy level interventions, anthropologists such as Robbie Davis-Floyd, Brigette Jordan, and Emily Martin have conducted research to understand the role of contested knowledges in the context of the medicalization of birth. Through looking closely at the interactions

between pregnant women and their care providers during labor and birth, these anthropologists identify the impact of biomedicine as an institution on individual bodies. Additionally, anthropologists of reproduction have applied a critical feminist lens to the study of obstetric access and intervention to show that policy motivated changes in healthcare affect individual bodies and populations. Such effects are evident in how policy changes influence women's individual birth practice decision-making (Davis-Floyd 1992; Singer 2016). Vania Smith-Oka and Sara Price conducted ethnographic studies on maternal healthcare in Mexico and India respectively to show how reduced time allocated for care of women in remote and rural areas results in their direct physical harm (Price 2014; Smith-Oka 2013). Because reproduction is responsible for creating and maintaining populations, reproductive policy often enacts excessive control over the population as a whole (Greenhalgh 2003; Kligman 1992; Miranda 2017; Morsy 1995). Anthropological studies focus on marginalized women to emphasize that the impact of policy and biomedical control burdens particular populations more heavily than others in all global contexts. For example, Castro & Savage's investigation of how obstetric violence- structural and individual mistreatment, abuse, or disrespect during childbirth- is far more present in the birth experiences of racially and economically marginalized women in the Dominican Republic (2019). Many of the women interviewed expressed a lack of privacy, verbal abuse, and poor healthcare professionalism, yet the authors found that women did not speak particularly negatively about this mistreatment and generally expected and accepted poor quality of care. The authors conclude that this acceptance of abuse proves especially problematic in the Dominican Republic healthcare system that is stratified by race and social status and is very inequitable. Anthropologists such as Dána-

Ain Davis and Sandra Lane have done extensive ethnographic exploration of the higher maternal and infant mortality rates of Black women in the United States through investigating both overt and covert racism in clinical settings, adding narratives to numbers, and discussing inaccessibility of resources for Black women to have healthy pregnancies (Davis 2019; Lane 2008). In this dissertation, I hope to follow the lead of these anthropologists of reproduction to situate birth choices and empowerment in rural areas within a framework of stratified reproduction.

Later in this dissertation (specifically Chapter 3) I will discuss how many women I worked with cited the documentary *The Business of Being Born* as responsible for their revelations about biomedicine, capitalism, and birth. I had a similar revelation, but the people responsible for that were Robbie Davis-Floyd and Khiara Bridges. Davis-Floyd is an anthropologist of reproduction who has written extensively on childbirth in hospital and home contexts in the US and Mexico. Davis-Floyd uses ethnography to understand the entrenched scientific ritualization of biomedical childbirth and how that affects mothers. She explains how Americans view the intensely medicalized practices including interventional drugs and the separation of mother and child immediately after delivery as necessary to any healthy birth, yet other anthropologists have studied vastly different birthing practices around the world that result in equally healthy mothers and children. For example, she discusses the repetition of ritual and quotes an obstetrics resident who described the process of delivering babies to be like an assembly line. Bridges is another anthropologist of reproduction who shows how medical institutions exhibit control over women's bodies and lives during pregnancy. In her ethnography of pregnant women using public insurance in New York City, Bridges delves into how race

constructs women's treatment and experiences during prenatal care (Bridges 2013). This emerges through surveillance and stereotypes which influence how employees treat women based on their economic class and racial identity. Both Davis-Floyd's and Bridge's assertions on medicalized control are crucial to understanding the experiences in this dissertation. These two ethnographers were critical in my understanding of pregnancy and birth in American and the control of biomedicine and the State.

Ethnography in Rural North America

Anthropology is a discipline was born of colonization and "West-Rest," "salvage ethnographies" designed to collect and compile non-Western human experiences to further understanding of the world and fuel colonizing projects (Lewis 1973; Elie 2015). While Euro-American anthropology has made some changes since its inception tied to colonialism and the spread of capitalism, there is still a largely unspoken assumption and pattern of ethnographies that ask one to leave their home country to explore an issue elsewhere in the world[11]. I have been fortunate to be surrounded by a strong cohort of US-based anthropologists at the University of Kentucky (Alisha Mays, London Orzolek, and Annie Koempel) as well as professors who have built their careers in ethnography within the US (Ann Kingsolver, Mark Swanson, and Nancy Schoenberg) who helped push back against the assumptions of anthropology and show the possibilities of US ethnography. Though some have criticized a lack of rural focus in the United States in anthropology, as Jane Adams writes, "The urban focus of the dominant U.S. intellectual

[11] Kiran Narayan's description of a "real" anthropologist versus a "native" anthropologist.

culture should not lead anthropologists to overlook the long history of research in rural North America. The ethnographers of the 1920s and 1930s, like W. Lloyd Warner and Walter W. Goldschmidt, did not treat those they studied as "exotic" or radically "other." They viewed rural regions as legitimate arenas for significant social scientific inquiry that could be understood using ethnographic methodologies." (Adams 2007:4). The anthropologists of North America who have published critical ethnographies of the rural US and Appalachia that follow the trend that Adams outlines have guided the groundwork for this dissertation.

One point that ethnographers of rural America have worked tirelessly to communicate is the necessity of "rendering the rural multiple" (Blanchette and LaFlamme 2019). In their introduction to the Journal for the Anthropology of North America's 2019 issue on rural America, Anthropologists Blanchette and Laflamme write that the goal of rural ethnography in the US is not to "to locate the essence of small-town life in a single, "typical" place, but also resist more contemporary modes of ideological synecdoche that, for instance, ask a homestead in the US Midwest to stand in for all possible visions of an ideal family farm. If anything, our authors approach such rhetorical moves as data, part of a lively social field in which any bid "to impose a 'definitive' rural domain is itself an exercise in power" (Murdoch and Pratt 1993, 423)" (2019: 57). Several authors in this issue work to complicate stereotypes and simplistic ideas of rural America to question the structures of that contribute to the uniqueness of the rural experience. For example, Canay Özden-Schilling investigates power grinds to examine "unevenness in the governance of our shared grids, and by extension our public infrastructures, prompts citizen reflection on their senses of rural, suburban, and urban

belonging. Attending to infrastructures as milieus of emergent political consciousness thus provides an opportunity to understand rural and suburban politics through a wider optic than the "red versus blue" narrative by which politics in the United States is so often understood" (2019). Beyond the "red versus blue" dichotomy, ethnographers have worked to illuminate the experiences of racially minoritized people living in rural spaces (Ansley 2012; Harrison 2008; Henderson & Louis 2017). This type of ethnography is key to understanding the diversity within rural America.

One of the most influential insights to this project comes from Ieva Jusionyte's ethnographic description of an Emergency Medical Technician (EMT) rescue in rural Arizona. Jusiontye writes, "We are used to talking about space through reference to time. Knowing that Arivaca is an hour away from Tucson is more practical than measuring distance in miles. In emergency situations, this substitution is particularly notable. The estimated time of arrival (ETA) matters more than the length of the road to the hospital, as the speed of travel varies depending on weather and traffic. Rural temporality reminds us how our lives depend on healthcare infrastructures… Here, space is experienced as time" (2019: 94). Imagining rural space as time in emergency situations is directly applicable to obstetric closures in rural America and is a critical point to communicate to policymakers.

Ethnographers of Appalachia make key contributions to "rendering the rural multiple" (Blanchette & LaFlamme 2019) through thorough research and presentation of the origins and problematic nature of common stereotypes. These authors often write in direct opposition and response to more problematic memoirs and pieces that reinforce largely untrue Appalachian stereotypes. These responses, such as Elizabeth Catte's *What*

You Are Getting Wrong About Appalachia[12] and Dwight Billings, Gurney Norman, and Katherine Ledford's edited volume *Backtalk from Appalachia: Confronting Stereotypes*[13], potently show how Appalachia is a dynamic place of diversity that is far more complex than it is often presented to be. In this dissertation and in my life in general, I am committed to pushing back at the long-standing stereotypes of rural America. In the many years I have spent living and working in rural communities, I have met people from a wide spectrum of gender identities, citizenship status, races, ethnicities, socioeconomic statuses, and political parties. It is important to realize that many of the "black and white," cut and dry categories ascribed to rural people are in themselves complicated. Identities are not a checklist of stereotyped qualities. Just during my time doing this fieldwork, I met deeply conservative, Trump-loving feminists, anti-abortion advocates who always vote democrat, and 7th generation Appalachians who practice Buddhism, just to name a few. Anthropologists of Appalachia show this dynamacy through careful consideration of global dynamics in the region (Kingsolver 2011), the tracing of poverty and economic hardship as an intentionally created force (Billings and Blee 2000), and examination and illumination of identity politics and subsequent erasures (Gray 2009). This dissertation also draws inspiration from the keen and insightful ways anthropologists have delved into everyday dynamics in rural America with attention to how people in small communities relate to and support one another (Benson 2011; Bell 2016).

Researcher Positionality

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[12] A response to JD Vance's memoir, *Hillbilly Elegy.*

[13] A response to Response to Robert Schenkkan's Broadway play, *The Kentucky Cycle.*

Donna Haraway compares the production of knowledge to the authoring of poems (Haraway 1988). Poems are a piece of writing which reflects the intentions, feelings, worldview, and experience of the author (Haraway 1988). She argues that knowledges should also be viewed as products created by authors (Haraway 1988). Based on this insight, I aim to view each interlocutor present in this dissertation as an author of their own knowledge. Additionally, I view myself, the researcher, the same way. As a key practice in feminist methodology, I must locate myself and my own situated knowledges within my fieldwork (Davis & Craven 2016). Each interview, informal conversation, and insight from an interlocutor is a poem they authored. And this dissertation, which I am writing and presenting those insights is therefore a poem I, Sia Beasley, am writing.

They say home is where you feel most like yourself. Although I primarily grew up in Western Pennsylvania, I spent much of my childhood (and even more of my adult years) with my grandparents in rural Southern Indiana where my family has lived for generations. I have witnessed the closures of many proximate health services in our community and complicated policy changes surrounding Medicare and Medicaid coverages which have resulted multiple in untimely deaths within my family. The landscape of care never improves; it only ever gets worse. In addition to witnessing the declining availability of care, I was always frustrated by media depictions of rural America as backwards, ignorant, and stagnant because this does not adequately reflect the complexity of rural communities. When I was younger, I could never put words to the ease I felt here; I always knew it was where I belonged. I struggle with mental illness and sensory disorders, so being in a rural community is not only what I prefer but is also what several of my care providers recommend. I also always knew I wanted to work on rural

inequalities, specifically in healthcare. Early on in my undergraduate education it became clear that I did not have a knack for hard sciences and therefore being a rural health physician was quickly ruled out. I decided that I really enjoyed social sciences and saw a lot of value in investigating rural inequalities through that lens. Upon choosing to pursue graduate school, proximity to my grandparents was a key factor in my decision. Moving to Kentucky allowed me to spend much more time in the country, and by 2020 and the shift to remote learning, I was living with my grandparents in Southern Indiana full time.

In college I became particularly interested in maternal health in rural areas because much of the rural US biomedical and public health research is fatalistic about the futures of rural communities, focusing on heart disease, smoking, obesity, and substance use (Doogan et al. 2017; O'Connor & Wellenius 2012; Patterson et al. 2004; Rigg et al. 2018). While providing valuable information, over-focus on these topics is myopic, devaluing rural communities and erasing the significance of local context, while overemphasizing "bad behaviors" as the source of health inequities. Pregnancy represents a contrast to this trend; it is an everyday health event which calls for more focus in the context of rurality. During my undergraduate education at Emory University, I studied in the Rollins School of Public Health and worked as a research assistant on an epidemiological project designed to evaluate the social impact of health problems on children. I was responsible for outreach efforts, in-depth interviewing, survey analysis, and data entry for this project. The families I interviewed were primarily rural southerners, forced to travel up to eight hours to reach the closest quality specialized care. During interviews, many pregnant women conveyed their frustration with birthing resources in their home communities. This research experience elucidated the value of

qualitative methods. The stories of those families continue to inform my approach to this project.

As a young, cisgender, white woman from an upper middle-class background, I both share and have divergent experiences from my research interlocutors. The population with whom I conduct research reflects that of Appalachia and therefore is composed of people with diverse racial and class identities. When working with women who are living in poverty and are experiencing economic marginalization, I understand and acknowledge that we have very different life experiences. I conducted this research with generous support from the National Science Foundation and therefore was fortunate enough to have plenty of funds to not struggle financially during this time. This difference became very clear when I talked with women who had multiple children and were having a hard time making ends meet, especially during the research period from October 2020- September 2021 that was dramatically transformed by the start of the COVID-19 Pandemic. I am cognizant of this privilege I have. Additionally, many of the women I talked with and learned from had far less access to education than I do. I was born and raised in the United States. I have a rural background and roots. Yet the differences between myself and interlocuters are clear. Ruth Behar (1993) discusses this phenomenon in a chapter on her relationship with her friend Marta, who immigrated from Mexico but lives in Detroit, very close to Behar's home in Ann Arbor. Behar discusses this friendship and relationship as genuine, but the class differences and dynamics are impossible to ignore in their interactions. Behar uses this relationship and explanation to interrogate place and class and how there are very clear borders even within borders (Behar 1993).

These borders can be further reified when working with racially minoritized women. I am a white woman, so my white privilege and experience of whiteness as I move through the world are central aspects of my identity and interpretations. During this research, I primarily worked with other white women. But knowledge and understanding of whiteness is critical to understanding all narratives presented in this dissertation and will be discussed throughout. As Kimberlé Crenshaw so clearly explains, “the experiences of women of color are frequently the product of intersecting patterns of racism and sexism, and…these experiences tend not to be represented within the discourses of either feminism or antiracism. Because of their intersectional identity as both women and of color within discourses that are shaped to respond to one or the other, women of color are marginalized within both” (Crenshaw 1991: 1245). Many Black women and women from non-Western backgrounds have discussed and written about how White Western feminism has been damaging to many women and has take priority, further obscuring non-white voices (Bolles 2013, Lewis 1977, Lorde 1983, Collins 2002). As Lynn Bolles discusses, this has happened systematically within the academy but also in society at large (Bolles 2013). It is crucial to keep these concepts in mind for any social science work, especially in the United States.

“Do You Have One?”: Motherhood Status

In Kirin Narayan’s seminal piece, “How Native is a Native Anthropologist” (1993), she asserts that anthropologists should be viewed with shifting identifications based on context and power relations instead of the simple dichotomy of “insider-outsider” (1993). Narayan writes, “We are instructed as anthropologists to "grasp the native's point of view, his relation to life, to realize his vision of his world" (Malinowski

1961[1922]:25). Yet who is this generic subject, "the native"? To use a clump term is to assume that all natives are the same native, mutually substitutable in presenting the same (male) point of view. Yet even received anthropological wisdom tells us that in the simplest societies, gender and age provide factors for social differentiation" (1993). Narayan's piece is important to my own role as an someone born and raised in the same country where I conduct ethnographic research. I have already discussed how my race, class, and gender commit me to an identity that experiences inherent disconnection and "outsiderness" during my research. But another major aspect of this project which lends itself to introspection is the topic of pregnancy in Appalachia.

Many anthropologists who study reproduction, pregnancy, childbirth, and motherhood are mothers themselves. I consider this aspect of my identity as I approached my research and fieldwork. I am not pregnant, I have never been pregnant, and I am not a mother. During my fieldwork I often received questions about my own pregnancy or motherhood which indicated to me that my parenthood status may have limited the trust I was able to foster with interlocutors. In describing birth experiences, women often said, "well I don't know if you have given birth," before continuing to explain part of their experience. During interviews and conversations, I often felt like having a child or my own birth experience to discuss would enable people to feel more comfortable or would give me insight to ask more specific and relevant questions. I often thought about anthropologist Cecilia Van Hollen (2003) who reflects on this subject reflexively in her ethnography of childbirth in South India. She made multiple trips to her field site over the course of her research. During her first visits she was not pregnant, but the next time she returned she had a child. Van Hollen found that this shift in motherhood identity helped

her gain more access to mothers. They could relate to her more because she too had given birth. But on the contrary, anthropologist Sarah Pinto, who was also doing fieldwork on pregnancy in rural India, became pregnant unexpectedly while she was in the field (2008). While she thought that this would help her connect with pregnant women in the area as it did for Van Hollen, she found that it pushed her further away. Throughout her pregnancy she could clearly see how different her expectations and desires were from her interlocutors. She explains that it seemed that her interlocutors felt this way too, making both parties uncomfortable and altering her research dynamics (Pinto 2008). While there clearly is no consensus, pregnancy and motherhood are a part of identity which I have considered often during this fieldwork. In my own experience, I was honestly anticipating my parenthood status being more of a hurdle in this research than it was. It seems that being a young woman was enough to comfort people doing interviews to open up about more personal bodily aspects during birth. But this is hard to discern entirely as much of my research was conducted remotely, which will be explored in the next chapter.

Overview of The Dissertation

Chapter 2 describes the details and methods of this project. I begin by outlining my preliminary fieldwork and the lead-up to my long-term research. I also discuss the emergence of the COVID-19 pandemic and its relevance to this project and the impact it had on my methods. Because the pandemic impacted this research so much, I reflect on anthropological methods such as semi-structured interviewing and the required remoteness of pandemic-time work. I provide more details about my living situation in Southern Appalachia and the specific area where this research occurs: The Sunflower Mountain Region.

The central thread of **Chapter 3** focuses on Annabelle, a pregnant mom who is passionate about her choice to give birth at home. Through Annabelle's own words discussing the challenges and limitations of being a low-income woman with a preference to have a low intervention birth, I will discuss opinions and desires on hospital birth in the region. Additionally, Annabelle's story is key to discussing the domino effect obstetric closures in hospitals have on other services offered in the area and ultimately the choices women have in their birth experience. Stratified Reproduction (Colen 1995) is used as a key theoretical framework to understand choice in birth and violence and trauma inflicted when women feel forced into options they do not desire. The goal of this chapter is to establish the impact of obstetric closures on individual women and illustrate how one service cut has wide impacts across the region and within people's personal lives.

Chapter 4 focuses on the experiences and expertise of health care providers working in the region. Connecting ethnographic accounts with insights from existing scholarship, I delve into a central question of this project: why do obstetrics close? I also discuss the disconnect between policymakers and local people who experience the consequences of closures. Additionally, I explore some of the creative solutions professionals are using to reverse the negative impacts of obstetric closures. This chapter is necessary to juxtapose women's narratives of their pregnancy experience to larger trends in policy and resource provision.

Chapter 5 focuses on the specific challenges of pregnancy during the pandemic. I discuss how women have been impacted by COVID and how they navigate the complexity of having a baby during this time. The postpartum period has been especially

challenging for many women. I also use this chapter to discuss wider conversations on COVID and pregnancy and how health professionals have responded to best support their community. I will also discuss the discourse on vaccination and masking in the community and how it seeps into pregnancy and birth. The goal of this chapter is to document and explore novel experiences of birth during a pandemic and hypothesize how this global crisis can be a learning experience for the future but also carries long term impacts on everyday life.

Chapter 6 discusses the realities of rural pregnancy and postpartum resources. I focus on accessibility and the privileges involved in advocating for oneself during pregnancy to reach support and resources. This chapter builds on chapter 3 in discussing the impact of birth beyond labor and delivery to unpack what happens before and after involving social life, family support, and access to resources ultimately showing ways that reproductive experiences and outcomes are further stratified when marginalization is increased. Here I follow the narrative of a young mother named Kara. She has very little support in her life and birth experience. I discuss her narrative in contrast with women who have more economic and educational privilege. This chapter aims to enrich this dissertation with further discussions of class and access.

The final ethnographic chapter, **Chapter 7**, discusses more individual narratives of women. Throughout my interviews in this region, it became clear to me that many women have very little education on sex and pregnancy and high levels of Christian religiosity. This often results in unplanned and unwanted pregnancies. When a very religious woman ends up in this situation, she has a potent and devastating feeling of being trapped and having to navigate a new and unwanted reality. I want to discuss how

women work through this and the trauma that results from it. Here I take Gibson-Graham (2006) up on their plug for using "Weak Theory" and I attempt to employ an unconventional theoretical framework to emphasize the knowledge and resilience of women in rural Appalachia.

In **Chapter 8** I conclude this dissertation by discussing solutions to this problem that are already happening as well as the hopeful recent research and interventions that I learned about during my field work. I summarize my findings with short, digestible sentences and subsequent elaborations. Finally, I include some recommendations for mitigating the harm of obstetric closures in the US. In this chapter I also reflect on how and why anthropology and ethnography are useful to public health policymaking.

CHAPTER 2. METHODS AND FIELDWORK: NAVIGATING THE OXYMORON OF REMOTE ETHNOGRAPHY

Fieldwork

My preliminary fieldwork for this project began in the summer of 2019 when I travelled to two different states in Appalachia and conducted interviews with maternal health professionals to gain a more robust understanding of maternal health inequalities because of obstetric care shortages in rural areas. At this point in my graduate career, I had done a substantial amount of reading and felt as though I had gained a better grasp on anthropology as a discipline. I also kept up on reading about the obstetric shortage crisis and closures in the United States. During this two-month research period I conducted participant observation and interviews with a wide variety of maternal health professionals including doctors, midwives, social workers, therapists, and public health officials. The conversations I had varied greatly in tone, length, and content, but I used the same general set of guiding questions to inquire about central issues within the community pertaining to maternal health. Problems that emerged most frequently in these conversations were a lack of mental health care, substance use issues, insufficient access and transportation, smoking, and a high percentage of elective inductions and Cesarean-sections (C-sections). Additionally, the theme of feeling forgotten or overlooked emerged through different comments about lack of resources, inadequate program designs for rural

areas, awareness of stereotypes, declining populations and coping mechanisms, and services cuts and closures. This preliminary research was critical to developing more nuanced interview questions and research foci as well as making connections and securing permissions for my long-term research. Insights from this preliminary research are present throughout this dissertation, but I ultimately chose one of these two states as the location for my long-term fieldwork. From there, I thought everything would proceed in a straightforward manner. I would move to this location, conduct participant observation and interviews, write up my dissertation, and move on. But in March 2020, just as I was finishing up my coursework and looking towards getting started on research, the COVID-19 Pandemic began tearing through the world.

Unprecedented Times: COVID-19

In December of 2019, scientists discovered the SARS-CoV-2 virus in Wuhan, China (CDC 2021). This virus causes COVID-19, a potentially fatal, highly infectious disease that quickly spread all over the world causing major shutdowns beginning in March 2020. While it initially seemed that the virus carried mild symptoms for most people, it proved to be extremely dangerous for elderly adults and many people with underlying health conditions. As I write this in mid-2021, there have been at least 40.6 million cases and 635,000 deaths from COVID-19 in the United States alone (CDC 2021). These numbers are rapidly rising due to the emergence of new variants such as Delta and Omicron. While the pandemic is inherently global and the message of “we’re all in this together” has been resounding over the past two years, COVID-19 has been characterized by different waves and variants which cause rates of infection and deaths to rise and fall in unequal ways around the world. For example, in 2021 when the United

States was experiencing its first periods of infection rate decrease and vaccine initiatives, other countries such as India were experiencing the most devastating waves of COVID-19 infection with some of the highest number of deaths in the past two years (Dauderstädt 2021). Even within the United States, the devastation and extents of infection waves varied from state to state and within state borders. The COVID-19 Pandemic is not a singular event or entity, but a cascading, amorphous, asymmetrical pandemic with unjust impacts.

In March 2020, COVID-19 cases were increasing to the point where most public institutions closed or shifted to an online platform. This happened immediately at the University of Kentucky. All classes and university functions moved fully online for the remainder of the school year and continued in a hybrid model for the following year. This altered research plans for students and many of my peers who work internationally were forced to reconsider their project to best respect public health and safety. The Institutional Review Board (IRB) ordered an immediate halt to most social science in-person research. These abrupt and entirely necessary changes to what was allowed by the University and the IRB between 2020 and the present prompted me to reconsider how I would proceed with my dissertation project.

The regulations necessary for safety during the pandemic started a conversation amongst anthropologists and social science researchers on how to proceed with ethnographic research in an effective way (Lems 2020; Lupton 2020; Briggs 2020; Hussain 2020). Annika Lems poses a series of hard-hitting questions: "How do we cope with this unheard of situation? How do we make sure that this crisis does not force the next generation of researchers – the doctoral students who have had to interrupt their

field research or were prevented from beginning it – to cease activities altogether or hinder them from properly learning the tools of our trade? And how can we study the pandemic and the radical effects it has had on the everyday lives of people around the world when we can't be there and talk to them in person? We did what people have ever done during crises: we improvised" (Lems 2020). Anthropologists pivoted to online and virtual platforms when possible. Although this brought criticism from those who claim that social life can only be truly understood through full, in-person, immersive engagement, the necessity of using anthropological tools in creative ways and avoiding methodological essentialism invites space to "devise innovative knowledge-making practices for creating more health, just, equal, and environmentally sound worlds" (Briggs 2020). There are many limitations to adjusted methods such as the inability to engage closely with everyday activity (Lems 2020). But ultimately, continuing to adapt methods for a changing world is critical and a worthwhile task.

The COVID-19 pandemic has been indescribably devastating for everyone in the world. But not everyone was impacted equally. The pandemic highlighted pre-existing inequalities in society based on class, access to housing and food, healthcare, and education. This phenomenon has been observed and studied by many people over the past year. For example, in a 2021 study, Perry et al. found that the pandemic very clearly exacerbated already present inequality in rural Indiana. They write, "Crises lay bare the social fault lines of society. In the United States, race, gender, age, and education have affected vulnerability to COVID-19 infection. Yet, consequences likely extend far beyond morbidity and mortality. Temporarily closing the economy sent shock waves through communities, raising the possibility that social inequities, preexisting and

current, have weakened economic resiliency and reinforced disadvantage, especially among groups most devastated by the Great Recession" (Perry et al. 2021). They concluded that the pandemic contributes to a "Matthew Effect," which is a theory that can be summarized by the cliche "the rich get richer and the poor get poorer." The COVID-19 pandemic disproportionately affects historically marginalized and disadvantaged groups. This ultimately works to widen inequalities which are already so overwhelmingly present, especially within rural Appalachia (Perry et al. 2021). The pandemic also tested and continues to upend healthcare systems with rural hospitals lacking solid infrastructure and resources, and therefore becoming more overwhelmed with treating COVID-19 patients.

Another relevant aspect of COVID-19 to this project was the constantly changing and unknown impact of the virus on pregnancy. New information was frequently emerging about how risky it is to contract the virus during pregnancy and potential impacts to the fetus. When vaccines rolled out in January 2021, there was even more debate over the safety of pregnant women getting vaccinated and even questions about how the vaccine might affect the fertility of women of child-bearing age. In April of 2021, the CDC announced that vaccinations were safe and recommended for pregnant people, but public distrust was already high due to the general vaccine debate and initial four months of vague and uncertain recommendations by scientists. What is certainly known now is that women who contract COVID-19 in pregnancy are more likely to have preterm births and severe illness (CDC 2021).

With all these changes unfolding as I was about to start fieldwork, I had to consider my options. I could have waited it out to begin research when the pandemic was

over or at least had settled down, but it seemed like this was a long-term problem. Things were not going to be "over" anytime soon. Secondly, with the major impacts COVID-19 has on the questions I ask in this dissertation with increases in inequality, impacts on rural healthcare, and relevance to pregnancy, I felt as though my research became even more urgent. How did the pandemic impact pregnancy and birth in rural Appalachia? What sacrifices were women making? How did people adjust and navigate pregnancy and birth in a global pandemic? These questions pushed me to reimagine my fieldwork and continue with this project.

Field Site: Deterritorializing Ethnography

In Dána-Ain Davis' ethnography *Reproductive Injustice*: *Racism, Pregnancy, and Premature Birth,* she writes: "Traditional ethnographic research has been place-based, but I take the view that feminist ethnographic inquiry can transcend parochial methods of participant observation in one locale with one group. An alternative to more traditional ethnographic inquiry is deterritorialized ethnographic inquiry, which centers on an issue, not a place (Wies and Haldane 2015)" (Davis 2019:21). Davis was studying how pregnancy, premature birth, and race intersect in the United States. Her initial plan was to use one NICU as her field site, but there was large scale construction and ultimately her plan fell through. Davis writes, "In the end, given what some of the doctors and nurses shared, it was best not to have been at only at one site because the multiple locations afforded staff anonymity, particularly for personnel of color who are often the only Black doctor or nurse at a hospital" (Davis 2019: 21). Davis went on to interview people in a

wide variety of institutions and locations to best ethnographically study NICUs. This concept of "deterritorialized ethnography" has always been intriguing to me but I could not imagine a way to design that type of project for a dissertation. But similar to Davis' unexpected complications that disrupted her field site, the pandemic forced me to alter my methods. I was no longer able to be in confined spaces, especially medical ones. I shifted a lot of interviewing and observations to a remote setting. This had limitations, but it also allowed me to widen the scope of my investigation and talk with people who have different expertise but may not live very close to me. The adaptations I had to make due to the COVID-19 pandemic worked to make my project more deterritorialized than it was designed to be, which added some unique value. For example, I was able to reach wider populations than I would have with tightly place-based ethnographic work. Whenever I heard of a person or place of interest somewhere else in the state or country, I never hesitated to reach out and ask for a phone interview to learn more. The new routineness of phone and Zoom interviews for this project made me more comfortable to use these methods to capitalize on connecting to people living in working in different places. Most of my data comes from my specific field site, but insights from interviews and conversations with people not located in the counties where I did research are also presented throughout this dissertation. I believe this enriches this project and allows for wider conversations on maternity health and pregnancy inequalities within the United States.

Southern Appalachia

Author and Historian Elizabeth Catte writes, "Appalachia is, often simultaneously, a political construction, a vast geographic region, and a spot that

occupies an unparalleled place in our cultural imagination (Catte 10). A National Public Radio "All Things Considered" segment titled, "Celebrating the History of Appalachia," touches on some of the reasons why Appalachia is such a unique region. The host explains, "The birthplace of entertainers (Lucille Ball), musicians (Patsy Cline) authors (Cormac McCarthy) and scholars (Henry Louis Gates Jr.), Appalachia offers a rich slice of American history. But it is often steeped in mythic lore and stereotyped as backward, uncultured and poor" (NPR 2006). The cultural construction of Appalachia defines it as a pristine, ecological wonderland of mountains while simultaneously a run-down, impoverished, wasteland. These contradictions contribute to the "unparalleled place in our cultural imagination" that Catte describes.

Appalachia is a region which spans 206,000 square miles between southern New York and northern Mississippi (ARC 2021). Approximately 26 million people live in 13 different states that comprise Appalachia (ARC 2021). Obviously, this region is vast. Appalachia also encompasses diversity in people, ethnicities, experiences, industries, and livelihoods. It is home to some of America's most committed and vocal environmental activists, cutting edge artists, students, and educators. Yet Appalachia is infamously dubbed to be a place of homogeneity, whiteness, and backwardness. One of the essentializing stereotypes of Appalachia is that the region is homogenously White and conservative, and therefore full of ignorant and racist people (Billings 1999). But, "There's not a single social problem in Appalachia, however, that can't be found elsewhere in our country. If you're looking for racism, religious fundamentalism, homophobia, addiction, unchecked capitalism, poverty, misogyny, and environmental destruction, we can deliver in spades. What a world if would be if Appalachians could

contain that hate and ruin for the rest of the nation. But we can't" (Catte 2017:8). While most of the people living in Appalachia are white, Black and Hispanic people are coming to the region at a more frequent rate than elsewhere in the US (Catte 2017: 14).

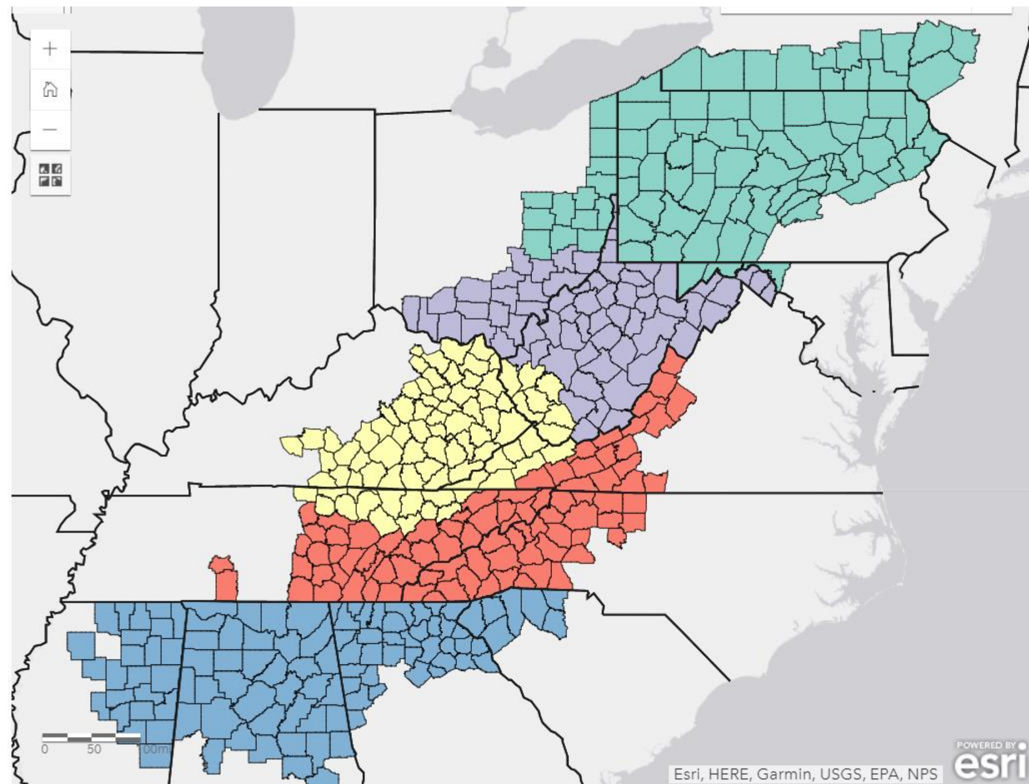

Figure 2.1: ARC map of Appalachia.

Appalachia has roots and a long history of extraction and economic exploitation. Much of this dispossession traces back to substantial absentee landholding by wealthy people living outside the area and land-grabbing done by coal companies in the early 20th century (Dunaway 1995). Other scholars argue that this history of exploitation travels back even further to assert that federalism and early Taxation was responsible for destroying ecological subsistence strategies of small-scale farmers in Appalachia thus solidifying state economic control over the region (Stoll 2017). Within the discussion of

absentee landholding in Appalachia, Appalachian scholar Dwight Billings emphasizes the fact that regions do not exploit other regions, but instead classes exploit other classes (2016). There is a debate in the scholarship over who to blame for high levels of poverty in Appalachia (the absentee landowners, settlers, problematic discussions of the "culture of poverty" and folk systems), but it is important to shift that debate towards a wider view of "how places grow poor" to urge policy makers to avoid blaming poor people in the region and focus on the systematic issues (Billings and Blee 2000). To focus on the structural issues within the region it is important to recognize that the legacies of absentee landholding and resource extraction continue to impact the high levels of economic distress in Appalachia today.

As anthropologist Shannon Bell writes, Appalachia can be understood as "a region where the land and much of the population are exploited in order to keep the costs of energy low for the rest of the country" (Bell 2016). Histories of extraction of coal and agriculture created Appalachia as a zone that is exploited. The need for resource extraction works hand in hand with the stereotypes and othering of Appalachians. This exploitation results in the perpetuation of poverty. The overall poverty rate within Southern Appalachia is 15.7% (ARC). The Median household income in Appalachia is only 82.6% of the national median household income (ARC). As sociologist Cynthia Duncan explains, "I think that chronic poverty in rural areas, and urban areas for that matter, really represents long-term neglect and lack of investment—a lack of investment in people as well as communities. And in the rural areas that I know in America, that lack of investment began as deliberate efforts by those in power—local elites or employers—to hold people back" (PBS 2005).

The assumed universal conservativism of Appalachia is another tool to marginalize and other people living in the region and projects a very specific narrative on the region to those who do not live in Appalachia. This likely stems from the creation of the Appalachian Regional Commission (ARC) during the President Lyndon B. Johnson administration's War on Poverty initiative beginning in the mid-1960s. The ARC "defined Appalchia as a coherent political entity" and attached a lens focused on poverty (Catte 10). While there are certainly many conservative people living in Appalachia, Catte reminds us that ultimately, "we are all residents of Trump country" (50). After the 2016 election, pieces from the Huffington Post, CNN and New York Times profiled Appalachia in articles using grainy black and white photographs of run down gas stations alongside the title "Inside Trump Country" (Catte 2017: 53). Catte finds that within one of these profiled areas, McDowell County, WV, only 27% of the residents voted for Trump. Trump won the county because of incredibly low voter turnout. Like concerns of many Appalachian scholars[14] Catte wonders about diverse portrayals of reality in Appalachia when she queries why there were no news stories on "Bernie Country" within West Virginia (2017: 53).

Due to the marginalizing processes that are exacerbated in Southern Appalachia including higher rates of poverty, more people who are uninsured, negative social stigma, assumptions of health fatalism, and unique mountainous geography, the site for this project is a multi-county region in Southern Appalachia. All names and locations are pseudonyms to protect the anonymity, livelihoods, and social wellbeing of those involved in this research. Therefore, I will refer to this region as the Sunflower Mountain Region.

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[14] See *Backtalk from Appalachia.*

While I did weigh my options in identifying this region by name to tell its unique story as other researchers[15] have done in powerful ways, I believe I can convey the unique details of this Appalachian region while maintaining anonymity, as other anthropologists have done (Davis-Floyd 2003). I also think that keeping the name of this region anonymous to readers might contribute to my goal of writing a dissertation that speaks to issues in rural America as a whole.

The Sunflower Mountain Region

There are attributes of the Sunflower Mountain Region that are completely unique and cannot be found elsewhere in the United States. But the region experiences trends and issues like rural Appalachia and rural America. Rurality is dynamic, diverse, complex, and multi-faceted, but people living in rural regions tend to share certain experiences and challenges (Bell 2013). The Sunflower Mountain Region is a 7- county region situated in the mountains of rural, southern Appalachia. The counties are as follows: the northern-most Laurel County, it's neighbor to the east, Coyote County, The southern-most Franklin County, and the three to the north, Harvest County, Rita County, and Beulah County. In the center of the region sits Lowland County, which marks the base of the mountains and the beginning of Sunflower Mountain Region. The counties that comprise this area encompass many miles but share resources through health departments, local governments, and tourism economies.

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[15] Some examples include anthropology dissertations by Lee Bullock: *Community Development, Livelihood Strategies, and Carceral Privatization in the U.S. South (2020)* ,and Veronica Miranda: *Reproducing Childbirth: Negotiated Maternal Health Practice In Rural Yucatan* (2017).

Each of these counties has an average population density of 250 people per square mile or less, officially designating them as rural (USDA 2019). The Sunflower Mountain Region extends more than 1,500 square miles and is home to more than 130,000 people (CensusReporter.org 2021). The poverty rate in the region is around 17% which is higher than both the state and the country (CensusReporter.org 2021). The average per capita income is $27,000 (CensusReporter.org 2021) which is only slightly higher than the state poverty line of $25,520 for a household of one person (Department of Health and Human Services 2021). The region is comparably much whiter than the state and the country with 91% of people identifying as white, 5% identifying as Hispanic, 2% identifying as Black, and 1% identifying as Asian (CensusReporter.org 2021).

The mountainous terrain of the Sunflower Mountain Region contributes to risky travel situations, especially during birth. The area is rapidly losing obstetric services and maternity units with two major centers closing in 2017 and the most recent hospital losing services in December 2019, making it a crucial site to study this problem. Care networks extend throughout the 7-county region and residents of certain areas often must travel into different counties to access health services. The interconnectedness of the Sunflower Mountain Region is notable. People often cross county lines for work, food, and notably for this project: maternal health care. The flows of care and support in the region also mean that deficits such as obstetric care removals in one county can affect many other people living in the other counties in the area.

Figure 2.2: An example of a town area in the Sunflower Mountain Region.

Figure 2.3: An open field in the Sunflower Mountain Region.

This region is an incredibly unique place. During the research period, I lived in Beulah County, which is widely considered the centerpiece or heart of the 7-county area. Beulah County is home to the largest town in the area, Carter. Carter is a small town, but it reaps the economic benefits of being home to a medium-sized state University. The school draws a younger, more diverse, and wealthier population to Carter. While the

University is a major employer in the region, local residents often voice their frustration with the growing student and out-of-towner population. This resentment is exacerbated by the growing rate of people buying second homes in the county. The region is a popular site for second-home ownership and tourism activities. These can be vital for economies of rural mountain regions (Ciccantell 2018) but also act to further marginalize those who have been living in the area for generations. Second-home real estate drives up land prices and invites newcomers who can penetrate local political and social institutions and sway the demographic profile of the region (Walker 2003). Most of the tourists and second-home owners come from Florida. Many of these people choose to build extravagant mansions in the mountains to spend their summers when it gets too hot in their home communities. It is jarring to drive through the winding mountain roads and see gated communities of mansions directly next door to extreme poverty.

The Sunflower Mountain Region encapsulates a lot of the diversity within rural Appalachia. As you drive down the main stretch of Carter, storefronts are lined with rainbow flags and Black Lives Matter signs. Young college students in this area are really engaged in activism and there are frequent protests and marches around the University. But as I drive out away from town towards my home in the Western part of the county, the rainbow flags are replaced with blue-striped American flags and Trump signs. The area where I lived during the research period is much more conservative and lower-income than most of Carter. This area is more rural, and my phone service usually cuts out in some of the dips in the road on my drive home. Most of my neighbors are small-scale farmers. Once I was taking a walk around the street I lived on and I stumbled upon four tiny kittens in a woman's front yard. I obviously had to stop to pet them, and we got

to talking. She had lived in Beulah County her whole life. Like many locals, she seemed not to care for the out-of-town population that is rapidly increasing. She talked about how it makes the whole county feel different culturally. She said, "If you ride the bus into town, there could be a college student and a [Beulah] local sitting right next to each other- but really they are in entirely different worlds." You can also see the resentment through the frequent bumper stickers that read: "Go Back to Florida" and "Carter Sucks! Tell Your Friends."

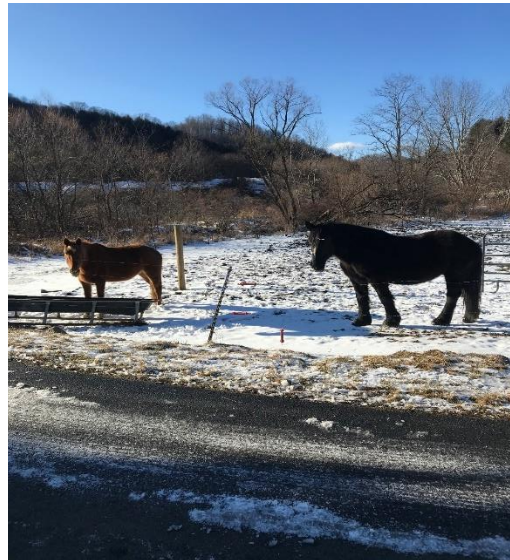

Figure 2.4: A small horse farm next door to the house where I lived.

On Whiteness

I have touched on the increasing diversity in Appalachia, but as the statistics clearly show, the Sunflower Mountain Region is primarily comprised of a white population. Obscuring processes of marginalization is the best way to preserve them. Oftentimes in discussions of Appalachia an attitude of American nothingness, or the idea that the United States and whiteness are the norm, emerges. When this way of thinking is

adopted, systems of oppression are subject to being hidden through a lack of questioning of social entities, colorblindness, and taking social stratification as a natural, irreversible American fact.

To understand how race emerges as a socially meaningful topic, social theorists Michael Omi and Howard Winant's (1994) classic book *Racial Formation in the United States from 1900-1990* details how racial projects are created and made meaningful and widespread. They discuss race as "common sense" and within that common sense are structures and hierarchical implications of white supremacy and non-white inferiority. To fully understand this "common-sense" oppression and racism in American society, the "unmarked nature of whiteness" must be a focus of study (Bialecki 2016: 86). In John Hartigan Jr.'s (1997) article "Establishing the Fact of Whiteness," he explains the importance of critically studying Whiteness and establishing it as a racial fact. Hartigan encourages people to seriously study whiteness and White people. He delves into the term "white culture" to refer to the material and social structures that reproduce white privilege. Some scholars push to abolish whiteness and view it as something other than a racial category which obscures racial privilege and reinforces dominance. Additionally, Hartigan explores various ethnographic research on whiteness in different national contexts to discuss if whiteness should be theorized as a universal phenomenon or should be considered in more nuanced contexts. The author points to his ethnographic study of three different primarily white neighborhoods in Detroit to show the diversity in whiteness and conclude that context is important although there are key tenants of white supremacy which are shared. Hartigan explains how anthropology can make a significant contribution to understanding the heterogeneity of whiteness.

Highlighting the role of whiteness as it intersects with health in Appalachia is critical because race impacts every experience. Physician Jonathan Metzl's *Dying of Whiteness: How the Politics of Racial Resentment Is Killing America's Heartland* provides an example of how whiteness has very real embodied implications. Metzl discusses how white Americans are harmed in pursuit of supremacy. In his multi-cited ethnographic study, he identifies the physical manifestations of whiteness that harm everyone. Metzl travels through Missouri, Tennessee, and Kanas to interview both Black and white people about gun rights, the affordable care act, and education funding. In a particularly striking interview with Trevor, a White man living in Tennessee and dying of hepatitis C, Metzl writes:

> "Dogma told him that governmental assistance in any form was evil and not to be trusted, even when the assistance came in the form of federal contracts with private health insurance or pharmaceutical companies, or from expanded communal safety nets. Dogma that, as he made abundantly clear, aligned with beliefs about a racial hierarchy that overtly and implicitly aimed to keep white Americans hovering above Mexicans, welfare queens, and other nonwhite others. Dogma suggesting to Trevor that minority groups received lavish benefits from the state, even though he himself lived and died on a low-income budget with state assistance. Trevor voiced a literal willingness to die for his place in this hierarchy, rather than participate in a system that might put him on the same plane as immigrants or racial minorities." (Metzl 2019: 4)

This narrative illustrates how power stems from governmental decision making and structures of society, but those central powers are upheld by the feelings and actions of people like Trevor, who constitute masses in the US. Whiteness becomes more than a quality or identity, but a cause for which is worthy of laying down ones' life. Marking unmarked whiteness is critical to illustrating processes of marginalization in everyday life. Because this dissertation is primarily composed of the experiences of white Americans, laying this groundwork is necessary.

Living in The Mountains

During my time in Beulah County, I lived in an old farmhouse that rests back from the road below a holler. The sun rises late and sets early due to the high mountains that surround us. My roommate and I would talk about how we understood the meaning of the line, “Where the sun comes up about ten in the mornin', And the sun goes down about three in the day” from the Song “You’ll Never Leave Harlan Alive.”[16] The location is beautiful. A vast cornfield extends from the small creek that surrounds the house up to the road. Large trees frame the driveway so when you pass through you feel like you are entering a nature-made tunnel. The nights are jet black and quiet and you can see the stars so clearly they might as well be just a few feet away.

Figure 2.5: The home I lived in in Beulah County.

[16] By Darrell Scott, made popular by Patty Loveless.

Figure 2.6: A view from the driveway of the farmhouse I lived in.

A 69-year-old woman named Mary Kate owns this home. She raised her four boys here and has lived here for nearly 40 years. She rents out her extra rooms to individual people. The residents jokingly refer to this place as a commune. While that is not totally accurate, many aspects of living here are communal. Beyond sharing the common house utilities, we often eat meals together, bake and cook for each other, and make bonfires together. I lived in the main house with the owner of the home (and her many friends and guests who come through), a young man who works in housekeeping at local hotels, a woman who works on a mountain doing trail maintenance, a 30-year-old man who works for the local paper, and a 63-year-old retiree who thrives on hunting, camping, hiking, and snowboarding. In the guesthouse there are 4 more people. One local man in his mid-50s who works at the Sunflower Mountain Region visitor center and builds custom banjos for a living. He is also Carter's only Uber driver, so he is kind of a local celebrity. Below him lives a small family with a 13-year-old daughter. This is

certainly a motley crew, but we all get along very well, and living here with this diverse group of tenants really helped me transition into the community seamlessly.

I spent time working in each county in The Sunflower Mountain Region: Beulah, Rita, Laurel, Lowland, Coyote, and Franklin. If you look at a political map of this area, Beulah County is a light blue due to the University presence and the other six Counties are deep red. Agriculture, oil, gas, manufacturing, mining, and construction are the major industries. These areas are also deeply religious with various sects of Christian churches dotting the sides of the road at an intense frequency. While many of the counties I work in are overwhelmingly conservative, I aim to push back at the assumptions of what that means. I met many people who identify themselves as conservative and Christian, but these identities are often far more complex than what they are presented to be in the United States public imagination. This will be explored in later chapters.

Methods: This Was Complicated

To say my fieldwork was complicated is a massive understatement. This field research and whole dissertation project are defined by adjustment and adaptation. In response to the COVID-19 pandemic, social science research looked very different. Coming out of the 2020 Biden-Trump presidential election which arguably made rurality as tangible and polarized as ever (Siegler 2020) in combination with the COVID-19 pandemic's impact on childcare, parenting, and uncertain effects on pregnancy, it became clear to me that doing this project at this time would yield different insights than I initially imagined. The domestic location and generous funding awarded for this US-based project enabled me to move forward with my originally planned timeline despite

the pandemic. I could easily make some shifts such as moving in-person interviews to phone or Zoom format to promote safety and social distancing during the pandemic. So, I quickly worked to amend my IRB and flyers to advertise for phone interviews. All my preplanned partners[17] agreed to continue working with me to help advertise for interviews, but since each institution is medical, it would be impossible for me to work in person in any capacity. Even after mask mandates were lifted during summer 2021 and most institutions returned to normal capacities, the health department and pregnancy care center worked remotely because of the uncertainty that accompanies pregnancy and the coronavirus (and vaccine). I still wanted to continue to be involved in the community and volunteer for participant-observation, so I shifted my focus to other places pregnant people and mothers engage with. This led me to a year of being closely involved in childcare throughout the two of the counties I worked in. This necessary adjustment reframed how I engaged with the community and how I focused on my research questions.

Some of the only programs continuing to run in person are the ones deemed completely essential. One day I was leaving the Rita County YMCA after going for a swim and I saw a flyer advertising work for the local Afterschool program. This program takes place in elementary schools and allows higher risk children in grades K-5 to have a safe place to play, do homework, and eat from the time school ends until 6pm. Research shows that most adverse activity that may cause trouble or trauma occurs between 2pm and 6pm, so Afterschool acts as a safety net to try and keep high risk kids away from issues at home or in their community (Youth.gov). I emailed the administrators and asked

[17] I initially planned to work with a Pregnancy Crisis Center and The Health Department.

if they accepted volunteers and explained my research to them. They were thrilled to have some more help because they experience chronic understaffing at these schools. While working with kids K-5 did not necessarily provide specific insights on how pregnant women navigate giving birth amidst service closures, it illuminated daily life for children and parents and the resource shortages they must confront. Childhood is inextricably linked to birth as parenting is often inextricably linked to pregnancy. Additionally, being closely involved in elementary schools helped me to bridge some of the gaps in rapport that I felt during interviews because I have never been pregnant and I am not a mother. Being able to discuss teachers and events we both knew helped foster more trust.

Another opportunity that came about in an adaptation period was my work at vaccine clinics. Initially, my plan was to work with the maternal and child health staff at the health department through their programs. Like most other things, the pandemic completely halted any in-person engagement, so I could no longer work there. I reached out to the coordinators to ask if there was anything I could at least do to help, and they explained that all the maternal and child health staff was focused on vaccine delivery. I offered to help there, and they were glad to have me. For my first few months in the area I spent a few days per week doing various jobs at the local vaccine clinic. I worked just about every position, but the one I frequented the most was temperature taker. The health department staff was shocked that I was eager to take on such a mundane task, but for an anthropologist, nothing could be more thrilling. I saw and spoke to every single person who came to that vaccine clinic. Again, while not relating specifically to pregnancy and

birth (but note that I did see very few pregnant people come through the line), this helped me deduce a lot about the county, the demographics, and the reaction to the new vaccine.

Working this job eased me into the health care scene and gave me great visibility and social capital in town. For example, one night my next-door neighbor had some friends over for beers and he was talking about everyone who lives in our area and what we all do. He said "Sia is a PhD student working on research" and his friends said "Hey! We met a friendly girl named Sia working at the vaccine clinic the other day." There are not usually a lot of "Sia"s around, so of course this was me.

Working in the county schools also awarded me a lot of good favor and access to interlocutors. I started work at Afterschool in two different elementary schools with two different organizations: the YMCA and another local youth engagement program. Working with the two directors was a great experience. As the school year ended, they both asked me if I wanted to help and recruit participants from their summer camp programs which ended up working very well and even furthered my connection to childcare and education in the counties. Additionally, working with the YMCA enabled me to create my free swim program for mothers and their babies. While it became clear that I was not working with who I initially thought, I believe this pivot was fascinating and exposed a whole different angle to this research.

Figure 2.7: A picture of me in the mountains, drawn by one of my Afterschool students.

In the summer of 2021, mask mandates had relaxed and things were returning to previous versions of normal due to the increase in vaccination rates. I reached back out to the health department to see if they were working in person again. They were still remote, but the WIC department was happy to advertise for my interviews which generated more enrollment. During the spring of 2020 I had reached out to a brand-new health department program that offers home visiting services to pregnant women and mothers in the county. They initially said they were way too overwhelmed to consider working with me due to the pandemic and the newness of the program. When I recontacted them in spring 2021, they were settled down much more and looking to expand into two more counties as well. They gladly took me on as a volunteer. For the first few months I worked with their community outreach specialist to load resources into a database that the home visiting nurses would use to refer new mothers to various helpful tools available in the area. This work was tedious, but it really helped me establish an idea on what is available in the area and the accessibility of information about these resources. Working

through creating the spreadsheet, I found that information is difficult to find. For example, one of the categories of information is “eligibility requirements” which asks for what is required of a person to participate in and be eligible for a program. Most of the state resources assert that people need to “meet the income requirements” and do not elaborate further. If they do, it involves a complicated chart that I often had issues interpreting. I could not even imagine how someone would interpret these cryptic messages or even know what to search to find them. My position working in the school system offered me insight on the state of some social service resources, but while working on compiling the spreadsheet I input information for some programs I had never even heard of. This makes me wonder how truly accessible these places are. During my interviews with pregnant women, mothers, and health professionals, access to resources was one of the major themes.

As I continued to sort through community resources and plug in all relevant information to this spreadsheet, I reached the Department of Social Services page and programs. There are a series of programs designed to support families, including child support and subsidies, home visitations, Medicaid enrollment, Supplemental Nutritional Assistance Program (SNAP), and temporary emergency funding. As I plugged in the easily answerable information about DSS I did so with the constant thought of my experiences working in the public elementary schools and everyday life in the county where it is common knowledge that DSS is exceptionally bad and corrupt. This seems to have been the case in the Sunflower Mountain Region for many years. Mary Kate, my landlord, lost her oldest son to a drug overdose 25 years ago. She saw his addiction becoming lethal and called DSS to intervene to hopefully provide safety and help to her

baby granddaughter and be a wake-up call for her son to get clean. With tears in her eyes, Mary Kate recalls how she sat in the DSS office begging someone to help. When the social workers finally did a home-visit and welfare check, they called her son one week in advance to schedule the meeting. This gave him time to clean up the house, hide all evidence of drug use, and take measures to pass a drug test himself. Mary Kate still thinks that if DSS had acted more responsibly, it might have saved her son's life. Obviously, these issues persist today. At Afterschool, we frequently work with children who are very clearly not being taken care of at home as evidenced by their tendency for accidents, the state of their clothes and bodies, and reports of their lives at home. During summer school we had one particularly bad case. I worked with two experienced teachers who acted with rage and sorrow when confronting the realities of this family. Working with these children can feel helpless. Options for help are limited, and in my experience of working with children in distress at home there were several times where a family member of some of these children of concern even worked for DSS or a similar social service.

Reflections From The Void: Remote Interviews

Ultimately, I conducted 60 formal interviews with 53 different people. These people included pregnant women who were not mothers yet (10), pregnant women who were already mothers (33), and health professionals (10). I talked to 7 different participants more than once to either get an update on the person after significant time had passed or to talk to a pregnant woman after she had given birth so she could reflect on her experience. Through my participant observation and volunteering, I had several informal conversations that also contributed to this research.

As I previously mentioned, anthropologists have been writing and thinking about the ways in which the pandemic has impacted fieldwork. Many have reflected on the challenges of doing people-based research far away from people and the gaps that emerge when embodied aspects of ethnography are no longer an option (de Faria 2020). These conversations will be relevant moving forward to reimagine how anthropology can work as times and social contexts change. My experience was characterized by successes and failures and I hope to document my own reflections to contribute to this conversation on fieldwork, remoteness, and ethnography.

When the pandemic began and persisted, it became abundantly clear that I needed to shift methods of interviewing to be completely contact free and remote. It seems that "remote fieldwork" was something the anthropology community was grappling with (at least on twitter) and attempting to navigate despite the inherent contradictions of fieldwork and remoteness. I recognize that the option for a phone or Zoom interview was impossible for many peoples' projects and field sites. Again because of my US-based location, phone and Zoom interviews were very doable although not ideal. Instead of trying to use these new methods to make my project as similar to how it was originally written and compensate for the loss of human contact, I tried to focus on what remote interviewing might add to this work.

Conducting interviews remotely was challenging. I found that there was absolutely no way for me to predict how a conversation was going to unfold. My recruitment methods involved interested people reaching out to me via email or phone to let me know they wanted to schedule a time. A lot gets lost in written communication, which made interest in participating difficult to gauge. Sometimes I would have a three-

hour long phone conversation that was excellent, informative, fun, and cathartic. Other times I would get one-to-two-word answers and could hardly keep the other person on the phone for more than eight minutes. These types of interviews left me discouraged, thinking that this really was not going to work. It was these phone calls that also reminded me of what is lost in a phone conversation. There was no way for me to read facial expressions, body language, or even feel the types of energy you get when conversing with someone. Another aspect of talking via phone made me think about how I was being perceived. Without meeting in person, a person doing an interview would have no concept of how old I am, what I look like, what I am most interested in, and how I respond to others. Because my name is unusual and not Anglophone in origin, I imagine that some people might not have a clue about my gender identity before we began conversing. One woman explained how she thought I might have an accent or not be American at the conclusion of our call. Usually, those type of assumptions are proven or disproven with an in-person meeting, but this was never possible with my remote interviews.

This leads me to another massive and uncomfortable observation. When I walk around town doing just about anything, the anonymity of a phone call feels especially palpable. For example, when I pass by a woman I have never seen or met in the grocery store and we smile to acknowledge each other out of politeness before continuing our respective shopping, it occurs to me that I could actually know many intimate details of this woman's life and every step of her birth process and neither of us would ever know it. We might have talked for two hours and shared laughs. She might have told me about her secret marital issues, her deep struggles with postpartum depression, or the challenges

and trials of raising children in a pandemic. And there I am, passing her in the produce aisle, letting her merge into my lane, and holding the door for her at the gym all while acting as an unassuming, anonymous vessel for her private words. I wonder how she feels. Did she hang up the phone and feel as though she was talking into the void? Did she second guess her decision to confide things to the voice on the phone, or did the lack of personal, visual, connection make it easier to do so? Does she ever pass by other people in the grocery store and hold eye contact with them for just a second longer and have the thought that maybe that's the "PhD candidate from the University of Kentucky doing research on rural maternal health"? Maybe she's the one who listened, recorded my words, relistened to them, wrote them down, reread them, attempted to analyze them, and sent me a gift card? These pervasive produce aisle thoughts are yet another reminder of the value of social science research and how actually engaging and conversing with people in person reveals way more than just the interview transcript may show.

While conducting phone interviews felt distant, there are many moments within these conversations that reminded me of the value of using technology to continue on with this project. Many of the mothers I spoke to had multiple young children or were very pregnant or both. Several of my phone conversations would be interrupted by the screams of babies, toddlers pleading for attention, or moms coming to the door for a playdate. We could continue our conversation as mom would ask me to "hold on just one second" to negotiate peace with a "mommy is on the phone right now." Each of my interlocutors would always apologize for the interruption, but these moments gave me more insight into her home life and the everyday aspects of having young children: especially during a pandemic which asked us to remain at home with them. Oftentimes

these moments in our conversations had me thinking it was crazy of me to ever think I would ask a busy mom or pregnant woman to leave her home and young children to come meet me to do an interview for my research project. Or even come over to her home where she would have to worry about the mess, be a host, and accommodate an outsider. How selfish. The ease of phone interviews is not insignificant. No commute, no gas used, no childcare required. When the IRB no longer required remote work, I began to give interested participants options for interviews. We could do them outside, on a walk, with masks on, at a playground, at a location of their choosing, or via phone. Many people still opted for the phone call. I thought about eliminating this option, but the degree to which that would increase the difficulty of even participating for mothers was steep. It seems that remote interviews forced me to completely center the person participating. They got to choose where they did their interview and I did not even ask them. All I did was call. They got to negotiate where they would be and did not even have to consult me. If they wanted or needed to back out at the last minute, all they had to do was ignore the call. Easy, no questions asked, no pressure.

About six months into my research, interview inquiries had really slowed down. I was initially working off those who completed my survey in the fall and indicated they wanted to participate more in the project. Once I had run through that list, I had only conducted about twenty interviews. I would occasionally hear from women who saw my flyers at the pregnancy care center but those were also becoming fewer and further between. By this point I was involved in many community organizations and my flyers were very present in libraries, the health department, Pregnancy Crisis Center, and childcare locations. I started to figure that I was not getting as many interviews as I had

anticipated because of the obvious: this is a low birth volume area. Perhaps people were not interested on top of the fact that not that many people live in this area. I had come to terms with this fact and was thinking about ways to work around the scant interview number on top of the already impossibility of participant observation. But one day I was teaching swim lessons at the YMCA and when I got back to the locker room and pulled out my phone, I had over 20 texts, emails, and voicemails inquiring about participating in an interview. I was completely shocked and confused. I scrolled all the way down to my very first message from the past hour and it was from the WIC coordinator at the health department. She apologized and explained things had been so busy she had completely forgotten to send out information about my study to the WIC mailing list. She had just done it. This explained my suddenly overwhelmed cell phone. So I worked through about 30 interviews in a three week period. This was the first time I was able to offer people in-person meetings, and about half of them chose that option. Most of my in-person interviews took place at or near a playground. Moms either came with their kids or had someone else there to take the children to the park while I got to talk with their mom.

Working through in-person and phone interviews simultaneously also provided a lot of insight on methods in anthropology. For example, see the following excerpt from my field notes on July 18, 2021:

> *"One thing that I think is interesting is how in person interviews enable me to ask way more personal questions than via phone. For example, [name redacted] had her first baby when she was in 8th grade. It was way easier for me to ask her questions about her experience with that/ if it was planned/ who the father was, etc. Whereas when I was talking with [name redacted] about her 12 children, I*

> *felt too uncomfortable to ask her about the fathers and so on. I was trying to get more indirect and implicit ways to deduce that information based on what she was offering. I didn't want her to feel like I was judging her. With [the woman I talked to in person], I could use faces and body language to show I wasn't judging her but on the phone it is way more difficult."*

My experience is in line with many others. Louise Scoz Pastuer De Faria conducted fieldwork during the pandemic and found that when she did video calls and could see the person, people felt more comfortable opening up about sensitive topics. De Faria writes, "Video calls during quarantine, especially in the professional context, exposed the sphere of intimate life in an unprecedented way. We can no longer choose the environment, compose the scene or silence the children playing in the room" (2020). Phone and video interviews in the home do expose a whole new level of domestic life that is typically more concealed. These unique observations of conducting social science research during a global pandemic have many implications on this work and will continue to be considered throughout this dissertation. In the first ethnographic chapter that follows, I will discuss the impacts on pregnant women when obstetric services are eliminated in the Sunflower Mountain Region.

CHAPTER 3. "EVERYONE SEES EVERYONE": THE IMPACT OF OBSTETRIC CLOSURES, CHOICES IN BIRTH, AND EMPOWERMENT

"It's a shame because there are really no other options for OBGYN care in town, so you are at their mercy. If you go to this office, be prepared to really have to advocate for your own care, double check all scheduled appointment times/procedures, and hold staff accountable." -A public google review of Friendship Hospital

Introduction: Meet Annabelle

It was a dewy summer morning in July and I sat waiting under a small local park's pavilion. The park was completely empty this morning. The playground was worn and looked in desperate need of some new equipment and a parking lot pave-job. This park was only about five minutes from my home in the western part of Beulah County. This area is in a mountain valley, so the fog lays low and thick on the playground and engulfs the swings and slides so you can only fully see the tops of the structures. The morning stillness and fog is not eerie; it is peaceful. I was waiting there to meet a woman named Annabelle. She reached out to me after getting my information from the local WIC office. We had set up a meeting for last week, but she had forgotten so we rescheduled for today.[18]

Eventually a woman who seemed to be in her early 30s with bright red curls wearing a long, loose summer dress bounced down the hill towards me. She was holding

[18] I found that this happens frequently when working with busy mothers. See this haiku I wrote on 7/16/2021 in my fieldnotes while waiting for Annabelle to show up:

"Interview Stand Up"
I sit in the park
She's busy, but it's fine
The weather is nice

her one-year old son whose blond tuft of hair had been braided so it popped off the top of his head like a soybean sprout. The arm that she was not using to hold her son was toting a small but clunky plastic tricycle. The fullness of her hands made her walk cumbersome and labored. She managed a small finger wave towards me as she approached my picnic table. When she reached me, she immediately began apologizing for missing our interview last week. She has a lot going on and it just completely slipped her mind. I assured her it was no issue and that I understood. Annabelle introduced me to her son, Caleb. I cooed and made what I describe as a "hi baby!" face at little Caleb. She gently said to him, "Caleb, this is my friend. Do you want to say hi? You don't have to if you don't want to." This introduction struck me. She was acknowledging that her one-year-old child could say hi but only if he wanted to. This moment was a precursor to a lot of Annabelle's ideas on parenting, respect, consent, and proper human treatment. She was extremely warm and had a huge smile and often giggled as she spoke but she also had an unmistakable sense of conviction and earnestness with her words. She spoke to Caleb using sign language and he signed back to her. She explained how that was the most effective tool for him to communicate at this age and she always wanted him to feel heard and understood. Again, in the first few minutes of our interaction here I immediately had a feel for her parenting and life philosophy.

Annabelle used to be a professional ballerina. She moved to Beulah County in 2014 to open a dance studio in hopes of bringing accessible ballet lessons to rural Appalachia. She always wanted to live in a rural area and get away from the stress of the city and rigid regulations of professional ballet. She explained how she was frustrated with the high standards of studios and the limits of gender roles and how that negatively

impacted children. Annabelle imagined a ballet studio that was more open and creative and brought ballet to an area that did not have dance resources. This was a success initially, but due to personal reasons she had to step away and the studio ultimately closed six months later. To make an income during this time she worked as a full-time nanny. Up until having Caleb and the start of the COVID-19 Pandemic, she worked a lot and was making a steady living. She gave birth to Caleb in February 2020. After her postpartum recovery she went back to work for about three days and then everything shut down because of the pandemic.

After making small talk, meeting her son, and getting some background information about her life, I asked the next question on my interview docket. "So, where did you have him?" I asked as I gestured towards Caleb. She quickly replied, "at home." My jaw dropped. This was my first interview of anyone who had a home birth. I excitedly exclaimed, "you had him at home?!" And she casually answered in a tone that contrasted my enthusiasm, "Yeah, at home. It was unplanned though."

Chapter Overview

The purpose of this chapter is to explore the birth narratives of women like Annabelle to uncover the local-level impacts of obstetric closures in the Sunflower Mountain Region. I begin by discussing one specific maternity unit closure in Rita County. Next, I delve into the impact this closure had on other obstetric services in the Sunflower Mountain Region including the introduction of a new system of care providers seeing patients that eliminates a lot of choice in the birth process. I also discuss the differences in biomedical and holistic birth and use Robbie Davis-Floyd's framework of the "conceptual outcome of birth" to understand how women's birth experiences that

defy their wishes cause trauma (Davis-Floyd 2003). I connect the lack of choice that accompanies obstetric closures to disempowerment for pregnant women in rural areas. Finally, I return to Annabelle's home birth narrative to illustrate what happens when birth resources are inaccessible.

A Note on The Use of Interview Quotes and Data

In this chapter, much of the interview data are direct quotes from women discussing their birth experiences. This is intimate and personal, and these women's knowledge and insights are what answer the research questions of this dissertation. Out of respect to the women who graciously gave their time, openness, and insight to recalling birth narratives, I have left much of the interview data and responses in full tact. This is especially true when discussing Annabelle's story. No one can tell a birth story better than the woman who experienced it, so I have left large segments of interviews in this section to prioritize the voices of the women telling their stories.

What Happened to Birth in Beulah County?

In 2014, Pine Ridge Hospital, the only hospital that offered birthing services in Rita County, shut down its labor and delivery unit. Rita County is vast and is made up of especially mountainous terrain. Pine Ridge Hospital houses all medical services in the county. When the hospital stopped providing birthing services (the details of which are further discussed in Chapter 4) community members had to go elsewhere to have their babies.

This shift posed a series of challenges for pregnant women living in Rita County. As I explained in the introduction, poverty rates in the Sunflower Mountain Region are around 15.7% (US Census) which is a rate similar to the numbers throughout the

Southern Appalachian region. When proximate birthing services shut down, women living in rural areas must travel long distances down single-lane, low-visibility mountain roads. Additionally, women with lower socioeconomic status often lack access to reliable transportation and flexibility to restructure their time during labor and birth (Faisal-Cury et al. 2015). For example, if a family only has one vehicle and the husband is at work while the wife goes into labor, it is challenging to find quick transportation. Gas money is valuable and substantial when driving these roads. As I drive around Rita County I often get stuck behind large farm equipment that has to move at 20 miles per hour and is unpassable. In the winter, driving conditions become even more hazardous with significant snowfall and ice.

As a direct result of the Pine Ridge Obstetrics closure, most women living in Rita County opt to go to the bordering Beulah County to deliver their babies. Because Beulah County has a greater population and vibrant town life on account of the university in Carter, the hospital gets relatively steady traffic. The name of the hospital in Beulah County is Friendship Hospital. The labor and delivery unit is small with only a handful of providers. When Pine Ridge closed its birthing unit, all the Rita County patients had to go to Friendship Hospital to get prenatal care and give birth. The staff at Friendship were already extremely busy as it is the only place to give birth in Beulah County. So, when all the Rita County clients shifted to Friendship Hospital, the doctors and midwives were completely overwhelmed.

“Everyone Sees Everyone”: A New System at Friendship Hospital

There are nine providers at Friendship Hospital in Beulah County: four midwives and five doctors. Prior to the closure of Pine Ridge Obstetrics in the early 2010s, women giving birth at Friendship would choose to give birth with **either** a doctor or a midwife and would be seen by the provider they chose throughout their entire pregnancy, labor, and delivery. When the demand increased at Friendship because of the Pine Ridge closure, the hospital had to adapt and create a new system that equitably accommodates and respects the work lives of the providers. This new system is often informally described as "everyone sees everyone" by both health providers and community members. The idea is that whoever is on call whenever a woman goes into labor will be the one to deliver her baby. It does not matter if this person is a doctor or midwife. If it is their shift, they will attend the birth. To make this system more comfortable, the staff schedules pregnant women to see a different provider for each prenatal appointment to hopefully ensure that they have at least met the person who will help them deliver their baby.

"Accept Care From Him or Leave": Frustrations with the System

Many women who gave birth at Friendship explained their frustration with this system. A new mother named Andrea explained that she understood the necessity of seeing all providers, but still sees many limitations. She said, "If it was one provider, that person would never have time off. But at the same time…I understand how some women would be like, but I want you to know, if I'm puffy or not puffy you know all that kind of stuff. If you see a different person every time they can't tell those differences." This is a resounding critique of the system. Women rarely get the opportunity to know their provider very well and in the worst cases they do not even meet the person who helps

them deliver their baby. Additionally, if a woman does not like a provider for some reason, they have no way to prevent that provider from being the one on call when they go into labor. Andrea is a strong-willed mental health professional who is comfortable advocating for herself in the health care system. I asked her if she felt like she could let them know that she did not like a certain provider and wanted to avoid giving birth with that person. Andrea said, "No. I asked, because I met with [one particular doctor], and he was downplaying the pain that comes with a Pitocin[19] induced birth. And I thought, you don't know pain! You've never given birth! You know. I remember very clearly, he was like, 'Pitocin doesn't hurt. People just say that it hurts because it happens really fast.' And then in the same appointment he was complaining about how bad his COVID test felt in his nose and I was just like, you have no fucking clue dude. You thought that hurt? And you're downplaying the pain in labor? Anyways, I asked. I said if he happens to be the doctor on call, do I have any options? What are my rights? And they were like no, we don't have anyone else. I mean, your right is to accept care from him or leave."

The stress of not knowing your provider or even knowing you dislike a provider is very harmful for pregnant women and their families, but the hospital claims that the system is necessary to support their staff. This new system melds together two different systems of birth: a biomedical birth with a doctor attending and a more holistic birth with a midwife. Doctors and midwives undergo different training that perpetuates a difference in how they approach births. Pregnant women tend to have a preference on who they chose to deliver their baby and this preference aligns with their own views, beliefs, and

[19] Pitocin is a synthetic version of Oxytocin given intravenously to cause the uterus to contract and thus induce labor. Pitocin tends to cause contractions to start off stronger and more frequent which leads to women reporting more painful birth experiences (Mayo Clinic).

worldview. Therefore, the fusion of these two systems in such an unpredictable way creates friction and issues for women having babies.

A Deep Dive into Two Systems of Care: Biomedical and Holistic

Anthropologist Robbie Davis-Floyd's (2003) concept of the "technocratic model of birth" or biomedical birth claims that bodies are like machines, and female bodies are very prone to malfunction and need to be managed, especially during birth (Davis-Floyd 2003:52). The opposite of the technocratic model is the "holistic model of birth," which prioritizes midwifery care over obstetrician-led care and insists that "The mother's body knows how to grow a baby and how to give birth; she can trust the 'knowing,' for it belongs to her. The uterus, much more than an involuntary muscle, is a responsive part of the whole" (Davis-Floyd 2003:157). While technocratic birth relies on authoritative knowledge which is paternalistic and inflexible (Jordan 1997), holistic birth uses embodied and intuitive knowledge of the birthing woman (Daviss 1997). Due to contrasting natures, there are undeniable tensions between those who believe in and practice holistic birth and those who believe in and practice biomedical birth.

A Note on Terminology

In the following chapter I use the terms "biomedical birth" and holistic birth." As Robbie Davis-Floyd repeatedly points out, most births in hospitals in the United States have aspects of both systems (2003). This is very true. When I use these terms to refer to someone's birth experiences as biomedical or holistic, I mean "more biomedical than holistic" or containing more biomedical aspects than holistic aspects or "more holistic

than biomedical" or containing more holistic aspects than biomedical aspects. I am using the terms for brevity and flow but I acknowledge that most births contain aspects of both systems. Additionally, I am discussing these concepts in the context of the United States, a very biomedically-centered place that adheres to Western medicine trends and principles which will be explored in the next section. Systems of belief and medicine differ substantially across the globe. I do not assert or imply that biomedical birth is the most advanced and cutting-edge system of care. Instead, I consider it just as any other system of belief.

Biomedical Birth

Biomedicine is a hegemonic system of care in the United States and other regions of the world, meaning that it occupies a heavily weighted role in society. It is also taken for granted as the default field for addressing health and wellness as opposed to alternative medicine approaches. Biomedicine is a system of medical care and intervention that relies on mechanistic treatment of the body, science and clinical evidence of efficacy, and authoritative knowledge to preserve its legitimacy. Biomedical pushes in health and hygiene have contributed to major successes in reduction of morbidity and disease. For example, the medicine of the 21st Century and germ theory have saved countless lives through interventions such as handwashing, medications, and vaccinations. Biomedicine is central to life and worldview in the United States. While it has been good for public wellness and a general reduction in morbidity, there is a lot to view critically within the belief system.

An understanding of the key tenets of biomedicine is integral to delving into any medical or lived phenomenon pertaining to health and illness within a biomedical care system. Biomedicine is a framework and philosophy that is the foundation of Western science, medicine, and technology. Because it is a framework, is holds a set of assumptions that become woven into everyday systems like medicine and healthcare. Biomedicine is constituted by three major points which epidemiologist Nancy Krieger identifies: first disease and its causes can be understood only through biological, physical, and chemical explanations. Secondly, there is an emphasis on laboratory research trials and repeatability of those trials with the same results. Biomedicine inherently discredits any research that cannot be studied and repeated through randomized clinical trials[20]. Finally, biomedicine holds that bodies are best understood and viewed as a collection of parts instead of a cohesive whole (Krieger 2011). Another critical point about biomedicine is that it is not a universal truth but instead is "one of many medicines…culturally and historically specific and far from universal" (Gordon 1988). Gordon also argues that although biomedicine has created technical knowledge, the underlying philosophical tenets of the framework draw upon ways of ordering the world, ideas about truth, distinctions of reality, and assumptions about knowledge (Gordon 1988). Despite cultural insistence in the US on biomedicine as evidence-based, strictly scientific, and objectively correct, the principles upon which biomedical care is based are "rhetoric, a series of efforts to persuade relevant social actors that one's manufactured knowledge is a route to a desired form of very objective power" (Haraway 1988: 577).

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[20] For example, the dissertation you are presently reading.

The Biomedicalization of Birth

The term "biomedicalization" refers to the process of reducing something that is biocultural purely to its biology. When something is reduced to its biology, the only way to "cure" or fix it is through medical intervention. Gay Becker and Robert Nachtigall concisely explain this phenomenon when they write that infertility is a "social condition that has recently been recast as a disease" has undergone biomedicalization through its placement into the biomedical system as something to be "fixed" through purely medical intervention (2008: 456). Biomedicalization is common in American society. This has happened with obesity, aging, sleep, substance use, and more. For example, mental health has been heavily biomedicalized in the US through an emphasis on mental illness as a chemical imbalance and focus on over-prescription of psychopharmaceuticals instead of an alleviation of social and cultural factors that tend to exacerbate mental illness such as the 40-hour work week, the pressure of capitalism to be constantly productive, and the comparative and competitive aspects of American social life.

Pregnancy and birth are prime examples of natural phenomena that have been biomedicalized. Childbirth has been pushed into the biomedical realm over the course of time all over the world to varying degrees. Birth began as a highly individual act, but with evolutionary changes of bipedalism, encephalization[21], and methods of birthing, infants are more helpless and dependent upon the mother and others supporting her for safe delivery (Trevathan 1997). Anthropologist Wenda Trevathan writes, "I conjecture that ancestral females who sought assistance at the time of delivery simply had more

[21] The evolutionary increase in brain size in humans over time.

surviving and healthier offspring than those who continued the ancient mammalian pattern of delivering alone. Thus, the transfer of authoritative knowledge from the birthing woman to her attendants may have begun as long ago as five million years" (1997: 82). This ancient shift from birth as an individual event where the woman herself held the most knowledge to a process where professionals who have more knowledge must be present marked the beginning of birth's move towards full biomedicalization.

During the 1800s in the United States, mostly all women, regardless of race or class, gave birth in their home with a midwife (Craven 2010). Women in the North relied on midwives who were trained in European countries and immigrated to the US while women in the South primarily depended on African American midwives (Craven 2010, Fraser 1998). As the 20th Century progressed, wealthier white women "lived in fear of the natural biological process of birth, dreading the pain, the danger, and the loss of modesty and control" and began to travel to Europe to have their babies while under the influence of scopolamine, a drug that allegedly allowed women to give birth while unconscious (Davis-Floyd and Sargent 1997: 9). This began the movement of patriarchal, biomedical birth that occurred with high levels of medical intervention and inside the hospital. The field of obstetrics emerged from this movement.

The biomedicalization of pregnancy and birth brings focus to how the hegemony of biomedical practices and interventions in something as natural and longstanding as childbirth prompt women to view and understand their own lives and bodies. As Gordon writes, biomedicine "teaches us to interpret ourselves, our world, and the relationships between humans, nature, self, and society" (Gordon 1988). Biomedicalized pregnancy certainly teaches pregnant women how to interpret themselves and their bodies. In *Birth*

as an American Rite of Passage, Robbie Davis-Floyd gives clear and in-depth descriptions of ritual in hospital birth, but her ethnographic approaches and methods are critical to solidifying her analysis of birth and the effect it has on women undergoing the rites of the biomedical system. While a critical piece of this anthropological study is Davis-Floyd's outline of the "standard procedures for normal birth," her description of the rationale behind each step, how women respond, and the ritual purposes contributes rich ethnographic insight (Davis-Floyd 2003: 83). For example, one step that routinely occurs in the biomedical system of birth is the shaving of the woman's pubic hair before she gives birth. While the official rationale found in medical texts and physician interviews is to increase visibility and reduce the danger of infection, scientific studies have found that "Shaving in fact *increases* the risk of infection in the open abrasions and small lacerations often left by the razor, which can serve as excellent breeding grounds for bacteria (Cruse 1977)" (Davis-Floyd 2003: 83). Many women disliked being shaved and felt as though the process was dehumanizing and degrading (2003). Women's responses clarify the fact that shaving the pubic hair acts to establish "the institutional marking of the laboring woman as hospital property" (Davis-Floyd 2003: 83). This illustrates the role biomedical intervention plays in constructing childbirth and creating controlled, submissive birthing bodies, which confirms the meaning imbued in each step and lack of "objectivity" or inherent correctness of the biomedical model. Biomedicine relies on "authoritative knowledge" or the concept that "The central observation is that for any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger

power base (structural superiority), and usually both" (Jordan 1997: 56). Jordan uses an example of a birth in an American hospital to show how the woman's knowledge is completely discounted, the physician is protected as a valuable, all-knowing, revered figure, and the focus is on technology and not bodily cues to guide birth. This also dismisses embodied and personal knowledge making women feel powerless. Anthropologist Dána Ain-Davis puts the frustration of the impact of authoritative knowledge into words: "And so I repeat, women's own words are a legitimate source for knowledge production" (Davis 2019: 23).

It is important to acknowledge that obstetricians do excellent and necessary work in many cases. Whenever birth complications arise and women require C-sections or other interventions, obstetricians are the experts and are responsible for the health and safety of women and their babies. They are trained as surgeons and therefore are extremely competent in conducting emergency birth services. But the way hospital birth has evolved assumes that most births are emergencies and require some level or intervention or surgery. Midwifery and holistic birth acknowledge that pregnancy and birth are natural human processes and not sicknesses that require intense intervention.

Holistic Birth

As previously discussed, hospital birth is a relatively new phenomenon and has become the norm in biomedical medical systems like the one in the US. Anthropologist Barbara Katz Rothman laments the shift to paternalized hospital birth and explains that midwifery is feminist praxis because "Midwifery works with the labor of women to transform, to create, the birth experience to meet the needs of women. It is a social, political activity, dialectically linking biology and society" (Rothman 1989: 117). This is

opposed to obstetrics, in which the job of the physician is to separate the mother and child "so they can 'recover,' so that the woman can 'return to normal,' and the baby can be 'managed' separately (Rothman 1989: 117).

Many of the core principles and values of midwifery today outlined by the American College of Nurse-Midwives (ACONM) illustrate the antithesis between the two models of birth. Their general philosophy of care is as follows:

> "We, the midwives of the American College of Nurse-Midwives, affirm the power and strength of women and the importance of their health in the well-being of families, communities and nations. We believe in the basic human rights of all persons, recognizing that women often incur an undue burden of risk when these rights are violated." (ACONM)

This statement shows how midwifery centers families and women. It also immediately acknowledges the harm and risk of violating human rights, especially during birth. ACONM also emphasizes the intuition of midwives and a spiritual connection to life, womanhood, and pregnancy. Anthropologists Davis-Floyd and Davis (1997) examine the role intuition plays in how mothers and midwives act during birth. They explain that connection is essential to homebirth and midwifery which is antithetical to biomedical processes. The authors also hypothesize that the more formal biomedical training women receive, the less likely they are to be in touch with spirituality and connectivity principles (1997).

While there are many principles outlined by ACONM, some of the most notable that show contradictions to hospital birth and biomedicine are as follows:

- “Advocacy of non-intervention in physiologic processes in the absence of complications”
- “Promotion of continuity of care”
- “Utilizing an understanding of social determinants of health to provide high-quality care to all”
- “Advocating for informed choice, shared decision making, and the right to self-determination”
- “Empowerment of women and persons seeking midwifery care as partners in health care”

Biomedical birth relies on medical interventions whereas midwifery seeks to avoid these interventions unless there are medical complications which absolutely require them. Biomedical birth does not prioritize the kind of continuity of care that midwifery care does (as evidenced by the “everyone sees everyone” model). Midwives also tend to focus more on the whole woman who they are caring for and acknowledge the wide variety of social, physical, and community factors that create health. Therefore, midwives tend to get to know their patients better and prioritize spending enough time with them to do this. Doctors are more likely to do a quick visit or checkup to communicate necessary information and keep the workday moving. Many women I spoke with talked about how their doctor performed interventions without their approval or knowledge. Midwives take informed consent as a core value and work to establish a sharing of knowledge instead of an authoritative power that obstetricians often convey. Finally, I would assume that most obstetricians would not consider female empowerment to be a priority in their birth

attendance. In general, midwives and doctors are trained differently and hold different values in their approach to birth.

Conceptual Outcomes of Birth

The situation at Friendship Hospital shows how birth can oscillate between the technocratic and holistic model. Women must switch between different obstetricians and midwives from appointment to appointment, with the final determinant of how they will give birth left up to the randomness of labor and whoever is scheduled for that particular shift. It is significant to understand how pregnant women navigate this space in between birth models.

Additionally, it is important to think about how this affects pregnant women and their conceptual outcomes of birth. Utilizing Robbie Davis-Floyd's framework of the "conceptual outcome of birth" helps elucidate the outcomes women experience when they lack choices during the birth process. Davis-Floyd writes, "By 'conceptual outcome,' I mean the woman's ultimate physiological interpretation of her birth experience as positive or negative, empowering or victimizing, joyful or traumatizing- in other words, whether that experience tends to affirm or destroy the self-image she wishes to hold. As stated previously, the single factor that most influences the conceptual outcome of a woman's birth experience is the degree of correspondence between the technocratic model of reality dominant in the hospital and the belief system the woman holds when she enters the hospital" (Davis-Floyd 2003: 187). By this, Davis-Floyd means that if how a woman imagines or wants her birth to occur based on her personal knowledge and beliefs and the way she actually gives birth do not align, her conceptual

outcome will be negative. A negative conceptual outcome of birth can result in psychological issues, increase in postpartum depression, and general trauma. One woman I talked with had an extremely negative conceptual outcome of birth because her birth experience was not anything that she wanted or expected. She explained, "It's not supposed to be some traumatic story that we have to recall and tear up about because it sucked, but that's what so many women experience because it's not this good story we can recall. Instead it brings back fear and triggers us." In the context of birth at Friendship Hospital, women's ideas and choices are at the mercy of structural restraints. This has a significant impact on birth experience and self-image.

In rural areas where obstetric services are continuing to be affected by budget reductions, I hypothesize that these spaces in between birthing systems and ultimate conceptual outcomes of birth will become increasingly relevant as they have in Beulah County. That may be because of a similar situation to the Friendship Hospital "everyone sees everyone" model or perhaps accidental birth on the side of the road or in an emergency room because the hospital was too far away. Either way, ethnography within the in-between zone is necessary to understand how uncertainty in birth affects how care providers alter their own personal and professional values to accommodate the hybrid system and how women's conceptual outcomes change when they give birth in an unanticipated manner. Thus far it has probably become clear that I personally have hesitations about biomedical birth. But that is not what this is about. Of the women I talked with, some strongly preferred a biomedical birth while others preferred a holistic birth. I do not question or push their preferences. The point is that when a woman has her preference and that is violated, she is violated. In the following sections, I will analyze

and discuss interview data to show how women are impacted when their conceptual outcomes of birth are transformed when they lack choices during the birth process.

"We're Just Not Hippies": Wanting Biomedical and Getting More Holistic

Many women I talked with who prefer a more biomedical birth cite fear and pain as their main motivators in making this decision. Diana is a 29-year-old woman who had her first baby at Friendship Hospital which is about a 45-minute drive from her house. She and I talked on the phone for nearly two hours. She is a mother of two young boys and was pregnant when I talked with her. Diana is a spirited and hilarious storyteller and certainly loved to talk and recount her experiences. She has lived in the Sunflower Mountain Region her whole life and she and her husband currently live in a house just three doors down from her childhood home. When I asked her about her preferences on how she would give birth, she said, "I told the doctor I want to push, but I don't want to feel anything because I don't handle pain well at all. Because I have a syndrome with my heart and so it will send my body into shock and I don't deal with pain at all." She told me that she had this conversation with the provider at nearly every prenatal appointment. She knows the limitations of her body and she was very worried that the pain of childbirth would affect her heart. Diana told the following story about the birth of her first son:

> My epidural had run out. Well I told them and it was two hours later until the nurse came. And she checked me whenever I first rang my cowbell and she said you're just at 6 inches dilated right now we will just get you some more epidural medicine that way, you know, you're good. Well two hours of laying there with nothing and I rang it again and said he's on his way out. He is coming now! And

> she didn't bring me nothing and I feel every bit of this. Well this nurse looks at me and tells me no. You're not having him now, you're at a 6. And I'm like honey, I'm telling you his head is coming out right now. And so there his head was, popped out, and she gave me all kinds of attitude and she was like well I'll check you again but there is no way he's coming out. And I said well honey all you gotta do is look. And she pulled the sheet up and looked and she said, OH MY GOD GET THE DOCTOR! Yeah. It was awful. I'll never have a baby there again. I'll go further out of my way to not have a baby there again.

Diana's story illustrates in-the-moment frustration of having a health professional disregard her birth plan and wishes. She had to have her son in a more natural way without an epidural even though she really wanted pain management medication. This brought her a lot of physical pain but also extreme frustration and feelings of disrespect, especially because she had described her wishes for her birth to each provider she met throughout her pregnancy. Her personal knowledge about her body was disregarded by the providers. She had her next two children at a hospital further away from her home because she refused to be subjected to that experience again.

Another woman I spoke with had a similar sentiment to Diana when it came to childbirth and pain. Candace and I spoke via Zoom during a break in her workday. Her family owns a business and she was able to work from home. Her 8-month-old son was in the room with her. From the beginning of our conversation, I could tell Candace seemed reserved but extremely sharp. Her wit was quiet but clear. She seemed low energy but happy to talk. I figured this was a direct result of being a new working mom. When I asked about her views and wishes for her birth she replied, "I had done the whole

pregnancy pro-medicine because I was having a terrible time. And I was like, I'm not gonna do this like a hippy. That's what we told the doctor. Whatever our birth plan is, we're just not hippies. Give us medicine."

This idea that those who choose a more natural birth are "hippies" is interesting and likely fueled by popular media depictions and the legacy of midwifery slander in the early 20th century. Two Canadian PhD students conducted a meta-analysis with a survey on ideas about midwifery in North America. They concluded that participants in their study seemed to think that those who "choose midwifery care value 'the natural,' actively eschew the medical system, rebel against convention, value personal experience, and maintain alternative lifestyles. Midwifery care and midwife-assisted births were characterized as facilitating a positive prenatal and birth experience for the mother but were also often characterized as risky for the pregnancy overall, and in particular for the baby, requiring a high degree of trust on the part of the mother. Midwifery care and midwife-assisted births were described as old-fashioned, and ultimately uncommon" (Sangster & Bayly 2016: 38). In 2012 the New York Times published an article claiming that because so many celebrities were turning to midwifery care for their births public perception was changing to view no longer view this as a weird, fringe practice favored by crunchy types, but as an enlightened, more natural choice for the famous and fashionable" (Pergament 2012). Because midwifery is a marginal medical practice, midwives are left to navigate these stereotypes and misconceptions in their career (Foley 2005).

So, Candace wanted medicine and did not want to be a hippy. When she started feeling contractions, she called the hospital to ask if she should come in. The physicians

and nurses explained that she could come in if she really wanted to, but if she was not dilated enough and making enough "progress" they would send her home. Based on informal conversations throughout fieldwork, this is a tactic hospitals use to minimize the time women spend taking up beds during labor, birth, and recovery. She told me, "Well I ain't going all the way over there to come back. When we go, we're going for good." Candace and her husband live about an hour away from Friendship Hospital and wanted to make sure they were not going to make an unnecessary trip that would waste time and gas. Finally, her pain got unbearable and they decided to go to the hospital. Candace explained the rest of the day:

> So we finally get there and they check me and say ok now you're at eight and you're clearly making progress. And I say ok well I just want medicine because this is terrible. And they say well sorry now it's too late to give you anything. I was like are you kidding me? You told me not to come and now I can't get anything? And they said 'well, if we call the epidural guy, it might take him an hour to get here and you might have the baby by then.'

At this point in the conversation I could tell Candance was sinking. It seemed like even recalling the birth was traumatic for her. She ended up having her son with no medicine at all. "None of it was what I wanted at all," she said shaking her head with tears in her eyes. She carried the frustration of her birth experience into the following days. She told a story: "After the baby was born, while we were there, the nurse kept… she wouldn't shut up. I couldn't stand it. My husband kept saying things like it's ok, and it didn't bother me, he was being encouraging. But this woman was driving me crazy. And he said it one more time and I just said if you say that one more time, I'm gonna kill you."

Candace knew the staff was just trying to be supportive but she was extremely irritated during her time in the hospital.

Both Diana and Candace had a difficult time during postpartum life. Diana explained that she experienced severe postpartum depression and struggled to care for her newborn. Candace began to talk about starting to take antidepressants after she had her baby, but she began to tear up again and curtly stated: "I don't want to talk about it." This is all in contrast to another woman named Angelica[22] whose birth experience lined up with what she wanted and expected. Angelica scheduled a completely elective C-section. When I asked what led to that decision, she told the following story:

> Family history and paranoia and being scared. Yeah, yeah. My mom and both my sisters tried for natural births and all ended up in emergency C-sections. And so I felt like the odds were against me. And then I watched my niece give birth to my great niece naturally and- It was a- she did- I mean, she was a rockstar and she definitely was not one of those who was like screaming and crying hysterically, but it was scary. She was losing the baby's heartbeat and she was crying and everything was rushed and panicked and her mom was crying and which was not a good experience. And they were getting ready to prep her for an emergency C-section. And then my nephew's wife, she also had tried for a natural delivery with their first child and went so far into labor that she was actually questioning if there was a baby in there. She was fully dilated and she pushed and pushed and pushed and then ended up having to go to an emergency C-section because the baby's head got stuck down there. And I was just like, hey, you know, yeah, yeah.

[22] I will delve more deeply into Angelica's story in Chapter 7.

> I was like, I want one healing. I want one recovery. I don't want to be recovering from both.

When I asked her if it went how she expected, she said:

> The C-section was really great. I would use her again in a heartbeat. My experience was great. The nurse and doctors were all great. It wasn't painful at all. I mean of course there was... It's not like it felt great. You know, but there was no pain involved, soreness, or tightness during the actual thing. And the recovery was super easy. I just followed the doctor's instructions, really just, you know, take an Advil when you need to, don't lift anything heavy, Yeah. So I just did what I was told and I was sort of holed up, and it was fine and everything, but everything down there stayed, yeah, where it was supposed to be. And I remember my niece healing from her vaginal delivery and it was like weeks and weeks of pain and soreness.

Perhaps Angelica’s high level of satisfaction with her birth experience and complete alignment with her worldview and hopes facilitated her easier time in the postpartum period. She felt that it was peaceful and good. She enjoyed this time with her newborn. This is in line with Davis-Floyd’s theory which asserts that a woman’s conceptual outcome of birth has an impact on her time postpartum and life moving forward. Angelica did not struggle with any postpartum mood and anxiety disorders and had a smooth transition to motherhood. Of course, this is not a simple connection. Having a good birth experience does not mandate a smooth postpartum period. But perhaps it has an impact for some women.

While Angelica did have a positive birth experience, her prenatal care was aggravating. She always knew she wanted a C-section, so it was frustrating that she had to see all the providers in the everyone-sees-everyone model at Friendship Hospital. She said, “I didn’t want to waste my time having to see these five midwives when I know that none of them are going to be my provider or my doctor, and they were still going to make me have to go see all of them. So I kind of viewed it as I went to work because they had to. Yeah, you rotated through all the providers.” This is a frustrating situation for Angelica because it is true: midwives would never advise an elective C-section unless it was absolutely medically necessary. The midwives she had to see throughout her pregnancy did not offer her much support and advice about her delivery because it is not their expertise. She wished she could have only seen doctors or even better, only seen the doctor who would actually be delivering her baby.

“I generally have an innate distrust for doctors”: Wanting Holistic and Getting Biomedical

Based on all the interviews and informal conversations I had during the research period, it was clear that most of the women I talked with wanted to have birth in a more natural way to some degree. This trend that I experienced in my data is reflected in wider research findings as well (Özcan 2015; Calik et al. 2018; Downe 2018). Recalling what Davis-Floyd asserts, most births have components of the technocratic system and the holistic system. So when I say “natural,” I mean with less medical intervention than is normally given in a hospital birth. Like the three women in the prior section many women have worries about the pain of childbirth and know they want an epidural during

birth. But some expressed fear over this as well, like Kara[23] a 20-year-old woman in her first pregnancy who said, "I've read a lot of things and I know people personally who it's messed up their back or it was injected wrong and it completely did the wrong thing. Like instead of numbing from the waist down, from the waist up. And I've just heard horror stories about it. But I know that I'm going to be one of those people to go in like, oh, no, the second I'm in pain. Give me all of the drugs."

Even if people want this intervention or generally prefer a physician over a midwife, they typically also expressed a desire for some aspects of the process to be more natural. People resisted inductions, Pitocin, and other invasive processes. The reasons for this varied, but most people discussed getting their information from a friend who had a negative experience with the hospital. A few women cited *The Business of Being Born*[24] as central to their knowledge and ideas. This popular documentary outlines a few key facts to reframe obstetrics and hospital birth. The filmmakers give compelling statistics and stories to show that hospital birth is a business and the priority is money, obstetricians are surgeons and very few have seen a "normal" birth without any intervention, and natural birth is safe and effective for the mother and child.

Another woman named Cora Lee who was pregnant with her second baby explained how she wanted to go into labor naturally this time around. She was induced with her first baby because she was just tired of being pregnant. When I asked her about her ideal birth scenario for this baby, she replied: "well I want to be able to do it like,

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[23] Kara's story is further explained in Chapter 6.
[24] This popular documentary was directed by Abby Epstein (who herself was pregnant while filming) and produced by actress and activist Ricki Lake. Lake was inspired by her own birth experience to look more closely at Western Medicine and how it impacts birth. These two are currently working on a similar project delving into birth control.

basically, I don't want to have to be induced, I kind of want to let the process take its course and you know just naturally go into labor. Because I've read a lot of stuff that being induced causes more pain because it brings labor on faster, and basically being able to decide, pain management options and having those available if I decide I want to go that route, and not being forced into having a natural birth due to the hospital not being able to accommodate that." Essentially Cora Lee's answer straddles the middle of the natural and biomedical schools of thought. She would prefer to go into labor more naturally, but she also wants access to medication in case she changes her mind. This hybrid model in itself is a worldview and if it were to be violated in some way that could result in a negative conceptual outcome of birth. Another woman named Billie's doctor offered her the option of having a C-section and she was still considering it. She said, "yeah I haven't decided yet for sure. I will probably not go with the C-section because, I feel like I should just be able to push him out and everything be ok!" Sentiments like Billie's and Cora Lee's exhibit the inclination towards natural birth and trusting the natural process of birth but reliance on the socially and culturally pervasive biomedical system that is pushed by people with authoritative knowledge and power.

Other women are extremely committed and passionate about natural birth. There are a lot of knowledge sources that contribute to desires to have a more natural birth. For example, a 30-year-old woman who works in healthcare named Caroline discussed how excited she was for a low intervention birth. She said, "I was reading all of this Ina May[25], natural childbirth, things you know. So, I was like, really amped on all that kind

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[25] Ina May Gaskin is an American midwife who founded "The Farm" which is an intentional community in Tennessee which is also the home to the modern home birth movement. Gaskin is often described as "the mother of authentic midwifery" and has authored books and articles to help educate others on midwifery.

of stuff." Caroline ended up having a C-Section. She talks about this experience and says:

> I was just freaking out about it and I kept thinking, something's wrong, something's wrong, and um, and then when they said, you know, they did the exam, and there were like, the nurses were like, looking concerned, and had someone else look, and I was like oh my God what's happening, and they said, look, oh he's breech, we have to do a C-section. I was like oh, that's it? Oh that's fine. But afterwards I felt really bummed. In the moment I was like cool, whatever you need to do. I felt really disappointed, um, yeah I just, I had this picture and the whole thing happened so quickly, um, like I had sort of this picture, that I was going to be pregnant for six more weeks, have all this stuff to do, write the birth plan, make a playlist, and then it was like, I was pregnant and now I wasn't. In like a matter of hours.

Caroline's discussion of feeling relief in the moment but disappointment and failure afterwards shows how the discordance in what she wanted and what actually happened affected her and her self-worth.

Another 30-year old woman named Melissa went to Friendship and saw all the doctors and midwives during her prenatal care. She preferred midwives the entire time. One time during an appointment a doctor suggested she schedule a C-Section. She was surprised because none of the midwives had mentioned this. She said:

> But the way my pelvis sits and everything else, it took a lot to get my other two out. Just the way that everything sits, and the way that it moved it and everything being so close together he told me we were possibly looking at, just to be on the

> safe side and scheduling a C-section. And I don't want a C-section! I'm not even gonna lie I don't want a C-section. Because I know that's gonna hurt a lot worse than stitches.

Melissa felt immediately threatened and scared by this suggestion. She wondered what would happen during her birth if this doctor was attending it. She voiced her opinions on having a C-section but she really worried about trusting him.

I also spoke with Halle, a local woman who teaches prenatal yoga classes and is prevalent in supporting mothers in the community. She is 44 years old and reflected on the birth experiences of her now-teenage children. She also is a strong natural birth advocate. I asked her how she developed that viewpoint, and we had the following conversation:

> Sia: Going into it did you know that you wanted to give birth with a midwife?
>
> Halle: Yeah, pretty much yeah, I think that um you know, when I was younger, I'm 44, when I was younger most OBGYNs were males. It was kind of like you had to search out female doctors. It is so much more prominent and easy to find female OBGYNs now than it was even you know 20 or 30 years ago, um, and so when I moved here and someone told me about the midwives here and it was just sort of word of mouth and it was like instantly like yes, I would much rather go see this person than a doctor. I'm not a huge fan of doctors and I mean I have lots of friends who are doctors, but I generally have an innate distrust for doctors.
>
> Sia: Ok, that's really interesting. Is that based in anything or just-

> Halle: I would say that I have just learned that there is an intuition that doctors are not really taught. It's very, you know, like, I just went to the doctor the other day because I have chest congestion and I have a cough in the morning and I wanted to make sure that it was still okay for me to get my vaccine even though I have this chest congestion and they asked me all the questions and listened to my lungs and gave me antibiotics and steroids and I'm just like I really don't want antibiotics and the steroids. I've studied herbal medicine for quite some time and I just feel like there's an intuition. There's a looking at the whole person that is missing in the medical field. You know, it was a male dominated profession for so long and it was, it's a different kind of thinking you, you're not taught to think with your heart or your whole being. You're taught to think with your brain. And you've got so many other resources of knowledge so many other information systems than if you're just using your brain then you're missing out on some other information in my personal opinion.

Halle's sentiment about doctors lacking an intuitiveness is shared by many women I talked with who were passionate about midwifery and natural birth. Because Halle gave birth at Friendship before the Pine Ridge closure, she did not receive care in the "everyone sees everyone" model. She only met with her midwife, whom she adores. This was our exchange when I explained the new model to her:

> Sia: Well now they literally have everyone see everyone so like-
>
> Halle: They have them see the midwives and the doctors?
>
> Sia: Yes, so if you go into labor and there's just a doctor on call like-

Halle: That's who you get.

Sia: He's gonna deliver your baby, yeah.

Halle: So fucking awful.

Additionally, I talked with a few women who did not have a plan or preference going into their birth but in hindsight they realized they would much prefer the natural system. Tess is 25 years old and gave birth to her first and only daughter at Friendship three years ago. This is her account of her birth experience which ultimately was traumatizing for her:

> I think it was all very weird because it's like, I kept telling myself you know I can't really plan for it, I don't know what to expect, and I also didn't really make a decision before going in whether or not I wanted an epidural, just kind of wait and see but assume I will get one, I'm sure it's not gonna be bearable without one. Like I was not anticipating a lot of things that happened. I was trying to like, I basically read a lot of books about it beforehand and stuff to kind of know somewhat to expect, but for instance my water broke initially and everyone was like, that only happens in the movies! And I was like ok, so it's not gonna happen. And then my water did break so I was like freaking out! And then I like still had some time to like, get to the hospital before my contractions started and stuff. But my labor progressed super quickly. So, I was only in labor for seven hours total and two of those I was pushing. So like, yeah I dilated really, really quickly. And I think I wasn't you know, mentally prepared for that. I was going into it thinking you know for most people it takes all day or you know whatever it is. And I

> thought I was gonna be able to maybe get in the water to labor or do some different things. I could not move my body I was already way too far ahead. I think for that reason, by the time they were like, oh do you want an epidural now? It was already too late, kind of, I felt like to get the epidural because, like and I mean it was painful to get it obviously too. But then it was like I had lost feeling, and I felt like I lost control. And I was not really sure what I was doing. You know? Or how to really give birth?

Tess began to panic because she felt like this whole process was not what she expected. The intervention was intimidating and consisted of things she had never even heard of which caused her to panic even more. Her story continues:

> Tess: And like, nurses, I think, sometimes too can feel a little burnt out occasionally on their job. So I think it's dependent on who you have with you. But I just remember I had one nurse who was like yelling at me to push and screaming in my face, and it wasn't like that bad, but when I'm already in that much pain and I just need help, it was very upsetting and just not, you know, I felt like I was like failing a little bit at giving birth because I couldn't push and then they did have to do an episiotomy[26] which you know, that just happened and I didn't even, you know, like of course it has to happen to help the baby out. It was one of those things I was not expecting. And was like, and even after that I was just like pushing for a while and stuff so they had to have, I think they said

[26] An incision between the vaginal opening and anus to lengthen the opening for birth.

something like I could try to push like two or three more times and if that didn't work they would have to do a C-section.

Sia: Oh my gosh.

Tess: I know! But before that they brought in the doctors to use the vacuum to help basically like suction her out. And that terrified me because I didn't know that was like, you know, I didn't know they did that! Even with all the reading I was doing of this could happen, this could happen, and hearing from people, like I never once heard that, you know like, using like tools to assist delivery in that way sort of thing. And so, oh that's what it was! They could try that two or three times and if that failed then that's when they would have to like do a C-section or something instead. I think that's what they were saying. It's all a little blurry honestly too.

The new interventions continued and Tess implies here that there was a lot she did not consent to in the process. She also references feeling like a failure. Several women who had to have interventions when they were planning on having a more natural birth concurred with Tess's feeling. Some of the common themes were claims that women felt like their body *should* be able to get through labor on its own so when it unexpectedly needs help it is disappointing. A lot of this lack of or miscommunication is caused by the fact that professionals tend to spend very little time with women during their prenatal appointments. At Friendship, this can be attributed to the high patient load that resulted from the Pine Ridge Closure.

Tess did not know the provider who ended up helping her deliver her baby. This contributed to her birth trauma. She said, “I think, like, I thought that’s just kind of like the way it was, you know? But I think it, it, I think like probably subconsciously even when I was in that place it bothered me a lot. Just because like it would be, like it was just not expecting to feel so, uncomfortable and kind of like, even like embarrassed a little bit? Because it’s like, I just felt like if I was with someone I knew and was really comfortable with, it would have been a little bit better. I just didn’t expect the feelings of like oh, I don’t really want to birth my baby in front of all these random people who are just like, you know like staring at me naked? It was just, I just didn’t expect you know it to be that like intense I guess.” This is a scenario that unfortunately happens often. While Friendship tries to arrange for each patient to meet each provider, sometimes there are schedule conflicts and a woman may not meet everyone which carries the risk of her delivering her baby with a stranger which is frightening and disempowering. I asked Tess how she would prefer to deliver her next baby after having this traumatizing experience. She said:

> I think I would want to go somewhere like an actual birthing center or somewhere that’s like a little bit more like, centered around care of the mother and giving birth and providing support and like a comfortable environment. And like, tender care. Ha! And care that’s just like much more like of a peaceful environment sort of thing. And I think if I ever got pregnant again, I would really get into like researching it a little bit more and finding out exactly where I would want to go or potentially doing a home birth or having a doula or something very personalized to me so I can be comfortable with, beforehand and stuff. I would definitely

> research my options a little bit. And then kind of like choose something like, not a hospital setting basically.

Once again, Tess is an example of someone who wished they gave birth in a more natural way. Unfortunately, her desire to go to a birthing center for her next pregnancy is one that will be very difficult to navigate in the context of scarce obstetric care facilities where she lives.

“The One Game In Town:” Choices Matter

It surprised me how many women echoed Tess’ desire for a birthing center. But up in the Sunflower Mountain Region there are only a few hospitals that provide birthing care. None of these hospitals are top tier and therefore cannot perform high risk births such as Vaginal Births After Cesarean (VBAC) or other specialized services. There is only one birthing center relatively nearby and it is about two and half hours off the mountain. In discussing her birth experience Caroline said that she “went to the one game in town” to give birth. Her phrasing struck me: Friendship really is the one game in town for pregnancy and birth. For Rita County residents, there is no game in town, so Friendship is their one game as well. This scarcity of birthing resources has a lot of impacts but women who imagine a birth not in a hospital are immediately thrown out of their worldview thereby altering their conceptual outcome of birth. As Caroline explained, “Um, I had wanted to go to a birth center. That would have been my chosen, like birth plan. But the closest birth center is two and a half hours away. I’ve heard a lot of people say that actually. But really our only choice here is Friendship if you want to stay in town. And so I did that.” Her use of the oxymoron “only choice” is especially

prevalent here. Caroline told me she did have a good experience at Friendship. When I asked her if it met her expectations she said, "well, there were some kind of preferences I had had, I really wanted a room tub, I would have preferred to be in a bath while giving birth, although that wasn't an option. I had wanted to try to do it without an epidural although that ended up not working. I did get one because I had back labor. I wanted to have a doula but because of COVID I couldn't do that. I wanted to have kind of like a quiet, space around me and that didn't really happen because it was a tiny room and just so many nurses in and out. Which is fine, I get it." Because she did not realistically have the option of using a birth center like she wanted her preferences seemed to tumble down like dominoes. Like so many women, she was forced to forgo her ideal situation due to structural limitations.

Birth, Choice, and Empowerment

In an online survey I conducted in October 2020, 12 of the 26 respondents who chose to answer the question: "What would you change to make your birth experience more positive?" explained that they were frustrated by their lack of choices. One notable response is as follows:

> "The lack of birthing options in [Beulah County] is very limited (only the hospital or a home birth). I wish there were more holistic birthing options or a birthing center. It feels disempowering to not have any options."

Empowerment, or "a process by which those who have been disempowered are able to increase their self-efficacy, make life-enhancing decisions, and obtain control over resources" (Prata 2017), is often brought up when discussing pregnancy and birth. As Marianne Nieuwenhuijzea and Patricia Leahy-Warren established in content review of

articles on empowerment in pregnancy and birth, "Empowering women is expected to have a beneficial effect on a woman's psychological well-being during the childbearing period and her readiness to face the challenges after birth, where she needs to adapt to a new role as mother responsible for raising a child (Garcia and Yim 2017; Raymond et al. 2014; Nilsson et al. 2013). Additionally, a positive birth experience also seems to have an empowering effect (Olza et al. 2018; Lewis et al. 2018)" (Nieuwenhuijzea and Leahy-Warren 2019). Through this analysis, the authors found that general empowerment during pregnancy and birth can be attributed to a set of external and internal factors. The external factors are gender equality, access of control and resources, and facilitation of women's choices and decisions. The internal attributes are women's belief in own abilities and control over situation, self, and others (Nieuwenhuijzea and Leahy-Warren 2019). This list of factors is relevant to the situation in Beulah County and the narratives of birth experiences dictated in this chapter. The level of belief a woman has in herself and control of her birthing situation is affected by her intersectionality and positionality in society. For example, the fact about giving birth as a Black woman in the United States is: "In the United States, if a Black woman and a white woman with the same exact physical characteristics (weight, height, blood pressure, etc.) receive the same prenatal care, the Black woman is likely to have a worse outcome than the white woman. Black women are more likely to have small babies, early babies, pre-eclampsia and high blood pressure. What's more alarming, Black women are about four times more likely than white women to die in pregnancy, and their babies are two to three times more likely than white babies to die within the first year" (Barnes 2020). In public health dialogue, race is often tagged as a "predictor" for negative birth outcomes (Fulda et al. 2014). But that is a

misconception. Racism is the actual predictor. When Black women understand the higher risks of birth they experience due to massive medical racism, it is understandably far more difficult to feel empowered and confident.

Each of these internal factors are relevant to this research but the external factor of facilitation of women's choices and decisions are nearly absent in birth situations at Friendship hospital. Removing these choices and decisions is an example of a stark increase of risk. When women do not have these choices, their risk of feeling disempowered during birth increases substantially. Women have no control over the type of birth and provider they will have which leads to disempowerment in birth (Nieuwenhuijzea and Leahy-Warren 2019). The authors also identified a series of antecedents to empowerment, or factors that enabled women to realize and achieve their empowerment. One of the most critical antecedents is the ability to make choices in the birth process. The authors write: "The opportunities for a woman to make her own *birth choices* also need to be present, explicitly mentioned in some papers were access to home birth, physiological childbirth and midwifery care. Acknowledging a woman's participation and control over her care can facilitate her empowerment in pregnancy and childbirth. A philosophy of *reverence,* which includes trust, listening and respect for a woman's autonomy also contributes to her empowerment" (2019). While there are ways to combat the disempowerment a lack of choice presents, the onus falls on individual women to exhibit high levels of resilience to adapt and find empowerment despite the structural limitations. As shown through the narratives of women whose conceptual outcomes of birth were negative and their wishes and ideas were disrespected, birth choices and respect of preferences are severely lacking in the Sunflower Mountain

Region. The lack of choices, especially at Friendship Hospital, is caused by the elimination of obstetric services in the region. Eliminating rural care is an act of mass disempowerment.

Back To Annabelle: What it Takes to Be Resilient

> "I will say my birth was the single most empowering thing of my entire life. The most empowering. I felt like the most badass woman ever. Like I just felt so empowered. And why would you want a whole generation of empowered women? Because let's see... who's in power and who has been in power since Christianity took over if we really want to get into it? It's the patriarchy and the men. So let's take away their midwives and take away their herbs and let's burn them and kill them for being witches and free thinking. And let's put them on their backs for labor and let's give them things and let's use forceps, which were invented as a torture tool actually. They were not invented to help they were invented as torture. And used readily. Everybody had them. And that was just something you started to use. Then started giving women medication so they couldn't remember and making them docile. There's just like so much that's really in it where I feel like now we are finally, most of our generation is starting to be like, we don't want children or like no we're taking back an empowering birth. And um, it's going to be an interesting paradigm I think. Yeah. Because it is powerful. And it is amazing. And we are birthing nations. We're keeping the human race going. And we don't need a lot of men to do it."

Annabelle, the woman I opened this chapter with, had what she adamantly described as an "empowering" birth. She is the only one of the 53 women I interviewed

who used the term “empowering” when discussing her pregnancy and birth. Like several women, she expressed that she wanted to give birth at a birthing center. But unlike everyone else, she decided to commit to driving the distance to do it. Annabelle’s story shows the lengths she goes to push back against the risk of disempowerment in birth that was structurally likely in her home county due to the lack of birth choices. This is extreme resilience. As I stated in the introduction to this dissertation, resilience can be empowering, but also exhausting, frustrating, and even risky in itself. Annabelle’s story exhibits this. I asked her when she made that decision, and we had the following conversation. I started by asking her if she was always planning on going to the birth center as soon as she found out she was pregnant:

> Annabelle: I was absolutely like, we are absolutely not going to the hospital. It’s not happening.
>
> Sia: Just from things you had heard?
>
> Annabelle: Yeah because I was a nanny I was able to like, hear things. And I was really interested in the birth world, interested in becoming a doula a while ago, because I found it fascinating and I was just learning what I could. And through that, there’s an awesome documentary, it’s called *The Business of Being Born* and that’s just like uh huh, nope. They don’t have my best interest at heart. They don’t have my, my wishes I guess. Or my vision. They don’t...It’s just one of those things like, I don’t trust them, I don’t trust them not to perform things without my consent. I don’t trust them to not bully me. I don’t trust, I just don’t trust them. And I’m not going to put myself into the most vulnerable position of my life not

> trusting people. Not trusting people and having them tell me something is wrong with my body and making me not trust myself. It's kind of like gaslighting really."

Annabelle became interested in birth when she first started nannying. She happened to work for families who all were part of the home birth community in the area. Conversations with these families catapulted her interest and inspired her to do more research and learn more about birth in general. She is extremely well informed and clearly has done a lot of reading and thinking on this topic. Throughout our conversation she was casually dropping statistics and facts and I really learned a lot in our time together. She referenced "horror stories" of local care but did not want to discuss these because she did not want to violate the women who she heard them from. But she was strong in her conviction that she was not going to Friendship. She even said, "I would have rather not had prenatal care than go there. I would have rather done it myself and just been like, if there's something wrong, I'll know." Other women I spoke to had similar sentiments of distrust but only Annabelle weighed the risk of hospital birth as less desirable than driving a massive distance to prenatal care and delivery.

The birthing center is two hours and fifteen minutes from Annabelle's home. She started by finding the closest birth center that her Medicaid would cover and then went to visit. The center is everything Annabelle imagined for her birth: beautiful comfortable rooms, a large tub, and a luxurious, clean feel. Because she lived so far away, her midwives allowed her to space out her prenatal appointments to every six weeks instead of every four weeks. She was also able to do this because she had no risks in her

pregnancy and was completely healthy. When I asked her about the long drive to care she said:

> God, it’s so annoying. Um, yeah it was really annoying and I think towards the end it was almost, it was uncomfortable because he [Caleb] hated the position I was in when I was in the car. So he would like, push. The whole time he would be pushing up or pushing out at my ribs. And they have really bad food options there, it’s like only fast food. I mean I'm not gonna lie, I’ll eat fast food. Especially in the first trimester more than really ever in my whole life. But you finish your prenatal appointment and it's not like I’m like let’s go to McDonalds. It’s just like I want a frickin like yummy, something. And I suppose I could have like brought lunches, but it's just more work. It is a whole process. It’s a whole day thing. It is *a whole day thing*. Fortunately, I don’t know any different. I don’t know what it would be like to just go locally and just have it be like a twenty-minute thing out of my day. I only know four and a half hours of driving probably like a half hour of waiting, a half hour of an appointment. So, five and a half hours.

A five and a half hour round trip for a prenatal appointment is a huge deal. Both Annabelle and her husband had to take off work for the entire day for these appointments. Fortunately, they both had a lot of schedule flexibility at the time, but the loss of a day’s income was tough. But she prioritized feeling safe and supported during birth and she truly viewed this as the only option for someone living in Beulah County.

Annabelle does have a series of factors working in her life that allowed her to navigate the long drive to the birthing center that other women who would want to give

birth this way may not be able to do. First of all, she worked as a full-time nanny which allowed her much more schedule flexibility than someone who may be working in a factory, at a hospital, or in food service. She created her own hours, and her employers were mothers in the home birth community and were very supportive of her choices. She describes herself as a low-income person and uses all programs she is eligible for through the government to help, but at the time of her first pregnancy she was married to a person who also was working. This made them a two-income household. Many other women who I talked with are single mothers, have rigid schedules, and would not be able to afford the gas money to drive to the birthing center. Additionally, this was Annabelle's first pregnancy meaning that she did not have other kids to worry about with travelling or finding childcare. Her specific life structures enabled her to make this difficult plan to access the birth she wanted. Her second pregnancy will look much different as a now single mother who has lost a lot of work due to the pandemic. I will discuss those changes later in this section.

"It Was Unplanned, Though"

At 36 weeks into her pregnancy, Annabelle felt a sudden urge to begin collecting lavender, chamomile, and hibiscus. She explained, "I was like, hey you know I'm getting this inkling I should start collecting herbs for postpartum hemorrhaging. I'm just going to start gathering things in case he comes at home." This inkling even surprised her. She always liked the idea of having a homebirth, but she really did not feel comfortable enough to do it. The firm plan was to make the two hour and fifteen-minute drive to the birthing center. But if that did not work out for some reason, Annabelle made it very clear that she would not be going to Friendship Hospital or any hospital. She continued, "There

is a local homebirth midwife, which is technically illegal in the state so I'm not going to mention names, I asked her like so, if I were to gather herbs what would you recommend? The main ones I should get. So I just kind of looked locally super casually. Like if I see them, I'm gonna get them, but I'm not going to worry about it because that's not my plan, right?"

Annabelle's gut was right. Here is her voice telling the entire story of her unplanned homebirth:

> Annabelle: So we drove down to the birth center, we got there around two in the morning. And there they don't do cervical checks unless you're in labor in order to be admitted because of the state regulations for birth centers[27]. You have to be progressing a certain amount per hour or every four hours or else you have to transfer to a hospital. And that's not their thinking, that's state regulations. So they don't like to admit, especially first time moms, because it can take longer. They don't like to admit them until they are four to six centimeters dilated which is almost active labor. Because usually from active labor it's shorter time there and there's less transfer rates. So most women, when they're in labor, get like a hotel and then go back. So I got checked, I was one centimeter. But we are kind of penny pinchers so we went outside and walked around, but then I was like let's just go back home because it will probably be a few days even. Like there's no... I mean it would be another thirty hours at the least. Because that's kind of average first time labor I guess. So we came home and we got home around 4:30 am

[27] Note again the state requirements for hospital admission based on "progress" in labor which is used to shorten hospital stays.

and… my husband, I guess we're still married, but at the time, he went to sleep. He was like, 'I'm gonna get some sleep.' And I was like, 'I'm gonna get some sleep too because I want to be good to go for tomorrow, because he [her baby, Caleb] will come tomorrow.' So I was like we will just go to sleep and wake up and drive down once we get a full night of sleep. So, he went to sleep and I kept trying to wake him up but I was in the bathtub and I didn't have my phone with me. But finally as he [Caleb] was crowning, so I don't know if you know much about birth but there's a good while where, whatever body part is gonna come out first will come down into your birth canal and go back up, while your fundus[28] is trying to go up and over, and then the fundus will come up and over and then there is what they call the fetal ejection response, so the fundus will push the baby out. *You* don't have to push a baby out. That is a MAN not woman, a MANMADE thing used in order to intervene and torture women. Back when obstetricians, OB and gynecology started becoming a thing and they started demonizing midwives for abortion and witchcraft because they were using herbs. Not that we're getting into that! HAH! So anyways, I'm waiting for that and I'm like, oh my gosh, in my mind it wasn't a baby coming out in my mind it was like my bowels. Because I was told I was like one centimeter. And when you're that far into labor you're kind of in la la land. Even my friends who have had many children are like yeah, I don't even know I'm in labor until I'm pushing the head out. Because it is so painful...

[28] The large, hollow part of an organ furthest away from the organ's opening.

Sia: You kind of dissociate a little?

Annabelle: It's absolutely what happens! Um, I was almost even like hallucinating like my ancestors around me and I was like this is the most beautiful spiritual experience ever! I didn’t even realize what was going on. So anyways I was like, oh gosh, something is really wrong. And I must have on some level realized what was happening, but that wasn’t the dialogue going through my mind. But it was painful. He was coming down and went back up a couple of times. And I was like this hurts so bad! And so I got out of the tub, opened the bathroom door, screamed for my husband and just hobbled back to the tub sobbing. He’s like, ‘what's going on! What’s happening!’ I was like, ‘I need you to go to the car and get the birth bags and get the paperwork in the birth bags.’ And he was like, ‘ok ok,’ so he was trying to find it. And he’s wearing boxer briefs and big skein socks and nothing else. Like completely, just like so dorky right. So he’s like, ‘I can't find the paperwork! Why do you need paperwork? What’s going on, why are you like this?’ And I was like ‘I need to figure out when we need to call the midwife! Because I don’t remember when we were supposed to do that.’ But I remember we were supposed to call at some point, but I need the paperwork to figure out where I am in labor so I can figure out when to call. And he was just like, ‘well I think we should call now.’ I was like, ‘wait are you sure we should call now? I don’t want to bother her.’ I was like yeah you know, with him coming down my water hadn’t broken but I could feel a sac of water. So I was like, I did try to break my water. He was like, ‘ok so you tried to break your water… we need to call. You’re supposed to call immediately when your water breaks.’ So we finally

> called her at 8:09am and he [Caleb] was born at 8:20am in my bathtub. She was trying so hard to get me in the car. I was like, 'yeah, I'm not getting in the car.' And she talked us through everything, like afterbirth, cutting the cord.

There is a lot to unpack about this unexpected home birth story. First of all, Annabelle's herb collection speaks to the intuition pregnant women and mothers often have in regard to their body and their children. This sentiment is recurring throughout the interview data that emerged from this research. Women who did go to hospitals often felt like they knew their body better than their provider, but the provider seemed to think they knew better. For example, Diana in the previous section had to tell her nurse that her baby was actively emerging while the nurse kept denying that that was a possibility. This results in a lot of frustration in birthing interactions. Secondly, the state laws that prohibit birth centers and hospitals from admitting women who are not "far along" enough because they won't "progress" fast enough is an example of how these institutions are businesses that have a goal of getting people out the door and not occupying one bed for too long. Additionally, this does a massive disservice to women living in rural areas who often live very far away from the place they intend to give birth. Annabelle could not afford to stay in a hotel closer to the birth center so she had to make the two hour and fifteen minute drive back home. Annabelle reflected on what happened that night and what might she could have done differently:

> I still sometimes am like, how did I not realize what was happening? But even if I had, we would not have made it because he was so tired. And I couldn't drive in labor. And Paul [her husband at the time] was so tired. He could not have driven back down there. He was already almost falling asleep on the way home. We got

> home at 4:30am. He needed to sleep at least thirty minutes, you know. Um, yeah. So we would not have made it. At that point we wouldn't have. The only other option would be the hospital. And I'm not doing that. Because that would have been closer! Unless there had been a true emergency, and there are very rarely emergencies despite what they tell you. But it is a business and they do need to make money. And the more interventions they put in place the more money they make. So… They're not gonna be supportive of a hands-off interaction. Because the more they interact the more they make."

There was no way they would have made it back to the birthing center. If they would have tried, they may have been in an accident due to driving while exhausted or perhaps Annabelle would have had Caleb on the side of the highway. Annabelle spent about an hour with her newborn at home before her then-husband drove her to the birthing center to be checked by the midwives. Although this home birth was unexpected, Annabelle felt empowered by her ability to deliver a child by herself in the comfort of her home. Her ultimate fear and aversion was any kind of hospital and unnecessary intervention that might be pushed upon her in a time of vulnerability. She was able to avoid this entirely through her home birth.

Clearly, Annabelle went to great lengths to access the type of care that was inaccessible to her in her home community. She had to drive a long distance. The distance from provider, which is an effect she experienced that results from few birth choices in the Sunflower Mountain Region, created a risky situation. She was unable to make it to the birth center to deliver her baby and had an unexpected home birth. In this scenario, her choice to pursue the option for a birth the way she wanted it was

empowering but also risky. Additionally, the work she put into ensuring she would have a positive birth experience took excessive time and finances in travel and gas. Her choices, although empowering for her, result in stress over money and frustration in the fact that she must do this to simply access the care she wants. This shows how resilience is an admirable and positive response to obstetric closures, but it can also be exhausting, frustrating, and even risky.

Making Home Birth Accessible

When I talked with Annabelle she was 16 weeks pregnant with her second child. This time she was planning for an unassisted home birth with a midwife coming in afterwards to check on her. This is a tricky plan. First of all, in this state (and many others throughout the United States) having an assisted home birth is illegal. You can legally give birth at home by yourself, but a certified midwife is not allowed to attend the birth. Many women are not willing to give birth alone at home and therefore even if they are interested in home birth it is not an option for them. In this state it is legal to have a nurse midwife overseeing a home birth, but nurse midwives have to be overseen by an OBGYN, and there is only one in the entire state who is willing to attend home births. Essentially, this option is not accessible.

Even though Annabelle is committed to her home birth and has prior experience she still has many concerns. She explained:

> This baby might come New Year's Eve, New Year's Day. Up until between Christmas and New Year's. Which in this area is usually snowy. And babies tend to come when the barometric pressure changes. That's when they tend to come which is when he [Caleb] came too. It's probably very likely that baby will come

> during a snowstorm. And we live up a mountain. So it just depends who [which midwife or professional] can get here. Especially around the holidays because they have families too. So, um, it's just one of those things where it's like ok I have you, you and you. And the main deciding factor for that is cost. Because we can't afford- and I don't even know if I'm going to invite the father who is still my husband but we're not together. I don't want him there but can I do that and be ok with that later down the road? Um but the cost factor of having [a professional] there for the whole thing is way… we can't afford that.

Cost concerns come from the fact that Annabelle would have to pay a professional for their time out of pocket. Medicaid does not cover this at all because it is illegal. Annabelle has been fervently reading home birth books and other resources to ensure she is as knowledgeable as possible. I asked her about her ideas on potential emergencies and her backup plans. She obviously has thought about this a lot. She shifted a bit in her seat and looked over at Caleb playing on the nearby playground as she spoke. Her response almost felt like she was thinking through it out loud to me:

> If it's an emergency I'll probably be having a C-section and in that case it doesn't really matter. I'll just go to the closest place. Might even have to go, if it was an emergency I could even go to um, [the next state over]. Which is further away by like ten or fifteen minutes but they've got a better NICU there and things like that. And Medicaid would cover an emergency there. So it would just kind of have to be like, we would have to say 'oh we're travelling! We were just driving through [the nearby State] and it happened!' But there are things that are like, just be

> aware of this. And this is an emergency. Obviously if my placenta[29] is covering my cervix I won't be able to give birth at home and I will need the C-section. And that could be planned out in advance. I probably wouldn't plan it in advance other than in my mind. I would not schedule it. I would just be like oh well I'm in labor. And go in and be like I'm in labor and my placenta is covering my cervix so take me into a C-section. Ahhh!

Even when thinking through an emergency situation, Annabelle prioritizes having as little interaction as possible with the hospital and staff. She seemed nervous and stressed while talking about the possibility of a C-section. Clearly with her worldview this is not something she would ever want but she is very knowledgeable on the necessity of some interventions and is realistic about that in her planning. She continued:

> Annabelle: And obviously if your cord comes out first, cord prolapse, you either need to push that baby out in the first one to two minutes it happens or you need to stop pushing, put your butt up in the air and get to a C-section immediately. And that is the only situation where I feel nervous because we are far away from the hospital. That's the only situation that I am really nervous for. Because it would be faster for us to drive there versus an ambulance, because an ambulance would have to come here and then go back. And they can't perform a c-section in the ambulance. The only thing is that an ambulance can drive through red lights. Which you can't do as a civilian even if it's an emergency. So, that part I haven't

[29] An organ that develops during pregnancy in the uterus to provide nutrients to the growing fetus.

> really given much thought to. It's more of a keep that in mind that could happen type of thing.
>
> Sia: But you have a healthy pregnancy and everything?
>
> Annabelle: Yeah for sure. But with a prolapse you don't really know when it's happening. So that would be something where I would have to try to push that cord back in and put my butt up in the air and go. Go naked. Butt naked. Cover me with a sheet, call the medical center right now and let them know we are on the way and they need to have an OR prepped and ready to go. Things like that where it's like, ok that does need emergency care. I think it happens with 3% of births in the hospital and it happens more with induced labors. So it happens very rarely with, there's no studies on, there's not *no* studies on but there's less studies on how often it happens in undisturbed birth.

Clearly Annabelle knows her options and has plans. It seems that this deep knowledge enabled her to feel as empowered as she did in her birth. As previously stated, Annabelle was the only mother I spoke with who gave birth at home. Other women expressed an interest in doing this, but due to the illegality of assisted home birth and subsequent cost this is an inaccessible option.

The illegality of this method combined with social and medical pressure to give birth in a hospital with a doctor is very limiting. Reporter Sara Burrows wrote an opinion piece on this topic. She explains: "obstetricians actively seek to suppress home births. As partial justification, they cite a study published by the *American Journal of Obstetrics & Gynecology* warning that planned home births have a neonatal death rate "at least twice

as high" as that of planned hospital births...But the figure is misleading. A rate "twice as high" represents two out of 1,000 deaths, rather than one out of 1,000 deaths. That's a miniscule difference, if you trust the study, which most home birth advocates don't. What the doctors also failed to mention is that the same study admits there is no significant difference in perinatal mortality (or the death of a fetus), which includes stillbirths" (Burrows 2012). This relates to a lot of the anthropological research on home birth that discusses the stigma that home birth mothers feel when professionals assert that they are being reckless. Many anthropologists, social scientists, and activists have written about this concept. In Melissa Cheney's study on homebirth systems and challenging authoritative knowledge, she interviews a woman who says, "When I told my doctor I was thinking of having a homebirth, he said 'Cool, and while you're at it, don't bother with a car seat.'… He totally discounted me even though I had printed out a full bibliography of over 100 studies on the safety of planned home birth for low risk mothers" (Cheney 2008: 258). Like Annabelle, the mother in this study was completely aware and knowledgeable about her options but the skepticism about homebirth from many biomedical professionals is potent.

Actually, Just Making Something Accessible

To be transparent, I myself am an advocate of home birth and midwifery care. Making home birth and non-hospital birth (ie. in a birth center) accessible to all women is feminist praxis, empowerment, and a restoration of equity. This is a statement of my own personal ideas based on my reading and research. After talking with Annabelle and hearing her keen statements of female power and capability in birth combined with the necessity of not leaving her home to have her baby, it seemed to me like advocating for

and making home births more acceptable and accessible would be a productive way to support pregnant women in areas that lose proximate maternity services. Additionally, after learning more about hospital birth and the priority that profit takes and hearing stories of trauma and hurt, I even had the thought that the solution might be for everyone to give birth at home. Of course, that cannot be the answer. As I explained earlier, eliminating rural birthing care is an act of disempowerment of rural women. Disempowerment is a result of a lack of birthing choices. At its core the elimination of rural obstetric services is a removal of choice. Women deserve choices in their birth processes. Home birth is not the full answer but making it more accessible at least restores some other kind of option in the birthing process. When policy-makers close maternity units in rural counties they are eliminating choices and restoring nothing in their place, cementing the disempowerment in birth in rural America. The next chapter will explore the decisions that powerful stakeholders make to close rural obstetric services and the motivations and perceived consequences of that choice.

CHAPTER 4: WHY DO RURAL OBSTETRICS UNITS CLOSE?: TWO PERSPECTIVES ON A MATERNITY UNIT CLOSURE

"When an obstetrics clinic closes, it always sort of follows, like for the most part I can kind of pretty much predict how it's going to be. And it's usually like the hospital is like, man, we don't have enough births in the county and it's really expensive. And anyways, there are other obstetrics units like an hour away. So, you know, they close the unit now and that's it. And that's kind of how it is. And, you know, sometimes there's like, depending on who owns the hospital, maybe there will be a hearing about it. Maybe the county will be involved, but it's always the same. And so then what happens is people are outraged, right? Usually people are like man, like is this is the fate of our children and our women?! This is really awful. And sometimes they might form like Facebook resistance or write letters or show up in meetings. And it would be very, very emotional. But that tends to fizzle out because what ends up happening is the hospital is like, well, we're closing it, we're done, and there's nothing that they can do about it." -Ellen Mengel, Local Health News Reporter

Introduction: What Happened to Birth in Rita County?

Ellen Mengel is a local rural health reporter. She covers all the obstetric closures in the state. At this point she can easily lay out the template for closures because it happens frequently and tends to play out similarly each time. I will return to Ellen and her expertise later in this chapter. Her potent words and concise summary of how obstetric closures play out in rural communities concretely describes many of the dynamics of closures.

In Chapter Three I discussed the Pine Ridge Hospital obstetrics closure and the impact that has on individual pregnant women and mothers throughout the entire Sunflower Mountain Region. As I explained, the Pine Ridge closure caused an increase in patient flow to Friendship Hospital in Beulah County which resulted in the "everyone sees everyone model." This model can be disempowering to pregnant women as it eliminates the choices they have and negatively affects their conceptual outcome of birth. This has lasting effects on their lives and parenthood. This closure also has substantial impacts on everyday lives in the community. Beyond the impact on pregnant women, closures also affect health professionals trying to provide the best care possible for their community. It is important to trace the closure from the point of view of providers and professionals. The goal of this chapter is to explore the Pine Ridge closure from the perspective of healthcare professionals, CEOs, and others involved in the decision-making process to show how the decision to close a rural obstetrics unit is made. Ultimately, chapters three and four together aim to show the impact of this closure on multiple people who experience it on different levels to understand more about the risk of closing obstetric units in rural Appalachia. I have previously stated that when hospital administrators choose to cut an obstetrics unit, they shift risk away from the hospital system and onto the individual bodies of pregnant women. The risks the hospital considers is primarily in terms of money: whether that be income from insurance and patients or the potential of lost income through costly lawsuits. In this chapter, I will focus on the risks hospitals face by keeping obstetric units open in rural areas and ultimately why they are frequently shut down.

Chapter Overview

In this chapter, I present two different accounts of the Pine Ridge Hospital Obstetric closure that occurred in 2015. The first discussion of the closure comes from the point of view of Dr. Christopher Gallagher. Dr. Gallagher was the primary family doctor in Rita County throughout his career and delivered most of the babies in the county during this period. He also sat on the board of directors at the hospital when the decision to close Pine Ridge obstetrics was made. As a health professional seriously impacted by the closure, his story is very important. The second account will come from Jeffery Donovan, the CEO of the hospital system in the region at the time of the closure. He is the one who had to make the decision and cut obstetrics at Pine Ridge, so his perspective is very interesting as well. I go on to explore the narratives of rural healthcare providers to show how obstetric closures impact their work and the creativity they use to support the community. I use the framework of "sacrifice zones" (Scott 2010) to understand how obstetric closures create sacrificial zones of birth in rural Appalachia.

Two Accounts of the Pine Ridge Closure: Dr. Gallagher

The first midwife I met in the Sunflower Mountain Region (Meredith Jones, introduced in Chapter One) sent me contact information for the primary care physician who she worked alongside at Pine Ridge Hospital. She said he would be a great person to talk to because he was the primary care physician in the county for four decades, meaning that he attended the births of much of the Rita County population. Before calling him, I googled his name to see if there was any more information on the internet. The first result was a retirement announcement and long biography and life story of Dr. Christopher Gallagher. A large photo by the title of the article showed an older man with light gray

hair and a warm and soft smile. He was wearing khaki pants and a light blue sweater standing with his arms crossed in front of the hospital. The tone of this article was evidence that Dr. Gallagher was a huge community stakeholder and was respected and cherished by the entire county. I already knew he was a big name in the area. Nearly every person who I talked with who lives in Rita County speaks fondly of Dr. Gallagher and explained how he is missed in his retirement. There is a local hospital and exercise building named for him. Coincidentally enough, when I applied for the PEO women in education scholarship, I was interviewed by a woman on the board who was originally from Rita County. She had not lived in the county for many years now, but she also remembered and raved about Dr. Gallagher. This man has a big name in Rita County and beyond, so I was really looking forward to talking with him.

I gave Dr. Gallagher a call on a fall afternoon in October 2020. I only had his office phone number so I could not contact him beforehand to set up a time. It felt like an ambush, but this is part of the COVID phone interview game. He answered on the second ring with a formal *"hello?"* likely because I was calling from an unknown number from out of the area. I explained who I was and asked him if he would be willing to talk with me for a little bit. He knew of me through Meredith and was happy to chat. We immediately connected as we discovered that he spent some time living near where I grew up and he trained at the university where I completed my bachelor's degree. I started asking him more questions about his work, but about 8 minutes into our conversation he explained that his sister was in town and he and his wife had plans to meet up with her this evening. I profusely apologized for interrupting his day and assured him we could reschedule. He said, "well how about tonight when I get back? I'll give you

a call around 9 pm." I told him we could do another day not so last minute and late, but he definitely wanted to talk as soon as possible. When he called back that night his voice was slightly hoarser likely from an evening of catching up with family and he stopped every few minutes to cough a little bit. I told him I would be as fast as possible but he kept re-stating how happy he was to talk and can tell me whatever I need to know.

Dr. Gallagher has been living and working in the Sunflower Mountain Region for about 45 years. After medical training and various hospital experiences, the Gallaghers settled in Rita County. When I asked him why, he said: "well my wife and I both like the idea of living in a small town. I didn't know it would be *this* small, but where we live here it's about 300 people when everybody's home. Yeah, but we both liked that idea, and it really is fun to be an integral part of the community. You know everybody and they know you. So, yeah it's a lifestyle more than it is a job." Much of this response aligns with anthropologist Christopher Lockhart's work on rural physicians and rural healthcare (Lockhart 1999). Lockhart records how physicians describe their "quest" and "journey" to becoming a rural doctor. They view this journey as personal and wholistic and prefer the blurring of dichotomies (personal and professional) that a rural clinic offers. Dr. Gallagher also expressed the challenges of being a rural family practice doctor. When I asked him about the difficulties of his job, he responded honestly that it's not a very lucrative way to be a doctor. After saying this he quickly added: "But that's ok, that's what I chose to do." I could already tell that Dr. Gallagher was not in this for the money. Another challenge that he faced as a rural doctor was the isolation and pressure you feel as the only provider. He explained:

> It can get pretty lonely. You know, when it’s just you through all the nights with a labor that’s not going well and it’s two in the morning, there was this patient who stopped progressing and you don’t have a surgeon right next to you, what do you do? You know do you stick it out? Or do you need to call in or transfer? Just, so you really are more on your own in that moment than any other time and you have to exude confidence with your patient. So, with your patient you know, you explain to them what’s going on, but you don’t want them to know that all of your hands are tied here.

This is a very legitimate fear and issue for rural practice physicians, especially those delivering babies. For the same reasons that women in the region face barriers to getting proximate obstetric care, physicians face barriers to receiving timely support from backup such as other doctors and surgeons. Dr. Gallagher went on to tell me a story of a time he had delivered a baby but then the mother’s uterus became completely inverted. He had never seen that in his career. He ended up calling a surgeon in a different county who luckily was able to talk him through this. Dr. Gallagher said the key to facing this issue is being honest with yourself. You have to know what you can do and you have to know when and how to ask for help with the knowledge that help may not get to you in time. This is a high-pressure situation. Dr. Gallagher said, “With delivering a baby, I’ve always heard that obstetricians are bored one minute and scared the next. I never was bored, but I sure was scared.”

Two Accounts of the Pine Ridge Closure: Jeffery Donovan

Mr. Jeffery Donovan was the CEO of The Sunflower Mountain Regional Healthcare System between 1989 and 2017. He was the CEO during the Pine Ridge

Obstetrics closure. I found his email address in May 2021 and contacted him to see if he would be willing to talk with me. In his retirement he teaches a few courses at the local university. Because we spoke in May just after the school year, I could tell he was exhausted by the pandemic virtual teaching shifts and was ready for his summer vacation. In fact, at the end of our conversation he confessed that he had not really wanted to talk to another student on his break, but he saw I was from the University of Kentucky which was the reason he decided to call me. He laughed through his explanation: "The only paper that I ever wrote that was published was published by the University of Kentucky. And I actually was able to come up for an event. It was the late eighties, I guess. And I got to present my paper at the University of Kentucky, and it was in that building...It was just like a really tall classroom building. So yeah, on my resume that that's listed as my one and only sort of academic thing." I was very grateful that Kentucky (and the Patterson Towers) pulled through for me on this and gave him a sign. He took a break from mowing his lawn to talk with me.

There were other reasons he wanted to talk to me as well. Early on in his career, Mr. Donovan developed a passion for maternal and child health. In the late 1980s, the state had some of the worst infant mortality rates in the country. This was shocking to many people. As Mr. Donovan said, "we knew we probably weren't the best… but we at least figured we were mid-range!" Mr. Donovan began doing some informal research through asking around and found that one large determinant of the infant mortality rates was a lack of consistent prenatal care. In the rural area he was working in, Mr. Donovan heard from health providers that many women are unable to attend their prenatal appointments due to a lack of transportation or gas money. Mr. Donovan began applying

for state grants and endowments to work towards a solution. Back then the region did not have many midwives and it was difficult to get healthcare providers to accept midwives into their practices. Mr. Donovan started pushing for midwifery to be prevalent in the region which ultimately resulted in better prenatal care and birth outcomes. Additionally, the team he compiled found that transportation was a huge barrier to accessing care. This is still one of the most substantial problems in the area. He explained his work on this project:

> But what we did with it, we hired a staff, probably three or four people maybe, and we bought vans. We had three vans that we would make a circuit. They would go out and they coordinated it with the patients, with the mothers to be. But they would actually go up to our county and surrounding counties and provide transportation back over here for particularly the prenatal care and at the time of delivery...At that point, I think they think they could get here for the delivery, but it was their prenatal care, prenatal care that was missing. They might make one visit and then they just wouldn't make any more to show up in the emergency room with the delivery. So we worked on that.

This intervention was very successful in improving infant mortality rates in the state. Mr. Donovan clearly has a lot of experience working with maternal health. He also held his CEO position for over 30 years, so he is very well-versed in healthcare in this region.

Dr. Gallagher and Mr. Donovan are two very impressive professionals who have had successful and impactful careers. They experienced the obstetric closure at Pine Ridge from different perspectives which illuminate the points of agreement and disconnect on the state of rural obstetrical care. Dr. Gallagher has a close connection to

the patients who are directly impacted by the closure while Mr. Donovan has more connection with upper-level decision-makers.

The Scene at Pine Ridge Hospital

I spent a lot of time at Pine Ridge Hospital during the research period. I would have ideally liked to volunteer in the hospital to do some participant observation, but COVID protocols were very rigid during 2021 and the hospital was not accepting any volunteers. I still ended up in the hospital building very frequently because the Rita County YMCA is located there as well. While the infrastructural overlap is unique, YMCAs typically partner with health organizations for insurance initiatives like Silver Sneakers[30]. I offered free swim lessons to mothers, babies, and toddlers at this YMCA pool. The drive from my home in Beulah County to Pine Ridge Hospital is beautiful. Rita County sits at a higher elevation so much of the drive is up the incline of a major mountain in the region. The closer you get to the hospital the sparser buildings become. There are occasional billboards advertising a proximate state park and the sides of the road are dotted with Dollar Generals and small-scale farmer's stands. I would ideally like to take the opportunity of this long drive to call my grandma, but I always lose service on the trek up the mountain. The road is winding, and the traffic consists mostly of large trucks carrying lumber or other farm equipment. The final stretch involves taking a turn and winding up a steep, mile long drive to the hospital parking lot. At the top you can really see the elevation you just travelled. The mountains stretch far out into the distance.

[30] There are several examples of this across the United States. One Iowa YMCA partners with the local health system to "Lower health care costs as individuals become more involved in community wellness programs and less time in hospitals and emergency rooms. Engage individuals across the continuum of care addressing primary, secondary, and tertiary prevention." (Community Health Partners: https://my-chp.com/)

The hospital itself does not really look like a hospital. It is an old building made of white wood and stone with brown trim. If it was not so clearly labeled, it might be mistaken for a hotel lodge. There are typically several cars parked in front of the building but the entrance and parking lot have a feeling of stillness that most hospitals lack. There are not many people moving in and out. Most of the foot traffic is going into the YMCA, and there are occasional people wearing scrubs smoking in the parking lot. I try to imagine what this place might have looked like seven years ago when the birth and delivery unit was in full swing. Perhaps the traffic would be more bustling. Maybe the cries of babies would be more frequent and would occupy the large silence of this quiet parking lot in the mountains, signifying new life.

Figure 4.1: The Pine Ridge Hospital.

Figure 4.2: A row of empty "Doctor Parking" spots at Pine Ridge.

"Stellar Care": The Closure

At the time of the Pine Ridge Hospital Closure, Dr. Gallagher and two midwives (one of whom was Meredith Jones) were responsible for delivering all the babies in Rita County. Dr. Gallagher had been there the longest. He explained that he was always on call 24/7, but there were only a few weeks in his career when he was literally the only one in the county who could deliver babies. There used to be another hospital in the area that had physicians trained in birth so when that was operating his load was split. Then he brought on the two midwives to help at Pine Ridge. They were also constantly on call. This is what Dr. Gallagher had to say about their system at the time of the closure: "But when we had that group, we were providing, I think stellar obstetrical care. We were just really up to date and had really patient oriented care." Dr. Gallagher's explanation of having "up-to-date" care refers to the hospital having the newest technology and well-

trained staff. This is significant because many rural hospitals are criticized for being "behind" the times in terms of technology and workforce capabilities[31] (American Hospital Association 2019). People who require more major or complicated surgeries often must go off the mountain to larger city health systems for care. Dr. Gallagher continued, "And people would drive from two or three counties away to get their OB here, with us. We had the first birthing room in the Sunflower Mountain Region in our first hospital. It was just great." Because of this typical trend in the Sunflower Mountain Region, this is remarkable and a reversal of the norm. The strength of family doctors and midwives is their compassion for people and families and very personalized care. The Pine Ridge Obstetrics Program prioritized patients and their experience. The community absolutely loved this service and word spread quickly. People were opting to travel to Rita County even when they lived closer to a different hospital. This was back when women in the area had more choices in their birthing experiences which made it a healthier and happier environment for pregnant people. Dr. Gallagher and the midwives worked tirelessly to cultivate this cutting-edge obstetrics center that worked seamlessly with the community. Dr. Gallagher explained that he had worked very hard at that. He said, "that's where a lot of my energy had been. Going to that birthing room, creating just a wonderful family, OB experience. Whole families would show up for deliveries and extended families would show up for deliveries. It was such an uplifting experience." This is the type of personalized care that a lot of women who I spoke with desired. For example, in the survey I conducted one woman responded: "I felt like a number at

[31] This is an issue that has been exacerbated by the COVID-19 pandemic. Monetary and labor force strain in rural hospitals was further tested when rising COVID infection rates necessitated the use of more hospital beds and increased levels of care. (Diaz et al. 2020).

[Friendship] OB. I understand that people are trying their best but I would have felt more confident leading up to my second birth had they been more patient focused." A smaller hospital and family doctor can give personalized care, and Dr. Gallagher's office was doing just that for people to have great experiences.

Why Do Obstetrics Close?

In the opening pages of this dissertation, I claim that if you google the phrase, "rural obstetric closures" you will find pages of results about this crisis. Many journalists and researchers have written and observed this trend. Yet typically when I describe my research interests to people not directly living in rural America or completely immersed in this issue, their first question tends to be along the lines of: "Wow, really? Obstetrics is the first thing to go? Why?" That is a great question. On the surface, the choice to close obstetric units first when funding difficulties arise seems counterintuitive and blatantly misogynistic. Approximately 28 million women of reproductive age live in rural America (National Rural Health Association). Yet many of these women who are pregnant, mothers, or interested in becoming pregnant live in a county that has no obstetric services.

The National Rural Health Association has investigated this problem closely with a research team who delved into the closures from a public health and safety perspective. They identified the main factors that lead to obstetric closures in rural counties. The list includes: general cost, the complexity of Medicaid reimbursements, demographic shifts, workforce challenges, requirements for rural hospitals, the role of insurance, and patient choice (NRHA). Every one of these factors was discussed in my interviews and work during the research period. In my conversations with Dr. Gallagher, Mr. Donovan and

several other professionals, the most potent factors that contribute to obstetric closures in the Sunflower Mountain Region and beyond are low birth volume, a lack of skilled labor, and high cost of providing service. Each of these factors contributes to the general risk of operation for the hospital system. When risk of operation becomes too high to maintain, the unit must close. The following sections will continue to follow my conversations with Dr. Gallagher and Mr. Donovan as they discuss these factors that push closures.

Reasons for The Closure: Low Birth Volume

Although Dr. Gallagher was providing stellar care at Pine Ridge, of course there are disadvantages to having a practice in a rural county. The program was very small. Dr. Gallagher estimated that they were delivering 110-120 babies a year which is only about two per week. Those numbers are low but are normal for a rural county with a small population (Handley et al. 2021). The lowest birth volume category used to organize US hospitals is 10-500 births, so Pine Ridge was in this range (Handley et al. 2021). As time went on and Friendship Hospital in Beulah County got bigger, more people started delivering their babies there. Dr. Gallagher said, “We were having even fewer deliveries because the hospital in Carter [Friendship Hospital] was developing. So that had previously been one that people would pass by to come to ours, and because it was improving, they started just stopping there.” This caused a decrease in births at Pine Ridge that made the yearly deliveries very low. Mr. Donovan explained that the drop in birth volume was the biggest reason for the closure. He said: “Well, the big problem, believe it or not, the volume, it really dropped. But they had a really strong midwife over there and a family practitioner also did obstetrics, and he was high quality. I mean, that was something that he always had as a part of his practice. So, he supervised and that was

working OK. But it had dropped to like, oh, gosh, I think it was thirty deliveries a year or something like- thirty something- that they had." The high-quality family practitioner that Mr. Donovan is referring to is Dr. Gallagher. So as the CEO of the healthcare administration, Mr. Donovan recognized the high quality of birthing care at Pine Ridge Hospital but flagged the very low number of yearly births.

Low volume of patients is a well-documented issue that rural regions throughout the US must confront and navigate. This presents a series of risks to the hospital system. Research supports that hospitals with lower birth volumes consistently experience more negative health outcomes in the patient population than hospitals in high birth volume areas (Kozhimannil 2016). "Low Volume" is generally considered 90 or fewer births per year while "high volume" is 400 or more births per year (Hung et al. 2017). Clearly the 30 births per year that Pine Ridge had put the hospital at very low volume status. Having very few and decreasing births in rural regions is a driver for decisions to close their maternity units. Without births, staff cannot be as experienced and therefore the hospital cannot make enough money. Additionally, in a 2016 study Kozhimanil et al. found that low volume hospitals fared far worse than higher volume hospitals in maternal morbidity and birth health issues in low-risk pregnancies (Kozhimanil et al. 2016). These outcomes constitute the high risk for hospital administrators of maintaining a maternity ward in low volume areas.

The trends in rural counties in the US generally show that young people are moving out and a faster rate than ever before. Reporter Diane Maron explains, "Low birth volumes make the economics of obstetrical units harder still: Rural communities are generally graying, a demographic fact that reduces the number of births and makes it

difficult for hospitals to financially justify having maternity wards at all" (Maron 2017). Trends of outmigration in rural America and especially rural Appalachia are often discussed in academic literature and pop culture narratives. This includes the Appalachian "brain drain" in which young, educated, talented people from the region leave to find better opportunities elsewhere. This has a negative impact on rural regions. There are also theories of "rural return," or a more recent trend of highly educated younger people returning to Appalachia to work and live (Leisure 2016). The Sunflower Mountain Region experiences young people moving out, but there are many educational opportunities within the area which makes it unique. Rita County has about a 30% poverty rate so many people are unable to move due to financial strain. Additionally, some of the women I interviewed expressed that they wanted to stay because they had a lot of family and extended family living nearby. As Dr. Gallagher explained, Rita County was already a low volume area due to the small population. The advancement of obstetrics in Carter at Friendship Hospital also led to a patient decline. As I think through how low birth volume is the first domino in a line of factors that close obstetric unit doors, I remember an interview I conducted with a health professional back in summer of 2019. He said, "there may not be a lot of us, but we're still here. We're still people and we're still here. And these women still need to have their babies. We're still here."

Reasons For The Closure: Labor Force

Another reason both Dr. Gallagher and Mr. Donovan cited as a reason for the closure was the difficulty of keeping a skilled workforce in their staff. This problem is directly related to the challenges of operating in a low birth volume area. The staff has

less experience and practice on a daily basis which can result in lower skill levels. Dr. Gallagher explains this connection:

> And this was getting to be a real problem six-eight years ago, we could not keep our nurses skilled. They were not OB nurses, they were just nurses. So just nurses who would come in off the job search and do OB and some would just refuse but the ones who didn't, we would try to keep educated and experienced but with a low volume site like that we couldn't keep them skillful. The other problem is we could not recruit doctors to come here. Because a family doctor who wants to do OB wants to do a lot of OB. And we didn't have that here. The midwives were doing the motherload with those deliveries so doctors who came in would not get a lot of OB cases for themselves. And forget about an obstetrician! They wouldn't even think about coming to a low-volume area like that. So, it was just kind of the perfect storm. We couldn't keep nurses experienced and we couldn't get doctors to come and we were starting to get rumblings from our malpractice insurance from the hospital that they were uncomfortable supporting us.

Mr. Donovan expands on this point by discussing the need for "whole package" obstetrics. Once again, Mr. Donovan and Dr. Gallagher are on the same page:

> But the big issue, the big problem was the rural surgeons who would say, 'I want to do a C-section.' OK, so that then created a real problem in that the requirement was that if you're going to do obstetrics, you've got to be able to do the whole thing. I mean, you got an emergency C-section and one surgeon had some illness and so he had to back off and then the other surgeons said I can do this, but I can't do this forever. And there was no way that we can recruit another general surgeon

> wanting to do a C-section because the volume just wasn't there. So basically, it was we couldn't, we couldn't guarantee the proficiency of the practitioners. Volume was too low and we couldn't do the whole package.

A 2019 report by the Center for Medicaid and Medicare Services predicted that the United States will be short 6,000-8,000 providers specializing in birthing care by 2020 with that shortage increasing to 22,000 by 2050 (Center for Medicaid and Medicare Services 2019). Workforce shortages are a prevalent problem all throughout the US, but they are more pronounced in rural areas. The risks of having workforce shortages or ineffectively trained staff are clear. With this setup, the hospital staff is more likely to make errors which could result in injury, deaths, and subsequently, big lawsuits. Like Dr. Gallagher says, there are a lot of reasons why obstetricians and OB nurses would not want to train and practice at a place like Pine Ridge Hospital in Rita County. There are not a lot of births, the compensation is not nearly as lucrative as in other regions, and oftentimes people prefer to live in urban areas with stronger school systems and more resources.

In a move of deterritorialized ethnography which allows for broader enrollment in ethnographic study, I reached out to a leader of a national rural health organization based in Washington DC. Mr. Brooks Davidson has a career of experience in being a CEO of a rural hospital. He then went on to work as the head of this national program to improve rural hospital outcomes. He quickly agreed to talk with me and we had an hour long phone conversation. After talking about his career for a bit I asked him about of the biggest challenges he faced as a rural hospital administrator. His top answer was keeping quality and well-trained staff at the hospitals. Mr. Brooks was the CEO of a rural hospital

that had to close its obstetrics unit in the early 2000s. I asked him what led up to that decision. He did not take any time to think and quickly replied, “The direct answer is a sincere concern over the quality of care. And that was directly related to workforce issues.” Mr. Brooks was having a hard time keeping enough skilled nurses, much like Pine Ridge. Additionally, he had an issue with a C-section surgeon who was unavailable for long periods of time. They could not afford to hire a backup surgeon, so they ultimately had to close. This connects to Mr. Donovan’s point about needing to provide full-service obstetrics which requires nurses, doctors, and surgeons. Mr. Donovan’s example of their surgeon who said he “couldn’t do this forever” is important as well. The following quote from a Scientific American article illustrates this point: “The problem also has a multiplier effect. “It’s a quality-of-life issue. You don’t want to be the only OBGYN in a 150-mile radius. You’d never sleep!” Michael Kennedy, associate dean for rural health education at the University of Kansas Medical Center said at the NRHA conference” (Maron 2017). Being one of the only or the only one providing care is unappealing to professionals who also have a personal life. It is not a sustainable way of living. The staff at Pine Ridge experienced this firsthand. Meredith Jones, the midwife, adored her job in Rita County. When the obstetrics unit closed at Pine Ridge, Dr. Gallagher and Meredith had to adjust to a new way of seeing patients. Dr. Gallagher said, “We were always on call 24/7 for our patients. We would both be there if our patients went into labor, and patients loved that but that was not sustainable. Because other doctors coming into the area were not planning to do that and the obstetricians and town didn’t want to do that. But Meredith has adapted and I think she sees that her family time

and lifestyle have improved with that shift." It is clear how this system creates demanding and unsustainable work lives for rural health professionals.

Reasons For The Closure: Money

One of the first things Mr. Donovan said in our conversation was: "the thing with hospital obstetrics, which you probably have heard by now, is it's not a moneymaker." He was definitely right, I had heard that a lot by now. Administrators and public policy officials I talked with tend to refer to obstetrics as "a loss leader." For example, one rural hospital administrator frankly said, "with any type of a maternity program it and particularly in a poor, rural county, it's a loss leader for the organization." With American healthcare money is always an issue at the forefront. But rural hospitals and especially rural obstetrics are hit particularly hard.

When I asked Mr. Donovan to talk more about his decision to close obstetrics at Pine Ridge, he insisted that finances were not the leading factor pushing him to make the decision. That surprised me, so I asked for clarification:

> Sia: so, so, the financial aspect wasn't as prominent in this decision?
>
> Mr. Donovan: I mean, it was there, but it was by no means the leading factor on it.

The combination of low volume and quality of care stood out to him more. But I almost wonder if that was something he was just saying to appease me perhaps to sound less caught up in the capitalist venture of healthcare. I do not really know, but finances are certainly central to this story. In fact, Dr. Gallagher seemed to think the decision came down to money. He said, "And finally the hospital system decided that we were not just unprofitable but that we were a big drain on their financial assistance." Dr. Gallagher sat

on the hospital board for the years leading up to the closure and said that the board had been worried about the money loss for years and Dr. Gallagher did everything he could to prop them up and convince the board it was worth the money loss. But ultimately, as Dr. Gallagher said, “the wind was just too much in our face to keep going.” He was disappointed that such a fantastic unit had to close because of a financial problem. This is the first point where Dr. Gallagher and Mr. Donovan see the closure differently.

While Mr. Donovan insisted that finances were not the reason for the closure, he definitely acknowledged that the money problem was there. Mr. Donovan explained why obstetrics is so costly in rural areas:

> Most of our the deliveries are paid for by Medicaid. Yeah. But the big issue in maternal and child health and so forth is the fact that the vast majority is paid for by Medicaid and Medicaid just does not pay a lot. And then if you’re in a state where they didn’t expand Medicaid, it’s still... it’s pretty much Medicaid is only for children up to the age of six and for maternal health. And because that’s public money, you know, it’s at the discretion of the policy makers that the legislatures and Congress perform. And if so, it’s sort of hard to for hospitals to do extra and add more expense to that experience.

I heard time and time again that Medicaid simply does not pay enough to cover the costs of childbirth. This leaves hospitals with a bill they cannot pay. When in an area where most of the births are covered by Medicaid instead of a private insurance company (e.g. low-income areas), that bill gets more expensive and harder to pay. Additionally, Medicaid requirements and payments are constantly changing and becoming lower. Another hospital administrator explained this to me:

> I would say 80, 90 percent of our deliveries were Medicaid. So, so that was another factor in terms of trying to be able to keep that unit going is the reimbursement problems from the Medicaid agency. We were paid with a per diem through the Medicaid program and so you know just little things like, for example, if a patient should experience a C-section during their prenatal stay. It used to be that they would have five days. Well, then Medicaid lowered that, I think, to three days. So, you know, they just, they just had payment changes that made it more difficult to afford. And I understood that. I mean, it's like there was no need to keep somebody for five days, but it helped to pay back the costs of the entire birth. We needed that five days of payment of the premium to cover the whole cost of the care.

This is perplexing. First of all, why does Medicaid not pay enough to cover the costs of what they are paying for? Hospitals are left scrambling to creatively redistribute funds to attempt to cover the bill. I asked this administrator if they had any kind of communication with Medicaid where they could express that the funds are not adequate. The answer to this is also complicated: "Yeah, the problem was, is that the office is not open. So the physician coverage issue is like a separate topic from our reimbursement for the services, because we're kind of, we're siloed in terms of policy. So hospitals are paid by the hospital part of Medicaid, but then the physician coverage and services are paid for directly to the physician." This silo and closed route of conversation contributes to the massive inefficiency that is already present in this system.

Medicaid functions on a "base rate" system, which means that they do not pay the costs of service set by the hospitals or actual incurred expenses of any given procedure or

event. Instead, Medicaid has set "base rates" they pay to hospitals for various services. They can also include supplemental payments that vary greatly from state to state. The expansion of Medicaid with the ACA improved these payments but unfortunately this had a very negative impact on states that chose not to expand (Kaiser Family Foundation 2019).

While Medicaid provides solid coverage for many people in Appalachia, the states that make up southern Appalachia failed to expand Medicaid upon the rollout of the Affordable Care Act, leaving millions of people in a "coverage gap" and therefore without insurance (Garfield et al. 2021). People who fall in this gap rely on the healthcare "safety net," which provides care for the uninsured (Becker 2008). In her 2008 study on safety net healthcare, Gay Becker found that discrimination against racially minoritized people seeking healthcare without insurance is so commonplace and pervasive that many marginalized people avoid seeking care altogether to avoid having a negative experience (Becker 2008). Having coverage does not mean care is free of cost. In an ethnographic study with the United Steel Workers in Central Appalachia, anthropologist Rebecca Fletcher shows that there are substantial inequalities in access to care amongst those who are insured (Fletcher 2014). With current pushes to reduce benefits and increase copays and deductibles, simply having health insurance does not equate to having access to healthcare that is affordable (Fletcher 2014). The average amount women on employer's private insurance plans pay out of pocket for a vaginal birth is $4,314 (Moniz et al. 2020). Birth is becoming even more expensive; deductible payments for birth have increased 62.3% between 2008-2015 (Moniz et al. 2020). This cost is substantial, but birth for uninsured women is astronomically expensive. The average amount hospitals

charge for uncomplicated vaginal births is $32,093 (Glenza 2018). The United States is the most expensive place to give birth in the world (International Federation of Health Plans, McCarthy 2020). The US has particular policies that qualify pregnant women for coverage, but this coverage ends 60 days after birth (CMS 2020). With the rapidly rising cost of birth and lower Medicaid reimbursement rates, hospitals run up very high bills that they cannot pay making operation a massive financial risk.

"Real Emotional": Community Impact of The Closure Told By Dr. Gallagher

When I started this research, some of the first conversations I had were with Dr. Gallagher and Meredith Jones: two professionals who were directly impacted by the closure. In these conversations it was hard for them to tell the story of the Pine Ridge closure without pausing to choke back tears. This emotional reaction was striking to me. Even nearly eight years after the obstetrics unit closed, they got so immediately upset when recalling the moments when it all ended. It felt like a big open wound that time had not healed.

I was a little hesitant to ask Dr. Gallagher to describe the closure in detail because I could hear his voice drop a bit when we got onto the topic. Clearly this shift in care was devastating for him. He said, "Whole families would show up for deliveries and extended families would show up for deliveries. It was such an uplifting experience. So when we had to close down obstetrics... I got real emotional when I had done my last delivery at that old hospital. Our numbers were just declining and even though we tried all we could, the writing was just on the wall." Meredith the midwife struggled through the story while pushing through tears. She talked about what Dr. Gallagher describes. She just had a hard

time with the closure because the passion and care they were putting into providing excellent services just was not enough to keep this vital place open to serve the community.

Receiving news of closures, especially obstetric closures, is highly disappointing and emotional for care providers and community members alike. During an informal conversation with a nurse who experienced an obstetric closure at the clinic she was working, it became clear how this one decision has multi-faceted implications. She had her first baby at the maternity unit where she used to work. She kept emphasizing how special this work environment was. The staff was incredibly close. They had parties together, were friends beyond work, and cared immensely for one another. She also explained that they worked as the most well-oiled machine and provided outstanding, compassionate care. Unfortunately, due to many of the factors discussed in this chapter, the small rural unit had to stop providing maternity care. Beyond being outraged, the staff was heartbroken. The administrators came down to the clinic to talk with the staff about the future. The staff was indignant and were vocal in expressing their feelings to the administration. The nurse said the administrators seemed overwhelmed by this response. She had to explain to them: "You have to understand you just told me I no longer have a job AND I will not be able to have the pregnancy and birth I had planned on." Most of the staff was not done having babies and giving birth in this special environment was important. This nurse was devastated. Even as she told me this story, her eyes welled up with tears: "I like my new job and all, but that was just so heartbreaking."

Stories like these are common. The raw emotions of having to close a maternity unit emerge even a decade after the closure itself. The outrage of staff and communities

are also a common thread in these stories. As I previously stated, people were likely outraged because obstetric closures alleviate the risk from hospital administrators and system but place higher risk on community members who now must travel further to access care and have fewer choices. I asked Dr. Gallagher if his patients were upset to hear about the closure and subsequent shift of care and he quickly said, "Oh absolutely. And Meredith got more of an earful of that than I did. You know I was on backup; they would call me if they needed some help but there was a lot of negative feedback when we had to stop delivering here. A lot of angry, mostly upset patients, but some angry when they realized they could not deliver here." One reason is the basic fact that women and families now needed to find a new doctor which would inevitably be far away. Dr. Gallagher explained: "Where our hospital is, it's an easy thirty-minute trip to town. But if you go to the edge of the county, the southern end of the county around the river… well also the other thing that happened two years after we did the hospital in Harvest County had to shut down deliveries. So, then anybody on the south end of the county, it was going to be an hour no matter where they went. So, I don't know if this has happened yet, but it will happen… there will be a baby born on the side of the road." The need to travel so far for maternity care is life changing for many Rita County residents. They will now need to take more time off work, figure out childcare, save more gas money, and plan ahead to set aside long days to get down to Beulah County for prenatal care and delivery. Upon hearing the news of the closure, Rita County residents knew this would change a lot and they were outraged and outspoken.

Another reason for that anger was simply the fact that families in Rita County loved and depended on the delivery unit. Dr. Gallagher and his team are valued and

adored community members who care deeply for their patients and provide excellent care. This is especially important in rural communities. It was getting late towards the end of my conversation with Dr. Gallagher, and I wanted to ask him one more question. I said to him: “Dr. Gallagher, I really don’t want to keep you too long here but I do have one more question. What is it like to deliver babies?” There was a long pause on the other end of the phone. I started to feel like this was a silly question and he was shocked that I would even ask it. Just as I was about to hop in and say “never mind” or rephrase that to be something more straightforward and concrete, I heard a small sniffle into the phone. He warmly said, “Oh well. You just made me smile.” I believe the remainder of Dr. Gallagher’s response to my question of what it is like to deliver babies shows why and how maternity care in rural areas is so integral to people’s lives and the community. Here it is in entirety:

> It is just great. Because I never got tired of that. I’d be so tired at the end of a long day and someone would come in in labor, but I never felt like I should be doing anything else. And you know, what happens when you’re doing primary care, people have chosen you to deliver their baby. And that’s an honor and you need to respect and feel good about that. But after nine months, you want to be there. You want to make sure everything goes well. And you built up a mutual trust because you’ve been seeing each other every month and every week, so you really have a good idea about what they expect from each other. And sometimes you have a formal written birthing plan you’ve already talked about, and that never happens. Something always comes along to change that. But the point is you ought to be there for each other. And to be there and watch new life come into the world and

> watch the parents when they see that their lives change forever, it's just unbelievable. You know, for twenty years I've delivered babies for women I had delivered. There was a couple, three times, when I delivered babies and I had delivered both of the parents. And when you see that happen, you are family. You are part of the family. And it's just so rewarding. Just emotionally rewarding, you know. I think I stopped delivering babies at the right time because now I'm 74, I get tired late at night! And I don't think I could stay up all night at the bedside and try to continue to work the next day. Used to be I'd be up all night, deliver a baby, work the whole next day, I'd be tired but I'd be ok. But you know, my birthdays are catching up with me. I couldn't do that now. But it was so valuable when I did. And that's part of a family practice that I teach all my students over the years: when you're a family doctor, you have a key to where all the important things are happening. And that's something you should value and respect."

After hearing such a potent description, I felt as though I understood the gravity of these service losses on a logistical and emotional level. I immediately wondered how administrators navigated making these decisions and delivering the news. Did it have a similar impact on them? Did they feel the anger and loss? Would that ever make them feel like Dr. Gallagher and Meredith Jones felt in the face of those closures? My conversation with Mr. Donovan shed light on these questions.

"Not A Big Deal": Community Impact of The Closure Told by Mr. Donovan

I talked with Mr. Donovan after I had talked with the Pine Ridge team. I already heard their heartbreaking descriptions of community reactions to the closure. But I

wanted to hear what Mr. Donovan thought, so I asked him a question I already knew the answer to: “So when you had to close the maternity unit, did you get a sense of how people reacted to that? Was it accepted or was there some outrage?” The nonchalant tone of Mr. Donovan’s response was an indication that he did not have the same personal ties to Pine Ridge and Rita County that Dr. Gallagher described. Mr. Donovan explained:

> You know, the team really did a great job of making the decision and they weren’t real happy about it, but they intellectually understood it. So, we sort of let it sit there for a while. In other words, we didn’t do it overnight. And so, after a month or so, because they’re smart, people did absorb. They realized that we were giving them ample time to make this work for the community. So, it actually played out awfully well. And I don’t remember exactly how many, I don’t know if it was a whole year or not, but then I named a president for [Pine Ridge Hospital] that happened to be a nurse and from that community. So, he had a lot of trust and respect. And what he understood, he kept on board and started going to places like of civic clubs, community outings and so forth and explained it.

Mr. Donovan did a great job of instating someone who was trusted in the community to do outreach and explain the closure. But based on this response in contrast to the other professionals, Mr. Donovan holds an emotional distance from the decision he made. His following statement shocked me a bit and I was grateful to be on the phone and therefore not socially required to conceal my facial expression:

> **And to be honest with you, it really wasn’t that big of a deal.** Like I think people probably thought the reason for it was financial. We started explaining it

> was the proficiency of the nurses, the staff. And we just can't, we can't guarantee the high quality and we don't want to call for something else. We can't do it in a quality way. They began to accept it.

To hear the words "not a big deal" in reference to this closure was completely novel for me thus far in conversations with anyone. It indicates how administrators who often make these decisions are disconnected from the people who they affect. Mr. Donovan was not the one who had to tell each patient that they could no longer give birth in their home county. He likely did not face the backlash that the providers did. This certainly skewed his perception of the reaction to the situation. Additionally, his assertion that "people probably thought the reason for it was financial" in this statement implies that community members were more accepting of the closure because they assumed it was because the hospital did not have enough money to continue operations. The idea that financial hardship is the most excusable reason for these critical services to close reflects the qualities of capitalism and how they have become infused in American biomedicine and healthcare systems. The connection between finance and healthcare seems confusing and insurmountable which is likely a reason for Mr. Donovan's comment on the assumption of financial hardship and the community not taking the closure too hard.

The contrast in Mr. Donovan's and Dr. Gallagher's remarks illustrate a common issue in administration and policymaking, especially in rural areas. This situation is like what the nurse described when her OB unit closed: the administrators who delivered the news were shocked by the emotional responses of the nurses because they did not realize these women were not only out of jobs, but out of the birth experience they had imagined for themselves. That was not something the admins considered to be a

factor. Policymakers often fail to consider local knowledges and context, which results in ineffective policy (Brodwin 1997). Additionally, institutions such as hospital systems, like social service programs such as Medicaid and DSS, tend to operate without much attention to how people and communities actually interact with these services. This is especially important in rural communities which face health policies that are unsuitable for the area, such as the Pine Ridge closure (Hill 1988). People living in rural areas are subject to social stigmatization which affects cultural representations and policymakers. As anthropologist Susan Greenhalgh (2008) clearly shows in her study of the one-child policy in China, even though the state, policy, and science are frequently portrayed as objective and correct, people create policy. The people who create policy are also members of society who are subject to ideological messaging, media depictions, and political and financial pressures. This partial perspective means that the knowledge each policymaker brings is situated and imbued with different values and goals (Haraway 1988). This type of misconception and disregard for local knowledges, strategies, and experiences impacts how locations are viewed and policies are created. To fully unpack the disconnect between policymakers and high-level hospital administrators and local populations, it is important to look towards the structure of the American healthcare and hospital system.

Looking All The Way Up

In the early 1900s, nearly all hospitals in the United States were owned by states and counties working with medical schools or non-profit organizations with religious backgrounds (Morgenson and Saliba 2020). For-profit hospitals existed, but they were rare. Now they are the majority of hospital systems in the country. An NBC News article

reports, “For the past 20 years, private equity has been a source of immense wealth for the executives overseeing the entities. Most of those who head major private equity firms are reported to be billionaires, like the two men atop Blackstone: Stephen Schwarzman, a close adviser to President Donald Trump, and Hamilton “Tony” James, a major donor to Democrats” (Morgenson and Saliba 2020). Private equity purchases have recently increased. Rural hospitals, hospice, and nursing homes are often the first entities purchased in these buyout deals. Private equity buyers purchase these hospitals when the hospitals are struggling financially. The new owner then loads the hospital with debt and reduces costs to create more earnings and the appearance of profitability for future buyers (Morgenson and Saliba 2020, personal communication 2021). As the NBC article reports, “In the business of health care, the drive for profits can run counter to the goal of helping patients and protecting workers” (Morgenson and Saliba 2020). There is substantial research that indicates that these purchases result in lower quality of care (Morgenson and Saliba 2020). The pressure these for-profit hospitals place on money making creates conditions that force rural OB units to close their doors.

The Sunflower Mountain Region Healthcare system is still not-for-profit. But as the former CEO Mr. Donovan explained, there are unique conditions that have enabled the protection from big healthcare private equity buyers:

> And the other advantage that we had here for so many years was still largely because the highways coming up here weren’t good. So, it would take you several hours to get out to the city. So people wanted to stay here and they didn’t want to travel. And so that allowed us to play off that even though our population wasn’t huge. But if we branched out into these four or five counties, we would come up

> with 150,000 or so population. And that was enough. We could then recruit. Yeah, an orthopedist, an oncologist, and the other specialties. And that was the advantage that we had even as the roads have improved. So, it's easier now to get to bigger cities, but still there is a sort of somewhat tendency to want to stay here and stay drivable. And one other big advantage that we had was, of course, the tourism creates a little bit of a cosmopolitan atmosphere so that helped in recruiting. But there's a lot of resorts up here and a lot of wealthy people who would come from Florida. But and they were more than happy to share some of their wealth with us. So our foundation, we would raise several million dollars a year with our foundation that actually during my tenure got to be a little bit easier because they were coming from Florida and a lot of hospitals in Florida did what you said, they sold to for-profit companies. Well, they no longer want to give their personal money to a for-profit local hospital. So, they would give it to us because they were spending four to six months of their life up here anyway.

A rural health system nearby was recently purchased by a large for-profit company. As Mr. Donovan explains, there are a very specific set of circumstances that protect the Sunflower Mountain Region healthcare system from being taken over by one of these bigger for-profit organizations. The tourism economy and wealth disparity in the region that is widely criticized by locals was key to keeping the healthcare system local and avoid being bought out by a larger corporation. But just because it is still labeled as "non-profit" does not mean the leadership is not taking many of the same steps a for-profit owner would with respect to slashing expenses to create more profit. In fact, I heard a rumor through one of my social networks that the system is run entirely like a for-profit

system (personal communication 2021). One of the biggest differentiators in how for-profit and not-for-profit hospitals are run is that for-profit hospitals tend to spend more resources on advertising and marketing (GWU 2021). This allocation is often criticized because those funds could go towards better medical equipment that may improve health outcomes at the hospital (GWU 2021). These general transformations in the US healthcare system create conditions that make rural obstetric closures so frequent.

Bridging Gaps: Local Work

The disconnect between decision-makers and those affected is very prevalent in these healthcare situations. The work of local people working in healthcare, social services, journalism, and other fields is critical to bridging this gap in understanding and support. Throughout my time leading up to and during research I always kept up with local news. I noticed I was reading and citing a lot of articles by one health reporter named Ellen Mengel, quoted in the introduction of this chapter. I decided to reach out to Ellen. Even though she does not live in the Sunflower Mountain Region, she was the lead reporter on rural health in the general part of the state and once again capitalizing on my remote interviews and deterritorialized ethnography, I had a great conversation. Ellen got into reporting because she found that "public health lives in a vacuum" and many professionals have problems communicating with the public. Beyond the public health issue, Ellen noticed that rural reporting was especially problematic. Oftentimes newspaper funding is limited. This is especially true in under-resourced rural areas. One of my roommates works at the Beulah County local paper and he would constantly come home with woes of understaffing and budget cuts. Local news is absolutely critical when

it comes to big community issues like maternity unit closures. Ellen described the problem of obstetric closures with a lack of local reporting with my own emphasis added:

> But what happens in these rural areas is they don't, you know, they don't get the sort of fair warning kind of thing because it doesn't end up in any paper or maybe ends up in a paper that's really small. And somebody is just saying, oh, there's a public hearing about the state of this obstetrics unit and maybe people don't see it at all. And then suddenly they hear that the hospital is closing or obstetrics unit and they feel like they were like, **it just came out of the blue when it really didn't**. It's just that there was no journalist there to be like this thing is happening and, you know, kind of covering it so that people know to sort of mobilize or to do whatever it is that you want to do or feel however they want to feel, **because it's not my job to sort of tell them how to do things, but like to kind of like have that sort of warning so they can do something about it, if that's what they chose to do.**

Ellen's job is to alert the community of happenings like this in healthcare so they can mobilize, understand the decision-making process as it unfolds, and make plans for the future. Even if there is nothing that can be done to change the closures, the community deserves the ability to voice their opinions and plan for changes. Ellen's work enables this agency.

In addition to Ellen's work to alert rural communities of major changes such as obstetric closures, there are many dedicated health professionals who work creatively to best support pregnant women and mothers who lack access to many things they need to

have a healthy birth. Rural health practitioners consistently describe the need to "get creative" to piece together solutions and navigate supporting their community despite challenges and a lack of resources (personal communication, 2019). In the Sunflower Mountain Region, there is a major nonprofit organization that focuses on maternal and child health. I had a conversation via Zoom with one of their social worker employees, Katerina. She explained some of their creative methods: "one of the things that we did for a lot of our resources was that we moved the location of some of our services to places where the need might be greater. For instance, our diaper bank program, typically parents would come into the office and be able to receive a pack of diapers, and now we're we had that moved to the health and hunger coalition. It's high need, people can already go can be getting what they need, and we are also trying to expand what we have been offering. So, trying to be able to recognize the need is greater and we need to be more visible. Another thing we have done is that we've started a mobile service, one of our awesome staff members, takes a van and she will travel to different church communities or things like that all around. Different areas and be out and will try to promote it on Facebook, doing a lot of social media is a way that people are trying to get more creative and push things more." Bringing resources to more accessible places, especially when birthing services are more inaccessible, makes a huge difference for pregnant women and new mothers. Additionally, the local WIC representatives are helpful to mothers. One new mother gushed over the WIC employee she worked with and claimed it was the only way she could have gotten through the first few months of being a single mother. She said, "They just, are willing to go above and beyond to help you. And give you ALL the information. She also sent a link for um, like the parks and rec scholarship application so

that we can go to the little indoor pool thing. Because we've been once but it's expensive! So we went once. We can't really do that a lot. So just like the above and beyondness of like, oh hey you're interested in the community so I'm also gonna give you this. And it's like cool, so if I ever had a question I know I could ask people to help."

WIC does have services to help with transportation to birthing units and gas money. Annabelle, who will be driving a long distance to access her prenatal care, explained that she did not know about the gas reimbursement feature but her WIC support person guided her through it:

> The person at WIC recommended that I apply for transportation through Medicaid and there's a way for me to provide my own transportation but have them reimburse my mileage. So I'm trying to work that out but it's still up in the air. The government is so hard to navigate. It's not user friendly. It's all so confusing and you're just like, I don't know! I think they do that on purpose. It deters people. Especially, hmmm, the undereducated population that is really usually is having a minimum wage job, have more children, and need the help the most. And most of those people are not white. I'll just leave that there.

Rural health professionals really must step up to fill the gap when maternity units close. As Annabelle points out, helping people navigate Medicaid and WIC is an act of social justice. Because the system is set up to be confusing for both social service professionals and applicants. Having someone to walk through the complexities and red tape to advocate for pregnant women is critical work. This is especially important when the pregnant woman is socially marginalized.

Home Visiting

One of the most effective ways local health professionals are prioritizing pregnant women and mothers is through their commitment to home visiting maternity health services. This type of intervention directly reverses a lot of the challenges women face when obstetric care is removed from their community. Because transportation is such a barrier, research shows that bringing professionals to a woman's home to administer prenatal and postpartum education and care improves health outcomes (Novoa & Taylor 2017). One nurse I talked with who passionately believes in the power of home-visiting programs told me all about how her patients call to cancel all the time because they cannot make the trip for one reason or the other. This includes gas prices being too high, a partner using their only car, their vehicle breaking down, or inability to secure childcare. She sees firsthand how home visiting programs can make care way more convenient and accessible for everyone: especially people who miss their appointments for these reasons. As we talked about this topic her voice got louder and she was really gesticulating with her hands. I could tell how passionate she was about this intervention. Her passion was confirmed when she exclaimed, "home visiting would make the healthcare system…well actually, you know what, FUCK the health care system! It would make HEALTH better!"

In the short window of time that the Sunflower Mountain Region reopened during summer 2021 (post vaccines and pre COVID Delta variant) I was able to work and volunteer with two different home visiting programs in different stages of development. I described the first program in the introduction of this dissertation. It was just beginning to develop so I worked to compile community resources for when the home visiting began

to operate and nurses could refer mothers to all relevant support they can access in the community. The second program, Sunflower Visits, is located in Harvest County. Like the other regions, this county is very rural. But it differs from Beulah County and Rita County because it has no major town like Carter and it is not a tourist destination like much of Rita County. I had Zoom calls with the women working on the team, but I also got to meet them in their new office one time before the health director ordered everything to return to remote operation. On the morning of the meeting I once again drove up the winding mountain roads lined with Dollar Generals, Trump signs (yes, in July 2021), and small hair salons. This area is full of farms and vast green land. Every once in a while, I pass an older man out mowing his lawn wearing a flannel and straw hat. I smile and wave at these men. Each one could be my grandad. I planned to meet the home visiting team after their weekly update meeting. I was going to come at 10:00am, right when they finished their business so we could all talk. I finally reached their office building. To call the large building "multi-purpose" would be an understatement. At first it seemed like a community center that rented out individual rooms to different people. I saw some rooms advertised as churches, daycares, and small stores. The building was dark and empty and I kept getting turned around in the hallway trying to find my way. I was getting anxious because I was now a few minutes late to my meeting. I turned a corner and ran almost directly into a creepy mannequin in front of a what I assume was a beauty shop or hair salon. I gasped and quickly walked to the end of the hallway where I finally found the home-visiting office. I turned the corner and all six women who work there were sitting around a table, seemingly waiting for me. I felt flustered and slightly embarrassed after my walk there and I apologized excessively for being late. One woman

smiled and said, "we figured you might be wandering around the building. It's confusing in here!" Another chimed in, "did you meet our mannequin friend?" We all laughed and I took a seat at the table.

The six employees were warm and giggly in a way that I could immediately tell they were all coworkers and friends. They had a cake at the table to celebrate the director's birthday. Each of the home visitors has a background in social work. One woman named Nicole explained that working in home visiting is such a wonderful transition from her old job in DSS. Instead of intervening *after* something bad had happened she feels like being a home visitor allows her to give preventative intervention and really help high-risk mothers thrive. Essentially what these professionals do is enroll pregnant women in their free program and visit their home to help them learn more about pregnancy and birth. They continue these visits up until the child is five years old. They also provide essential resources like bottles, diapers, and baby food. Similar to WIC, these home-visiting employees are doing social justice work. Through preventative support to marginalized women who are considered high-risk due to their income level, health, or past trauma, home-visitors can implement a safety net that propels women who do not have access to everything they need for a healthy birth experience. Their work is hard and they encounter pregnant women in really difficult situations. Mary, a worker about to retire, explained that sometimes you feel discouraged if a mother you are working with goes to jail or faces some other hardship. She then said, "but I have to remember, it could have been much worse if I wasn't involved in the first place. And now I am there to support her and she has someone. That is more helpful than can be measured." It is evident how helpful home visiting programs are especially in rural areas.

Additionally, at this meeting I learned how small groups like this in rural counties are deeply influenced by decision-makers in the US Congress. Once again, it is clear how policymakers often are disconnected from the people who their policy decisions impact. The following is an excerpt from my field notes from this meeting:

> *The director explained to me how their funding works which was super interesting. Basically she said that maternal health funding is extremely political and bipartisan. With the introduction of Obamacare, home-visiting programs began to take hold and get funded. Luckily, their funding on their end stays pretty steady and reliable, but up in Washington they really have to juggle it around because of how divided it is because it is looped in with the child abuse clauses. To be totally honest, she was speaking a little cryptically likely because she did not want to offend me if we were on different political sides. But I actually couldn't tell which side was which? (July 7, 2021)*

After doing some research in secondary sources through the Health Resources and Services Administration on this question, the funding processes of this in congress seem very complicated. Based on my preliminary ethnographic research in 2019, home-visiting programs must provide extensive "proof" that they are working to maintain their funding from the government. This includes extensive documentation of participants and their "progress," which can be problematic. For example, while I was shadowing home-visiting workers in 2019, it became clear how frustrating this paperwork can be. Home-visiting workers were consistently finding that women tended to indicate that their trauma and stress *increased* after participating in the program as opposed to the goal of decreasing this. Yet, this was something that only increased on paper. The professionals

told me story after story of how successful their program is in offering women support during pregnancy when they often have none. The reason that it looked like women who participated were having more adverse outcomes after being in the program was that in filing the "after" paperwork, women trusted their home-visitor much more and therefore were more honest in responding to the standard questions. This means that on paper, the program was not helping women at all. This was extremely concerning to home-visitors because they realized if they continued to show this increase in stress and trauma, the program would likely not get funded. To combat this issue, professionals worked with women to fill out the paperwork and give a more thorough explanation of what the questions were asking to prompt women to respond in a way that emphasized their triumphs from participating instead of their stress and trauma. While the government does give a lot of funding for these programs in every state, there are several regulations and requirements that make the paperwork and daily work more complicated.

This story indicates how maternal health home visitors and other professionals go above and beyond their job description to do what they can to serve their community. Clearly these professionals view their positions as critical to support which is ultimately an act of social justice. Like the professionals at WIC in the Sunflower Mountain Region who work tirelessly to advocate for women and connect them with resources and help them navigate the complexity of paperwork, these jobs are not only necessary to provide people with healthcare but work to advocate for marginalized women.

Obstetric Closures and Sacrifice Zones

In *Removing Mountains: Extracting Nature and Identity in the Appalachian Coalfields,* Rebecca Scott writes, "A sacrifice zone is a place that is written off for environmental destruction in the name of a higher purpose, such as the national interest (Kuletz 1998)" (Scott 2010: 31). Appalachia has been constructed and held as a "sacrifice zone" within the United States in terms of economic production, environmental destruction, cultural diversity, and health knowledge production. This means that Appalachia and people living in Appalachia "are culturally and economically marginalized, and the national/ corporate interests they are asked to serve are not necessarily compatible with the survival of their communities and practices" (Scott 2010:31, emphasis is my own). The term "sacrifice zone" typically refers to geographic locations that have been environmentally destroyed by large corporations for profit and has mostly been used to discuss the effects of coal mining, nuclear weapon use, and chemical pollution. But I view rural obstetric closures like that of Pine Ridge Hospital another expression of sacrificial zones. When funding becomes short (as it always will be in rural areas with high Medicaid rates), obstetrics is the first to be cut. Hearing Mr. Donovan and other health professionals rationalize this choice makes it clear: obstetrics is more expensive than what it pays because of low Medicaid reimbursement rates, there are difficulties keeping staff highly skilled, and ultimately very few people give birth in rural counties making the money issue even more pronounced. As researcher Katy Kozhimannil said, "We need to recognize that hospitals and hospital administrators are in the business of staying in business, so of course they are going to look at where they can be efficient with their use of resources" (Commins 2015). Eliminating obstetrics is a

move of financial efficiency. And for the administrators "in the business of staying in business," it is a clear choice. The impact of the clear choice is massive. In chapter three I discussed the widespread impact of this closure and how it affects women in all the surrounding counties. Additionally, the complications increase with windy mountain roads, winter weather, and precarious transportation. When women lose proximate access to obstetric care, they face a series of complications. They are less likely to attend prenatal appointments because it is often very challenging to even get there. The actual birth has increased stress factors which impact women and their babies.

Whose Sacrifice Is It?

Eliminating obstetric services in rural counties has a massive impact on the women, families, and health providers in these areas. While it does seem like an administrative move of efficiency because obstetrics costs too much money, it is important to look closely at why obstetrics is in this position in the first place. Is the fact that the few people who do give birth in rural areas tend to use Medicaid and therefore are of lower income status make a maternity unit worthy of closure? Ideas like this permeate into popular culture and policy decisions. Elizabeth Catte writes, "Many Appalachians are poor, but their poverty has a deep and coherent history rooted in economic exploitation" (2017:14). A popular misconception of the economic landscape of Appalachia is based on the idea that poverty is a direct result of the backward, isolated, small-scale mountain economy. There is a lot of blame and stigma that come with the class status in Appalachia. It is important to recognize how these stereotypes and ideas seep into health policy and decision-making.

At the beginning of this research I had a solid idea of whose fault this was: hospital administrators and CEOs are making decisions that harm local communities in the name of profit. But after talking with Mr. Donovan and several other rural hospital personnel, it became very clear that this goes all the way up to the top. When Mr. Donovan made the decision to close the Pine Ridge Hospital birthing unit, he was doing so because of restraints he was given by the system that he operates within. If Medicaid did not have such low reimbursement rates, perhaps obstetrics would make more profit. If rural physicians made more money and had better systemic working conditions, maybe there would not be a staff shortage. On a much larger scale, if people were not encouraged to migrate out of rural Appalachia, there may be more babies born. These issues are large and reflect what society and the US government value most. But rural people, poor people, and women do not make the list. So, although Sacrifice Zones usually refer to environmental destruction, I see one here very clearly. In Scott's book, people's health is harmed due to environmental destruction that accompanies coal mining which is prioritized for profit. In obstetric closures, people's health is also put in danger due to service cuts that are prioritized to keep hospitals profitable. Rural Appalachia is a sacrifice zone for birth.

Why Keep Maternity Units Open?

Rural Appalachia is a sacrifice zone for birth. But what exactly is sacrificed to save the budget of larger hospital systems? In the previous section I discussed some of the major factors that contribute to the decision to close rural obstetric units. These reasons for closure are not inconsequential and certainly cause a lot of strain on rural maternity units. In other words, they make a compelling case for closure. In chapter three

I discussed at length the impact obstetric closures have on the degree of choice women have in their birth experience. As I concluded, removing access to choices makes for a disempowering birth experience for many women. This is a massive sacrifice to make in the name of money. Beyond the level of choice, removing obstetrics also increases risks in emotional and mental health, stress, and physical health of the mother and baby. Additionally, obstetric closures alter the dynamic and longevity of hospitals in general. The following section will explore those sacrifices.

Impact on Physical Health and Stress

In Hung et al.'s 2017 research study, the authors found that women in areas that closed their OB units were more likely to still deliver at those units even without services, which is a significant risk. Additionally, throughout interviews with health professionals over the past three years it emerged that women who do not live close to obstetric units often just try to make it to the closest Emergency Room or Fire Station to deliver. This also poses a substantial risk to their health because although both of those places have trained medical professionals, none are trained in birth. Another health concern that many professionals express is that a lack of proximate access to a maternity unit leads women to skip critical prenatal appointments (BlueCross BlueShield 2020). One health professional I spoke with explained her fears with this: "If you like to get into the crawlspace, start realizing that everything is connected to everything. Yeah. And it's like, you know, OK, so, you know, this maternity unit closes and now what happens? OK, well, the women have to travel further. Maybe they'll just like blow off some of their, like, preventative appointments because you know how many times you have to go as a pregnant woman…it's like a full-time job." Transportation is already a major issue in

rural areas. Many women lack access to reliable vehicles or gas money. Traveling far to access care is complex. Without all necessary prenatal appointments both the mother and baby have increased health risks and risks of complication (BlueCross BlueShield 2020).

In the online survey I conducted in fall 2020, nearly half of the respondents expressed some kind of concern about making it to the hospital in time for a safe birth (see Figure 4.2), showing how prevalent this fear is. Having this concern can lead to elevated stress during pregnancy and labor which is an already stressful time. The physical impacts of high stress are well documented and can cause negative health outcomes. This fear was clear in many interviews I conducted. For example, one woman named Michala lives about an hour from the hospital where she will deliver her baby. She already has two kids and was pregnant with a third. When I asked her if she ever had concerns about making it to the hospital on time she said, "um, well with my first one, my husband, he works a lot more. Like a lot more hours. So I was alone more. And I could not deal with being up there by myself and I was so scared I was gonna go into labor and he wasn't gonna be there and he would be working. You know doing construction you can't always answer your phone. So if he's on a roof on a house on the side of the mountain, or wherever they might have been working however many hours away, it's just like oh my gosh what if I go into labor and you're not here?! So as I got closer to my due date, it was like panic. Like I don't want you to leave and go nowhere you can't leave me by myself." Michala's husband had to take the family car to work so if he was unable to answer his phone she would really be stranded while in labor unable to go anywhere. Even when he did arrive, it would still be another hour drive to the hospital. She thought for sure she was going to have her baby on the side of the road.

Another young woman named Kelsey had an incident during her pregnancy that also increased her stress relating to her baby. She told me the story: "when I was pregnant with her, I had a little minor car accident. I got ran off the road and lost control and spun out. And my blood pressure shot up from stress. And I wanted to make sure [the baby] was ok, so we did go to the hospital. And that was so very stressful because it's an hour and fifteen minutes so that ride was just really long and I was worried that she would be ok." Other women who had these concerns also emphasized that their fear and stress increased when their babies were due in the wintertime because the mountain roads become very treacherous. In fact, multiple women who planned their pregnancies made sure that their due dates would be in the spring or summer to avoid this possibility.

Stress has concrete effects on pregnancy and birth. Another change women make to accommodate the stress of long travel during labor is the choice to schedule an induction so they know exactly when to arrive at the hospital to have their baby. This allows them to plan and ensure transportation and enough travel time. But elective inductions have potential health consequences. The home-visitors I worked with expressed concerns about the high rates of elective inductions in their rural communities. Inductions are typically scheduled before 39 weeks so natural labor does not occur before the chance for induction. One nurse said, "Babies are in there until they are ready to come out for a reason. They still need all that time to develop. Our moms who have inductions have harder times with breastfeeding and latching. The baby needs that time to develop, and we are taking them out early." Inductions are medically necessary sometimes but in cases where they are scheduled for convenience or because they are the only option for some women who do not live near obstetric units, they are not medically necessary. Some

of the other potential risks include infection, failure of induction resulting in C-section, bleeding, uterine rupture, and low heart rate (Mayo Clinic). Additionally, as evidenced by interview data, many women feel like failures when they must be induced as opposed to allowing their body to go into labor naturally. Induction should not be the answer for women who live far from obstetric care or do not have flexible or reliable access to transportation.

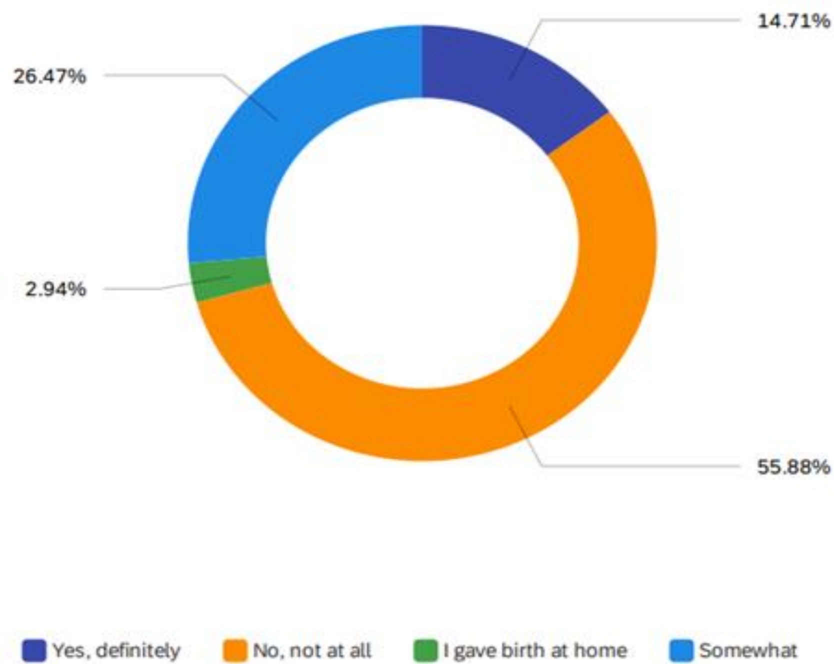

Figure 4.2 :Survey Results for "Did you have any concerns about making it to the hospital on time?"

More Than a Loss Leader: The Role of Birth in Hospitals

Beyond improving the quality of everyday life in accessing care, keeping obstetric services in small rural communities adds value to hospitals. When the Pine Ridge

Hospital Board kept suggesting the closure, Dr. Gallagher did everything he could to save his birthing unit. He pleaded with the board: “I said ok, so we’re not making money for y’all. But the community support and the overall wellbeing of the community, having babies there, is just too big an attribute to give up.” A birth and maternity unit is a substantial attribute to a hospital. As Mr. Donovan said, “Now we had very low volume, but you wanted it to be a good experience because the female typically then will bring the males and the rest of their family to your medical community.” This is how it usually works. Where the mother gives birth, she tends to find a pediatrician and a doctor for everyone else in the family for convenience. So obstetrics itself is a “loss leader,” but in the larger equation it brings business and profit to the hospital. Beyond the business aspect, having a place to give birth is also an image and morale booster for the hospital. The reporter Ellen Mengel explained that the availability of birthing services is a real invigorator for small rural hospitals and communities. She said, “So the hospital, like, you know, on the one hand, it’s like, yes, it’s very expensive to run a labor and delivery unit. But I think it matters for people like the idea of a hospital like not just like this is a place where grandma died, but like this is the place I was born.” This is especially important in rural communities where so much of the dialogue and narrative from media and culture is that rural America is aging and dying (Semuels 2016; Garcia 2021). Obstetric services are more than just a loss leader. They provide hope and momentum in rural hospitals and communities. Hope and momentum are critical, especially when facing new problems like the COVID-19 Pandemic. In the following chapter, I will explore how pregnant women, mothers, and health professionals experienced and navigated the challenges of the pandemic.

CHAPTER 5: PREGNANCY AND RURALITY IN A PANDEMIC: CHALLENGES AND ADAPTATIONS

"Pappy, we're gonna be fine in 2021, right?"

"Son, we're mountain folk! We will always be alright!"

-Caption on the cover of the December 2020 issue of the Sunflower Mountain Region Magazine

Figure 5.1: A discarded mask.

Introduction

In apocalyptic movies that depict a group of people attempting to survive in unusual conditions amidst the end of the world, there always seems to be at least one token pregnant character[32]. It is a classic trope in post-apocalyptic fiction perhaps because pregnancy and new life represent a glimmer of hope for the future during bleak times in an example of literary foil and metaphor. But also, the inclusion of pregnancy increases the stakes and precarity of survival, creating a more intense and nail-biting scenario for the viewer or reader. This is because ultimately the state of being pregnant is viewed as socially and physically vulnerable (Colciago et al. 2020). Beyond the added physical burden of carrying a baby in the womb, pregnant people are responsible for their own health and safety as well as the health and safety of a fetus. This is a substantial source of pressure in everyday life, let alone an apocalypse.

Early moments in the pandemic felt as scary as one of these movies. I recall being at the grocery store one early morning in March 2020 (before masks were even a suggestion) and seeing a pregnant woman with a cart full of food that was clearly for children. The eerie mood in the half-stocked grocery store at dawn and the frantic look on that woman's face made very clear the real-life stakes of having young, dependent children during an unknown crisis. Every single time I talked to my own mother on the phone during the early days of the pandemic she would say, "I just keep thinking how grateful I am that you guys (referring to me and my siblings) are 19, 21, and 23 during

[32] For example: *Bird Box, A Quiet Place, Children of Men, The Walking Dead*

this instead of 3, 5, and 7." It does not take much mental gymnastics to imagine how difficult parenting young children was during the 2020-2021 year.

Delving into fieldwork with pregnant women and mothers during the pandemic put me in a unique position to discuss and witness parenting and pregnancy in this context. Over the course of the 60 interviews and series of informal conversations I had with pregnant women, mothers, and health professionals, I talked to women who had given birth at various stages over the course of their lives. Some had toddlers, some had newborns. Some had combinations of way older children and a younger child. Some of the people I interviewed were health professionals who had no children. But the final question I asked in every single interview was about how the person's adaptation to the pandemic year had been. The reaction to this question was always strong.

Thus far in this dissertation, I have shown how rurality makes pregnancy and birth more precarious through geographical barriers and limited healthcare infrastructure. A pandemic or any kind of public emergency also puts rural health in flux. This chapter discusses the intersections of these two factors (rurality and pandemic) and identifies the unique challenges women living in rural areas face while being pregnant and giving birth amidst a pandemic. Hopefully this sheds light on future emergencies and crises because ultimately, like in the movies, people will continue to be pregnant and have babies. Throughout this chapter I provide analysis and theoretical frameworks to understand the experiences of pregnancy and birth during the COVID-19 Pandemic. But another critical goal and purpose of this chapter is to simply document and give space to women discussing and explaining how they navigate this very novel challenge. As one mother named Judy keenly observed, "It's such a unique experience that the people who gave

birth during this past year are going to be the only ones who experienced that. What it's like to live through birth and postpartum in a pandemic." I hope to put the uniqueness of this experience in writing through the stories in this chapter.

A Framework for Understanding: Moral Pioneers

A concept that has been discussed frequently during the COVID-19 pandemic is that of "decision fatigue." Psychiatrist Dr. Rashmi Parmar explains this phenomenon: "A seemingly ordinary day in your life today requires you to make a series of decisions with every passing minute...With the uncertainty and chaos that set in earlier this year with the COVID-19 pandemic, people have been forced to make additional choices about their lifestyle and safety, which has added to the dilemma of decision fatigue" (Curley 2020). Decision fatigue is like physical fatigue in that it wears down one's mental abilities and results in increased strain, stress, and exhaustion. Decision fatigue substantially increases stress, anxiety, and burnout (Curley 2020). Pregnant women and mothers during the pandemic are subject to these high levels of stress due to their already elevated concern with caring for themselves and a fetus. Many parallels can be drawn between this stressful impact and anthropologist Rayna Rapp's research with the Prenatal Diagnosis Laboratory (PDL) in New York City on prenatal genetic testing. Rapp's research shows how increased biomedical technology creates new moral dilemmas (1998). She is specifically referring to amniocentesis, a procedure that tests a pregnant woman's amniotic fluid for signs of various genetic syndromes that would result in disabilities[33] in her child. Rapp dubs women who face this new testing technology "moral pioneers"

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[33] Specifically, Downs Syndrome.

because they must confront a series of heavy decisions: whether or not to get a genetic test, whether or not to look at and interpret the results, and whether or not to abort their child based on those results (1998). I argue that the current COVID-19 pandemic creates new moral dilemmas for pregnant women and mothers. Suddenly decisions pregnant women must make every day: whether to go to the store, to see family, to wear a mask when others are not, to go to church, to get a vaccine, and so on become weighed with morality and risk. Therefore, pregnant women during the pandemic are also moral pioneers placed in precarious decision-making situations that oscillate between giving them full agency and no agency at all regarding their lives. Like the women Rapp worked with, pregnant women during the pandemic are often blamed for not using their agency to make the "right decision," or the decision that others interpret to be "right." This elicits blaming pregnant women. Ultimately, the women in Rapp's study cited personal experience, cultural knowledge, religion, other life responsibilities, and personal scientific understanding to make these large moral decisions. This myriad of factors influenced the choice each woman made, and the right choice for some women was not the right choice for others. The ways that being a moral pioneer requires weathering sporadic responsibility shifts on pregnant women and mothers and using personal knowledge and life factors to make decisions throughout this period is evident through all stages of birth: pregnancy, labor, and postpartum. In the following sections, I will discuss each of these stages and the challenges and barriers women faced throughout.

COVID Babies: Pregnant in a Pandemic

On a spring afternoon I sat in my car in a Walmart parking lot getting ready for a phone interview with Judy. Judy and I had been texting back and forth for a while to

figure out a time when she could talk. I was connected with her early on because she is trained as a social worker and is good friends with one of the other professionals I worked with frequently throughout this research. Judy grew up in a county just off the mountain and moved to the Sunflower Mountain Region for college and never left. She is now in her early 30s and works in academic support at the local University in a program that supports first-generation high school and college students. She also has two young children. As I explained earlier, phone interviews are complicated and can be unpredictable. My conversation with Judy was my favorite type of call. She was warm, funny, and very insightful about her birth experience. At the end of the interview she actually thanked me for giving her space to reflect about these things despite the fact that she was the one doing me a massive favor. When I asked Judy when she gave birth to each of her babies she responded: "so I had my first in September of 2017, and my son is turning one this week, so he was born March 2020. Yeah! A COVID baby."

"My Life Hasn't Stopped": Deciding to Have A Baby

People like Judy who had their babies in early March sometimes laugh a little when referring to their child as a COVID baby. Obviously, Judy had not planned to give birth during a global pandemic. It just happened that she experienced the final two weeks of her pregnancy in the early panicked days of the pandemic and gave birth amidst the initial shutdowns and regulation changes. The women who had to give birth in March 2020 had unique experiences of fear and uncertainty that accompanied the early days of the pandemic. While Judy joked about her COVID baby, others did not feel as though it was as light of a topic. In another phone interview, I talked with Diana who had one baby during March of 2020 as well. She was also pregnant with her third child when I talked to

her in the winter of 2021. When I asked her about her experience during that time she firmly said, "I've seen a bunch of posts since I've had my second one and been pregnant with my third one, I've seen a bunch of posts on Facebook that people are like 'oh my COVID baby!' No. My baby is not no COVID baby. Just because it's in a pandemic that does not make my youngin a COVID baby." She explained how she hated the joking discourse around quarantine parents being bored and making "COVID babies." She never wanted such a horrible pandemic with deadly consequences attached in any way to her newborn. Whenever people implied that, she immediately pushed back at them and shut them down.

Because Diana and Judy gave birth in March of 2020, they did not make the decision to be pregnant during a pandemic. But other women did proceed with pregnancy even when the pandemic was at its height, forcing them to make a weighty decision. Christina, a 27-year-old woman who has lived in the Sunflower Mountain Region for the past 10 years, had her first baby in May of 2021. I talked with her just one week after she gave birth. When we were talking about the challenges of being pregnant in a pandemic she expressed her frustration with the way people were treating her in public on a daily basis. She explained, "Everyone was like, why did you plan to get pregnant during a pandemic? What's wrong with you? I guess a lot of people looking down on our decision. But it's kind of like, well, my life hasn't stopped because of COVID. I still had to go to work. I still had to do my job. I still go to church, I still go to the grocery store. So what's different?" Christina was met with a lot of dissent from her friends and family about her decision to proceed with pregnancy during 2021. She and her husband had been wanting to start a family and did not want to put it off any longer despite the pandemic. They

ultimately felt like they could do this just like they had been doing everything else this past year. The responses from others highlight the consequences and backlash moral pioneers face when they make a decision that is viewed as incorrect by others. As Rapp highlights, there is no right or wrong decision in these situations. But because pregnancy is such a public experience it invites others to react and judge a woman's decision-making based on what they think is right or wrong.

The moral disapproval Christina faced from her family and friends occurs at the intersection of COVID-19 and pregnancy. COVID-19 raised many moral issues because the nature of the initial strain and the predominant strains of the virus at the time of writing (Delta and Omicron) is that it tends to be more deadly in older people and people with other health conditions (CDC 2020). The idea that contracting this virus may be mild for some but life-threatening for others raises the stakes of the risks of transmission[34]. This is reflected in a lot of the public messaging of the pandemic where people are asked to "do your part" and "protect your neighbors" by social distancing, wearing a mask, and getting a vaccine. When the vaccine rolled out, conversations of herd immunity, or the concept that when a large portion of a population is immune to a virus, the spread of the virus will be mitigated ultimately protecting the entire community (MAYO Clinic 2020). Many of the factors that could have alleviated the devastation of COVID-19 were ignored which led to public discussions of people who do not wear masks, social distance, and get a vaccine as selfish and hedonistic (Duffy 2021). For

[34] I contracted a breakthrough case of COVID-19 in August 2021. Even worse than the symptoms was the massive guilt I felt for possibly transmitting it to more vulnerable or immunocompromised people. While I was sick and worried about this I spent a lot of time googling 'COVID guilt' and found that this was a lively discussion online, indicating that my worry was common.

example, young people throughout the world who continue to travel and party on spring break even though they are knowingly acting as super spreaders of the virus which will likely result in many deaths were a major example of this selfishness and seemed to be morally reckless.

Even without pandemic conditions, pregnancy is frequently viewed and scrutinized in public with a moral lens. One critical example of this is Dána-Ain Davis's examination of the reaction and treatment of Nadya Suleman, who gave birth to octuplets in 2008. While the case was initially hailed as a medical miracle, as more information emerged it became clear that Suleman used Assisted Reproduction Technology (ART) to conceive her octuplets. Much of Suleman's private life became a topic of public discussion. She deviated from the stereotyped script of who uses IVF: white, wealthy, married couples with no children who are trying desperately to have one of their own. Suleman already had six children when her octuplets were born, she was a single mother, and she was using food stamps and disability payments (Davis 2009). Media discussions of Suleman became outraged. Davis finds blog posts that read: "Who know who the dads are?'' [of the other six]. Another wrote, ''Now she brings a [liter] litter of eight kids into an already overpopulated world. Those babies will cost taxpayers millions. I think this is criminal'' (Posted by Joe 1/29/09 6:13 pm FLA Times Blog)" (Davis 2009). Popular news shows, media outlets, and conservative figureheads criticized Suleman relentlessly, feeding into the stereotype that single, low-income women and women of color are not good mothers (Davis 2009). Davis writes, "There were further insinuations that Ms. Suleman had mental health issues, and some television broadcasters made provocative comments saying that Suleman would not be able to love 14 children; she has an

Angelina Jolie fetish; and that her priorities were mixed up because she got her nails done after the delivery and release from the hospital. By demonizing the woman, it is easy to see the way that presumptive rationalizations emboldened in neoliberalist ideology was reshaped to rescind ‘‘choice.’’” (Davis 2009:110). The way that Suleman’s pregnancy and choices surrounding her own childbearing were berated and dissected by the public and created a lasting cultural motif give an example of how pregnancy “choices” are fragile and personal decision-making is subject to scrutiny (Davis 2009). Christina is a white woman, so her decisions are not racialized and as criticized as women of color. Yet she still faced backlash associated with her pregnancy choices calling into question the necessity and freedom of choice associated with reproductive justice and rights.

The moral weight of pregnancy intersects with the moral weight of the pandemic. These layers of moral heaviness can exacerbate the effects of stratified reproduction. There are already plenty of ongoing conversations about the ethicality of ever becoming pregnant with the state of climate change, social conflict, inequality, and other general despairs of the human experience. A concept in philosophy called “anti-natalism” holds that procreation is morally wrong because the fetus did not consent to being born (Rothman 2017). This movement is gaining popularity in academic and everyday circles. On a more practical level, a worsening economy, increasing expenses, and waning environment all call into question the quality-of-life children may have going forward.[35] When used selectively, anti-natalism can broach a slippery slope into eugenics. For example, stratified reproduction claims that women with lower socioeconomic status are

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[35] For example, to recall my opening discussion of apocalyptic movies, when I saw *A Quiet Place* in 2018, when the pregnant character appeared for the first time my friend and I immediately turned to each other and exclaimed, “Why would anyone get pregnant in that kind of crisis?!”

more likely to be discouraged from having a baby. The pandemic exacerbated wealth inequality and many families struggled to make ends meet with an increase in job losses (Kaiser Family Foundation 2021). This implies that more women face increasing barriers to optimal pregnancy care and reproductive support. On top of the practical challenges presented by the pandemic, the new moral layer also introduces judgment and expectations upon women that only people with ample wealth should make the decision to become pregnant. Arguably, morality is a substantial aspect of stratified reproduction especially when discussing proper reproductive support. For example, even an off-handed comment from a grocery store clerk to a pregnant woman using food stamps about being sure if she wants a baby has a large impact on how a woman feels socially and culturally supported in her pregnancy. With the introduction of new moral ground accompanying the pandemic, these judgements (like those Nadya Suleman faced) contribute to further stratifying reproductive experiences.

The COVID-19 pandemic represents an immediate risk to fetuses who are about to enter the world and has implications for their lives after doing so. Questions of the ethics of becoming pregnant during public health crises are not completely novel in the US. During the HIV epidemic after scientists had discovered that the virus could be transmitted perinatally, many entities including the CDC recommended that women with HIV delay any pregnancies until more was known (Rasmussen 2020). Additionally, "during the H1N1 influenza pandemic, as data emerged showing that pregnant women with H1N1 influenza were at increased risk for complications and death, some clinicians called for the CDC to recommend that women wait until the pandemic was over to become pregnant" (Rasmussen 2020). The same concern was raised during the Zika virus

outbreak in 2016 and 2017 (Rasmussen 2020). Ultimately using public and scientific authority to govern a personal decision such as procreation has ethical issues as well (2020). Also, this type of guidance prompts increased discrimination because policies have stratified impacts on different groups of people with varying racial, gender, class, and ethnic identities. This is not unprecedented globally. In April 2021, the Brazilian Health Ministry asked women in the country to delay pregnancy to ease the stress of the health system (Reuters and Simoes 2021). While a government or public institution asking women to delay their pregnancy shifts the responsibility of the state on to individuals, the logic behind doing so is clear. This type of messaging permeates society and bolsters the morality of delaying pregnancy in the pandemic. Research shows that many women did delay or abandon plans for having children when the pandemic began (NYU Langone Health 2020).

Christina's choice, even though she felt like it was looked down upon, worked for her. She had a healthy baby girl in May 2021 and she was pleased with the timing. She certainly faced struggles with the pandemic but had no regret with her choice. This aligns with an observation from a health professional I talked with who runs a pregnancy support group. When I asked her how the pandemic impacted how people experience pregnancy she said:

> My moms that have been in group since the pandemic and, I think they got pregnant during the pandemic, we like talked about it and planned, and the moms that you know, had been going to Friendship before and knew the restrictions had been guided, you know. So we kind of made this plan and the moms who just delivered had a better experience than the moms that delivered earlier in the

> pandemic because they set themselves up for like, they took coolers of food and thermoses, and had people lined up to bring them food if they had to stay for a longer period of time. You know, the water in the hospital sucks so they brought their own water, they took more time to prepare.

Women who gave birth later in the pandemic (ie. Late 2020 into 2021 and 2022) had more time to prepare for the realities of COVID-restricted birth and therefore had more positive experiences. People like Christina who actively made the choice to have a pregnancy at this time had a better idea of what to expect. Even women who had unwanted or unplanned pregnancies later in the pandemic could at least practically prepare for giving birth amidst COVID restrictions. In this situation, women took on more agency regarding their pregnancy and birth experiences. Women who were pregnant when the pandemic started did not plan for this to happen and felt more tumultuous in the whole experience. One more pronounced fear that was a constant force that women who experienced their entire pregnancy during the pandemic was in relation to catching the virus while pregnant and the uncertainty of the effects and consequences of becoming ill.

Health Anxiety

Another maternal health professional I talked with explained how health anxiety differs depending on what point during the year a woman became pregnant. She said, "It kind of depends on where you are so for pregnancy, it's about physical health and wellness right now. So at the beginning of the pandemic there was information coming out about how the virus doesn't seem to adversely affect pregnant women as much, it

doesn't seem to impact the fetus and development, you know, it just, the risk wasn't as... let me think about how I'm saying this. It's not that they were saying, 'oh if you're pregnant and get COVID you're fine,' but they weren't saying anything like there is heightened risk. And now what we know is that there is." This is certainly true. As the pandemic unfolded new information was constantly emerging but some of the most closely followed shifts were that of how the virus impacted pregnancy. At first the CDC claimed that pregnant people faced no additional risks compared to the average person who contracts COVID unless the pregnant person had other health risks that made them more susceptible in general. Now it is very clearly understood that because one's immune system changes in pregnancy, pregnant women are highly susceptible to becoming very sick when they contract coronavirus (Sheffield 2021). This rapidly changing advice was confusing for pregnant women and health professionals alike. Ultimately the conclusion that getting COVID during pregnancy is extremely dangerous shifted a whole new level of moral responsibility onto pregnant women because the threat of contracting the virus is very threatening to themselves as well as their fetus.

Taking Extra Precautions

As soon as the increased risk of COVID during pregnancy was advertised people understood the gravity of avoiding the virus. Pregnancy is a time of heightened health anxiety in general because it marks a shift from caring for just your body to caring for your body which is growing another body inside of it. Essentially, during pregnancy individual health has higher stakes because it is no longer individual. Many women I talked with explained that staying healthy was very hard and the biggest challenge of pregnancy during the pandemic. Even in early 2020 when CDC guidance assured that

pregnancy did not increase COVID risk, most of the pregnant women I spoke with still felt that they wanted to avoid the virus at all costs. Although Christina was happy with her decision to be pregnant, she also struggled with many factors. She had to continue to work in person at the YMCA but had constant fear that she would contract COVID. She explained, "The hardest part was trying to still go to work, I have to work because I need the money, and working in a place that's so hands on, seeing all those people and trying to clean. So it was hard to distance myself and still do my job." Many women expressed this fear. Macy, a new mom who was also pregnant, could work from home so she really did not go anywhere during her pregnancy. She said, "I was pretty scared to go out because, in those times we didn't know, we didn't know much about how COVID could impact a pregnant person or fetus, and so I, yeah. I didn't really go out much." Macy also revealed that she feared that people were judging her for going out whenever she was in public shopping, buying groceries or really doing anything outside of the home. Once again, this is a consequence of being a moral pioneer. The visibility of her pregnancy brought the perception of judgement whenever she was in public. This increased Macy's feelings of isolation during her pregnancy. She was unable to see friends or family and she felt like she was stuck inside all while dealing with the novel experience of being pregnant: a time when she could have used a lot of help and support. Women reported taking these kinds of precautions a lot and having deep stress and anxiety every time they did have to leave their home out of fear of contracting COVID.

Losing Resources

Another common struggle pregnant women face in the pandemic is the loss of critical pregnancy resources. COVID precautions closed any in-person experience for

nearly two years. Candace, who I mentioned in Chapter 3, was pregnant during the pandemic and claimed that the biggest downside of her experience was that she was unable to take any of the pregnancy classes she wanted to take. This was her first pregnancy and she felt like she really needed much more education than she had when she arrived to give birth. When I asked her if she felt like she had enough knowledge when she got to the hospital she exclaimed: “When I went to give birth? NO! But it was mainly the pandemic that was the issue with that. Because there was a flyer at the doctors that was about taking a prenatal class and we were like we need to do that. So we called them and they said we’re not doing those. We’re doing one on one with parents if they want that. And no one ever got back to us about that. So we were like… ok, we’ll be fine I guess. So we watched a Youtube series. I remember we watched a few videos of women who gave birth in the car on the way to the hospital. But yeah, not going into give birth. I didn’t know anything.” She was frustrated by this. She has friends who were able to take the prenatal classes and she envied their experience. Another woman, Caroline, expressed the same grievance. She was actually taking prenatal swimming classes when the pandemic started. She had only been attending them for a few weeks before everything was cancelled. “I really was enjoying those classes,” she said. “I was learning so much that I didn’t know and I was making pregnant friends. The education and support was invaluable. And I got the added benefit of exercise. Whenever it was all shut down, I just kept thinking, boy, I am really missing out. I was bummed about that.” The impact that shutting down prenatal support resources has on pregnant women is evidence that they are very effective and appreciated by community members. In a rural area that does not have many resources in the first place, the loss of the programs that were up and running

was devastating for many women. The inaccessibility of services due to COVID-19 marks another shift of agency where pregnant women do not have options for programs and support. Even if these programs were continuing to run in person, pregnant women might still fear contracting COVID or being judged for not taking on the most effective prevention of infection which is staying at home completely alone.

Pregnancy and Vaccines

Like the general guidance on COVID contraction and pregnancy, the safety of the COVID-19 vaccine for pregnant women wavered over the course of the year. By mid-2021 it was solidly proven that pregnant women are strongly advised to get the vaccination as it has no negative impact on pregnancy or fertility in general (Sheffield 2021). But with a vaccine that is so hotly contested in the first place the lack of an immediate reassurance of the safety of a vaccine and pregnancy produced substantial trepidation. When I volunteered at the county COVID vaccine clinic, I took temperatures at the door which meant I saw everyone who came to the clinic. I did this job multiple times per week for four months and I only saw three women who were visibly pregnant come through the line. I was really surprised by how few pregnant women I noticed. One woman who came through was clearly towards the end of her pregnancy. As we made small talk at the door and I asked her if she was excited to get her vaccine today, she gritted her teeth and exhaled a big sigh. “I hope so. I know that it’s the right thing to do but I can’t help but be a little nervous. I hope it won’t hurt my baby.” I told her that I understood her concerns and I pointed out one of the nurses giving shots who herself was eight months pregnant. The woman in line smiled and said, “Oh wow, that definitely makes me feel better!” but her rigid posture and fidgety hands showed me that her stress

was only fractionally eased if at all. Just like the general anxiety about contracting COVID while pregnant, it seemed that women carried this pressure and anxiety into their decision about the vaccine. These discussions surrounding vaccinations and pregnancy are constantly evolving and provide yet another challenging and morally charged decision for pregnant women in a pandemic.

I asked the maternal health professional who runs a support group for moms if she saw a lot of conversation about vaccinations in her groups. She said that many women say something along the lines of: “I definitely want the vaccine, but I’m not getting it until I’m not pregnant anymore.” This is a common sentiment amongst pregnant women especially during the early vaccine days in winter of 2021. As of October 2021, only 33% of pregnant people ages 18-49 were fully vaccinated (CDC 2021). Compared to the general population eligible for vaccination, this is a very low percentage. When I asked this professional how she handled conversations about vaccination in her group she explained:

> For some people the preference is, well I'm going to keep doing all of my precautions and not get the vaccine until I feel like I'm in a safer place to get the vaccine. So, it’s, um, I guess another thing I’ll say to this too, this came up in a consultation group that I’m a part of, is the therapist and practitioner’s role in providing psychoeducation and correcting misinformation, because there's some of that where it’s really important to do. And in doing that I believe we are giving our patients greater awareness and therefore greater choice. If you believe that like, the vaccine is gonna implant a microchip into you, I mean of course we’re talking about conspiracy theories which are much harder, but if there is some

> level of misinformation about what it can cause, then being able to provide like, 'Hey! Where are you getting your information? Here's another place. This is what I've heard.' So that they can have greater choice. And at the same time, there's so much that we don't know. And we, it is still important to let people make their own choices.

This compassionate response gives insight on how maternal mental health practitioners were confronting and prioritizing vaccination conversations. Earlier in our discussion, this professional said that her top priority was ensuring and protecting autonomy amongst pregnant women. This means giving them space and resources to make their own decision and not disapproving either way. While it was personally hard for this professional to hear pregnant women turn away from the vaccine despite how much it would help them and their community, she remained steadfast in her commitment to autonomy and respect.

Labor in A Pandemic

The experience of laboring and giving birth during a pandemic is truly unprecedented for most women alive today. The challenges of this unique situation are hard to even conceptualize. This is especially true for first time mothers for whom giving birth itself is a novel experience. With the added complication of a pandemic to this already stressful event, women struggled to face the new regulations and once again, found themselves navigating uncharted moral decision-making territory. As previous chapters exhibit, navigating pregnancy and birth in rural communities is a challenge in

itself. When the barriers of rural birthing care and a pandemic intersect, giving birth becomes an even more complicated event.

One Person in the Room

The moral pioneering continues beyond pregnancy into labor. Throughout the entire pandemic and through present day (2022), Friendship Hospital in Beulah County and all other birthing hospitals in the Sunflower Mountain Region adjusted their rules for birth. Only one person (other than the pregnant person) is allowed in the room for the birth. This person is only allowed to enter once. Once the visitor comes into the room, they cannot leave again for any reason other than to use the restroom. This is to ensure that the visitor does not go elsewhere, get exposed to COVID-19 and then reenter the hospital room. This makes sense in theory but presents complications. Labor can last a long time and women can be in the hospital giving birth for days. Women who had their babies later in the pandemic had time to plan for this new regulation and pack food and clothes for the visitor, but it is hard to pack for an unknown amount of time and an experience they have never had before.

This new setup poses a new massive moral conundrum for pregnant women. The decision of who to invite to be the one person in the room can be highly stressful. I talked to 22-year-old Cassandra when she was five months pregnant. This was her first child, and she was nervous and did not really know what to expect. When I asked her who her one person in the room was going to be, she dictated an issue that pandemic pregnancy moral pioneers experience: “As much as I love my husband, he’s never had a child. He’s never delivered a child. So I would really prefer for my mother to be in there. But it kind

of puts you in a hard place of... I can't ask him to miss the birth of his child." Cassandra never could have imagined she would be confronting this conflict when facing the birth of her first child. "I never thought I would have to decide between my mom and my husband. They are both so important to me," she said. Having her mother in the room to guide her would be ideal because her mother has had birth experience but in all reality, she felt like she could not deny a father seeing the birth of his child. The onus of this moral decision falls on Cassandra (and other women in the same situation) to determine who will be the one to support them during birth and who will be granted the privilege of witnessing the moment this child enters the world. This is not a small decision and it obviously weighed heavily on Cassandra furthering her stress as a moral pioneer.

The one person in the room rule is strict. This extends to other health professionals who do not work within the hospital, most notably, doulas. Doulas are trained professionals who provide knowledge, education, and support to women throughout their pregnancy, birth, and postpartum periods. Doulas are associated with holistic birth and advocate for low intervention and more natural ways of laboring. There is a solid doula organization in Beulah County and people are generally aware of doulas and therefore they are commonly utilized. The idea behind doulas is that they are advocates for empowering childbirth and they act as a supporter in the room during birth. Women giving birth are in intense pain and therefore it becomes harder to advocate for oneself. The doula provides constant support and backup in the room. Research shows that when doulas are involved with birth, mothers and babies have better health outcomes (Gruber 2013). This is especially true with higher risk mothers who are socially marginalized like many of the mothers in the Sunflower Mountain Region. In a research

study on the efficacy of doula-assisted births, authors found that, “Doula-assisted mothers were four times less likely to have a low birth weight (LBW) baby, two times less likely to experience a birth complication involving themselves or their baby, and significantly more likely to initiate breastfeeding” (Gruber 2013). This is likely due to the support, education, advocacy, and encouragement doulas provide to women. Doulas are productive for birth, but one of the first things Sunflower Mountain Region hospitals did in the pandemic shutdowns was prohibit doulas from being in the room during birth to limit the number of people present and reduce virus risk. A health professional explained how this change occurred and the impacts:

> In terms of delivery and birth, things are more limited and I’m glad you said this is anonymous... so one of the things that was happening was the hospitals weren’t providing admitting privileges to doulas. And what we know about doula support in delivering pregnancy is that, when doulas are involved, there’s often less medical intervention, there’s reduced rates of emergency cesarean, and overall more positive birth experiences. So, what a colleague and good friend of mine shared with me who is also pregnant right now is that they had a petition in order to allow doulas to start being able to be present for deliveries. And one of the things that helped that was because the county’s C-section rate increased. This county already has a pretty high rate. I think for a long time my clients and friends who delivered, they were talking about ok, so do we need to look at going off the mountain where they are allowing doulas? So that was one thing. They were, you know, deciding to go from a rural area to a more suburban or urban area to deliver.

One interesting observation from this comment is the fact that this professional was relieved that her real name would not be used in this study. There is a clear indication of tension between doctors and hospital administrators and holistic birth advocates. As this professional points out, doulas are very important to women in the area. When they were banned from the hospital women had to weigh options of leaving the mountain to give birth which would make their labors far more complicated due to the distance they would have to travel. Another point of importance is the C-section rate. C-section rates tend to be higher in rural areas than urban areas (Greene et al. 2004). This happens for a variety of reasons. On the medical side, rural hospitals tend to have less access to technology and therefore procedures such as Vaginal Births After Cesareans (VBAC) are not possible in rural hospitals. This is the case in the Sunflower Mountain Region. So any woman who had one C-section can only have C-sections for the rest of her births. Additionally, there are non-medical reasons especially in small rural hospitals such as the "lack of surgical coverage on weekends leads to scheduled C-sections in anticipation of problems" (Greene et al. 2004). The Beulah County C-section rate was already high (4% higher than the state average and 5% higher than the USA average). But during the pandemic the rate skyrocketed, and many professionals hypothesize this was because of the lack of doulas in the hospitals.

Intersections of Rurality and COVID in Birth: A Labor Story

In Chapter 3, I discussed the "everyone sees everyone" model at Friendship Hospital in Beulah County. This is the system that was created out of necessity when Pine Ridge Hospital in Rita County closed its birthing services. To reiterate, the system requires women getting prenatal care to meet with both doctors and midwives because

the person on call when they go into labor will deliver their baby. They do not choose which provider will help them give birth. This increases stress and negative conceptual outcomes of birth because it limits the choices pregnant women can make about their care, thus reducing empowerment. The "everyone sees everyone" system which is a direct result of rural obstetric care combined with the restrictions of the COVID-19 pandemic create a chaotic, unpredictable, and stressful environment for birth.

Judy's Story

I opened this chapter talking about Judy and her "COVID baby" to whom she gave birth in March of 2020, right at the start of the pandemic. She gave birth to her first child in 2017 at Friendship Hospital and felt fortunate to get a midwife to deliver her baby. She loved the midwives she met and is passionate about midwifery care in birth. She explained her affinity for midwifery:

> Based on my experience during research, just the lower levels of intervention that people practicing midwifery seem to feel more comfortable with less intervention it seemed like. And that's been my experience anecdotally talking to the doctors and midwives at [Friendship]. And I knew going in that I wanted to do as limited intervention as possible, and I also liked just that the midwives in general seemed to be willing to think more outside the box for pain management and general support during the birthing process where the doctors were like, well we can induce I felt like they just went straight to medical things. Well if you hit 40 weeks and five days, we'll get you going as far as an induction and that sort of

> thing. I feel like the midwives are more willing to talk about other options before you jump straight to that.

Judy was able to compare doctor and midwife care because she had to meet with all of the providers through the "everyone sees everyone" system. She knew she wanted to give birth as naturally as possible and felt that the midwives would support her in that goal. She had a great experience with giving birth to her first child, a daughter. Her pregnancy lasted long. She was still pregnant around 42 weeks and the hospital was pushing her to schedule an induction. She explained, "I was really wanting for my body to go into labor naturally. And that's another, I think, a really big downfall of not having a more holistic birthing center is that they [the hospital] cap you at 42 weeks. Based on my experience with my daughter I went almost a full 42 weeks and with my son I think I would have as well. And you know everyone's bodies are different and due dates are just a guesstimate. It feels frustrating to have someone tell you no this is the way it has to be even though your fluids are fine and your body doesn't seem to be in distress in any way." Fortunately, when her daughter was born she was working with a midwife who supported her natural labor and they did not have to perform an induction. After hearing her speak so passionately about midwifery care and natural labor, I was surprised when she told me she was induced with her second child, her son. Clearly Judy could advocate for herself during her first birth even when her pregnancy extended some of the more rigid hospital guidelines.

When I asked her why she had an induction that she did not want she explained: "I think just going into my birth on top of the really swiftly changing policies due to COVID, it was really stressful and I actually ended up scheduling an induction because

the policies for COVID were changing really quickly. And at that time it was when New York state had just stopped allowing partners in the birthing room. And I was already at one week past my due date. And they were telling me at Friendship like, we just can't be sure what's gonna happen here as far as allowing partners in the room because at the time that seemed what was gonna be happening across the country. Pretty quickly, New York state retracted that like oh gosh this is a bad plan. But for that week where I was due it seemed really uncertain. So, I scheduled an induction so my partner could be there, which was obviously, like, not my plan going in." Judy is referring to the startling March 24th announcement by two of New York's major health systems (NewYork-Presbyterian and Mount Sinai) that no support people would be allowed in the room while a woman is giving birth (Van Syckle & Caron 2020). Women would have to labor alone. This decision caused fear and uproar from pregnant women everywhere because in March 2020 the rest of the country seemed to be following the lead of New York City in terms of COVID regulations. Later in the week Governor Andrew Cuomo issued an executive order which asserted that one non-sick person could be in the room while a woman was giving birth. One of Cuomo's top aides Melissa Derosa followed the executive order announcement with a tweet stating: "Women will not be forced to be alone when they are giving birth. Not in New York. Not now, not ever."

While the decision to ban anyone not giving birth from the hospital rooms was quickly reversed, in those early days Judy and her partner were rightfully nervous that those regulations would soon move to Friendship Hospital. She wanted her partner to attend the birth of his son and she was afraid to be there alone. The uncertainty of the providers also contributed to their nerves. They discussed it and weighed the pros and

cons and ultimately decided the safest move was to schedule an induction. Judy was disappointed that she was pinned into this decision, but there were also other reasons that an induction seemed necessary. Once again, Judy is facing a novel decision created by the pandemic. Judy said, “With my son, and with COVID on top of it, it was definitely more limited and I knew going in that there was a slim chance that I was gonna get a midwife even though that’s what I strongly preferred.” Judy previously talked about how much she wanted to ensure she had a midwife with her while giving birth as opposed to a doctor. With the “everyone sees everyone” system, she was already rolling a dice with the provider who would attend her birth. But she felt that the pandemic decreased her chances of having a midwife due to the scheduling changes that she explained: “I didn’t want to go into labor on the weekend because no midwives deliver during COVID on the weekends. I don’t know what their protocol is now. But at that time, starting Friday morning to Monday morning no midwives were on call to deliver babies. So I was hoping that if I scheduled an induction before the weekend that I had a higher chance of getting a midwife. I was like, looking at the scheduling basically like who was gonna be on call and hoping that I timed it right. Like, at least a chance of who I wanted.” This choice is ironic. Judy is someone so committed to midwifery and holistic birthing care that she had no alternative but to opt for one of the most invasive processes of birth: induced labor. Because of the combination of the system caused by rural obstetric closures and the pandemic, Judy had to make a decision that violated a lot of her wishes and ideas about birth.

Judy compared the birth of her daughter to the birth of her son. With her daughter in 2017 she had no interventions at all and was really pleased with her experience. But

with her son in March 2020, “I had every intervention possible. I had Pitocin, I had my water broken, it was all the things. And I wanted so badly for my body to just go into labor on its own. You know.” She felt disappointed that she could not allow her body to do what she knew it could do. Many women I spoke with described a sense of failure whenever doctors had to use interventions during their labor. Like Judy, they had the idea that their body should be able to do this on its own and when the provider must do extra work to help it is easy to feel let down and disappointed in oneself. This is another way that women ultimately have negative conceptual outcomes of birth. Beyond this feeling of disappointment, I asked Judy how else these interventions affected her, and she explained, “Well I mean I personally took on a lot of discomfort and pain. Being on Pitocin and the Foley Balloon[36] is not comfortable. And just feeling like I needed to do those.” Beyond these interventions that she did not want, she described a truly unbelievable and stressful scenario of attempting to have a baby while keeping an eye on the clock: “And there's also that timeline where I had the midwife, but I knew she got off that following morning and it was like 3pm and I had until 7am to give birth or I was gonna have this doctor I really didn’t want- my last case doctor. And it was like 6am, and she was getting off at 7am. And she was like, ‘you're 8 cm’ and I was like, ‘I’m gonna push this baby out now because you’re not leaving.’ And I started to push and she was like, oh my gosh let's do this! And she ended up staying up an hour over her shift and he was born at 8:10am. I literally think I forced my baby out because I was not willing... I mean I was done being in labor I was over it. But I was also like, I'm not changing to another provider again, this late. I know I can give birth to this baby. It’s funny saying it

[36] A device that is essentially a balloon attached to the end of a catheter. It is used to dilate the cervix during induced labor.

out loud!" When Judy recounted this labor and noted that it was funny to say her tone also indicated that she was disturbed by what she had to do and this was the first time she was voicing it. There she was in active labor literally watching a clock to make sure she could force her baby out fast enough to ensure that she could finish it out with the midwife. Additionally, Judy did hemorrhage[37] after the birth because of the high levels of intervention and the fact that her body was not naturally ready for labor yet.

The story of Judy's labor epitomizes what it means to give birth in a rural area during a pandemic. The lack of choices was further exacerbated and limited by COVID and the necessary regulations and restrictions. Birth in the Sunflower Mountain Region is already characterized by a lack of choices and subsequent disempowerment. The pandemic only made the few choices fewer, having a concrete impact on how women like Judy faced their labor and birth. Additionally, labor presents more situations of moral weight for women to make.

Postpartum and Parenting in a Pandemic

In normal times the postpartum period and adjustment to parenthood is a massive challenge for many women and families. About halfway through my interviews it struck me that every single woman I had interviewed or talked to about their pregnancy and birth experience mentioned struggling with postpartum depression and anxiety. This was not a question I directly asked, but it always came up. Adjusting to being a new parent brings struggles for families as well. The pandemic affected the way that every single

[37] Births with higher levels of medical intervention end with hemorrhaging more frequently than births without as much intervention.

person lives, but the impact on new mothers and mothers of young children is unique. Similar to pregnant women being moral pioneers, postpartum women are navigating the newness of having a baby in combination with an unprecedented pandemic. This furthers their role of moral pioneers that must navigate two complicated life scenarios at once.

"I can't even put into words how lucky I feel": A Great Adjustment

When I asked new mothers how they have adjusted and experienced the postpartum period during a pandemic, there was rarely a middle of the road response. Women either had an excellent adjustment and were even grateful for the pandemic conditions while others had an absolutely miserable time. One example of someone who had a good adjustment was Nancy, a 30-year-old mental health professional who had her baby in January of 2020, which was just about one and half months before the pandemic shutdowns. When I asked her what it was like to have a newborn when a global pandemic started, she responded: "I feel like it was wonderful." I really was not expecting this answer and exclaimed, "Really?!" Nancy went on to explain herself:

> So I had him, he came early everyone in the family is freaking out, and so we had so much help. Someone was at our house for the first month. And like, it was kind of helpful but also, and I've talked to other women who feel this way when they have their mothers come and grandma. They say they're gonna cook and clean but really they just want to sit there and hold the baby. And that was absolutely my mom. Like I was cleaning, my husband was cooking and my mom was sitting there holding the baby. So once we finally had an empty house it was like this is so much nicer. Then more family was going to come in the spring, and then the

> pandemic happened, and no one could come and I was like thank God! I'm burned out on this. And then my husband and I are very lucky in that we have jobs where we can work from home, our supervisor is tremendous, she's an RN, we both work for the health department. So we thought we were going to have to do daycare, but we haven't had to. We've been able to just like set up our schedules so we are both working from home. I mean I just can't like, we just feel so lucky. I can't even put into words how lucky I feel. And I can't imagine looking back, like in August having to put him, this little guy into day care? That would have just been, his life would have been so much different.

It seemed like Nancy could not even imagine a world without a pandemic. It really would have altered the trajectory of her family life. The timing of the shutdown worked perfectly for Nancy in that she got initial familial help and support but then had time alone with her baby when she needed it. She also was able to work from home and that saved her a lot of money because she did not have to use a daycare. Another mom named April had a similar adjustment. Her older child was able to stay in preschool and she and her husband could work from home. Having the two kids together was really helpful for the entire family unit and their bonding. April said, "Their relationship has like, flourished during this time. We're so, so, lucky. It worked out great. Like there really wasn't a whole lot of adjustment for us other than we had all these social things lined up for us this past summer and it obviously did not happen." Both Nancy and April's use of the word "lucky" when talking about the occurrence of the pandemic seems ironic on the surface but it shows their awareness of how hard this time has been for so many. Both of their tones indicated a level of disbelief that things went so well. Both women treaded

carefully when saying they were grateful for this time and acknowledged the extreme hardship that the world has faced. Nancy stumbled through her words when trying to express this and said, “I mean, it was so nice, I’m almost like- no, you know, I’m not glad it happened. It’s a horrible tragic thing that has ruined so much. All I’m saying is that it worked out for us and we are grateful.”

“I Blacked Out”: The Challenges and Ambivalence of Having No Support

While some women considered themselves lucky and had a really positive adjustment, the majority of women I talked with struggled in their postpartum times and in parenting. Judy was someone who struggled. After coming off a tumultuous labor shaped by the new COVID-19 restrictions, she was catapulted into a hectic postpartum period with a toddler and a newborn. When I asked her how this time was for her she laughed a little and said, “I’ve joked with friends that I blacked out during the first 8 weeks of my son’s life because my whole little four person family was at home constantly with no outside family support.” The lack of having in-person support was challenging for new moms during the pandemic. Many mothers planned to have family and friends stop by their homes, stay, and offer some help. When these plans shifted some mothers felt left alone. Interestingly, most women expressed a degree of ambivalence about being forced into nuclear family solitude immediately postpartum. It is nice and helpful to have support if it is available, but like Nancy described in the prior section, a lot of the initial familial help that occurs is people wanting to hold the baby and not really helping with things that need to be accomplished that actually cause the new mother more stress. Another new mother who had her infant during the pandemic explained: “Part of me wanted to just be on my own with my baby in a little bubble sort

of thing, which is kind of the way that it was. And then also realizing like, wow, I really need somebody." Remaining in this "bubble" was harder for mothers who had other kids at home because they were stuck caring for their children while trying to attend to their newborn and navigating postpartum stressors. Judy also wanted to rest and bond with her newborn, but the quarantine requirements interrupted her plans because she had a toddler at home as well. She said: "Honestly the whole first eight weeks were such a blur it's hard to even really remember what I even did to get through that time. I feel like my partner and I were just in survival mode. We just passed one kid, we were like ships in the night. One of us had my daughter one had the son, and we would just pass them back and forth throughout the day." She made all kinds of plans for her postpartum time to try and mitigate depression and anxiety and all those tools and her proactivity were made completely irrelevant by the pandemic.

Isolation

Even when new mothers do have family support to help them during the pandemic, many still discuss feeling isolated and deeply lonely. One critical aspect of new motherhood that was missing for many women was the inability to connect with other new moms. This is always a challenge of motherhood in a rural area (Hostetter & Klein 2021). Women may live in remote places and may not have access to transportation and therefore can be very isolated. This is a frustration that was exacerbated by being pregnant during the pandemic because they felt like they would have benefitted from having other pregnant friends for support. Those pregnant friends would extend into new mother friends. Women who were pregnant and gave birth in the pandemic had limited options to find this support. One new mother Tess said, "I don't feel like I can go out and

meet other moms right now. Or meet anybody and spend a significant amount of time with them, who also have kids or something like that outside of taking her to school so we just kind of like go to school and come home. So it's great to have that as our routine, but outside of that I do feel kind of isolated still. Even with my family support which I'm so grateful that I have, that it does feel, um, a little isolating for sure." Another interesting point that a few mothers discussed was the importance of the option of going out. For example, a mother named Allison said that she is typically a homebody and usually does not go out very much but when the pandemic began and she could not even go out if she wanted to, she experienced a substantial increase in stress and anxiety. She felt trapped with her newborn. Even though she was not going out much when the option was removed, she felt like the pressure of her life was too much to take. A new single mother named Melanie experienced this as well. She had her baby in December of 2020 so she was a few months postpartum when the pandemic began. Melanie discussed how she was struggling with a lot of depression and anxiety throughout and after her pregnancy. I asked her about how the pandemic impacted her and she provided this anecdote:

> Um, it's funny. I really didn't feel up to going out or doing anything almost up until that point. I think I went out one time. But other than that, I absolutely, I didn't leave the house. I want to say for the first few months, other than going outside for walks, I think right before things happened like early, early March. So it's kind of already popping up in the news, but we're not shut down yet. I took her out to the last restaurant that I worked at, and I, I stayed at the bar with a newborn because I was just I was really lonely. So I talked to a couple of my coworkers and we hung out for a little bit and see, that was the longest she slept during the

> day. We're in this loud, busy restaurant and I guess just all the noise of it put her to sleep and stuff and then that was it.

It almost seems like Melanie had an instinct about the impending shutdowns and made an unusual move to take her newborn to a bar just so she could interact with old friends. She was not doing that before, but she was very lonely. Postpartum is a lonely time in regular conditions so when all options of social connection are prohibited women felt the thickness of that isolation which often exacerbated postpartum mood and anxiety disorders. Of course, COVID parameters were not entirely mandatory, and people made decisions to see others in person and go out to populated places. But once again, the pressure of making that decision pinned postpartum women into the position of moral pioneers. They could take the risk of going out and meeting other mothers to combat their own loneliness but ultimately risk exposing themselves or their baby and family to the virus. Women talked about how difficult it was to weigh the pros and cons of this every day.

As I write this in late 2021, we still are living in a pandemic. A few researchers have documented the ways in which pregnancy in a pandemic affected new mothers. Most notably, a Swedish research study comprised of 14 in depth interviews found that women's postpartum experience was affected by the everyday uncertainty and loneliness (Linden 2021). Beyond the literal day to day loneliness of being a new mother during the pandemic, there is isolation in experience as well. The only other people who can truly connect in shared experience to the novelty of this are others who gave birth between 2020-2021.

“I was in tears every day”: Parenting Young Children in a Pandemic

One of the most unusual aspects of giving birth in a pandemic was the required results of that: parenting. Many women I spoke with had to parent their new infant as well as other children. A very common theme in conversations about parenting during the pandemic was the increase in daily stress. Amanda, a health professional who runs a support group for mothers in the Sunflower Mountain Region made a very insightful comment about the change in general tensions:

> I think part of what was going on, and I've shared this with people. I’ve noticed it with everybody, myself included. Especially at the beginning of the pandemic. All humans are built for survival. And so when there is a potential threat, real or perceived, our system is designed to respond and react. And so all of the sudden everybody is faced with this overwhelming uncertainty. And the uncertainty is a threat. And then on top of that, the physical, not only uncertainty about what is my job going to look like but uncertainty like when I go to the grocery store when I pick up this apple, did someone touch it before who had coronavirus? So I think that when we are exposed to threats, our most primal defenses come online. So everyone was responding. Even talking about things completely unrelated to the pandemic. I noticed family and friends and clients and even myself feeling a little bit more on edge. A little bit easier to react to people and shut people down.

This uncertainty that Amanda describes in combination with the isolation and quarantine certainly contributes to higher stress and tension in day-to-day situations. This seems to be especially prevalent in parents. Diana described how being more on edge affected her

home relationship with her husband. After long days of parenting three little boys and being unable to go anywhere else but home, she found that she and her husband would engage in more fights over small things. One day they fought over who finished the Little Debbie cakes. She laughed and said, “Afterwards I was like, this is the stupidest fight ever. Being at home causes so much stress. It causes SO much stress. And that eventually leads to hatefulness and argument.” The constant arguing was tiring for Allison and her family and it made parenting more difficult to navigate.

Some women felt lucky to have strong support systems to help with parenting duties. Diana said, “yeah, I mean it was stressful. I ain't gonna lie. It gets overwhelming sometimes with little kids. And I have a four-year-old at that time, he was two at the time and she was a little over one. So they were little, little. And you know it’s stressful having to stay in the house all the time and doing all that. But we managed to get through it and my husband helped out a lot. Like he would come home from work and he would give me a break.” The division of household labor and childcare alleviates some of the stress of parenting in the pandemic. But other mothers who do not have constant income and the ability to take much time off work or do not have a partner or any help at home face additional challenges. Darla is a single mother with many kids who has lived in the Sunflower Mountain Region for her whole life. Here is her description of the pandemic:

> I had to homeschool them on the computer. My one son had occupational therapy twice a week on the computer, speech therapy on the computer, therapy for his mental issues, all his schoolwork on the computer, group every day, one on one twice per week, then he had his written paperwork. And then I had a one-year-old

> and a three-year-old. And no help at all. I did it all by myself. So at the end of every day I was in tears.

She could not even go into more detail because she had a hard time talking about this period of time. The pressure of being the sole provider for many children during the pandemic was made more severe by school aged children needing to be homeschooled.

Another strange aspect of raising children during the pandemic is the interruptions of normal childhood events. For example, one mother described her toddlers having their first ever experience of a playground:

> We took our boys because our parks finally opened back up not too long ago and the other day it was really pretty and warm outside, and we took our boys to the park. And that's the first time they have ever been able to go to a park. Except for my oldest right before it started and even then he wasn't old enough to do anything at the park. And putting my oldest in the swing, I mean we sat him in the swings and he squealed, like he cried and cried because he had never done it before! And my youngest going down the slide they just thought the slides were this amazing thing and they were like, 'Mom, why are we leaving?'

She never imagined a world in which her toddler sons would have never seen a playground before. She explained how the strangeness of this whole situation really set in when she watched her boys be unsure what to do when they first arrived at the park. Another mother ruminated about life for her infant: "Is this real? Will my baby really never seen any other babies? It also made me think like, will this make my baby weird? (*Laughs)* No, you know what I mean. Will she be scared of other babies and people when

she finally gets to see them?" This concern is valid and children's socialization habits and resulting development have been impacted by isolation. I saw this firsthand while working at the local elementary school. Students struggled in the classroom even when things went back to in person instruction. One of the tensest weeks at school was the week of the state standardized tests. It was commonly understood that students were far behind where they should have been so teachers and support staff experienced high anxiety when that regression would be documented by test scores. The knowledge that students lost during the remote year was not helped with the return to in person. Students were constantly being pulled out of school due to COVID exposure or exposure of a classmate, teacher, or sibling. The students also had pronounced behavioral issues which were attributable to the lack of social engagement over the past year.

Frustration with COVID-19 Disbelief

In any discussion of COVID-19 and the pandemic, it is necessary to mention the substantial amount of resistance to masking and vaccinations within the United States. This is particularly prevalent in more politically conservative areas as former President Donald Trump sowed doubt that COVID was real into the minds of many from the very beginning of the pandemic. The doubt and conspiracy that it was all a lie to control the masses combined with general fatigue over mandates created a less cautious public in the Sunflower Mountain Region. One day as I was walking down the road by my house a white minivan zipped down the road beside me. The side of the car was draped with a large banner that read: "TAKE OFF YOUR FACE DIAPER." As I turned to watch it drive away, its final message to me was the large letters printed on the back of the car that said, "ARE YOU WEARING THAT MUZZLE TO SHOW HOW SUBMISSIVE

YOU ARE?" I rolled my eyes and kept walking. Unfortunately, these type of aggressive anti-masking messages were common in much of the Sunflower Mountain Region. Some of the pregnant women and new mothers I talked with expressed their frustration over the people who were not taking COVID seriously. As I explained before, pregnancy and new motherhood is already a time of increased stress and responsibility. So when others are doing things to put a new baby at risk, mothers experience intense fear. One young new mother explained this: "I already have immune system issues. So if I was to get sick that wouldn't be good for me and not for her. And where I do live a lot of people didn't take it very seriously. So it was hard to feel safe when no one was doing what I thought they should be doing." She constantly felt that her safety was violated. This was exacerbated when she had a baby to care for as well.

During my interviews I talked to many women who were definitely politically conservative, yet only one pregnant woman or mother I spoke with said that she did not really take COVID seriously or consider it a threat. The COVID disbelief in my interview pool was much smaller than that in my everyday life in the Sunflower Mountain Region. I hypothesize that this is because women are typically more health weary in general during their pregnancy, so any discussion of a viral threat becomes more relevant and concerning.

The Intersection of Place, Class, and Pandemic: A Feminist Political Ecology Lens

The experiences of pregnant women and mothers in the Sunflower Mountain Region throughout the COVID-19 Pandemic can be viewed through a feminist political ecological lens. Feminist Political Ecology (FPE) is a subset of political ecology which

uses gender to understand ecological issues. Feminist Political Ecology is a vast field and can be applied to a diverse variety of topics. Juanita Sundberg writes about the use of FPE and explains, “As a style of research, FPE works with feminist concerns about how oppressive relations are (re)produced at various scales of everyday life and makes significant epistemological and methodological interventions in feminism and political ecology alike. Working at the nexus of nature, power, and knowledge production, FPE promises to continue supporting broader feminist political objectives for more equitable and ecologically viable futures” (Sundberg 2016:10). Feminist political ecology brings innovative and thoughtful approaches to the field through a reorientation on how to incorporate a feminist perspective, ideas on knowledge production, and the linking of personal and political concepts. These tools ultimately create space for understanding the nuanced overlaps and connectivity of systems that influence life across multiple scales. Using FPE can help understand how class, a rural environment, and an ecological emergency (pandemic) intersect to reproduce oppressive relations throughout society and ultimately put marginalized women at risk for biological hazard. To illustrate this framework, I will discuss the story of a woman I met named Millie.

When Millie found out she was pregnant she immediately started saving up money so she could take eight weeks off work for maternity leave after her baby arrived. She works at a chain pizza restaurant that does not guarantee family leave or provide any financial support for new mothers. She pushed herself to pick up double shifts as frequently as possible because she knew how hard eight weeks of no paycheck would hit her. She was going to be a single mother so she would not have another income to help. While she was excited for her baby, she was especially nervous about the time off work.

Millie was planning to return to work as soon as possible and leave her baby with her mother while she was away. All of this changed with the pandemic.

Millie still had five months left of her pregnancy when the pizza restaurant reopened for indoor seating. She eagerly got back to work at the restaurant but then started having increasing anxiety. She read that you should avoid contracting COVID at all costs if you were pregnant. She encountered a lot of people every day at work and many of these people were not taking any COVID precautions and even ridiculed her for doing so. She was constantly dwelling on her exposure to COVID and thinking in worst case scenarios about her unborn baby. But what was she supposed to do? She had to work even more to save up for maternity leave. Work became extremely stressful but she continued to go because she felt as though she had no other option.

In addition to the daily stress of potentially contracting COVID at work, Millie was now rethinking her postpartum plans. She could not afford any childcare so her mother would be watching the baby during the days. But her mother has severe asthma and is 65 years old, putting her at high risk for death from COVID if she contracted it. Additionally, the hospitals in the Sunflower Mountain Region remained at full capacity throughout this time because they are small and do not have many beds. All of these factors made Mille second guess the risk of her plans. She still had to make money and she was still going to have this newborn. But in this process she was taking on massive health risks. She felt pinned into a dangerous corner.

Looking closely at the “nexus of nature, power, and knowledge production” (Sundberg 2016) that Millie is operating at helps show how larger institutions are

oppressing Millie and her fetus on an individual scale. Additionally, this nexus brings the risks Millie experiences into focus. First, the force of nature or ecology in this scenario is the coronavirus and the pandemic conditions that are acting as a threat to Millie and her fetus. On an individual level, if Millie contracts COVID while she is pregnant her life is at risk. Additionally, she must consider this for childcare because her mother has many pre-existing conditions that put her at higher risk for a severe case of COVID if she were to contract the virus. The ecological disaster of COVID intersects with the barriers of living in a rural geographical environment. Millie's rural home has few resources and the hospitals remain at capacity because they are small. This influences the risk Millie experiences because if she or her mother were to become ill, their chance of getting treatment is precarious. This is also entangled with larger power structures such as capitalism which devalues rural hospital care because of its generally low profitability due to low Medicaid reimbursement rates and lower populations. Another clear implication of the system of capitalism is the fact that Millie works a minimum wage service job and is embarking on becoming a single mother. Millie graduated from high school but had to start working at this pizza restaurant immediately out of school to help her own mother with bills. Millie never had the time, flexibility, or money to go to any kind of college. Therefore, she feels like she is not qualified for many jobs that pay her more than waiting tables. Additionally, the misogyny built into the patriarchal capitalist system trickles down to affect Millie. In the US, there is very little support offered in terms of maternity leave from many jobs. This time is typically unpaid leave, which is why Millie had to work even more shifts during her pregnancy to bank enough funds to take an appropriate amount of time off with her newborn. Millie's oppression and the fact

that she has no choice but to put her body and her fetus at risk in order to survive economically postpartum. These dynamics stem from large systems, but they trickle down and intersect to create a unique and oppressive situation on an individual scale in Millie's life.

Another way to understand the risk in Millie's situation is through Thomas Leatherman's political ecological frameworks to more completely understand poverty as a space of vulnerability. The "space of vulnerability" describes the intersections of health, nutrition, structural violence, political economy, agency, environment, political ecology, hunger, social status, and poverty intersect to create a wide variety of effects and impacts on individuals (2005: 51). Someone like Millie who is working a minimum wage job and is living in poverty was thrust into an extremely vulnerable space when the pandemic started. Because of her low income, she had no choice but to continue to put herself at risk. She was already vulnerable and ecological disaster only exacerbates that vulnerability.

Filling a Support Void: How Professionals Adjusted

I have already discussed the creative ways rural health professionals step up to support their communities despite the lack of resources and support they receive. The pandemic required these professionals to commit even more to creative solutions while maintaining COVID guidelines. One of the biggest shifts professionals made was to bulk up the available online resources and convert as many in-person options to an online format as possible. Many resources such as support groups, counseling, consultations and appointments were shifted to online platforms. While this was a necessary shift for the

pandemic and made things convenient because mothers could participate in things at home, there are inherent complications to online modalities in rural America. First, broadband access is severely lacking. Families have a difficult time connecting and maintaining connection to the internet from home. One of the mothers I worked with at the elementary school explained how she never had Wi-Fi at her home because it was always too expensive. With the shift to online schooling, she had to get it because the boys needed it. This made her budget very tight, and she was frustrated with how slow it was. She said, "internet is really expensive around here. And when you get it, it barely even works." Amanda, the health professional who runs a support group for new mothers, had to shift her group to an online platform. She made an interesting observation about how the demographics of her group have changed in the shift:

> Previously we would have, there would be a little more economic diversity there. Some people that are certainly in more rural areas that are maybe lower socioeconomic status, things like that. But they were able to attend group. What I've noticed recently, in the group that I have now is that the parents involved are, they may have higher socioeconomic status. Not all of them, but most of them. It's like, it's shifted a little bit. And so, I think that that's kind of, that feels like a concern to me because I think that in many ways this raises awareness of how much accessibility to resources is, there's also a matter of privilege involved in terms of an internet connectivity but also how to use and navigate that. And so for people that maybe don't have jobs where they interface using technology a lot, it feels like a lot more to think about how do I, how am I gonna like sit in front of a computer and it doesn't feel, for some of us that may be, there is an aspect of

> privilege here for sure for those of us used to working on our computers, it feels like it's not a bigger hurdle whereas people more in the service industry, it feels more like a hurdle. And so all of this to say that is an area I worry about because there are moms clearly that still need resources. Perhaps they have lost jobs or are a little more strapped and have to pick up a second job or second shift, they're not showing up to group anymore and that worries me.

The observation of how women with lower socioeconomic status have stopped coming to the support group in the online shift is indicative of the ways economic privilege grants some women access to key postpartum resources. She also makes an important point about the privilege in the ease of operating a computer or even owning a computer at all. For some women who work with computers or around computers, joining a Zoom meeting for the support group may have been far less daunting than it would be for someone who has never really used a computer for meetings. Like my coworker at the school explained, internet is expensive so a lot of families in some of the most rural parts of the Sunflower Mountain Region opt to not pay for it at home. The cost barrier to accessing any pandemic time resources is substantial and has a large impact on who was able to do so.

In addition to the privilege and cost barriers of accessing online resources, the sensitivity of engaging in these resources from home also impacts who can use them. Amanda often talks about the challenges of working in maternal mental health in a rural region. She explained how many of the communities she works with are very much faith based. While the church can be an excellent community resource, it can also interfere with mental health resources. Amanda also told me that it is difficult to navigate

supporting women with postpartum depression and anxiety who have been told by their faith leaders that the reason they are struggling is because they are not praying enough or are lacking faith in God. She has worked with clients before who were actively discouraged from seeking mental health care by their faith leaders. She is passionate about retaining and helping these clients but that also became a big hurdle in the pandemic.

When clients must do therapy sessions from home, there is a lack of privacy that may be a dealbreaker. Amanda lost a few clients who were simply unable to join from their home environment. She worried about the women she lost and was left to wonder if their home lives were interfering in a toxic way. As has been well-documented, the domestic violence and abuse rate skyrocketed during the 2020-2021 year (Boserup 2020). With increased surveillance at home, domestic violence hotlines experienced a decrease in call services by more than 50% (Evans et al. 2020). The rates of domestic violence did not decrease, "but rather victims were unable to connect with services" (Evans 2020). This problem has been overwhelming throughout the world over the course of the pandemic. In Pakistan, where over 90% of married women report physician or sexual abuse, domestic violence interventions were cut back because social welfare programs were shut down when the pandemic began in the chaos of overwhelmed health systems (Baig 2020). Additionally, as the Evans study suggests, women were unable to connect with services due to increased surveillance at home with their abusers. In the Pakistani province Khyber Paktunkhwa, 399 murder cases of women were reported in March 2020 "while only 25 calls were received at the police helpline" (Baig 2020). Research from Australia found that alcohol sales rose 36% during COVID shutdowns which exacerbated

domestic violence as well (Usher et al. 2020). In the Australian context, professionals "have highlighted concerns specifically related to reports from people whose intimate partners are using COVID-19 as a form of abuse" to create more fear and threat of contagion (Usher et al. 2020). An in-depth study from South Africa, one of the countries with the highest levels of intimate partner violence, women expressed intense fear and increased stress while stuck at home with their partner. One woman in the study explained, "It was like, now do I try to escape from this abusive man, or do I go out there and get corona?" (Dekel 2021). Due to the barriers to reporting much of this suffering was happening behind closed doors with no options to reach out for help.

Every professional I spoke with indicated that there is really no comparable substitution for providing care and support face to face. But remote resources do have some benefits that are important to consider for the future. Like I described when discussing my methods for this project, the convenience of a phone call for new mothers is completely unmatched. This convenience translates into a lot of other resources they can use while at home with their baby. The home-visiting group I worked with also identified some benefits to working remotely. Through their grant money they were able to purchase tablets and a full year of data for all of their clients to use for remote home visits. While they agreed that being in person is better, they also were firm in the stance that the remote options were way better than nothing at all. Additionally, they found that providing families with a way to access the internet and data created a domino effect of good in their lives. For example, one mother enrolled in home visiting was able to use the data to finally go through the steps of filing a restraining order against an abusive ex-boyfriend. She could not have done this previously because a lot of the paperwork was

online and she never had internet access. Another mother was able to create a strong resume and finish her GED online with the help of this data. Ultimately, providing families with these resources for one service turned into a wide variety of support and access to things that were previously inaccessible.

Conclusion

Anthropologists (Davis-Floyd et al. 2020; DeVellis 2021), researchers (DeYoung and Mangum 2021), and reporters (Ramakrishan 2022; Bahrampour 2021) have discussed the ways the pandemic has affected birth. While the logistics and challenges of doing so are well-documented, applying a lens of moral pioneering to ethnographic experiences helps illuminate the ways in which women struggle to navigate new problems and heavy layers of moral weight. Additionally, using feminist political ecology to view the pandemic as an ecological event that intersects with women's bodies and trends like stratified reproduction helps amplify and untangle several social, biological, and cultural forces acting to uphold inequality. This is even more clearly evidenced through Millie's ethnographic account. Using a wide variety of narratives from women with different identities emphasizes the similarity and differences of experiences of pregnancy and birth in the pandemic. This also helps to continue "rendering the rural multiple" through showing the diversity of experiences that exist in rural America (Blanchette 2019). Understanding the ways in which pregnancy and rurality intersect to create fewer birth choices is critical to gaging how empowering or disempowering a woman's birth can be. The ways in which these choices are even further limited by the COVID-19 pandemic exposes the precarity in rural health infrastructure. Additionally, the ways in which pregnant women face new moral pressures in decision-making

provides important insight on how pregnant women often shoulder burdens created by social and environmental disasters. In the next chapter I will expand on many of the factors discussed in Millie's story through an in-depth discussion of how social class in particular impacts rural pregnancy experience.

CHAPTER 6. SOCIAL CLASS AND STRATIFICATION IN A SACRIFICE ZONE

"Hi, my name is [Kara] and my son is [Aaron]. He was born 6/21/2021. I am a single mom. I cannot fully return to work just yet due to lack of child care. I am trying to raise money for [Aaron's] expenses such as buy diapers, cloths, medical bills, living expenses, etc. Everything helps and is so very appreciated! God bless you all!"- Kara's description on the public GoFundMe page she created after her son was born.

Introduction

On a summer afternoon as one of my roommates, Blake, was unloading his groceries we were just chatting in the kitchen. In the middle of our conversation he lit up and said, "Oh hey! I work with this girl named Kara and she's pregnant and she's like, really poor. She is struggling. I bet she would want to talk with you." Blake works as a housekeeper at a hotel in one of the more touristy and affluent areas in the county. He explained how his coworker is very pregnant and is still at work doing heavy lifting and cleaning every day. "I literally think she is going to work up until the day her baby is born," Blake said. I told him I would love to talk with her, and he immediately connected us. We set up a time to talk on the phone. Kara quickly confirmed what Blake told me and said, "Yep, I am *very* pregnant right now. I am huge."

Chapter Overview

Socioeconomic status (SES) has a well-documented influence on pregnancy and birth outcomes (Campbell et al 2017; Matijasevich 2012). Studies looking directly at socioeconomic status and health outcomes determine that people who have lower SES are

more likely to have low birthweight babies, fetal loss, and anemia (Campbell et al. 2017). Anthropologists who study the intersections of pregnancy and class find that SES also has impacts women's entire experiences of pregnancy, how they make decisions, how many choices they have, and how they navigate the healthcare system (Lazarus 2009). In this chapter, I follow the narratives of Kara and other women who have varying income levels and economic and educational privilege. I compare their pregnancy experiences in the Sunflower Mountain Region. I have already established that places that eliminate obstetric care become sacrifice zones for healthy birth, but in this chapter I will use anthropologist Shellee Colen's stratified reproduction framework to show the limits of stratification within a sacrifice zone.

Social Class in Appalachia

The seven counties in the Sunflower Mountain Region have some of the state's highest poverty rates[38] with the regional average lingering around 15% of the population, but various pockets in the area ranging between 30%-40% (USA Census). The economic makeup of the region is reflective of trends throughout rural Appalachia. Poverty in Appalachia has its roots in historical exploitation and has been preserved through classism and high-power politicians and businesspeople taking natural resources, exploiting the region, and preventing development. As Elizabeth Catte writes, "Many Appalachians are poor, but their poverty has a deep and coherent history rooted in economic exploitation" (2017:14). A popular misconception of the economic landscape of Appalachia is based on the idea that poverty is a direct result of the backward, isolated, small-scale mountain economy and association with subsistence farming popular in the

[38] See introduction for poverty line metrics.

early 19th century (Billings and Blee 2000). But as scholars have repeatedly shown, resources produced in Appalachia such as tobacco, oil, coal, textiles, and minerals are critical to global economies and circulate widely throughout the United States and world. Small tobacco and coal towns throughout Appalachia are connected to the global economy through resource production and provide valuable wealth within the system (Kingsolver 2011). Appalachia has always been affected by sways in the global economy and the introduction of newer modes of production and labor forces all over the world and was never an isolated economy (Kingsolver 2011).

Efforts catapulted by presidents John F. Kennedy and Lyndon B. Johnson to start the War on Poverty and develop the Office of Economic Opportunity (OEO) and later the ARC were put in place to assist regions such as Appalachia struggling with high poverty rates, but this programming failed to adequately incorporate grassroot participation which is lively in Appalachia (Davis and Baker 2015). Social programs did have some positive impact on Appalachia. For example, Appalachian activist Eula Hall (1999 in *Backtalk from Appalachia*) writes of being raised in poverty with no access to education. She was trapped in an extremely abusive relationship and could not leave due to her lack of money and resources. Through the Appalachian Volunteers and VISTA programs, she was able to tenaciously work, fundraise, and open a clinic in her home. While these programs provided useful starting points for Hall, she was able to utilize the funding to direct new and innovative community projects and become a central activist (Hall 1999).

Considering how legacies of economic marginalization and extraction, social, political and racial stereotypes, labor and activism, and environmental degradation impact pregnant women and mothers in rural Appalachia is key because of the historical nature

of all structures in society. This research focuses on how women like Kara, who I will discuss in-depth in this chapter, navigate structural barriers in the healthcare system and lack of resources but also the communities of support and innovative routes to care women take despite structural interference. Questioning how pregnant women navigate barriers and find support accounts for the political economy of economic marginalization, rurality and the profit priorities of healthcare systems, while nodding to the rich history of activism, organizing, resilience, and mobilization of local knowledge in the region.

Stratification in a Sacrifice Zone

In previous chapters I have explained how rural Appalachia is a "sacrifice zone" for birth and maternal health (Scott 2010). In this chapter I will look at the intersection of Scott's theory of a "sacrifice zone" and Colen's "stratified reproduction" (1995) to further understand classed experiences of rural pregnancy. A sacrifice zone is a region written off to environmental destruction in the name of a higher purpose, and stratified reproduction is the concept that different women are met with different levels of support to reproduce based on their identity. As previously discussed, the creation of a sacrifice zone must be enabled by devaluing the people who inhabit the region through the methods applied to Appalachia such as stereotyping and economic marginalization. When obstetric clinics close one of the primary reasons is to save money. This situation is analogous to that of Scott's study of mountaintop removal mining: the profit or gain from a destructive process is outweighed despite its direct detrimental impact on many lives. Without adequate access to birthing encouragement and resources, women living in rural Appalachia lack strong support to reproduce. Even within this population, reproduction becomes more stratified based on race, class, and citizenship.

According to Colen (1995), stratified reproduction means that women who are marginalized on the basis of race, class, citizenship, and ethnicity are not encouraged and supported in birth as well as women who do not experience marginalization. This lack of support in reproduction cements stratification during pregnancy and birth for women who are marginalized. Additionally, stratified reproduction also holds that marginalized women are actively discouraged from having children through this lack of support and encouragement[39]. This theory is useful when discussing socioeconomic status and the ways women with lower SES experience more barriers to healthy birth. I use this framework to argue that even within a sacrifice zone where choices for birth are very limited for all, women who are marginalized experience even more negative consequences of obstetric care closures. Birth experiences and messaging are not random but are systematically cultivated based on social inequality and stratification. In southern Appalachia where many people live below the poverty line, more women are susceptible to facing extreme hardship in birth because they live in a sacrifice zone and do not have money or material resources, putting them at a massive disadvantage.

Class and Pregnancy: Sacrifice and Stratification

I talked to Michala on the phone around 8pm on an evening in August. We scheduled the call for so late in the day because Michala works until 7pm every day. She works at a hardware store in town. She really enjoyed working for the company and had been doing this job since April, but up until then she had been a stay-at-home mom. When we got into talking about her pregnancy and birth experiences, she explained how

[39] Consider the use of long-acting reversible contraception (LARC) as a means to control the Black population during the early days of planned parenthood (Bavis 2019).

difficult it was to not have an obstetrician in town. Michala and her family live in a county that recently lost their OB provider, so they had to travel about an hour to get to the closest doctor. She said, “It would have been a whole lot easier had we had one in town, of course. But I mean, we've always, we've been low income for, you know, a really long time. Yeah. And we're finally starting to even out. But back then, you know, it was it was a stretch putting gas in our car. So, you know, it was a stretch, put in thirty forty dollars just to go to the doctor and back.”

In this situation it is clear how a woman’s income and access to money directly impacts her pregnancy experience. In Michala’s situation, she is experiencing unique struggles because she both lives in a rural sacrifice zone for birth and has a low income, meaning she is not adequately encouraged and supported in her reproduction. This is a prime example of how sacrifice zones and stratified reproduction intersect to perpetuate inequality in birth experiences. Michala and her husband had to be strategic with making ends meet and attending doctor’s appointments during her pregnancy. She had to skip a few scheduled appointments because they did not have enough gas money. Research shows that when a woman does not fully utilize prenatal care, the risk of low birthweight babies, infant and maternal death, and other health consequences rise (Rosa et al. 2015). The March of Dimes reports that in 2019, one in every 16 infants “was born to a woman receiving inadequate prenatal care in the United States” (March of Dimes 2019). Transportation, access to childcare, and the flexibility to reorient one’s time to accommodate an appointment are all challenges women with lower incomes in rural areas face (Meyer et al. 2016). As I have discussed in previous chapters, health professionals in the Sunflower Mountain Region say how common it is for women to call in and cancel

appointments due to lack of transportation or gas money. This experience is even more relevant in rural areas where obstetric care has been eliminated (like in Michala's county) because it costs much more to make it to the doctor's office and back.

Michala's situation shows a structural issue that impedes her ability to get care. In a study of socioeconomic status and pregnancy in Korea, authors found that low socioeconomic status can increase the risk of adverse pregnancy outcomes even in a universal healthcare system (Kim et al. 2018). This finding suggests that low socioeconomic status presents barriers other than accessing medical care during pregnancy. The authors attribute these results to the fact that women with lower SES face everyday barriers that impact their health. Women with lower SES can have higher levels of general stress which can negatively impact pregnancy (Kim et al. 2018). Additionally, they tend to work longer hours with more dangerous physical exertion and do so throughout pregnancy which can have negative impacts on the mother and child (Kim et al. 2018).

Navigating Birth: Kara's Story

I began this chapter by introducing Kara, a 20-year-old pregnant woman who has lived in and around the Sunflower Mountain Region her whole life. Kara has essentially no family relationships. Her mother and father are not in her life at all, and her mother was abusive during her childhood. She has always struggled financially. In the following sections I will discuss some of the realities and barriers in Kara's pregnancy and birth experience directly linked to her class identity. During my interviews I spoke with women from a diverse set of backgrounds. I will contrast some of Kara's experiences

with women who identified themselves as middle or upper-middle class to establish the ways that economic privilege acts to stratify pregnancy experiences in rural areas.

Employment Through Pregnancy and Postpartum

Kara is only 20 years old, but she has lived in many different situations and worked a lot of jobs in the area. She had been working at the hotel for nearly a year when I talked with her and before that she was working at a Walmart. Her work at the hotel is very physically demanding. She works long hours cleaning rooms and doing laundry. She works five to six days per week and weekends are always required. Overall, Kara enjoys her job. She likes her manager and coworkers. Even though her work environment is good, her job is physically exhausting, especially 37 weeks into pregnancy. She has no choice but to continue working as long as possible because she lives paycheck to paycheck and really needs the money.

Because of the rural tourism environment in the Sunflower Mountain Region, Kara's work is also characterized by precarity. Hotels are very busy during peak tourism season between spring and fall, but hours often get cut and workplaces temporarily close during the winter months. Anthropologist J. Hope Amason ethnographically examined how seasonal workers in Gatlinburg, Tennessee navigate making a home in the context of fluctuating and unpredictable labor markets like those in the Sunflower Mountain Region. Amason sought seasonal employment and described their living conditions and the economic flux that ensued. Through this study, Amason aims to show how neoliberal policy and conditions affect not only the conditions of labor, but how people constitute and create their notions of self. Amason writes, "The greatest threat to these carefully constructed domestic worlds was the economic uncertainty of the ever-fluctuating tourist

industry. As my first autumn in Gatlinburg waned, coworkers and neighbors voiced fears that their hours would be cut during the winter months, when there are fewer tourists. The souvenir shop where I worked closed an extra day, reducing my hours so much that I had to find another job. My coworkers and neighbors experienced similar cutbacks, leading them to ask serious questions, "Will I be able to make rent? Can I afford to stay here? Can I get a second job ... a third job? What will happen to my things? What will happen to my family?"' (Amason 2015: 6). This is a common issue amongst people living and working in tourism economies. Kara felt secure through the fall, but as winter approaches she will start considering taking on second jobs. At that point she will also have a seven-month-old baby.

In the United States, the Family and Medical Leave Act (FMLA) guarantees pregnant women and mothers twelve weeks of unpaid leave which allows an employee to keep their job. This only applies to people who have worked at a company for more than a year, and the company must have more 50 employees within 75 miles of the employee seeking leave's place of work (US Dept. of Labor). If a woman's spouse works at the same company, the company is only required to give a total of twelve weeks between the two employees (US Dept. of Labor). Companies sometimes offer some type of compensation during this time, but FMLA does not mandate it (US Dept. of Labor). This policy proves to be a challenge for new parents, especially in Appalachia where a significant part of the population lives in economic precarity. Twelve weeks without pay can be unviable for many families, especially when there are multiple children in the family. Additionally, in the time immediately after birth, American mothers have recently acquired a substantial hospital bill. This requires people seeking maternal leave to save

sick and vacation days to use on maternity to maintain some income. Kara's place of work allowed her to take unpaid leave and then guaranteed her a job back when she was ready. "It's annoying," she says, "but it's just the way it is." Her job in housekeeping has hourly pay and no benefits so she is not even able to use vacation days or paid time off for any of her maternity leave.

When I asked Kara how long she plans on taking off after her baby comes, she said six weeks. I asked her why she chose that amount of time and she responded, "That's just what I've read. That is how long it takes to heal. If it takes longer than that I guess I don't really have a choice on if I can go back or not because I will have an appointment six weeks after having the baby. They check everything, make sure I didn't tear back open and make sure everything's OK. And so I can get like my letter of, like, you're fine." Kara wants to return to work as soon as possible for the income and her own personal relief. She explained how she always has struggled with depression and anxiety and she was really worried about the six weeks of being alone with her new baby and not having work to keep her occupied. I asked her if she had any concerns about returning to work so quickly and she said, "One thing that I'm nervous about going back is being super, super tired from getting up every two hours to change diapers and hear the screaming all night and everything." Kara knew that having a six-week-old infant would make for very long days while she was at work. Additionally, she worried about doing physical labor so soon after delivering her baby. "I just hope I can still do everything I need to," she said. "If not I might have to do extra laundry work or something." Clearly Kara was one to push her physical limits as someone who was working a physical job so close to her due date

especially because she felt pretty sure that her baby would come early based on her symptoms and family history.

While Kara felt some anxiety about returning to work so quickly after she had her baby, she knew she had no choice. Taking six weeks without income would be very difficult for her, especially without support from anyone else in her life. This experience is directly linked to her class status as a low-income woman. The constraints that her income places on her life increase stress (both physical and emotional) and anxiety. Compare Kara's experience to Lana's, a therapist who works in her own private practice. Lana makes good money and defines herself as solidly middle-class. She has moved around a lot and lived in various major US cities during her graduate education and training but has been living and practicing in the Sunflower Mountain Region for the past two years. Lana encountered the same issues that many rural women described which are a direct result of giving birth in a sacrifice zone: she had concerns about making it to the hospital on time because she lived so far from it, she was worried about the competency of care, she felt disempowered by her lack of choices in birth, and she was frazzled by not knowing her provider when she gave birth. When I asked Lana about her time postpartum, she responded, "It's been really hard. She was a colicky baby and she cried all the time. And not having help and being a business owner and therapist and not giving myself enough time, I dramatically underestimated how much time I would want off after giving birth. So I jumped right in after eight weeks. And I was so tired and pretty depressed. Over time it kind of morphed into what I think I would call postpartum anxiety." Lana struggled a lot after having her baby. Her husband was supportive, but she did not have the familial and friend in-person support she wanted due to the pandemic.

Like Kara, Lana jumped back into work quickly but she waited eight weeks instead of Kara's plan of six. The difference in how they spoke about returning to work was clear: Kara spoke in "have tos" while Lana spoke in "want tos." Lana's husband works as a full-time health professional so he was able to continue to support their family while she closed her practice for her maternity leave.

Eventually, Lana did return to working from home. She was grateful to be able to spend time with her newborn while doing her work and continuing to make an income. Based on data from the US Federal Reserve, working from home during the COVID-19 pandemic is a privilege for highly educated, financially privileged employees (US Federal Reserve 2021). The report is based on survey statistics of US adults who were asked how much of their work was performed remotely in the week ending in April 4, 2020, a week which marked many shutdowns. Approximately 63% of respondents with a bachelor's degree or higher were working from home compared to 20% of people with a high school degree or less (US Federal Reserve 2021). Research finds that "Sales and service workers, manual operators, artisans and elementary occupations have little to no opportunity to work from home. Occupational inequality translates into inequalities in wage distribution. Indeed, those who can work from home are paid substantially more" (Centrula et al. 2020). Within this paradigm in the US, workers of color are overrepresented in essential jobs that could not be done from home (US Federal Reserve 2021). These trends also track with Lana and Kara. Kara does not have a high school degree while Lana has a master's degree. Kara cannot do her housekeeping job from home while Lana can use telehealth. The impact on the risk of physical bodies and the

connection between class status and labor during the postpartum period (especially in a pandemic) is clear.

Social Support

There has been extensive research conducted on social support and its positive impacts on health (Kana'Iaupuni et al. 2005). Some public health research establishes that lower income and educational levels tend to be associated with lower levels of social support (Weyers et al. 2008). More nuanced research finds that social support networks are extremely important and very much present in people with low income's lives (Lubbers at al. 2020). Social networks vary vastly and "social support is not necessarily a stable structure that families facing insecurity can fall back on, but rather a variable resource and fluid over time, as those who provide such support experience changing capabilities and needs" (Hill et al. 2020). Social networks also can act as an anti-poverty tool through depending upon friends, families, and neighbors to financially assist and provide a safety net (Lubbers et al. 2020). There is some debate within the research community about social networks and their presence in low-income families and individuals (Moskowitz et al. 2012), but most scholars agree that social support is a vital and essential human right and enabler of health and wellness.

Levels of social support are very significant when a woman is pregnant. Based on my interview data, social support and income status were not consistently and linearly linked. For example, despite her high-income status, Lana has a low level of social support. As someone relatively new to town, she did not have many friends. She lives with her husband, but both of their families live far away and they do not see them very often. Lana believes that these factors contributed to her loneliness during pregnancy and

postpartum which ultimately exacerbated her anxiety and depression. Another woman who I talked with who had a much lower SES than Lana had a very high level of social support which made her time immediately after having her baby much easier. She explained, “where we live, [my boyfriend’s] family is all within walking distance and they are all retired. So when I'm at school she will be watched by family. And when I'm at work, his mom will watch her. Then when I come home I will be with her and so will her dad.” This woman had an easier time transitioning back to her life after the birth of her baby because of this high level of support which was very geographically accessible as well. She did not even have to drive to reach her family.

Unfortunately, Kara falls at the intersection of low social support and low income which makes her pregnancy and life with a newborn very difficult. I asked Kara what her current living situation is like. She said, “well, right now I’m staying with the baby daddy. We are waiting to get approved for an apartment.” Essentially Kara was just crashing with her child’s father in between places. It is important to understand the flux and strain that Kara experiences due to a lack of a stable home. Returning to Amason’s study, working and living in a tourism economy shows the connections between capitalism, class, and home and social life. Amason writes, “On one hand, it is necessary to reveal the political and economic structures that seem to trap tourist industry workers in a cycle of uncertainty, where a combination of low wages, a fluctuating tourist economy, and high land values makes housing unaffordable. But this does not go far enough. It is also important to note how these structures become deeply entangled with diverse understandings of home, self, and the social” (2015: 14). Kara’s precarity in her work life and income as well as her overall class status infiltrates her social experiences

and her way of making a home. She is in a position of flux because she must temporarily stay with her baby's father. She was receiving prenatal care and working in Beulah County, but her child's father was living at home with his mother just off the mountain. This made Kara's commute to work and the doctor much longer which also posed further financial strain. I asked more about the father and she explained how she was living with him as a roommate off the mountain and had just moved out of living with him up to Beulah County to be closer to work when she found out she was pregnant. "We were roommates, like as just friends. We've always just been friends," she explained, "And then six weeks later I found out I was pregnant." I asked if this pregnancy was unexpected for her and she said, "Very. I was actually on birth control." Kara was clearly frustrated by this, and we went back and forth about how common this is (explored further in the next chapter). "Exactly!" she exclaimed. "My doctor said the same thing that he sees so many women come in that were on the pill that got pregnant." When Kara took the pregnancy test, she was shocked. To make matters more stressful, when she told her child's father, "he is like, well, I just don't believe you. They don't put ninety-nine-point nine percent accurate on the birth control box for no reason. And I was like, well, evidently, they did." After a lot of long and heated conversations, the father accepted the reality of the situation and Kara moved back in with him and his mother for a brief period before they could get their own apartment. I asked Kara why she would move off the mountain instead of the father coming up to Beulah County where she was and she frustratedly explained that the father's mother is difficult to get along with and is very overbearing, but she is the only familial support that either of them have. Kara said, "She pressured me to move back down here. So, I did feel like I didn't have any other options.

You know, I didn't really have anybody else to talk to about it. It was just her pounding me. ‘You need to be down here and stay down here and be closer to us.’ So I did it.” As I stated before, Kara has no family connections at all. Her child’s father’s mother is the only one stepping up and offering to help Kara with the baby. Even though she is overbearing and annoying, Kara feels like she does not really have anyone else. This makes her feel trapped and pressured into situations that she does not find to be ideal for her.

I asked Kara to reflect on her pregnancy and what would have made her experience more positive. She responded:

> “Well definitely not moving as much. But mostly a little less pressure from the baby daddy would be great. I mean, I'm already under a lot of stress thinking about a lot of different things because, you know, I'm so, I have that little piece in the back of my head that says, oh, you're going to end up being just like your mom was. And that scares me to death. So going back, if I had more moral support instead of pressure, I think my pregnancy would have been a lot better in general. And not having to worry about every little thing as much as I have to now. And I'm 20 years old. Doesn't help.”

I followed up by asking her what kind of pressure the father was putting on her. She said, “It's mostly just about money. OK, you know, like what I'm going to do during this whole thing? How will we afford this kid? How will I take so much time off work? What will like, I don't know.” Kara and the father were looking to move into their own place to have more space for themselves and the baby. I asked Kara how their relationship was and she said, “I feel like it's pretty stable. It's really just, I have so much stress and

worries about, oh, gosh, what am I going to do, you know? Yeah, I mean, don't get me wrong, if you are younger or 20 or whatever and you are financially, emotionally supported, whatever, stable enough to have a baby, you go right on ahead. I don't care if you're 13 or 47, but me personally, I just feel like being 20 is way too young just for me, just because of the economy that we live in, trying to find decent work to support yourself and a child is really, really hard. Especially with no family or friends to really lean on if something happens.” During this part of our conversation, it felt like Kara was saying many of her deepest, recurring fears out loud for the first time. Because she was so close to having this baby her fears were becoming even more real. I could hear the panic and fluster increasing in her voice. In an attempt to reassure her a bit, I asked:

> Sia: Even if your, like, mother-in-law type person is annoying and overbearing, hopefully she'll take the baby for a little bit and like, try and watch and help out. Do you think she will?
>
> Kara: I do. I just really hope she doesn’t get even worse than she is now about it. I mean, there's just so many things that she has done over the course of like three months.
>
> Sia: Yeah, that sounds intense.
>
> Kara: She’s trying to help. And, you know, I understand that. I do. I appreciate your help. But if I didn't ask for it, chances are I didn't want it just because of what her help consists of.
>
> Sia: Right, exactly. Yeah.
>
> Kara: Like telling me everything that I'm doing wrong.

Sia: Right. And I guess it'll just be like, it'll end up being kind of a balance of yes, it's annoying. But if she's willing to take the baby sometimes and you can get a nap or something like at least there's that.

Kara: That's true. I'm looking forward to that. She's going to want to see him as much as possible. So she'll like, that'll be a little better for me just because of the dad. He, I think he'll do ok. But I think he's like, really scared, which is understandable. I do get it because I'm really scared too. But he's like, 'I haven't really been around a whole lot of babies, like I don't know what to do. I don't want to change diapers. I don't want to do this.'

Sia: Oh my gosh...

Kara: And I'm like, well, I have some bad news for you. You'll be doing quite a bit of that. Especially since we're living together at the moment.

Sia: Yeah, right. Right. There'll be lots of diapers. Well hopefully there'll be a quick learning curve.

Kara: I'm sure. I've heard. I mean, I guess it's different for me because I am already carrying the baby, so I feel like I already have a connection to him. So it's a little better for me. And he's just kind of here watching me carry the baby right now. I think, I think that they'll kick in, you know, like his parenting instincts after the baby's here. And, you know, he hasn't really had the chance yet, I mean, he doesn't have the time to go up there with me to the appointments, and actually see the ultrasounds or hear heartbeat or anything like that.

Sia: That's hard. But yeah, I think it'll be different when you actually have a baby that he can hold.

Kara: Yeah. I think it'll be, it'll be fine. Yeah it will be.

Kara ended up having a healthy little boy who she loves very much. But a lot of her situation ended up not being fine. Just a week after she texted me pictures of her newborn son talking about how well things were going, my roommate Blake came home and asked me, "have you heard about what's going on with Kara?" He explained that after she had the baby, the father began doubting his paternity. He pushed her enough on the topic and so they gave the little boy a paternity test. It turns out he was not the father. With this realization he was relieved because he no longer had to support her or the baby. In addition, his mother was no longer involved in the baby's life at all. Although flawed, this woman's support was the only steady and responsible force Kara had on her side.

Kara dictates a lot of the struggles that young, low-income women with essentially no social support face during pregnancy. These issues represent how Kara, due to her income and social support level, was very unsupported in her pregnancy and birth experience. Her marginalization exacerbates the already-stressful experience of giving birth in a rural environment. This story is certainly an example of stratified reproduction. Kara experiences lower levels of support and access to resources to make her pregnancy healthier and less stressful because of her socioeconomic status.

Pregnancy Resources and Accessibility

I spoke extensively of a woman named Judy in the previous chapter. Judy works at the local university. At the very beginning of our conversation, Judy said, "I feel really passionate about birthing people, and having given birth I think that's really increased. And I definitely have seen, this doesn't have to do with me or my identity, but I have seen how limited the resources are here for birthing folks. For sure." Judy has a steady

income, and her husband owns his own business and makes very good money. She described them as being an upper-middle class family. She frequently acknowledged her privilege throughout our conversation and discussed how she knows that is not the average situation in the region. I asked her about those limited resources she mentioned, and she discussed how few choices there are for everyone regardless of their class status. Beyond the lack of choices, she explained that there are wonderful and supportive resources for pregnant women and mothers but she hypothesized that these may not be equally accessible to all women. Throughout my interviews I asked women if they used or were interested in any resources or programming. Some people raved about how amazing and helpful the resources were, but others were less enthused. I found that women who had some sort of connection to resources through their work, friends or family had a much easier time accessing help and support. For example, when I asked a new mother who worked in maternal mental health services if she was satisfied with her access to resources she said, “I was, and I attribute that to being in the profession. So I had pretty severe postpartum anxiety and some depression. And I just asked friends who they would recommend. And they hooked me up with someone who is like the most well known in the area to do postpartum stuff. Her website said she wasn’t taking new clients, so I don’t know if she took me because I kind of knew her and she knew all the people who recommended me and that stuff. And she also does a weekly group. That’s very helpful too. So that would have been open to anyone and it’s free.” While the group is open and free, this woman only learned of it through her professional connections. Family connections are helpful as well. In response to the same question about how she accessed resources to help during her pregnancy Diana responded, “Well my grandma,

she was a medical office assistant and a certified medical assistant and so I ask her. So she worked at the health department. So I ask her. Everything. And between her and my mom, and my aunt, because she works at my doctors and if she don't know she will ask my doctor." Both of these women benefited from knowing people directly involved with support resources.

Typically, people knew that the region did offer resources to help them during pregnancy and postpartum. As Judy said, "I think the [Sunflower Mountain Region] does offer so many support systems for parents and pregnant people. And I have been utilizing quite a few resources during this postpartum journey as well. But I do think the county has a really good job with their programming." One of the main resources women I talked with used was WIC. Everyone likes and appreciates WIC and the services they offer. One aspect of WIC that women find helpful is the breastfeeding support and educational aspects of the program. Additionally, WIC provides financial support for healthy groceries for mother and baby. Most women I spoke with liked these vouchers, but a few complained that the foods they helped with were not what they wanted or needed. For example, they provide support with fruit juice but not as much with whole fruit. During the spring of 2020, the regional WIC office approved a raise in fresh fruit and vegetable vouchers from $11.00 per month to $35.00 per month which women really appreciated.

During my time volunteering with a local maternal health organization, I worked to fill out a database of all the resources in the region. While I was searching and filling out the database, I found that there are indeed a lot of resources that exist. There is a spectrum of accessibility amongst the programs and resources. For example, some

programs are easy to access and completely free of cost like home-visiting while others are expensive such as private practice therapy. I also found that a substantial number of programs either had outdated and confusing websites or were still listed but are no longer functioning.

Overall, with such good resources available in the area I was hopeful that Kara might have gotten in touch with some for help and support. I asked, “I know up here in [Beulah] County, we have places like the Health Department and the [local non-profit organization] that offer a lot of services to pregnant women that can help you find support or answer questions. Have you found anything like that that you've participated in or just not really?” She responded, “I haven't participated in anything. I do know of one where they do like, infant care for moms. I have to go back to work afterwards. So it's like one teacher provides for babies, so it's super hard to get into it. But while you're pregnant, if you sign up for it, you can go in for like a support group or they can just give you like a phone call, checkup, see if you need anything and stuff like that.” Kara demonstrates that she knows about the programs but also said that she has not participated in anything. A little later in our conversation when Kara revealed more about her lack of social support and fear, I said, “I'm trying to think of, of things that might just because I know how hard it is to, like, face something like this and feel like you might not have as much support as you would like, but would you be interested in participating in some of those programs we kind of talked about earlier, like, you know, like home visiting kind of things just to get like someone in your home, like helping you with hard questions, especially postpartum?” Kara responded, “Oh, during my six weeks off. Yeah. That would, I would definitely be interested in looking into something like that. But as

far as during my pregnancy, I did have the choice to go into the support group, **but I really had no choice.** I was like, yeah, like I'm still working. I don't have time for this right now. It's so bad, but I just want to go to bed" (emphasis is my own). I felt foolish for not even really considering that Kara would pass up support opportunities because she had much more urgent needs. "Yeah, exactly. It's hard," I replied, "Like, even if you, even if you know when and where they are and even if they're free, it's like you're cramped for time when you're working right now." As I said this out loud I had a realization. Accessibility of resources is only one small piece of the equation it takes to support pregnant women and mothers in rural areas. Kara said, "I mean, I just, I don't feel like doing anything on, you know, two to three days off that I get a week or after work. That's kind of like my only time. Like, I just need to take some deep breaths." Free time is a privilege, and women like Kara who must work full time and have very little support must be selective with resources and how they fill their time.

A phrase Kara used throughout our entire conversation was "no choice." She had "no choice" but to move down the mountain to the father of her child's home. She had "no choice" when it came to accessing support resources. When she first found out she was pregnant, she had "no choice" but to keep the baby because of her religious beliefs. Her situation is another example of disempowerment in the context of no choices as discussed in chapter 3. The structures of Kara's life pinned her into situations where she felt like she was unable to choose what came next.

The Privilege of Advocacy

Another aspect of privilege that is relevant to birthing is the ability for a woman to advocate for herself. Advocacy and its impact on birth experiences and link to

privilege is another way that women with less social privilege are discouraged during pregnancy and birth. Judy explained that she believes her birth experience was so positive because she is someone who can really advocate for herself. She expanded on this: “During my actual birthing experience I definitely felt like I was supported and, I would also like to say that I'm good at advocating for myself. So, I know for a lot of people they would have a different experience if they weren’t comfortable asking questions and saying no, I need you to explain to me what’s going on before I consent to this. I think that in itself is a privilege in a couple different ways that you’re able to say to a medical provider, I need more information before I allow you to do that to my body.” The point of self-advocacy during birth came up several times in interviews and informal conversations. Women tended to be aware of their ability to advocate for themselves. Those who said they could not do this often experienced more chaotic and confusing labor and birth with traumatic effects. The women who claimed to not be able to advocate for themselves very well in medical settings were typically younger or mothers having their first child. Additionally, some women with less social support had a difficult time advocating for themselves and did not have much backup. For example, Maria had a very traumatic birth experience imbued with high levels of pain and intervention. Throughout her pregnancy, Maria felt like she was isolated. She said, “I am going to be honest, my support level sucked. So I don't have family up here and my mom passed away five years ago. That's kind of why I ended up moving up here, was to get away from all that. Me and my father aren't close. We had a falling out and a year after he passed away.” When I asked about how involved her child’s father was, she explained that they are still living together and have a good relationship. But in the early postpartum days he was less than

helpful. She said, “So [the baby’s] dad slept a lot… that’s me trying to be nice about it. And his parents, I don't love them.” Essentially Maria spent a lot of time during her labor and immediately after alone in the hospital room. She explained her birth story and noted that there are a lot of processes that she did not want that medical professionals imposed upon her. She did not know that she could say no to some of these things. In describing her days in the hospital immediately after birth she said:

> They did that thing again, I'm blanking on the word for it….where they compress your stomach after you give birth. It's supposed to help make sure that you don't have a blood clot or severe blood loss after. And it's if you have a C-section or vaginal birth both, they can shove down on your cervix as hard as possible. And that was the worst part because they did it the first time and they really didn't give me any warning. But I was like, what is happening? And then they come in and ask that they tell me, hey, I have to do this. I'm already in tears that they just told me they have to do it again because they did at least ten times. So I’m kind of like grabbing the railing, screaming and asking like, you have to do this? And they were like, yeah. And they don't. They don't have to do it. You can say no. But again, I didn't know.

Maria did not have anyone in the room supporting her or helping her determine what she could turn down. She did not know all the details of consent and therefore the medical professionals insisted on continuing this process which caused her intense pain. Maria is a young woman who works in restaurant service. She felt like she was out of her league in the hospital. This was exacerbated by the fact that this was her first child so the entire experience was unfamiliar.

Maria's negative experience was echoed by other first-time and younger mothers who felt intimidated by the hospital and healthcare professionals. Annabelle from Chapter 3 who is clearly very informed and conducts meticulous research even said, "I'm a very opinionated person, but I'm not a very strong person. So I was like, that's why I was like, I don't even want to go [to a hospital] because I wouldn't be able to stand up for myself." I exclaimed that this sentiment was very present in my research so far and I said, "That's the thing! Like advocacy is the only like, like that's when people come out the most satisfied is those who can advocate for themselves." Annabelle keenly replied, "Yes, which is also a privilege. Or you probably have to have had no trauma in your life, or have had a lot of therapy. Because I think most of us were raised with a lot of trauma in our childhoods. And we were taught not to stand up for ourselves, not to argue with authority. And be submissive and go along with it. And is therapy even accessible to the majority of people? There's just so many layers and it's just like, ok. Maybe do you accept PayPal installment payments? Maybe I'll watch your dog? I don't know." Annabelle's observation about submissiveness to authority is a gendered behavior that women are expected to develop because it makes patriarchal systems, like biomedicine and hospitals, run much more smoothly (Davis-Floyd 2003). Essentially, the various steps[40] imposed by hospitals and doctors which act as "rites of passage" during birth work to reinforce submission to the biomedical system and discourage pushback from the pregnant woman (Davis-Floyd 2003).

While several women I spoke with acknowledged their difficulties advocating for themselves, a few women like Judy expressed that they are indeed very good at doing

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[40] Including shaving the pubic area, changing into a hospital gown, confining a laboring woman to a hospital bed, refusing food, and encouraging intervention.

this. Judy attributes this ability to her education level and the support she has in her life. Having more education and preparation for birth can help women advocate for themselves in the hospital. Diana explained that having her husband as support helped her reinforce her advocacy and acted as a backup plan during the pain of labor and birth. She said:

> Diana: I did tell my doctor, I said I'm gonna be honest with you. I'm gonna give you a list of everything that I don't want to happen again and what I expect to happen because my last experience was … it has me terrified to have another baby up here. And the only reason I am up here is because I could not get an appointment at the other hospital. And this doctor has assured me he will do everything in his power, whether he's on call or not he will come in for my delivery. Oh and that makes me feel better. And I told my husband, I know you don't like to come off as any type of way, but I'm gonna need you to go full protective mode like, hey look, nuh uh. And he was like baby they're doing their job and I'm like nope. They didn't do their job last time and I don't want that happening again.
>
> Sia: It's good to have someone advocating for you like that.
>
> Diana: And he did to a certain extent, but then he was like they're doctors they know what they are doing! And I'm like no. You don't know that. None of that. No.
>
> Sia: It's easy to feel intimidated.

Diana: He didn't want to make them mad by annoying them. And I was like, baby, it don't matter.

Diana was able to advocate for herself for a variety of reasons. She had her husband for support and to back her up in the delivery room. She also had a traumatic first birth experience and she learned that the only way to make that more positive was to take control herself. She also discusses her personality and how she is not the type to sit quietly and take orders from anyone.

Advocacy and Birth Justice

Within the anthropology of reproduction and any discussion of pregnancy and birth, it is important to discuss *reproductive justice* as opposed to the commonly used term *reproductive rights.* Many feminist scholars who study reproduction identify with reproductive rights movements and aim to ensure rights for all. But as evidenced time after time, "rights" are different from reality. For example, people of color in the United States have the constitutional "right" to not be shot by a police officer in their own home while they sleep for no reason at all, but clearly what happens on the ground in lived reality is quite different from the metaphorical, abstract, often empty use of "rights." Another relevant example is that although abortion is legal in the US and therefore women have "rights" to terminate a pregnancy, access, social stigma, and money are all barriers to actually mobilizing that "right." Ginsburg and Rapp write, "Many of us have experienced tensions between scholarship and activism concretely, in the pull to listen carefully to what people say about their reproductive lives and in our commitment to advocacy and the championing of reproductive rights. But 'rights' are always historically

and culturally located" (Ginsburg and Rapp 1995: 9). Additionally, "rights" can be utilized by the state to control women's bodies. Elyse Ona Singer discusses the role of reproductive rights and "responsibilization" through a Mexico City public program that provides free abortion and contraceptive care. She spent eighteen months in a public clinic in the interrupción legal d'elembarazo (ILE) program which provides free abortions and contraception to women. Singer opens by contextualizing this public program in a very Catholic Mexico that just recently removed legal consequences from abortion. This shift is widely and publicly viewed by feminist activists as a progressive increase in rights for women, but Singer takes a more skeptical stance of the program to argue that this only increases reproductive governance through the enforcement of state agendas. Women in these clinics are subjected to "responsibilization" because they are scolded and constantly warned about the consequences of abortion thereby encouraging them to take more initiative to prevent pregnancy. Singer shows how the Mexican state is using infrastructure associated with "rights" and freedoms to further exercise control over bodies. Singer concludes by warning of the perils and trappings of using "human rights" language and pushes readers to consider what that really means and what the application of human rights programming may be obscuring. Because of the dangers and complications of "reproductive rights," employing a reproductive justice approach to studies of birth has been a critical framework in the field. Davis writes, "Reproductive Justice exists when all people have the economic, social, and political power and resources to make healthy decisions about their lives" (Davis 2019: 15). A strength of the anthropology of reproduction is this use of the reproductive justice framework to

contextualize birth, emphasize inequality and inequity, and illustrate the importance of lived experiences.

Voices For Birth Justice defines birth justice as “a movement that believes when birthing people recognize their innate power to make the best health decisions for themselves and their families during all stages of the pregnancy, birth, and the post-birth period, that power will have a transformational impact on their family and community. The long history of trauma and reproductive oppression that Black communities and other underserved groups have experienced is the constant force that drives and shapes the Birth Justice movement. To challenge systems of oppression, such as racism and sexism in reproductive care, Birth Justice advocates for culturally-appropriate, person-centered care while challenging disrespectful care. It also supports the sharing of knowledge amongst communities and improves access to breastfeeding support and traditional birth-workers, such as midwives and doulas.” (Voices for Birth Justice). The organization states that “this definition is inspired by the work of Black Women’s Birth Justice, Southern Birth Justice, and SisterSong.” (Voices for Birth Justice). A critical piece of Birth Justice is advocacy. One woman on the Voices for Birth Justice website writes, “When I hear birth justice, I think of advocacy, self-advocacy” (Voices for Birth Justice). Research has called for increased advocacy education amongst pregnant women, especially Black pregnant women who have the highest rate of maternal mortality in the US due to racism in society, medical providers and systems, access to healthcare, and various other factors (Wicks 2021). In her 2021 dissertation, Dr. Tiffany Wicks conducted a study in Dallas on the experiences of Black pregnant women who attended childbirth and advocacy courses. Wicks writes, “the findings indicate that when Black

pregnant women know their rights, confidence to advocate for birth is increased, and support teams can help ensure rights are respected in birth" (Wicks 2021). In a 2019 study of women who had an unplanned C-section, 73% of participants asserted that they regretted not advocating for themselves and that had they done so they may have had a better experience (Konheim-Kalkstein and Miron-Shatz 2019). Clearly self-advocacy is important and the inability to do so can be connected to a variety of factors including personality (like Diana explained), lack of education, and past experiences with authority. Researchers Konheim-Kalkstein and Miron-Shatz find that "There was a significant correlation between emotional support and self-advocacy regrets, which tentatively suggests that either when a woman feels emotionally supported, she is more comfortable advocating for herself, or that when a woman is emotionally supported, she does not feel the need to advocate for herself because her needs are being met and/or someone is advocating for her" (2019: 1947). This indicates again the importance of social support in birth. Self-advocacy is linked to birth outcomes and thus birth justice.

Who Is Filling the Gaps?: Women, Solidarity and Knowledge Sharing

Advocacy is important to birth justice, and emotional and social support enables and encourages advocacy. Even people who have very little social support like Kara discuss finding emotional support with other women in their lives even if they do not have family or close friends. When I asked Kara who she gets most of her information and support from during her pregnancy, she said, "Well, mostly my manager at work. I mean, I text her about like, just about everything. Like I have a question, I'll text her."

Based on my interview data, women who have lower levels of social support in their lives experience an even larger gap of support and information when they are

receiving care in the Beulah County "everyone sees everyone" system. For example, I asked Kara if she felt like she would have supportive people in the room with her when she gives birth. She was going to be in the room alone. She does not have any family in her life, and she did not want the baby's father in the room because "it's just not a very sexy time." I hoped she liked the nurses enough to feel supported, but she said, "um, not really, no. Just because I mean, I haven't even really had time to get to know anybody. [Friendship] is like, every appointment, somebody new." In rural areas where birthing care struggles with the barriers discussed in Chapter 4, women do not get substantial support from medical providers. This is not the fault of the providers. Many providers try their absolute best to meet their patient's needs, but resource and staffing shortages limit the ways they can offer support. When women do not have support, they will not be able to fill that gap with their medical care. I observed that time and time again it is other women in their lives who step up to provide that support, like Kara's manager at work. Kara does not have time to utilize programs in the county that might offer more information and support so she relies on her work manager who she sees every day. While her manager is not really her friend or in her social circle she acted as one of Kara's main supporters. Another woman named Autumn talked about having this type of unconventional support as well. She worked at a restaurant waiting tables all throughout her pregnancy. The restaurant happened to be across the street from a pregnancy crisis center and a woman who worked there came over to Autumn's restaurant for lunch very frequently. Autumn said, "she helped me with a lot of questions I had. I mean one day I even was having pain and couldn't walk and it was a nerve or something so I ran over there on my lunch break- I mean lunch breaks in a restaurant it was like ten minutes- but

she had me do all these stretches and it was really helpful. So, I was like, this is awesome! Thank you!" Autumn said this woman was one of her biggest supporters throughout her pregnancy. Another woman named Marcy whose family cut contact with her when they found out she was pregnant explained that the person who got her through was also a compassionate stranger. Marcy was working for the salvation army collecting money outside of a pharmacy. A woman walking into the store noticed that Marcy was very pregnant, so she went inside and brought her a chair and some water. They started talking and this woman ended up offering Marcy support and information all throughout her pregnancy and she remains a close friend in her life.

Pregnancy and birth are difficult in the Sunflower Mountain Region. Even for women with the most privilege and access like Judy, choices are extremely limited and birth can be disempowering. The difficulty in the landscape of pregnancy and birth fosters a sense of solidarity amongst women in the area who have given birth. For the purposes of this dissertation, solidarity refers to unity and mutual support especially in the face of a shared issue or experience, such as obstetric closures. The people who pick up the pieces and fill the gaps in support and information are other pregnant women and mothers. As Kara and Autumn describe, their colleagues or even strangers who patronize their place of work end up being some of the most valuable people to lean on during pregnancy.

These informal routes of knowledge production and sharing are extremely important for pregnant women who are marginalized. In the context of US biomedicine, women already face issues with self-advocacy due to the intimidation of the authoritative knowledge pervasive in the hospital. Anthropologist Brigette Jordan uses an example of a

birth in an American hospital to show how the woman's knowledge is completely discounted, the physician is protected as a valuable, all-knowing, revered figure, the focus is on technology and not bodily cues to guide birth. This also dismisses embodied and personal knowledge making women feel powerless. I argue that in the Sunflower Mountain Region, women who have gone through pregnancy and birth understand the challenges of doing so in a rural community. This prompts solidarity amongst women in the area. Knowledge sharing amongst women who may not even know each other but connect over a shared compassion for pregnancy in the Sunflower Mountain Region is a critical route of support and education that fills gaps that the infrastructure of rural health creates.

Conclusion

Women who have been historically and systematically marginalized in the United States face increased barriers to having a healthy pregnancy and birth. No one described this phenomenon better than Andi, a home visiting health professional. She stated, "Ripples can go in and go out. The positive and the negatives, when those things are happening, it's really hard for a family… if you live in a rural area." Describing these barriers as ripples is keen. Giving birth in a rural area creates one splash, and ripples caused by other problems in people's lives make everything more complicated. In this chapter, I have presented the potential issues that may cause more ripples in a woman's life. Struggles with low SES, low social support, and inability to advocate for oneself are all ripples that add to the current of rural birthing care. In the final ethnographic chapter, I will continue to explore narratives of women who face unique struggles in birth but I will

frame them in a way that proposes a different way of thinking and seeks to find hope, connection, and solutions.

CHAPTER 7. SERENITY, COURAGE AND WISDOM: UNPLANNED PREGNANCIES AND RESILIENCE

"God grant me the serenity to accept the things I cannot change, courage to change the things I can, and the wisdom to know the difference, living one day at a time; enjoying one moment at a time; taking this world as it is and not as I would have it; trusting that You will make all things right if I surrender to Your will; so that I may be reasonably happy in this life and supremely happy with You forever in the next. Amen."

− Reinhold Niebuhr

Introduction

As I mentioned in the introduction to this dissertation, I spent my time in the Sunflower Mountain Region living in an old farmhouse where the owner, Mary Kate, rents out rooms and lives herself. Mary Kate is 69 years old. Her life has been full of what I can only describe as unbelievable situations including escaping a religious cult, having a large family of boys, losing a son, raising a granddaughter, running her own business, and navigating tumultuous family relationships. She has spent her life pushing through extreme grief, loss, trauma, and hardship. Yet, Mary Kate radiates joy, happiness, warmth, and excitement for life. She takes the saying "never met a stranger" to a whole new level. One afternoon Mary Kate came bursting through the front door after a morning of running errands and going to the dermatologist. "How was your appointment?" I asked as she lumbered through the door with her always-full hands. "Well..." she started. She always has a story. "I went in there and the woman at the front desk was panicked talking about how she was pregnant again with twins. She has three others and wasn't planning on any more. She was all worried about her age and everything. So, I gave her some advice and told her how she needs to approach this. This

is the thing I live my life by: The Serenity Prayer. God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference."

Weak Theory and The Serenity Prayer

Upon planning and beginning this project, I wanted to present narratives and ideas that move beyond the "deficit framing" trappings (Villenas 2001:4) so common in social sciences. Yet there is no ignoring that this study is in many ways a story of loss, inequality, and trauma. In their book *A Postcapitalist Politics,* feminist ethnographic geographers Gibson-Graham introduce novel ways of presenting theory and social science data. They write, "Cultivating ourselves as thinkers of political and economic possibility has involved finding a stance that orients us, in a spirit of hopefulness, toward connections and openings" (2006: 1). Gibson-Graham recognize the radicality of this stance and how it contradicts and draws criticism from many social scientists (2006: 3). Gibson-Graham call on Eve Sedgwick to criticize the deficit "strong theory" present in the social sciences:

> Eve Sedgwick argues that the embracing reductiveness and confident finality associated with the practice of theorizing is a form of paranoia. As a psychic disposition of the intellect, paranoia wants to know everything in advance to protect itself against surprises. It attempts to show intricately and at great lengths how everything adds up, how it all means the same thing. Paranoia extends the terrain of the predictable, casting its hypervigilant gaze over the entire world, marshaling every site and event into the same fearful order (2006: 4).

This paranoia creates and characterizes “strong theory.” Gibson-Graham clarify, “Strong theory definitively establishes what *is,* but pays no heed to what it *does.* While it affords the pleasures of recognition, of capable, of intellectually subduing that one last thing, it offers no relief or exit to a place beyond. If we want to cultivate new habits of thinking for a postcapitalist politics, it seems there is work to be done to loosen the structure of feeling that cannot live with uncertainty or move beyond hopelessness” (2006:4). The hopelessness and chokehold of strong theory is pervasive when reading Foucault, Marx, and other theorists. These men repeat that everyone is just a cog in the capitalist machine and inequality is forever cemented. Gibson-Graham ask what if, “the goal of theory were not only to extend and deepen knowledge by confirming what we already know- that the world is full of cruelty, misery, and loss, a place of domination and systemic oppression? What if we asked theory to do something else- to help us see openings, to help us to find happiness, to provide a space of freedom and possibility?” (2006: 5).

To combat the overuse of “strong theory,” Gibson-Graham and Sedgwick propose the use of “weak theory.” Weak theory asks us to “act as a beginner, refusing to know too much, allowing success to inspire and failure to educate, refusing to extend diagnoses too widely or deeply” (2006: 8). In an attempt to use weak theory and undertake a reparative stance “that welcomes surprise, entertains hope, makes connection, tolerates coexistence, and offers care for the new,” (2006: 8) I use The Serenity Prayer to theoretically frame and organize this chapter.

Chapter Overview

The Serenity Prayer is as follows: “God, grant me the serenity to accept the things I cannot change, courage to change the things I can, and wisdom to know the difference.”

This prayer was composed in 1932 by American theologist Reinhold Neibuhr. The prayer spread widely and quickly and is commonly used including by Alcoholics Anonymous, US Armed Forces, and Children's Hospitals. Whether or not a person is religious, this prayer can be used secularly as just a piece of advice if you remove the "God, grant me" piece. The Serenity Prayer represents everything "strong theory" is not. It provides hope and space for openings and it moves beyond a deficit framing. It has real-life practicality and allows for connections and reparative theorizing (Gibson-Graham 2006). And ultimately, it is the supreme tool for combatting and moving past the paranoia that Sedgwick sees in so much theorizing. As I see it, the Serenity Prayer even in a secular view represents faith, trust, and peace in the world around us, which is the opposite of paranoia. In the following chapter, I will use this theoretical framework to organize and explore the factors prevalent in rural America which lead to more unplanned pregnancies and a lack of options that force women to feel trapped. I will discuss how people work through the trauma and barriers of not expecting their pregnancy. Finally, I will conclude with narratives of women who did not plan their pregnancies but reaped extreme benefits from having a baby.

Accept The Things I Cannot Change: Unintended Pregnancies

On an afternoon in mid-July, I sat at a shady outdoor table at a local bakery. I was waiting to meet with a mother named Angelica. She contacted me after WIC sent out my information. Her message stood out to me because she emphasized how much she wanted to participate because she was very passionate about rural studies. This definitely was not the usual response I got to my study flyers, and I was intrigued and excited. I watched a beige SUV pull into the parking lot with a large cross bumper sticker. A young woman

with a Guns N' Roses t-shirt, jean shorts, and long wavy brown hair got out of the car. She opened the rear door and leaned into the back seat for a bit, eventually emerging with a little baby boy on her hip. I figured this had to be the woman I was looking for, so I gave her a smile and a wave. She came up to my table to set her bag down and introduce herself and her son Michael who was wearing a matching Guns N' Roses T-shirt. She explained that she was going inside to get him some food and would be right back. I was immediately struck by Angelica's huge smile and compelling warmth. A few minutes later she came back out of the bakery toting Michael in one arm and dragging a highchair in the other. I rushed up to help her but she shrugged me off with a gentle, "No, no, I got it."

Angelica always wanted to be a teacher. She went to the local university and got a degree in history thinking that she would be a high school teacher. Once she got into that field, she quickly realized the public school system was not where she wanted to be. She ended up going back to school to get her master's in social work and ultimately ended up teaching at a community college. This was exactly where she belonged. She loved engaging with so many different people in one classroom. She is an adjunct, so her workload is heavy and her compensation is little. We talked a little about the woes and excitement of teaching at the university level because we had that in common. I asked her what her class load was, and she said that she would be teaching six classes in the fall. I was shocked but she did not even seem to indulge my surprise. "I really love it," she said. And I could tell that she meant it.

During this conversation I could not help but wonder how little Michael factored into Angelica's life. She was only 26 years old and spent a lot of her life in higher

education. I asked her about her interest in rural studies and she lit up while explaining how she used to be involved in a rural mental health research team through the university. She concluded, “but I never got to see how things ended up because well,” her eyes shifted to Michael who was occupied while trying to eat his yogurt, although most of it was on his face. Angelica grabbed a napkin and started wiping his face and shifted her tone up an octave to baby voice “this little guy made his surprise entrance, right buddy?”

One of the most unexpected things I learned from my interviews was that a lot of women I spoke with had “surprise” or unplanned pregnancies. I just had not considered that so many of the pregnancies I saw were unplanned and oftentimes unwanted. My own lack of consideration of this is probably because myself and my two siblings were carefully planned and timed intentionally. Unintentional pregnancy rates in the United States are going down, but according to data published in 2019, about 45% of all births in the country are unplanned (CDC 2022). Unintended pregnancies can potentially result in negative health outcomes including low birthweight, inability to breastfeed, and severe postpartum depression (CDC 2022). According to the CDC, Black women experience unintended pregnancies twice as often as white women (CDC 2022). Additionally, women with incomes less than 200% of the federal poverty level experience higher rates of unintended pregnancy than women with higher incomes. Medicaid pays for 68% of unplanned births and only 38% of planned births (CDC 2022). Ensuring that all women have the access and ability to decide if and when to become pregnant is a social justice initiative that would combat birth inequalities. This issue is on many public health agendas including that of Healthy People 2030, which has the goal of decreasing

unintended pregnancies and increasing access to effective birth control (Healthy People 2030).

I felt very fortunate that so many women I interviewed were so open about their experience of unwanted and unplanned pregnancy. As I reflected in my introductory chapter, it was always easier to broach this topic with a woman while we were talking in person. Pregnancy in general and especially an unplanned pregnancy can be a taboo topic to discuss because it involves the assumption of sexual activity and sometimes out of wedlock which some women hold to be important to their value system. While in person, I could gauge the facial expressions, body language, and nuanced aspects of conversation that could indicate whether a woman was open to discussing something. Via phone it was more challenging to determine what was off limits in the conversation. I always chose to let the woman who I was talking with lead that part of the conversation so I could follow. As interviews progressed and I found that more and more women explained that their pregnancy was unplanned, I decided it was important to ask this question in future interviews. I always did this gently with phrasing like, "so when you found out you were pregnant, what was that like for you? Was it exciting, was it a surprise? Or was it something you weren't really planning on?" There is no way for me to know how honest women were with me, but I felt like people answered this question in a straightforward way. Sometimes I was met with a big sigh and a "no, we were NOT planning on this" and other times the mother made it clear that they had been trying for a child. I became more interested in this aspect of pregnancy because of how it is impacted by rurality and further contributes to birth with a lack of choices which can be a disempowering experience.

In my interviews with women who had unintended pregnancies, many suggested that they had a difficult time accepting their pregnancy. One woman explained how she felt scared and "trapped" when she found out she was expecting a child. This feeling of being trapped is echoed in global literature on unintended pregnancies, along with feelings of unworthiness, ambiguity, shame, and detachment (Saim et al. 2014). Other research has found that a feeling of being trapped in a pregnancy has a high association with unaffectionate parenting and feeling inadequate at mothering amongst women into the child's life (East et al. 2012). While women in my interviews discussed these negative feelings, most also mentioned their process of accepting their pregnancy. One woman named Morgan explained how her pregnancy was completely unplanned and shocking. "I always knew I wanted a baby," she said, "but now was not the time for it. We were trying to save up some money and move into a house before this. But this is how God wanted it, so I guess we're doing it." When I asked another woman in a similar situation about how she was feeling about her pregnancy now even though it was a surprise initially, she said, "well, it's happening now so there ain't no use in sweating it!"

The theme of accepting unintended pregnancy was pervasive within my data. When women discover that they are pregnant, it is often viewed as something that can no longer be controlled as the Serenity Prayer mentions in the first statement. Weak Theory involves paying close attention to nuanced social moments and integrating those into meaningful theory. I consider acceptance of unintended pregnancy and the ways women find acceptance as an act of resilience. For example, Angelica's good-humored way of giggling and baby-talking to her son about his "surprise entrance" shows her level of comfort in her ability to adapt. Not only was she able to process and handle her

unplanned pregnancy, but she is also now making light of what used to be an extremely distressing situation to her which will be further explored in the next section. Morgan also exhibits a degree of lightheartedness in her adaptation to an unintended pregnancy. She cites her trust in God and goes on to exclaim how she bounced back from the surprise and is not going to sweat it. The nuance in the ways women discuss adapting to their pregnancies indicates their level of resilience. But resilience in these situations is not simply an admirable trait. It can be exhausting and involves substantial struggle and frustration. For example, Angelica had to put her schooling on pause. She loved what she was doing in rural health research, but she had to give up her position to have Michael. She explained how she would love to get back into it someday, but she was unsure if the same opportunity would be there for her. Morgan's resilient attitude is also commendable, but she and her family had to go through serious financial struggle to be able to afford her unplanned pregnancy. Through attention to these unconventional social moments, weak theory helps identify more everyday resilience. Ultimately it is critical to highlight this resilience, but it is also important to acknowledge the ways that resilience is tiring and frustrating. When pregnancy begins, it is no longer in the state of something that can be controlled for most of the women I talked with for reasons discussed later in this chapter. Acceptance is common, but the degree to which women can find serenity in this acceptance is based on a variety of personal, social, political, and cultural factors.

Enabling Serenity: Christianity in The Sunflower Mountain Region

A notable attribute of the Sunflower Mountain Region and also many parts of rural America is the role of religion, specifically Christianity. This is something that is present in everyday life. On my drive from downtown Carter back to my home in

Western Beulah County, I pass five large billboards that have messages such as “JESUS IS THE ANSWER TO ALL YOUR PROBLEMS” and “ARE YOU READY TO MEET THY GOD?” In the coffee shop that I sit in right now as I write, there are two young men at the table to my right having a Bible study. Text messages I receive from parents of kids I teach in my swim lessons often wish me a “blessed weekend.” In most businesses and public spaces there are bible verses and religious references. Most shockingly to me, the public elementary school where I worked had religious imagery and bible verses hanging on the walls in the hallways and restrooms. This seems like a violation of separation of church and state. Christianity is worked into the fabric of everyday life in this area. Research supports much of my experience with the religiousness imbued in my everyday life in rural Appalachia. There is a rich history of religiosity in the region (Photiadis 1977). Like many stereotypes of Appalachia, there is a lot of misconception of rural Appalachia as a place of religious individuality where people speak in tongues and dance with snakes in church and do not really adhere to a sect of Christianity. These stereotypes are ways of othering Appalachians while simultaneously normalizing deficit models of life in rural communities.

The Importance of the Church

Because religion is such a strong cultural force in Appalachia, it seeps into all aspects of society. This manifests in basic and more nuanced ways. For example, on Sundays most businesses are completely closed or have modified hours to be briefly open during the day. Most large community events such as farmers markets, parades, and festivals take place on Saturdays to avoid church conflict. Beyond store hours and heavy church traffic on Sunday afternoons, the level of religion in the region impacts other

social issues. This is well-documented throughout Appalachia (Leonard 1999). Because churches are such important staples of communities, they hold a lot of social pull and power. Some churches and religious leaders in rural Appalachia have used their platform to speak out against mountaintop removal mining. The organization Christians For the Mountains is a large group that advocates for environmental justice in Appalachia. As their website states, their core mission is to "honor the truth of Psalms 24:1" which reads: ""The earth is the Lord's, and the fulness thereof; the world, and they that dwell therein." They work to honor God by asserting that only God should move mountains. They spread this message on billboards to raise awareness and engage in activism and community projects to build community infrastructure and work against coal mining, fracking, and MTR. This project has been very successful because the Christian church has so much community value and influence. Churches also are involved positively in many public health interventions. One critical example of this is Nancy Schoenberg's "Faith Moves Mountains" project in rural Eastern Kentucky. Schoenberg has received millions of dollars in grants to foster connections with churches in the area and establish specific health interventions through them. The current project with a focus on testing and self-monitoring for type 2 diabetes has had great success with testing and lessons in churches. Churches and religious institutions can be used in very powerful and impactful ways in rural communities.

The power of religion in rural Appalachia can be used for positive health intervention but can also have negative impacts. Ellen Mengel, the health reporter I mentioned in Chapter 4, observed, "And the fact that, like churches, they are really part of the public health infrastructure, for better or for worse. So these are like, you know, so

you would hear about pastors who are like, you know, oh, we need mental health services here. Let's hire a counselor. But also you would hear about people who are like all you need is Jesus Christ. And so if you want something like, come to us and we'll pray for you. So you have those two extremes and everything in between as well. But you cannot sort of uncouple like health from churches in rural areas, right?" Ellen's points about the power of religion are very true. Other health professionals I talked with also expressed the challenges of working in a religious area. One maternal mental health professional said, "I wish everyone knew the benefits of like, just knowledge and education. If we're talking about birth or if we're talking about health, I think that that's a big epic part of it. This might sound kind of crazy but like religious beliefs that might overshadow some science. I mean like I was getting my hair cut earlier today and I was listening to two women talking about not wanting to get vaccinated and it was predominately influenced by people at the church. There is a hugely conservative Christian population in rural Appalachia and I feel like that it is a huge boundary to looking at really science and the medical evidence it blows my mind sometimes. And I'm a Christian!" Ellen and other health professionals mentioned the barrier religion can pose to accessing mental health services.

God Has a Plan

One day after finishing teaching swim lessons, I walked one of my 3-year-old students back over to her grandma. Her grandma explained how glad she was that her granddaughter was able to take swimming classes. We were just chatting and she said, "did I ever tell you about her mother?" I said that she had not, and she went on to explain how she had died during childbirth so now she was raising the daughter. I expressed how

sorry I was to hear that and the grandma said, “Thank you. It has been hard, but God has a plan, and we know that. And that helps every day.” The idea that “God has a plan” emerged in interview data when women discussed adversity, especially when facing an unintended pregnancy. Other researchers have found that religious women tend to cope with and find meaning in severe adversity more effectively through their theology than people who may not have that belief (Williams et al. 2011). Women in this research study discussed using their religious beliefs to help find peace and acceptance and serenity in pregnancy.

Religion and Pregnancy: Why Can’t I Change These Things?

Thus far in this section, I have discussed the ways religion helps women accept their unplanned pregnancies with serenity. Yet, ironically, one of the biggest factors that makes an unintended pregnancy something that even falls within the first tenet of the Serenity Prayer (something that cannot be changed) is that same religion that enables the serenity to accept that. The Christianity in this region clearly influences many aspects of public life and health and pregnancy is no exception. In fact, pregnancy is a space where the influence of religion is amplified. During one of the first weeks I was living in the Sunflower Mountain Region in January 2021, I was driving through downtown Carter in Beulah County on my way to the store. As I approached the town center I noticed a group of people conducting some sort of demonstration. This was not unusual. This same area had been a space for Black Lives Matter protests (mostly comprised of college students) and more often, anti-masking and vaccination rallies. This space is a good place to stand and make a statement because traffic through town moves very slowly giving people driving by ample time to read the signs people hold and hear what they are saying.

Additionally, many people walk up and down the town sidewalks during the day. As I slowly drove by this group I noticed that it was made up of both adults and children. They were all holding large signs that had messages like “GOD MAKES NO MISTAKES” and “PROTECT THE BABIES.” Clearly, this was an anti-abortion protest.

Reproductive rights in relation to abortion have always been hotly contested in the United States. This debate has always been fueled by religious (specifically Christian) pushes to protect the sanctity of life and the claim that life begins at conception. Abortion access in rural America is already infamously impossible (ACOG). During the course of my fieldwork many new laws and restrictions made abortion care even less accessible. In May 2021, Texas governor Greg Abbott signed the most restrictive abortion law in the country which limits abortions to only up to 6 weeks after conception. This is problematic because it essentially makes abortions illegal. Many women are not even aware of their pregnancy when the six-week mark passes. Roe v. Wade, originated in Texas, has held that abortions should be legal up to 24 weeks which is when the fetus could live outside of the body. Therefore, this new law is massively restrictive. An article on this new law states, “Abortion providers in the state have said, since the law took effect in early September, at least 80% of abortions previously provided are now prohibited. This forces patients to continue an unwanted pregnancy, to drive to neighboring states for an abortion, or to pursue more dangerous methods” (Spitzer & Ellmann 2021). The supreme court voted in a 5-4 majority to temporarily uphold this law. This threatens the precedent of the Roe v. Wade case. Many people gathered to march and protest in response to the Texas law while others celebrated and spoke about this as a massive victory for the unborn. The Christian principles that motivate these laws create

inaccessible abortion for millions of women in America, thus ensuring that the state of pregnancy cannot be changed.

Since I began conducting this research in rural Appalachia back in 2019, the conversations of abortion access and right to choose have been potent in the background of my work. In May 2019, Alabama Governor Kay Ivey signed the "Human Life Protection Act" statute, which makes abortion illegal in the state and threatens felony conviction for doctors who perform these procedures. When new restrictions in various states are passed and made public, there is often massive resistance and backlash. One way this occurs is through social media and the sharing and posting of graphics and images of quippy statements in bright pink block lettering such as "NO UTERUS NO OPINION"[41]. As a young, white, highly educated woman, a lot of my social circles reflect my identity. In May of 2019 I was conducting preliminary research in the Sunflower Mountain Region and another Appalachian state. Between interviews and participant observation I would scroll through Instagram and see reposts from my friends of these pro-choice graphics. This cultural conversation pushed me to do some research on how one could get an abortion in the places I was doing research. Even though neither of the states I was working in were the centers of the abortion restriction conversation, I found that there are legitimately no places to get an abortion in the areas I was working in. Finding abortion care is complicated and would require a long drive to even see a professional. Additionally, both the states I was working in have no public funding for abortion unless it is in the case of rape or incest. And even in those cases, proving that

[41] See figure 7.1 for examples.

intent is even more complicated. The barriers to obstetric care are massive in rural areas, so even imagining the Olympics of finding abortion care is maddening.

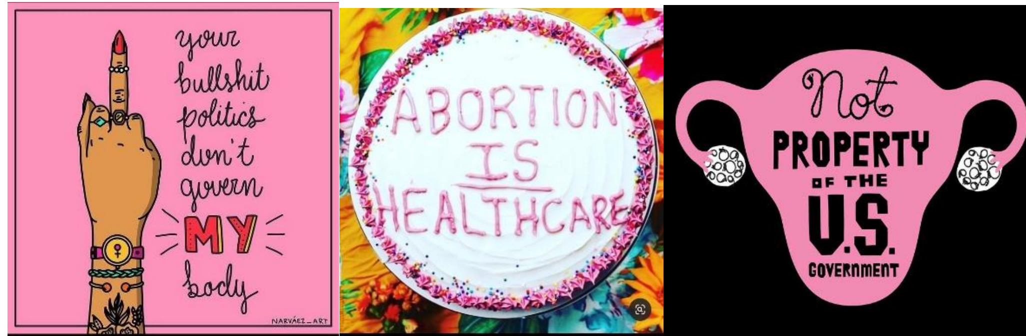

Figure 7.1: Popular Instagram pro-choice graphics retrieved from my own feed. Credit: Right to left: @narvaez_art; @therealmadisonyoung; @melindabeckart

Like so much in the United States, these abortion restriction laws have an unequal impact on people of color. The Guttmacher Institute finds that Black and Hispanic women have higher rates of unintended pregnancy and abortion than white women. They write, "These higher unintended pregnancy rates reflect the particular difficulties that many women in minority communities face in accessing high-quality contraceptive services and in using their chosen method of birth control consistently and effectively over long periods of time. Moreover, these realities must be seen in a larger context in which significant racial and ethnic disparities persist for a wide range of health outcomes, from diabetes to heart disease to breast and cervical cancer to sexually transmitted infections (STI), including HIV" (Cohen 2008). The higher unintended pregnancy rate amongst women of color can be attributed to the ways the US healthcare system fails and marginalizes minoritized people. The commonwealth fund reflects on how the new Texas law will disproportionately inflict harm on Black women: "Afflicted for centuries by poverty and discrimination, lacking access to reproductive health services, Black women

in Texas have been more likely to experience unintended pregnancies. The result is that abortion is accessed more commonly among Black women. Unplanned pregnancies are associated with higher rates of maternal mortality, prematurity, and infant mortality. S.B. 8 will therefore compound the long-term damage of racism in the Texas health care system, disproportionately injuring Black mothers and their children...This is how systemic racism works. Directly or indirectly, explicitly or not, it results in policies or institutional structures that hurt Black and brown people, perpetuating and increasing inequities that began with the importation of Black people to America as slaves in 1619 and persist to this day" (Blumenthal & Zephyrin 2021).

During my research, I only worked with white women, so I do not have interview data on this topic directly. But I do have some ethnographic insight on the disparities people of color face in Appalachia that indicates how difficult accessing abortion care might be. While working at a local elementary school in the afterschool program for high-risk children, I developed a close friendship with a third grader named Drake. Drake is a sweet and bubbly kid who loves to socialize with others, laugh, and draw. One day I was playing jump rope with him in the gym and he paused for a moment and made a comment about wanting to kill himself and "start over up there" as he pointed towards the sky. I was shocked by this statement and I pulled him aside to talk more about what he was saying. He disclosed that he was having trouble at home that made him sad and hurt. I wrestled with this information and conversation. I knew I had to tell someone, so I spoke with the lead teacher and principal of the school. They confirmed that they could keep an extra eye on him throughout the school day. We discussed the possibility of involving social services, but the teacher knew that Drake's family was undocumented

and that would cause more issues than help. This realization was devastating. Here was this kid who was clearly having issues but was siphoned off from necessary resources and intervention due to his family's documentation status. Drake's situation made me think deeply about how women with varying levels of citizenship status have the same barriers to reproductive care and justice. Inequality is present in every aspect of life for marginalized people in the United States. This calls intersectionality into focus as well. Overlapping axes of identity construct how people experience health, resources, and care in the United States.

"It just doesn't come up much"

Even though I was conducting field research on maternal health and pregnancy during two major abortion legislation decisions (Alabama and Texas in 2019 and 2021 respectively), abortion care rarely came up in interviews with maternal health professionals and pregnant women and mothers. This was always a bit surprising to me. I would sit in parking lots before interviews waiting for the right time and scroll through social media where I would see vibrant conversations about abortion restrictions, but then I would turn off my phone and enter the reality of areas without access to care and suddenly it was silent. During my preliminary research in 2019, I was very curious about the silence on abortion rights and laws amongst maternal health professionals in rural Appalachia. During one interview with a maternal health home visitor, I felt comfortable enough to broach the topic and ask her about abortion policy and demand in the area. When I asked if she ever had clients ask about options for pregnancy termination, she responded:

> I have not had anybody ask. I think some other home visitors here have talked to some high school girls who were like, I don't know what to do. And we give them the options. But I personally have never had anyone ask. But if they did, I would put my personal opinions aside and tell them the places they could go. They're just not talking about abortions a lot. But we would if they needed us too. In my experience, it hasn't come up a lot. I think that's a thing in rural areas. I think that just, country folk, after generations and generations, it's like, you made your bed you lay in it. You made that baby, you're gonna take care of it. I have never had a parent say I want an abortion. Or even ask me. It just doesn't even come up. And I would have to put my personal feelings aside because I do think that is murder. But I could put them aside. And I would give their options.

One initial observation from this response is the claim that there is a cultural and generational responsibility to keep and care for babies even if they are unwanted. This unspoken rule and pressure push people to accept pregnancy as an unchangeable factor in their lives. This point is very important and one I believe is often missed. In larger social and cultural discussions about abortion, it is absolutely critical to acknowledge the wants and needs of the women for whom we are advocating. So, despite that fact that from my very privileged liberal, white, feminist, educated perspective it seems clear that abortion access is reproductive justice and I would want every woman to have that, many of the woman I worked with would likely be upset to know that I would fight for them to have abortion access. This reality also pushed me to think about the women living in highly religious areas with no access to abortion who do want or need a procedure and how their stories are likely kept completely secret. Ultimately, this professional's repetition of the

phrase that abortion "doesn't even come up" is very consistent with the conversations I had in rural Appalachia. I talked with many mothers who told stories of how their pregnancies were unexpected and unwanted. But none of them even mentioned abortion except for Angelica.

Courage to Accept

Although it is not a technical part of the Serenity Prayer, Angelica's story exhibits courage in finding her acceptance. When I asked Angelica about Michael's "surprise entrance" that she referenced, she explained that this was an unplanned and unexpected pregnancy. I asked her to talk more about that and she revealed that she was committed to never being a mother. She explained, "I was totally content doing the aunt thing. I lost my parents several years back. My mom has been gone for seven years now, going on eight. He was actually born on the anniversary of her passing" she looked towards Michael and noticed he had a glob of yogurt dripping down his face. She wiped it off and helped him maneuver the spoon directly to the target of his open mouth. "Is that yummy? Yeah it is" she smiled at him and continued talking. "And then my dad, I lost him going on four years ago. But after that, I just kind of I was always kind of, young kids were not for me. And then after especially after my mom, I was like, you know, I just got kind of paranoid. And I was going through a lot of grief and I was like, I'm never going to have a kid and leave them like that. And just my sisters are both a lot older than me. And they had already had kids. My nieces and nephews are my age." Tears were forming in Angelica's eyes as she talked through the grief of losing both her parents and her reaction to them leaving her. She continued, "And so I had got to see my mom be a grandma. Yeah. To like all of my nieces and nephews and stuff. And I was just like not having a

kid because they're not going to have my mom. All of these types of things. And then just one day I was super sick for a week I was like, what is going on? So what was going on?" Michael began giggling hysterically at this point in the story. He was likely laughing at something passing by in the parking lot but the timing was ironic. "Oh, yeah. So funny. So funny" Angelica said to him as she flashed a big smile. She finished discussing her pregnancy "So I probably spent the first four months in tears. Yeah, crying just, I don't want to be pregnant, but I don't personally believe in abortion as an option for me. So I was like, I just had to be like, I don't like this." Angelica was shocked and devastated by her pregnancy. But because of her convictions, personal beliefs, and faith, she felt stuck and trapped into having this baby.

I want to step out of this moment and again discuss Weak Theory and how it can contribute to pushing back against deficit models of understanding. Kathleen Stewart writes, "The jumpiness of things throwing themselves together has become an object of ordinary attention. That's why models of thinking that glide over the surface of modes of attention and attachment in search of the determinants of big systems located somewhere else are more and more like road blocks to proprioception than tunnels that yield understanding" (2008: 75). The "jumpiness" of this moment with Angelica could be lost to "ordinary attention." But here I am, sitting at this table talking to Angelica about how much she did not want her baby son who was sitting there at the table with us indicates a level of acceptance and peace that can only be dubbed as truly resilient. Of course, Michael is too young to understand what we were talking about but his presence at the table and the way Angelica would pause her story of devastation at her pregnancy to smile and feed him a spoonful of yogurt and tell him how adorable he is and how much

she loves him is a unique and contradictory moment of human interaction. Looking at this moment magnifies how individual resilience functions in everyday life.

As I stated previously, many women I talked with had unplanned pregnancies. One woman told me that all three of her babies were conceived while she was on birth control. She frustratedly explained, “Yes. I had three birth control babies. First one was while I was on the pill. Then I was on the shot and that’s when my second one came along and then I decided to do the patch, with this one to see if it worked better because I didn’t really want to get the implant. But now, I'm getting my tubes tied because my husband has agreed. He said yes I will sign for you to get your tubes tied. I'm like THANK YOU!” I asked this woman to clarify that the process for hysterectomy works in a way where the husband has to sign and consent to the procedure despite the fact that he is not the one involved in the surgery. She said, “Yes, because he is financially responsible for all of my medical bills. Because we’re married. So if he doesn’t give the say so, well a lot of people say my body my choice, no. Not when you’re married honey. Because your husband is responsible for everything financial.” This woman seemed annoyed by her unexpected pregnancies, but she is also very religious and did not mention any thoughts of abortion or adoption. “I know it wasn’t how it was supposed to be, but I do believe children are blessings,” she continued. This woman’s trajectory is different from Angelica’s because she explained that she always knew she wanted children eventually, but she had not been ready yet when she started getting pregnant. This put the family in a difficult spot financially, but she was not nearly as devastated as Angelica was because the surprise pregnancies did not interrupt her life or view of her future as drastically.

Another woman named Darla had unexpected pregnancies that altered the trajectory of her life. Darla explained that she too is a very religious person and takes church and her faith seriously. She has twelve children. I assumed that this is what she wanted based on her faith identity, but I asked her if a large family was something she always envisioned. She frankly responded, “Oh no. Well, I thought I was done having kids after the second one, but the birth control never worked for me.” I could not contain my surprise and blurted out, “WOW. So you had ten birth control babies?” Darla’s tone never changed. She was stoic and matter of fact while relaying the details of her twenty-year childbearing stint. She said, “yeah and I was on the shots, and then the thing in my arm and I always ended up pregnant. And they told me after my little boy was born in 2004 or 2005 that I would never be able to have kids again and then I had two more. And my son born in 2014, he was a twin too but only he survived.” Darla said her mother, who had thirteen children, also had this issue with her body rejecting birth control. I could hardly believe my ears when Darla was talking. But she is a level-headed and fiercely independent person. To further illustrate her independence and toughness, consider the following excerpt of the conversation we had:

> Sia: Was transportation ever an issue for you? Like when you were in labor and having your babies?
>
> Darla: No. I drove myself.
>
> Sia: You drove yourself to the hospital while you were in labor?
>
> Darla: Yes. Every time.

Sia: Wow. You're so impressive!

Darla: Once I was in labor and I drove myself all the way from here to the bigger hospital which was two hours away. I had a checkup that day and the doctor was like, you're in labor. I'm going to send you over to the hospital where we deliver. And he said, ok do you want an ambulance? And I said no, my car is outside I'll just drive. Drove myself over there, got my bags out the car, went into the hospital, and walked up the stairs and checked myself in.

Sia: Did you have anyone with you?

Darla: Usually someone would come later on, after the baby was born.

Sia: To offer some support?

Darla: Yeah but they would just stand there and look at me like I was crazy but that's about all.

Evidently, Darla is a straightforward person who rarely expressed strong emotions during our conversation. Many of the things she told me were shocking but she relayed them just as one would tell you the weather. This is another moment of how looking at conversational nuance and how Darla carries herself indicates a level of resilience in adversity. So, when I asked her how she reacted to her pregnancies each time she found out, her response surprised me: "Well it was not, I cried. And whenever they told me I was pregnant, I screamed." She continued to tell the story of one specific time she learned she was pregnant, "I went in for my yearly physical and I had the birth control in my arm. And they took my blood and had me pee in the cup and all. And it come back I

was pregnant. And she was like, there's no way! And she sent me for bloodwork and it come back too. And she said I just don't see how! And so she sent me for an ultrasound. And I was looking on the screen, she gets another doctor, and I'm just like WHAT?! And she goes well you're pregnant, but you got two. And I'm just like, that can't be! I have this thing in my arm and I've had it for a year. And she's like well, there's baby A and there's baby B. and I'm just like, this can't be happening." Darla's assertion that she screamed and cried each time she found out she was pregnant is heartbreaking. Like Angelica, Darla's religious convictions and beliefs intersected with the failure of birth control to create a situation of being stuck in chronic pregnancy. At the end of our conversation, I asked Darla what she does for herself. She said, "Raise kids. That's about it. Well, this year I've got a garden."

Courage to Find Support: The Pregnancy Crisis Center

As I explained in the prior section, Angelica was the only woman who even mentioned abortion during our conversation. She was shocked and upset about her pregnancy, so she made an appointment at the local Pregnancy Crisis Center. She wanted to confirm her pregnancy and local OB offices will not accept patients who are less than ten weeks along. She talked about going to the Crisis Center: "I wanted to be sure, like, Is this real? Is there a heartbeat in there, like, you know, and so paranoid that I was like, I'm not believing it until I see it on the screen for sure. I need to know. And even though I am personally anti-abortion, I was so upset, so not wanting it, that there was a part of me that... I considered if there wasn't a heartbeat, you actually don't get a heartbeat until six weeks. Yeah. And so there was a part of me that was like, if there's not a heartbeat, I might consider this [an abortion] really. I mean, that is how I would feel. Yeah. I was so

shocked." Based on the way Angelica explained this, I could tell this was a huge deal. She is strongly religious and very anti-abortion, but she admitted that she even had part of herself consider it because she really did not want this baby. The Crisis Center was helpful to Angelica when she was in this desperate position. She said, "I went there and they were super helpful. They give you all this information. They were so nice and not judgmental. Being a Christian based facility, they obviously didn't offer any kind of information on abortion. But if you wanted counseling they would do counseling with you there. They would do counseling with your partner and they would give you up to three free ultrasounds if you needed it. They sent me home with, like, this cute little gift bag that had all of this, like, encouraging stuff, like a little journal and a little mug that said something about being a mother, and ginger chews and peppermint tea. Yeah, like a whole book. They sent me home with a book for my partner about first time dads. And it was like, they compared it to football or something. It was a football player who had written it. I felt it was really sweet. Yeah. They were a lot sweeter and nicer than my actual baby daddy." The Crisis Center provided Angelica with what she needed. She wanted Christian reassurance and support to help her get through this without violating her beliefs. Even though the experience was positive, seeing the ultrasound was very hard for her. She talked about that moment: "They pulled it up and I remember my sister went with me and she made some kind of joke right before they did it. And I started crying. And the sweet little people that were doing that, they were so good to me. And they're sitting there and they're pulling the ultrasound up and they're like, there's the heartbeat and they're all being so positive. My sister was like, oh, my gosh. And I was just devastated. Just like a knife through the heart. Like, Oh, there's a heartbeat. It's there."

The heartbeat was the non-negotiable for Angelica so the moment that it was confirmed she was really locked into her pregnancy. While this was a devastating day for Angelica, it was improved by the fact that she had support in that moment from similarly religious women who were encouraging her and ensuring her that she could do this despite her dread.

Pregnancy Crisis Centers

In September of 2018, I sat in the second row of a room in the University of Kentucky Gatton Student Center listening to a presentation by Planned Parenthood. This presentation was a part of the annual Kentucky Gender and Women's Studies Conference. The topic of this talk was the dangers of "fake abortion clinics." I listened on the edge of my seat while two young, spirited Planned Parenthood representatives gave an informative and compelling presentation on the insidious nature of Pregnancy Crisis Centers, or fake clinics. The presenters shared accounts of how the Crisis Centers aim to look like Planned Parenthoods (and also set up near real abortion clinics) so pregnant women looking for an abortion might accidentally walk into the "fake clinic." These establishments have been popping up rapidly around the United States and have received a lot of media coverage including a quippy and informative bit on John Oliver. After hearing this presentation and the ways that women looking for abortion care were misled and guilted into continuing their pregnancy by these Christian organizations, I began thinking of a lot of the very religious people in my life who might find comfort in this kind of organization. I waited until after the presentation concluded to approach the representatives and ask this question. Did Crisis Centers provide any good services for people who are looking for religious validation and comfort during their pregnancy? The

presenters did not know the answer to that question. It lingered in my mind as I approached fieldwork. In 2019 when I started working in the Sunflower Mountain Region, I interviewed a professional at the Lowland County health department. At the conclusion of our conversation, I asked her if there were any other professionals and resources that she works with in the community. She explained that the health department partners with the local Pregnancy Crisis Center and the Center Coordinator would probably be willing to talk with me. She gave me the Center number and I immediately called and explained who I was. They were excited to have a visitor and asked if I could come by that very day. I talked for a while with the director and they gave me a tour of the building. It is brand new, large, clean, and bright. There are hand-painted bible verses in warm colors across the walls as you walk down the hallway. The director took me downstairs to a series of rooms full of maternity clothes and baby supplies. "Our clients get store credit for participating in our parenting programs. Then they come down here and shop for things they need. We just show a lot of moms who don't think they can do it that they really can," the director said as I looked around the fully stocked rooms.

My day at the Crisis Center really did surprise me. I asked the director where they got funding and she explained that they are 100% funded by community donations. To me, this indicated that this was an entity that the community wanted and valued. I also asked the director what they did if a woman did come in there looking for an abortion. "It's happened before," she said. "We give them all of our information and if they are still wanting an abortion, we obviously want them to keep the baby but we want them to do what is best for them. We won't refer them anywhere or anything but we do tell them they are always welcome back." Each center is different, and some are more aggressive

and restrictive than others as they are all funded and overseen differently. The Crisis Center that I worked with is very religious, with bible quotes printed on nearly every surface. In a long conversation with the director, I learned that many of the women who visit are single, young, low-income women who do not know what to do when they find out about their pregnancy. As the director said, the crisis center will never recommend an abortion. In fact, they will use every tactic possible to avoid it including providing an ultrasound to foster emotional connection (Taylor 2009; Kaplan 1994). The center provides free maternity clothes, bottles, diapers, and education to pregnant women. The director, Carol, explained that their goal is to show women they can do it. In a way, the support that comes from the center fills in for the lack of the support the single obstetrician can provide for the whole area. This is both compelling and problematic: women who have little support and few resources can find help at an institution which will relentlessly push Christianity upon them. Conversing with Carol, a staunch pro-life advocate who had an abortion when she was sixteen, parallels what Faye Ginsburg finds in her ethnography of the debates over an abortion clinic in Fargo, North Dakota. Ginsburg explains that local pro-choice versus pro-life movements are shaped by identity and concept of self. They do not neatly divide based on economics, religion, race, or class (Ginsburg 1998). Ginsburg works with pro-choice and pro-life activist groups to contextualize abortion debates and representations. One particularly notable ethnographic anecdote Ginsburg provides is that of a young, pregnant women coming into the abortion clinic and explaining that she wanted to have the baby, but she could not afford it. The director of the clinic calls the pro-life coalition and sends the young woman to them to get help. This example shows how women on opposing sides of the issue care about

supporting others in their small town despite the drama and debate (Ginsburg 1998: 133). Ginsburg's ethnography is very important to my research because it shows how issues which seem to have two clear sides are more nuanced and influenced by contextual factors that often coincide or can be exacerbated by stigma and stereotypes in rural areas. Ginsburg writes, "Are right-to-life women simply trying to maintain a disappearing way of life, as Blake and Pinal would maintain? Implicit in this view is an equally flat depiction of pro-choice women as the vanguard of 'modernity.' From my research in Fargo, it appeared that this representation is a misreading of the movements and the effects they are having in the contemporary United States. Reducing the positions of each side to a defense of motherhood or 'liberation' fails to recognize either the structural conditions that limit women's access to other resources or the larger philosophy that links such viewpoints to critiques of the culture in general" (1998: 127). Following Ginsburg's example and closely interrogating generalized binaries is a way to add complexity and nuance to how rural areas are portrayed and understood.

What Can Be Changed?: Teen Moms, Sex Education, and Social Support

Another contributor to unplanned pregnancies is the high level of teen pregnancies in the Sunflower Mountain Region and rural Appalachia. The teen pregnancy rate is higher in the US than other countries of similar income levels (US Department of Health and Human Services 2019). The rate of teen pregnancy in rural counties in the US is substantially higher than any other geographical designation with a rate of 35.9 per 1000 teen girls (Boone 2018). The teen pregnancy rates dipped during the Obama administration due to the implementation of a national teenage pregnancy prevention program, but Donald Trump made significant budget cuts to this program so the rates

began to rise again (Boone 2018). In an article on rurality and opportunity, the authors claim that "There are strong ties between poverty and teen pregnancy, too. Though teen birth rates are currently at a record low — they've dropped 67 percent since 1991 — these improvements have largely been confined to the East and West coasts. While the coasts have improved, the Southwest and Southeast, as well as parts of Appalachia, the Mississippi Delta, and the Plains regions have seen little change over the last decade, according to the report" (Boone 2018). This trend is also highly racialized with the rates of teen pregnancy amongst Indigenous, Black and Hispanic teens being double that of Asian and White teens (Boone 2018).

During my research in the Sunflower Mountain Region, my enrollment was limited to women over the age of 18 for IRB and consent purposes. So, while I was not talking with teen mothers, I spoke with a lot of young mothers between ages nineteen and twenty-two. I also talked with some women who were older but could reflect on their teenage pregnancy experience. One of these women named Abigail gave a thoughtful reflection of her time as a teen mom. Abigail and I met on a summer day in a county library. There was a park outside, so her fiancé took the kids and played while we talked. I found a private room in the library so we could speak more freely. When Abigail first sat down, I could feel her nerves. She is a petite, 24-year-old woman with light blonde hair. She sat down in her chair still wearing her backpack, which made her look uncomfortable but was an indication that she did not really know how this would go or how long it would take. I immediately started to make small talk and asked to see photos of her children to try and ease her nerves more. Eventually when we realized we were the same age and this would be more of a conversation than a formal set of questions,

Abigail seemed to relax. She took off her backpack and settled in more to talk. She told me about her online classes at the local community college and how they were easy for her. She was working as a grocery store clerk but ever since she moved in with her fiancé who is a cop with two kids of his own from a prior relationship, she had been staying home with all the kids. She liked the pace of just doing school and being a mom. When I asked her how old her two children were, she explained that they were ten and seven. “Wow, those are fun ages!” I responded. I thought for another moment and realized that she was only twenty-four, like me. “Oh, wow, ok so you had your oldest when you were fourteen?” I asked. “Yes I did” she said through a smile and giggle, like she was divulging an embarrassing secret that was a little bit funny.

Like I explained in the introduction of this dissertation, I always had an easier time broaching difficult topics when I was talking with a woman face to face. I never wanted Abigail to feel like I had any judgment towards her and that was much easier to establish when we were sitting there talking together. So I asked, “When you first found out you were pregnant, was that something you were planning for or not really?” Abigail explained:

> I guess it kinda was, but it's like, it's like weird. So I think it was like during the break from school, like right before Christmas break, I got a boyfriend, like we were just there and everything. And then we were each other's first. And I just thought I was in love. And I was like, let's have a baby. And I guess I mean being young, you don't really think things through. So like I wanted to because like a year before that, my mom and dad had split up and they were split up for like six months. And it was really hard on me. And I just felt like I wasn't loved or

> anything. So then I was like, if I have a baby, like, they have to love me. Yeah. So I guess it kind of was. But it wasn't the same time.

Abigail delivered this story with a smile, but her words were heartbreaking. She was only in the eighth grade when she got pregnant. She made this decision because she was seeking love and based on everything she knew at that time, a baby was the only way to achieve that. She did not have enough familial and social support. So, when she found out, she was initially excited. But she quickly realized that this was a way bigger deal than what she thought it would be. Her mom and sisters took her to the health department where they did a test that came back positive. Her mom started sobbing in the health department. I asked her how that made her feel and she said, "well, I started crying too. I tried to hold it in, but in that moment, I was like, what have I done?" Abigail continued, "I didn't really think about, like, how it would change my life. My parents would have to take another child. Yeah. I didn't really think about those things. And my older sister graduated high school early so she could help take care of him and me. She took care of me a lot." Abigail's family was very upset by the pregnancy. Her father was outraged and the family knew he would be, so they sent their preacher up to his house to deliver the news. The way Abigail told this story made me imagine a blur of a week of chaos and anger and fear. Despite all of this, fourteen-year-old Abigail was still a little bit happy. She said, "like I said, I wanted someone to love me. I wanted someone to be there. And whenever he came out, I was really happy."

Abigail got pregnant at fourteen to fill the void of her unstable family situation. Betsy Dortch Dalton, a researcher from the University of Tennessee conducted a research study on the experience of young Appalachian mothers who consider motherhood to be

their salvation. Through her in-depth interviews with fourteen young mothers in Appalachian Tennessee, she found a consistent theme of pregnancy and motherhood as filling a void. She writes, “Most of the participants had described family life as disjointed and unstable, leaving them feeling rejected, abused, and unloved.” (Dalton 2014: 10). The woman participating in this study cited turbulent childhoods and feelings of being unloved as a reason for their pregnancy, just like Abigail (Dalton 2014: 12). Dalton also compares this finding to other research and writes, “Similar research has found that young women experience a newfound purpose in their child, a reason to live and love. Girls who had experienced unhappy childhoods were now able to recreate childhood in whatever happy and carefree way they should choose. They report increased self-worth, as well as heightened educational and career plans (Gregson 2009)” (Dalton 2014: 13).

Abigail made it clear that she does not regret having her son, but she reflects that wished she had waited to be a bit older before she had a baby. This pregnancy had a negative impact on her family life. It caused massive strife and made her father unbelievably angry. Her family had to confront a lot of community shame and whispers behind their backs. She lost friends because their parents were worried that Abigail was a bad influence. When I asked her what it was like being pregnant in high school and how she was treated, she said, “A lot of people are like, how did you handle that? I was like, oh no. Just like, you get pregnant, and you have a kid. I just thought, oh, there's no other way out. So, I just did what I needed to do.” Abigail’s statement of “no other way out” reflects a lot of the sentiments of other women with unplanned pregnancies. Instead of discussing how being pregnant in high school impacted her, she explains how she did not

even really think about that because it’s not like there was any alternative. Obviously, abortion was not an option or apart of the discussion.

Courage: Sex Education and “Knocking Down Mountains”

Some aspects of Abigail’s story relates to a 2017 CNN health article titled, “Forget Abortion: What Women in Appalachian Kentucky Really Want.” The article is about how women in rural Appalachia wish they had better sex education and general education when it came to pregnancy and access to birth control. The author writes, “Medical professionals can count on one hand the times they’ve been asked about abortions. Women who’ve had abortions rarely, if ever, mention it. For many, the clinic might as well be in Las Vegas. If you don’t have the means to get to Louisville – let alone pay for the procedure, lodging and child care – what difference does it make if there’s no abortion clinic in the state?” (Ravitz 2017). This is very relatable to the situation in the Sunflower Mountain Region and likely other places in rural Appalachia. On top of the logistics, the religious background of people and families also is a barrier to abortion care. This article also discusses firsthand stories of women growing up in rural Appalachia prompted to sign abstinence pledges in school and not given any information about sex and reproduction. All of the schools in the Sunflower Mountain Region have abstinence-only curriculums. In 2009, the state passed an Act that called for schools to use the following guidelines in their sexual and reproductive education programs:

1. Abstinence is the expected standard for youth.
2. Reasons, decision making skills, and strategies for becoming or remaining abstinent.
3. Strategies to deal with peer pressure.

4. Abstinence is the only certain means of preventing pregnancy and diseases.

5. The best lifelong means of prevention is fidelity in marriage, and the benefits of abstinence as compared to the risks of premarital sex.

6. Factually accurate biological and pathological information related to the human reproductive system.

7. How STD's are transmitted, the effectiveness of all FDA- approved methods for STD prevention, and information on local resources for testing and treatment.

8. Awareness of sexual assault, sexual abuse and risk reduction.

While the final three requirements would provide some more information about sex, this is by no means comprehensive or adequate, and schools are at liberty to teach what they want. The way sex is talked about in schools influences teen pregnancy. I was talking to a maternal health home visiting professional and I asked her if she saw many teens. She said yes and continued, "They have that 'It won't happen to me' stupidity. I mean, not in the mean way. Just some of the things we hear from these kids and people, it's like, ok, interesting! Are you stupid? No, they're not stupid. They're just not thinking. I've had, I couldn't tell you how many eighteen-year-olds, who say, I didn't know I could get pregnant. These kids are sixteen and eighteen, I can't even tell you how many kids say I didn't know I could get pregnant." I asked her if there is sex education at public schools and she sighed and explained, "well, here parents are really up in arms about what you can talk to them about. I can see that as a parent and teacher. If they're not getting it at home, they need to get it somewhere. Because their buddies aren't telling them the truth. It's falling through the cracks. If they aren't getting it at home, and then at school it's real general, like the sperm meets the egg, it's not like here's a condom. I cannot imagine the

uproar if the high school said, we are going to have a sex ed class, birth control, condoms, if they need them. There would be parents at the school board meeting raising all kinds of Cain. But they won't do it at home. Did I want to buy my sons condoms? No. But I didn't want them to be getting girls pregnant or getting STIs or something. Sex ed classes, I think they need them. But they don't have them. You and I could go out here and knock this mountain down before that would happen." This is a problem throughout rural Appalachia and America in general.

Another negative aspect of teen pregnancy is the high rates of high school dropouts that result from it. According to the CDC, only about 50% of teen mothers graduate with a high school diploma (CDC 2022). Interestingly enough, the pandemic may have an impact on these rates. One 18-year-old high school senior I talked with who just had a baby explained that the option for virtual schooling was a life saver for her this year. It allowed her to continue with her education while staying at home with her newborn. She is on track to graduate with her classmates in May. She explained that she imagined that this would not have been possible had this been another year and online school was not an option.

The suggestion that knocking down mountains is easier than implementing an adequate sex education curriculum in schools calls on the wisdom it takes to differentiate what can and cannot be changed. On a practical level ample research has indicated that comprehensive sex education reduces teen pregnancy and sexually transmitted infections (Orenstein 2016). In fact, the most progressive sex education programs bring the best results (2016). Yet on a social and cultural level implementing these programs is nearly impossible. In this situation unplanned teen pregnancies may fall into the category of

acceptance and the things that can be changed is the degree of support teen mothers get from their community.

Courage and Wisdom: "This Baby Saved My Life"

Even though many women I talked with had unplanned and unwanted pregnancies, many of them discussed how having a baby was life-altering in the most positive way. Putting emphasis on these stories and paying attention to the outcomes of unwanted pregnancies through a weak theory lens shows levels of resilience. Angelica was probably the woman who seemed most strongly affected by her unwanted pregnancy. She cried for the entirety of her 9-month pregnancy. She was devastated to find out she was having a baby. So I was surprised to hear her say: "I had baby fever literally the second they put him in my arms." "Really?!" I asked. "Like, it's just so wild how that happened," she responded, "It is like, I would have never, never in a million years, thought that I would have felt that way. You know, all of my friends and my family have always known that being a mom is not for me. It sounds awful, but I'm a selfish person. I like to do my things. I like to have my time. I was really into school. I knew I'm the type of person who would not do that with a child because everything would be about the baby. Yeah, which it should. But I knew that about myself. Like, I have a baby so my world is going to revolve around this baby. And it does. But now I'm OK with it. Actually I love it. Whereas at the time I was like absolutely not." Beyond just loving her life with Michael, she also credits him with saving her relationship with her current fiancé. Angelica and her boyfriend were planning on taking a planned break that was going to start the day after she found out she was pregnant. He was shocked and upset as well. On top of her own trauma and emotions with her unwanted pregnancy, he

was completely unsupportive and absent during it. She said, “And he handled it the wrong way. Right, in everything. Yeah. We ended up splitting through some of the pregnancy. We didn't speak to each other at all for about a month. He ended up seeing another woman for about a month….When I was pregnant, I was so terrified that he was just going to be either an absentee father or just not a good one. Yeah, and. As much as he did not want this pregnancy, he has done so well.” Angelica did not imagine a future with this boyfriend, but the birth of Michael turned things around. She said, “He, thankfully, has turned out to be the best dad. The best.” They are now engaged and living together in a house they bought. She credits prayer, relationship counseling, and the birth of Michael for the level of happiness and fulfillment she has in her life.

In July 2021, I met with a woman named Maria. She was single, living alone, and seven months pregnant. She was sweet and bubbly, but I could tell she was nervous about this pregnancy. “I’m 32 years old, but this was unplanned. I never thought I would be a parent. It just happened, so now I guess I’m doing it,” she explained when I asked her about her pregnancy. She was stressed about her finances as a single mother and the support for childcare. Additionally, she has bipolar disorder and she had to alter her medication during the pregnancy which was affecting her health negatively. We had a pleasant conversation about her experience and then parted ways. I was surprised when I got a text from her in September saying that she had her baby and would love for me to meet her and ask her any more questions. We met on an early fall morning at a 24-hour breakfast place. I walked into the busy cafe full of who I guessed were likely regulars and found Maria sitting there with her tiny newborn. Something about Maria was different. Her smile came more naturally and her nervous giggling and energy was gone. She

seemed to be glowing. A waitress came over to take our order and told Maria that she had an adorable baby. Maria grinned and thanked her. “People say that everywhere I go!” Maria beamed. She told me about the details of her birth which was actually surprisingly easy. Maria echoed Angelica when she said, “as soon as she came out, I wanted another one immediately.” “Really?” I asked. This surprised me. Maria’s pregnancy was unwanted and she was nervous about being a mother. She did not think it was for her. But suddenly the birth of her daughter changed everything. I asked her about getting back to work at a local restaurant. She absolutely loved her job and when we talked over the summer she expressed that she wanted to get back to work as soon as possible after she had the baby. “I mean, they said I can come back when I feel comfortable but honestly I don’t think I will. Her daddy is working full time now and childcare is just too expensive, so I might as well just stay at home. I don’t ever want to leave her anyways. I love being a mom.” I told Maria that I was surprised to hear all this based on our conversation in July. She said she was surprised as well. She explained: “This baby has made me grow up. I know that sounds silly because I am 32 years old, but I just wasn’t grown up. I was drinking a lot and using drugs a lot. I was just partying and wasn’t grown up. I only met her dad at a bar 1 month before I got pregnant with her. When I got pregnant, I stopped the drinking and drugs. I kept smoking but that’s the only bad thing I done. I needed her. I might have died without her. This baby saved my life.” As I watched Maria hold and look at her baby, I knew exactly what she meant.

Using weak theory to pay close attention to her actions and approaches to motherhood before and after she had her baby, it becomes clear that Maria exhibited courage in the face of her unwanted pregnancy. She quickly accepted the fact that she

could not change her pregnancy and decided to use that to push her to make positive life changes. It was not easy for her to quit drinking and doing drugs during her pregnancy but she felt motivated by her baby and pushed herself to do so. The alcohol and drugs were negatively impacting her bipolar disorder, so when she got sober for her pregnancy she found that her medication worked better and she felt like she had more control over her life. I asked her if she was more nervous about postpartum depression and anxiety because she had pre-existing mental health concerns, and she explained that having bipolar disorder actually helped her be more prepared for any postpartum mood and anxiety disorders she may experience. “I know what it feels like,” she explained, “So I can tell the signs easier. And when I know I am getting to a bad place I know to call my doctor and I already have my meds ready to go. I think a lot of women are caught off guard with the depression and anxiety but since I been dealing with this my whole life I feel more ready to handle it.” She explained that overall her mental health had improved dramatically since the birth of her daughter.

Dalton’s study had similar findings to Maria’s story. Dalton found that nearly every participant mentioned drug use and abuse in her interview. One mother she worked with, like Maria, used her pregnancy as a way out of her addiction. While Maria was able to stop using drugs during her pregnancy on her own, many women living in Appalachia face extreme gendered and classist barriers to seeking substance use treatment (Buer et al. 2021). In an article on drug use and pregnancy, authors discuss the barriers to substance use treatment during pregnancy. They write, “The particular regional context of Appalachian parents seeking substance use treatment that may be at once out of reach and also threatening to their chances of maintaining child custody is, we argue, a unique form

of gendered and stigmatized pregnancy surveillance for PWUD (People who use drugs) here" (Buer et al. 98).

Drug use during pregnancy is an issue that must be taken seriously, but I do not have extensive ethnographic data on this topic as it was not the focus of this research. What I do know is that drug use is a common conversation in this region. While living in the Sunflower Mountain Region, I joined the county recreation center and used the gym there very frequently. I became friendly with one of the front desk workers who I saw every day upon entering and exiting. One day I was talking with her about the busiest hours of the day and she explained that in the afternoons there are a ton of kids running around in the center. "Wow, that sounds hectic," I said. "It is," she replied, "but I love to see it. You know, it's hard to be a kid around here. There isn't much to do and then they end up getting into drugs. I would much rather see them hanging out and being busy around a place like this."

By placing the theoretical emphasis on the juxtaposition between the structural and cultural factors that pinned Angelica and Maria into a traumatic and unplanned pregnancies and the positive outcomes their babies ultimately had on their lives, we can see the openings that Gibson-Graham encourage. This use of weak theory also moves away from falling into the deficit framings common in social sciences. Angelica and Maria both experience financial, mental health, and emotional hardships in their lives as parents. They both discuss how they have life trauma and problems that their babies cannot solve. But the unexpectedly positive aspects of their unintended pregnancies is not trivial: it is an indication of resilience in everyday life.

Conclusion: Serenity, Courage, and Wisdom

I also became friends with one of the women who worked in janitorial services at the recreation center. Her name is Tammy. She wanted to start working out so we met up a few times per week so I could show her some basic exercises to get started. Tammy wanted to start exercising to feel better about herself. “I don’t know if you know this Sia,” she said one morning as we laid down yoga mats, “but I have a past. I was addicted to meth for 15 years. I went to jail too. But through God I know I can do anything now. He has changed my life.” Tammy has a 13-month-old daughter who is the center of her life. “This is my baby,” she said while showing me a series of photos on her phone. “She is my reason why. I want to give her a great life.” Tammy’s sentiments here mirror Maria’s. Her baby daughter has changed her life and given her motivation to push through challenges in her life. One day Tammy and I were talking while she was working and I was walking into the gym. She was asking me questions about what I do and my school and I explained how I was doing research for my PhD. Tammy said, “Wow, that is so impressive. You know I used to get discouraged when I would see people like you who are doing so much when you’re so young. I used to compare myself. But now I know that I can’t do that. I have been through a lot and I’ve made it. I just need to accept that my path looks different but I have so much to keep showing up for even if it isn’t how I imagined.” Tammy embodies the Serenity Prayer. She is able to accept what she knows she cannot change, she had the courage to overcome the things that she felt she could change, and in this moment, she shows the wisdom and reflection of knowing the difference.

Sedgewick, Gibson-Graham, and Stewart all employ weak theory with the goal of using theoretical engagement in a reparative way as opposed to a paranoid way(Stewart 2008). Through attention to the ordinary and small everyday moments, social phenomenon such as the presence of resilience become clear. Instead of focusing on oppressive forces of power and capitalism on a broad scale, weak theory allows us to look closely at local worlds and moments to theorize from the ground up. Additionally, a weak theory approach welcomes unconventional framings, such as the use of a prayer to discuss pregnancy in rural Appalachia. The Serenity Prayer is a useful framework to live life by regardless of religious identity or orientation. The tools of weak theory highlight moments that show how the tenets of this prayer can frame the pregnancy and motherhood experiences of many women living in rural America. I argue that this framework is especially relevant in places like the Sunflower Mountain Region when thinking about pregnancy, birth, and maternal health. I saw pregnant women, mothers, and health professionals using this as an unspoken guide to their work in the context of obstetric shortages and barriers to health birth especially during a global pandemic.

In this chapter I could have used Foucault's concept of Governmentality and Biopower to talk about the unavoidable treadmill of inequality that marginalized women must run on forever, and I would not be wrong or misled. But in my fieldwork I witnessed too much resilience fueled by serenity, courage, and wisdom to let the cruel structures of America have the final word. In the conclusion to this dissertation I will summarize my findings and make concrete suggestions for the future of pregnancy care and experiences in rural America.

CHAPTER 8. CONCLUSIONS

This dissertation has explored the risks, barriers, and agentive strategies that women in the rural United States experience and cultivate when obstetric services are closed and the ways pregnant women, mothers, and health professionals navigate accessing care when it is neither proximate nor ideal. Through engaging with the narratives of pregnant women, mothers, and health professionals, I have demonstrated the impact of these closures on individual and community levels to show how rural Southern Appalachia (and US rural regions in general) act as sacrifice zones for birth and maternal care. By this I mean that positive pregnancy and birth experiences and the safety of women in rural Southern Appalachia are sacrificed to uphold finances in the precarious US healthcare system. On a larger level, this in itself is a form of stratified reproduction. Women living in rural areas have far fewer choices in birth which results in wide disempowerment and ultimately, worse birth outcomes than their urban counterparts (Kozhimannil et al. 2018). Women who are further marginalized by their racial, class, or citizenship status experience even more negative consequences and inequalities of stratified reproduction. This dissertation also documents the novel struggles of pregnant women and mothers in rural areas amidst the COVID-19 Pandemic. I hope to have highlighted both the inequalities and structural violences that rural women face which are exacerbated when they are poor, a woman of color, or a non-US citizen.

I have also demonstrated the everyday resilience and solidarity present in rural Appalachia through ethnographic examples of women accessing maternity care, supporting each other, and professionals acting as social justice advocates. Based on the

ethnographic data, eliminating obstetric services puts women's physical and emotional health, wellbeing, and safety at risk. This is disempowering for women who live and have children in rural Appalachia. Of course, resilience in the face of obstetric closures is very present in the Sunflower Mountain Region through the actions and attitudes of pregnant women, mothers, and health professionals. It is critical to highlight that resilience to push back against deficit framings of rural health inequalities. While resilience is admirable and can be empowering, it is also exhausting. Several women I talked with exhibit high levels of resilience when facing obstetric shortages and a lack of birth choices, but resilience should not have to be the answer. People get tired of being forced into resilience by the structures in their lives. Through ethnographic narratives in this dissertation, I have followed the thread of the connection between risk, resilience, disempowerment, and empowerment and how they accompany the lived experiences of rural obstetric closures.

Based on ethnographic material provided throughout this dissertation, I have identified several main findings. In this concluding chapter, I summarize each finding: 1) Limiting choices is always disempowering and doing so makes a statement on the value of rural lives. 2) Disempowerment is increased when marginalization is increased. 3) If you have been to one rural community, you have been to one rural community. 4) We can and must do better for women in America. And 5) This is not hopeless. Additionally, I provide several suggestions to alleviating the stressors and negative health outcomes that are consequences of obstetric unit closures. These include expanding who gives maternity care, designing more effective programming, capitalizing on the strength of solidarity in rural communities, using the lessons of the COVID-19 Pandemic to question how

pregnancy is viewed in America, and calling on the state to provide more support. These points and suggestions are intended to propose practical solutions based on the research findings, but they also contribute important nuance to anthropological studies about stratified reproduction, resilience and solidarity, and health in the rural United States. Taken together, these conclusions provide steps for change while also highlighting the ways that limiting choices in maternal healthcare results in disempowerment. Looking closely at disempowerment during pregnancy and birth is important to understanding and identifying inequalities in maternal health throughout the rural United States and more broadly. Additionally, discussing the solutions and hopefulness of future pushes back against deficit models present in social science especially when discussing rural areas. Rather than rendering rural communities expendable in public health, policy, and popular culture, the experiences and narratives in this dissertation show the lived consequences of rural health inequities and the resilience necessary for survival.

Wrapping Up Fieldwork

In my initial proposal and plans for this project I outlined various community engagement projects to implement throughout my research. Because of the logistics and restraints imposed by the pandemic, I could not do these things as I had planned. For example, I wanted to hold bi-monthly maternal health professional connection breakfasts to help professionals in the area with idea sharing and support. I am disappointed that I could not do this. Key strategies of feminist methodology which contribute to nuanced and honest ethnography are dissecting failures (Visweswaran 1994) and approaching ethnography with humility and self-awareness (Abu-Lughod 1990). In reflecting on my own disappointment in being able to connect professionals in the area in the way I had

planned, I also considered the ways these meetings may have contributed to the labor that overworked professionals would take on. Perhaps I could have attempted to do this in a Zoom meeting, but that would have complicated the logistics of providing a meal and fostering a more informal, conversational, environment. But as feminist ethnographers Abu-Lughod (1990) and Stacey (1988) explain, there cannot be a true feminist ethnography because of social and power binds that restrict full equity and understanding (1990). As feminist anthropologist Kirin Narayan establishes, the insider/ outsider, native-non-native dichotomies are of limited productivity and instead “at this historical moment we might more profitably view each anthropologist in terms of shifting identifications amid a field of interpenetrating communities and power relations” (1993: 671). Blurring these boundaries and shifting the perspective on fieldwork can help decolonize unequal power relations and exploitative tendencies in the field, or in other words, doing “homework” as fieldwork in reverse to interrogate everyday life and privilege (Visweswaran 1994). I found that when conducting phone interviews and other remote work, the researcher-participant boundary was harder to blur. When I was unable to see the person I was talking with, the formal structure of an interview (I question, the other person answers) was harder to break. In person, it is easier to blur these boundaries and move into a conversational space where the person I am talking with is the expert on this research topic.

There were a few ideas that I could implement. In summer 2021 I capitalized on the window of time post-vaccination, pre- Delta variant and connected with a YMCA in Rita County. I worked with the aquatics director to offer a series of free swim lessons for the community. I offered a parent and me class, which is very beneficial for mother child

bonding and neurodevelopment of babies (Jorgenson 2012). I offered this class for 30 minutes two times per week. The attendance fluctuated because we did not require any signups or commitment, but I worked with about seven different families and their babies over the course of the summer.

While I was teaching lessons at the YMCA, I noticed that a lot of parents asked about swim lessons for toddlers. The YMCA and county did not have any swim lesson programs at all for this age group. I frequently talked with the aquatics director who explained that a lot of the challenges she experiences is that this region just does not have a culture of swimming. As a sport, Swimming in the US tends to be overwhelmingly middle-class and white (Layne et al. 2020) due to histories of exclusion of people of color from swimming (NPR 2008) and the general lack of accessibility of pools and swim facilities (Lo et al. 2017). Swim lessons also tend to be very expensive, so a lot of families are not able to enroll their children. We decided it would be beneficial for the community if I were to offer free group lessons to kids ages 3-10 and see if we had any interest. As it turns out, we had a ton of inquiries and people wanting to enroll. I ended up holding these classes between July 2021 through the end of 2021.

While drafting my dissertation I also worked to compile my research results and analysis into reports to send to a variety of state and national organizations working on maternal health. I am in contact with a team of researchers working on this topic and we collaborate to share insights. Finally, I am working on a separate version of presenting this data for women who participated in the study. Every participant was interested in seeing the results of the study.

While breakfast hours with professionals were too complicated to organize, I am organizing breakfasts and lunches at the organizations that helped me recruit participants and who I would have worked with if in-person volunteering was allowed (the pregnancy crisis center and WIC at the health department). During these events I will provide food and refreshments and give an informal presentation summarizing my results and answering any questions. Because I will be presenting to health professionals, I hope that these events will bring about conversations on the experiences of pregnant women and mothers in the region attempting to access pregnancy care. Through compiling ethnographic narratives and discussing disempowerment, lack of choices, increased risk, and the tolls of resilience, I hope to brainstorm ideas on how professionals (who also work within webs of limited resources and power) can support women having these difficult experiences. Additionally, I plan to stay in touch with the people and organizations I worked with during this year to continue to collaborate on solutions, support, and ways to advocate for policy-change.

Figure 8.1: The advertisement the YMCA posted for my Parent and Me Class.

Figure 8.2: The advertisement the YMCA posted for my free swim lessons.

Contributions of Anthropological Research

As I explained in the introduction to this dissertation, my research helps illuminate the stories and lived experiences behind the dots on the map that mark where obstetric units have closed in the rural United States. While these stories are interesting and often cathartic for people to tell, I argue that they are critical to creating and

informing public health policy. Anthropologist Dave Campbell explains why anthropology is scarcely included when developing public health policy: "The reason for anthropology's minimized role in health policy development is likely founded in its primary methodological approach: ethnography. Thanks to an unabashed focus on individuals and small groups, many involved in the process of policymaking have argued that the data that generated by anthropological research is less valuable because it does not lend itself to broad 'scientific' extrapolation, as does epidemiological data. Ethnographic research involves observing and conducting interviews with a small group of people. With such small numbers, it is possible to argue that these individuals could easily be unrepresentative of the general population" (Campbell 2011:2). Campbell's observation is true. This study only considered the perspectives of a relatively small number of people in a relatively small region in rural Appalachia. Therefore, statistically-minded public health professionals often dismiss this type of research as unreliable and unworthy of serious consideration. Yet it is important to consider the fact that public health involves health sciences as well as community and interpersonal interactions. When policy fails to consider the people it is created for, it will likely not be very effective.

This anthropological, ethnographic study contributes unique aspects to how obstetric closures are viewed and how interventions can be developed to combat the negative effects of closures. Anthropological methods are effectives in qualitative data collection and analysis which can contribute more nuance to policy, ultimately making it more appropriate and effective. In his article, Campbell provides four concrete ways anthropology can impact public health policy in ways that other fields such as

epidemiology cannot (Campbell 2011). The first is the ability to consider culture and context in a social world. My study focuses on several cultural concepts, a notable one being the religiosity of many women I spoke with and their actions, views, and considerations surrounding reproduction. An ethnographic approach allows social factors such as religion and family life to be considered as prominent factors in public health. The second contribution anthropology has is the ability to consider the whole. This includes acknowledging and incorporating lessons learned from details that may seem small and unimportant but are in fact critical. This happens through looking closely at individual people's lives and the structures that cause them to make the decisions they do. An example of this in my research is the detail that several women explained how they chose to schedule an induction because they were worried about giving birth on the side of the road if they did not make it to the hospital in time during labor. This intervention during birth may not seem like it is directly related to obstetric closures, but interviews reveal that in fact it is. The third way anthropology is of value to public health is its critical lens especially "its freedom from the theories and views of western biomedicine" (Campbell 2011:5). Listening to the birth narratives of women in the Sunflower Mountain Region and coding the similarities in the data revealed how many women experienced levels of intervention that caused them physical and emotional injury. As opposed to a biomedical or public health approach, anthropology enables an approach that can lay out the costs and benefits of American hospital care that is normalized and thereby imagine solutions that can occur outside traditional ways of thinking. For example, in my research I argue that increasing holistic care through midwives, doulas, and home births can be a solution to obstetric closures. The final contribution Campbell

identifies is simply the immense value of qualitative data. Public health approaches can be overly statistical and force people and problems into concrete categories. But people, problems, and solutions are not so easily defined. Campbell writes, “Many of the categories that are used are in essence constructs of the investigators and do not even exist in the worldview of the informant. This creates a false perception of reality in the minds of policymakers that cannot be avoided through structured, quantitative analysis” (Campbell 2011:5). Clearly, anthropology can make massive improvements to public health policy and ethnography is a vehicle to generating creative, nuanced, and effective solutions. Based on my ethnographic project I have determined several primary findings and potential solutions that can apply to public health policy. I will discuss these in the remainder of this chapter.

What is Being Done

The fact of the matter is: obstetric services and maternity units are closing rapidly in rural America. But throughout my fieldwork I also found that there are several things being done to combat the negative effects of these closures. One of the most impressive examples of this I saw was that of a small rural hospital located about two hours off the mountain. The county this hospital is located in lost its only maternity unit in 1991 when it closed due to the same issues I discussed in Chapter 4: a lack of funding and decreasing staff. In 2020, the state university, local non-profits, and health professionals worked together to reopen a maternity unit at the local hospital. This move is unprecedented in the United States. To my knowledge, no rural county that has closed an OB unit has ever reopened one. I was pleasantly surprised and intrigued to read about this hospital so I

decided to reach out to the CEO and see if he would like to talk with me. I emailed him and his assistant quickly responded to schedule time for a phone call.

The CEO, Joshua Samuels, explained that they are very proud of this model for reimplementing maternity care in the county. They managed to connect the new unit with primary care to fill too substantial needs in the area. Mr. Samuels said:

> There's a challenge across the country with increasing maternal death rates, infant death rates, and much of that is associated with the lack of access to prenatal care and proximity to actual labor and delivery care. And so working with our colleagues at the university school of medicine, they really developed this concept about how we could, redevelop a program really based not from an obstetrics base of care because that's one of the primary driving factors with maternity programs closing, that they are unable to, they don't have the volume, they can't really afford to recruit, not just one but multiple obstetricians to be able to provide 24/7 care that they do.

The challenges I discussed in Chapter 4 include low patient volumes, a lack of workforce, and unaffordable expenses. These problems are all closely associated with obstetrics. So instead of basing this new unit in obstetrics, Mr. Samuels explains how they based it in primary care:

> And so this was intended to be more of a cost effective and sustainable solution. Specialists like obstetricians, one of the dynamics I'm sure you're aware of is many of them don't want to practice in a more rural environment whereas with family medicine physicians, they are more inclined to operate in those type of

> environments. So it assisted with recruitment, it assisted with the cost sustainability of the model, so that was sort of the impetus. And then when you look at it from the public health aspect in many rural counties like we said they have a challenge with this, and our county is no exception to that. Even though we're a neighboring county to more developed areas but given the size of the county it means that many others are having to drive 30 minutes or sometimes closer to an hour in some circumstances to reach a site that can, that they can deliver their child at. So, you know it was a way both to meet the county needs but also to develop the model that could potentially be duplicated across [the state] and even potentially across the country.

As Mr. Samuels points out, this new system is excellent for physician recruitment, especially because they are partnered with a university medical school. Research shows that medical residents who do their training in rural communities are far more likely to have a career practicing in a rural community which generates more rural physicians (MacQueen 2018). This new model and hospital have been doing very well and the community is overjoyed with the opening. Prior to opening this unit, physicians held a series of listening sessions with the community to bring county-residents to the decision-making process. This maternity unit opening represents a hopeful move and provides a functional model for potentially doing the same in other rural counties.

Another positive move that is occurring in the Sunflower Mountain Region is the proliferation of home-visiting programs. As I discussed previously in this dissertation, maternal home-visiting services are critical to improving prenatal and postpartum health (Adirim & Supplee 2013). These programs provide an accessible, trained health or social

worker to aid pregnant women. Social support is critical to how women experience pregnancy and birth, so having a home visitor as an advocate and support person proves to be very helpful when resources are not accessible (Novoa & Taylor 2017). There are two major home-visiting services in the Sunflower Mountain Region. One has been operating for a few years but has recently started to expand. The other just secured grant funding and launched during fall of 2021. These programs are completely free of cost to the participants. The expansion of home-visiting programs makes them more available to more women, which is a very positive move. Home-visiting provides answers to many of the problems discussed in this dissertation. When healthcare closes and options are far from women's homes, it becomes difficult to make it to appointments. Having an at-home option is invaluable and can save women money on gas and childcare.

Several local health and non-profit agencies are constantly applying for grant funding to support maternal health initiatives. For example, the health department instituted a program that helps pregnant women quit smoking while also providing free diapers and bottles. One program last year even provided free doula care to any interested women. Grant funding is precarious and short term, but local professionals are constantly pursuing opportunities to find more money to increase resources and support for pregnant women and mothers.

Primary Ethnographic Findings

Throughout my research and data analysis I was constantly trying to think of conclusions and takeaways in brief, one-sentence form. I found this to be a productive way to organize my own thinking amidst a sea of interview transcripts, notes, and codes.

Additionally, inaccessible research is frustrating and unhelpful. Decolonizing anthropology and using vulnerability and reflexivity in methods to do so can create a critical tool to understanding society which impacts every facet of life. Therefore, it is important to mobilize and make anthropology easily accessible to the public. The ultimate goal of making anthropology accessible and integral to everyday life drives how I think about ethnography and research. Like decolonization, if engagement is the goal, it needs to be in the forefront of thought at every step in anthropological reading, researching, teaching, and writing. As anthropologists Baker (2004) and Low & Merry (2010) point out, anthropology began in the public sphere. Franz Boas was forced to publicly discuss race as a social construct and debate anthropological issues in the mainstream media (Baker 2004), but the public focus changed when the Cold War brought a host of funding to universities to establish tenure streams for anthropology professors which pulled them towards academic institutions. Additionally, the rise of McCarthyism threated publicly engaged anthropologists due to suspicion of communism, perhaps rightfully so in some cases (Merry and Low 2010). This institutional shift that pushed and cemented anthropology in the ivory tower had a significant impact on the degree to which anthropology and anthropologists could engage with the public. Many anthropologists discuss engaged and activist anthropology, and every single one cites the structure of the academy (tenure requirements, service and labor, professional risk, academic jargon) as a hindrance to public engagement. As I produce these short takeaways I keep in mind Mary Pratt's criticism of the discipline: "How, one asks constantly, could such interesting people doing such interesting things produce such dull books? (1986: 33; see also Agar 1996: 5)" (Waterson 2009).

I will now present my biggest conclusions in this format.

1. **Limiting choices is always disempowering and doing so makes a statement on the value of rural lives.**

As I explained in Chapter 3, women living in the Sunflower Mountain Region have very few options during pregnancy and birth. Not only are they unable to choose the hospital they go to, but there are no proximate options for birthing centers or more holistic options. Home birth with a midwife is illegal. Within the "everyone sees everyone" system, women cannot even choose their provider. They must give birth with the person who is on call when they go into labor. In hearing the birth narratives of women in the Sunflower Mountain Region they consistently were characterized by a lack of choice at every turn. I imagine this scenario as chipping away at a block. With every new closure or rigid system developed because of a closure, options which one would consider the bare minimum (ie. the ability to decide which provider will deliver your baby) are removed. The removal of choices is rarely replaced with any new alternative options.

Birth Justice is dependent upon empowerment. Empowerment comes from the ability to make choices. The removal of choices is disempowering. Hospital CEOs who must make these decisions based on funding, personnel, and birth volume often have no choices themselves. With obstetrics as a "loss leader," it stands out as the only real possibility for service cuts when the tightness of money becomes untenable. Obstetrics is a loss leader because Medicaid does not reimburse at adequate rates. Rural hospitals tend to have a high percentage of Medicaid births, so the debt adds up quickly. The decision-

less corners that rural hospital CEOs are pinned into speak to the lack of value placed on rural communities in the United States. Ultimately, babies are the future. The devaluation of obstetrics in rural communities represents the devaluation of the continuance of rural communities altogether. This trend compounds on a long history of rural disregard and stigmatization in the United States.

2. Disempowerment is increased when marginalization is increased.

As I explained, rural birth exists in the intersection of sacrifice zones and stratified reproduction. Rural women are already less supported in birth, so when rural women have marginalized identities, support and encouragement in pregnancy is essentially nothing. This fact emphasizes the importance of anthropological attention to intersectionality and understanding how multiple identities and social positions play into social inequality. In my research I aimed to recruit women with diverse backgrounds but I was not successful in doing so. I primarily spoke with white women. Recruitment during COVID posed many challenges and I was not able to recruit many women of color due to my own racial background and the lack of in-person methodology. One woman named Rose who is originally from Mexico reached out to me to do an interview, but she wanted to type out her answers and send them before our conversation because she was not completely confident in her English-speaking ability. She sent me the responses, but we lost contact during scheduling an interview and we never had our conversation. In a recent study, Altman et al. found that women of color felt as though their interactions with care providers during pregnancy were disempowering because providers were rude, disrespectful, and presented information in ways that limited their birth choices (Altman et al. 2019). Although I could not learn as much about Rose as I

would have liked, in response to the interview question about feeling disrespected or misunderstood by providers she wrote, “This last pregnancy was particularly different. In the free clinic I attended, I did not feel that some nurses would have liked me, in one of the consultations, when the nurse arrived, she gave me the bottle for the urine test and after that she asked me what was the reason for my visit, I already had a big belly. I told her I was there for my prenatal care, but she made me feel like I was out of place.” This interaction Rose experienced is consistent with the dynamics Altman et al. find between pregnant women of color and providers and is disempowering because of the condescending and disrespectful ways they are treated by providers.

As I discussed in Chapter 6, women with lower socioeconomic status experience pregnancy and birth entirely different than women who have more money and resources. Everyone’s choices are limited in the Sunflower Mountain Region. This stratifies rural women’s birth experiences because constant obstetric closures and elimination of birth choices is a way that rural women are not supported in birth. Within rural communities, women who experience further socioeconomic marginalization face more barriers and feel even less support in their pregnancy and birth experiences. This shows the importance of keeping intersectionality at the forefront of thought while thinking through these inequalities and coming up with solutions.

3. If you have been to one rural community, you have been to one rural community.

This research study takes place in rural Southern Appalachia. I hope that these findings can translate to inform similar issues in other rural communities, as rural areas

tend to face similar challenges to one another (Rural Health Information Hub). But rural generalization and stereotyping often causes more harm than help because it lumps different areas into the same category making solutions not as effective for all rural places. Rural America is a diverse place. In a brief on redefining rural America, authors Olubenga Ajilore and Caius Z. Willingham write, “Rural America is not homogenous and should not be discussed or treated as such. In order to properly address the issues facing rural communities across the country, advocates and policymakers must understand the diverse nature of rural communities and the various systemic challenges they face” (Ajilore & Willingham 2019: 3). The authors explain how significant populations of Black, Indigenous and Latinx Americans live in rural America. Additionally, immigrants in rural counties make substantial contributions to community and economic life and account for the reversal of rural outmigration trends (Ajilore & Willingham 2019). The Movement Advancement Project (MAP) finds that approximately 2.9 to 3.8 million people living in rural America identify as LGBTQ. Disabled people also face more structural barriers in rural America due to financial strain, inaccessibility of healthcare, and increased isolation (Ajilore & Willingham 2019). The authors conclude that “policymakers must resist stereotypes about rural areas that erase the struggles of marginalized rural communities, acknowledging that the intersections of racism, sexism, homophobia, transphobia, xenophobia, and ableism compound barriers to economic mobility and stability in rural areas” (Ajilore & Willingham 2019: 5). The way narratives of rural America are portrayed often erase people who are marginalized which only contributes further to their marginalization.

Beyond the wide diversity in identities within rural America, there is variety in types of industries and economies. National narratives that freely circulate in the US assume that rural America relies entirely on agriculture and mining (2019). While these are significant sources of industry in many rural counties, construction, manufacturing, and service often outnumber these fields in employment. The media and popular depictions of a stark rural-urban dichotomy have encouraged generalizations which assume the homogeneity of the rural United States. Yet clearly these depictions are untrue and cause harm through the erasure of various people and the ways stereotypes seep into policy-makers imaginations and influence the policy agenda. Additionally, the dynamics present within each rural community are entirely different, just as Chicago is different from New York City. This is a very important point that has a lot of influence on rural health issues.

After having such a positive and productive conversation with Mr. Samuels about reopening a maternity unit in a rural county, I asked if he thought that this model would work anywhere or if his county had defining attributes that enabled the reopening to succeed. He agreed with my question and explained, "we are a unique county as you said, we tend to have a younger population. But we're also a little bit, I describe this county as being the tale of two cities because in the eastern part of the county you have a very affluent area that tends to be a little bit older, but there are younger families moving in and that tends to be more bedroom communities to suburban areas. Then in the western part of the county where our hospital is, it's more of an economic disadvantaged community, it is more diverse, and um, that's really where our program is really more focused on from an access standpoint is trying to, we work with the health department,

we work through a federally qualified health program to be able to reach those communities, and then have their maternal care with us." It is excellent to hear that this new maternity ward is catered to historically underserved communities. But even within Mr. Samuels' brief answer, it is clear that this county has a unique setup of income inequality and racial diversity. Additionally, this hospital is partnered with the extremely well-endowed nearby state university. The medical school at the state university has a vested interest in creating more partnerships for student and residency training. The proximity to the university also ensures a steady flow of obstetricians and family practitioners which is necessary for the new unit. Without these unique attributes, this new maternity unit plan may not work. Therefore, the rurality of the county is important, but other qualities also determine the effectiveness of health interventions.

I do not bring this point in a hopeless way to slander good ideas, but instead to call attention to the fact that problems in rural communities must be approached with careful, nuanced thinking influenced by local demographics, dynamics, and voices. Rural communities are too often lumped into a mass category. Rural areas demand and deserve more careful and critical attention.

4. We can and must do better for women in America.

Throughout interviews and data analysis, this statement constantly ran through my mind. In prior chapters I have discussed the state of maternity leave in the US and how little support pregnant women and mothers are given. This is not the case everywhere in the world. According to data compiled by the Organization for Economic Cooperation and Development, The United States ranks last among countries of similar

economic development in government-mandated paid leave for new parents (OECD). For example, Sweden offers the most generous family leave time in the world. Swedish parents are entitled to a combined total of 480 leave days where they are paid 80% of their regular income (Killian 2011). The parents can split this time at their discretion, but fathers are required to take 60 of the days at minimum (Killian 2011). These days can be taken anytime between the birth of the child until their eighth birthday (Killian 2011). For the same reasons that FMLA disproportionately causes economic harm to people living in precarious situations in Appalachia, Sweden's generous parental leave policy creates more financial equity and opportunity across social classes. This policy also has further reaching effects on other social issues such as giving employers no incentive to not hire women who may have a child and need time off from work because both mother and father get paid leave (Killian 2011).

Based on my field work, paid maternity leave would alleviate many stressors that women face during pregnancy. Women often talk about having to push through working hard while pregnant to save up enough money to take a minimal amount of time to care for their baby postpartum. Giving women and families more support during this time would be invaluable. During the COVID-19 pandemic, many relief packages, unemployment extensions, and increased benefits were offered to Americans making it the first time the US had a legitimate social safety net. This support certainly helped pregnant women and mothers in the Sunflower Mountain Region. But the precarity and uncertainty of the duration of this help kept stress levels high amongst pregnant women who were struggling to make ends meet and plan for the future. More financial support for women would be very helpful. Another problem I saw frequently was the incredibly

high cost of childcare in the area. Options are scarce and expensive. One woman I talked with explained that she wanted to return to work, but she would end up spending all the money she earned on childcare, so she might as well stay at home. Prioritizing more accessible options available to all women in low-resource areas would make a substantial difference.

In addition to financial support, women need more interpersonal support during their pregnancy and birth. I listened to so many women discuss their chaotic and traumatizing birth experiences that involved procedures and interventions that they were unaware of and did not consent to. The implications of this are life long and women often cited that as a trigger for exacerbated PMAD. The US healthcare and medical system tends to be hard to understand and difficult to navigate. Having an informed advocate like a doula who can be a trusted supporter and champion for women during birth is invaluable. Even for women who do not want a more holistic birth, having a professional work with you through your pregnancy to support and advocate for you should not be a privilege that only some women can pay for. State and government funded programs for doulas that could provide these to women could alleviate the trauma that many women experience in birth.

5. This is not hopeless.

At many points in my research it seemed like rural obstetric closures and their impact was a problem that was unsolvable. Healthcare in the United States is a commodity, not a right. The elimination of rural obstetric services is a direct consequence of the business of healthcare. When the money is not there, the services cannot be there

either. Obstetrics is a loss leader. Rural areas experience more financial strain than suburban and urban areas. But the number of engaged professionals and women who are passionate about supporting their community indicates that the future is very hopeful. While commitment of local professionals is necessary to curb the negative effects of obstetric closures, it is important to do everything possible to support these people with resources. Additionally, I argue that hopelessness is an easy feeling to rely on that plays into constructing rural Appalachia as a sacrifice zone. If there is no chance of making things better, why not just continue to sacrifice rural areas and reap the benefits elsewhere?

Another point that is very hopeful is the scholarly and media attention rural maternal health has garnered in the past five years. Beginning with the research by Kozhimannil and her research team, various researchers and media outlets have covered the issue of rural obstetric closures. Research and focus on rural maternal health in other countries, specifically African countries, is often at the forefront of focus when it comes to maternal health initiatives. In the past several years more emphasis has been placed on these issues within the United States as well. The commonwealth fund, US news, CNN, and NBC have all covered stories on rural women in the United States struggling to access care amidst this crisis. The extensive coverage of this issue is important. I have seen this increase substantially over the course of my own graduate education. In my early days of course work I would google these questions and only find a few results. Now, you can see pages of articles that highlight the crisis. In spring of 2020, the Center for Medicare and Medicaid Services posted a call for information about rural maternal health and obstetric closures asking people with expertise to write briefs for

governmental consideration. I was thrilled to see that CMS was asking about this and submitted a statement. I look forward to following CMS and seeing the resources and initiatives they produce in response to the data they received in their call for information.

Lessons and Suggestions

As I previously explained, anthropological approaches can help generate effective solutions to public health problems. Based on my ethnographic findings, I have identified a series of solutions that could improve the maternity care problem in rural America.

1. **Expand who gives maternity care.**

Based on my research, the expansion of the maternity care force would help provide rural women with more choices thereby creating more empowering and positive birth experiences. As I discussed in Chapter 3, home birth is very limited in the state I worked in and most other states in the US. Additionally, midwives and nurses have limited control over the birth process and typically must be overseen by a presiding physician or OBGYN. Some states have made this shift and allowed these professionals to have more authority in birth which has had very positive health outcomes (Hostetter & Klein 2020). The restrictiveness and surveillance of midwives and nurses during birth centers patriarchy and biomedicine as the presiding authoritative knowledge system. Understanding that birth can happen and not be a medical emergency (as it typically is not) and trusting well-trained professionals to oversee births would provide an immediate boost to the maternal health corps and would alleviate personnel shortages.

2. Design interventions and programs with women like Kara in mind.

There are good, free resources available for pregnant women and mothers in the Sunflower Mountain Region. But when Kara (Chapter 6) told me that she would love to use these resources, but she genuinely did not have the time and energy I saw a massive gap. Women who are working to make ends meet, parent many children, or experience any sort of increase in barriers to care have differing abilities to access support even when it is free of cost. In designing public health interventions, it is imperative to keep Kara in mind to creatively think of ways to reach out to and help women who cannot necessarily come to the resources. Some examples of this I have already discussed in this dissertation like home-visiting and various forms of mobile care. Decreasing the amount of work women must do to participate in these programs is also critical.

3. Capitalize on women supporting women in solidarity. Use the strength of rural communities.

As I discussed in Chapter 6, when services are eliminated in rural areas that already struggle with fewer resources it creates gaps in pregnancy information, support, and advocacy. Ultimately I found that the most consistent filler of these gaps is not necessarily programs or professionals but everyday women who feel solidarity in pregnancy experiences and step up to support their friends, coworkers, or even complete strangers. This is a unique attribute that is so commendable and valuable in rural communities. Interventions and policy designed for rural communities should take into account the social support and solidarity amongst women and potentially harness and utilize that strength when looking to improve rural health care. Another critical strength

within many rural communities is the religiosity and importance of church and faith. While this can pose challenges to accessing certain care like mental health care and vaccinations (Swihart et al. 2021), churches are critical to rural health infrastructure and therefore provide a key point of access for public health and improving accessibility.

4. Use the lessons of COVID-19 to really interrogate how society treats pregnant women and find new routes of support.

The COVID-19 pandemic has brought severe hardship and tragedy to the world. The ways that it has affected the already precarious social and health structures in the United States exhibits how vulnerable these institutions really are and teaches many lessons moving forward. As I described in Chapter 5, rural health professionals made rapid and astute adjustments to continue serving their communities during the pandemic. In fact, many of the alternatives to regular in-person assistance had a domino effect of positive consequences (such as providing routers and internet data to families that did not have that before). Using the pandemic and these lessons to continually reassess how pregnant women and mothers in vulnerable situations is important. I argue that professionals should keep these crises at the forefront of their work to keep finding new solutions to the same old problems.

5. The State needs to step up and bolster support.

I have shown how Medicaid's lack of coverage of birth costs contribute to making obstetrics a hospital "loss leader." On a basic and immediate solution level, all states could expand Medicaid coverage. This has been shown to help improve rural hospitals' financial strain (Healthcare.gov 2021). Next, Medicaid coverage needs to adequately

reimburse rural obstetric services. Rural hospitals that have a high percentage of Medicaid births cannot foot the bill of these services when Medicaid is not reimbursing full costs.

To assist with birth justice, empowerment, and choices, the government could include reimbursement on services other than labor and delivery such as doulas and home visiting. Allocating funds to ensure that these services are accessible and viable in the long term provides more support to rural mothers who may be socially marginalized. These are also proven to create far better birth outcomes (Filene et al. 2021). Essentially what I have seen time and time again during this fieldwork is the state or hospitals removing services and providing no alternatives. If you absolutely must remove something from a community, I argue that it is your responsibility to at least try to fill the gaps created by the removal. The state has the power to mitigate these changes and prevent rural American, specifically rural Appalachia from becoming a sacrifice zone for birth.

On Unfinished Thoughts and Returning

Throughout this dissertation I have explored the challenges that arise in rural areas and the stereotypes and strong narratives that rural America is backwards, impoverished, narrow-minded, and stagnant. An undeniable factor that constructs rural America and contributes to these stereotypes is the high rate of outmigration of young, educated people leading to a region that is older and sicker than the rest of the country. Discussing these stereotypes is necessary in any conversation on rural America.

Stereotypes are more than ideas or fodder for Saturday Night Live skits[42]; they seep into the public imagination and impact everyday actions and policy decisions. One of the most pervasive ideas about rural America is the idea that people living there are less than (be it in sophistication, education, etc.) those living in urban areas and anyone who is smart and driven enough to leave will do so (Cromartie et al. 2015). I witness and experience the prevalence of this stereotype in my own life. I have always wanted a life and career in rural America. Family and friends who do not live in rural areas themselves tend to seem worried when they learn this. They say, "but you have so much potential" and "are you sure you want to do that?" or "you will be so lonely" as if to live and be in rural America is a waste of my intelligence, youth, energy, and personhood. But why do they say these things? Why does living in a rural area mean that I am not using "my potential?" Why would I be questioned on this more than my brother pursuing a job in advertising in Denver? We both went to school to study what we will do for a job. And why would I *not* be lonely in a city? Ultimately what this indicates is that stereotypes are unfinished thoughts. Oftentimes they defy logic and rely on simplistic, unnuanced thinking. For example, consider Khiara Bridges' questioning of the idea of a "welfare queen." The stereotype of the "welfare queen" is unintelligent and is committed to continuing to have children so she does not have to work but still can live luxuriously off state money. Some of the most potent pieces of the narrative of the Medicaid user is that she is an urban Black woman who is living luxuriously on the state's money while she does not desire or look for work at all. Bridges uses legal and historical information to show how the welfare queen has been constructed as "undeserving poor" because she does not

[42] For example, the recurring skit called "Appalachian Emergency Room."

fit in with the traditional, capitalist, “hardworking,” White, notion of American (2011). President Reagan is responsible for the public development of this narrative of cheating the system. In 1976, he campaigned hard for welfare reform frequently telling this story: “There’s a woman in Chicago, She has 80 names, 30 addresses, 12 Social Security cards…she’s got Medicaid, getting food stamps and she is collecting welfare under each of her names. Her tax-free income alone is over $150,000 (CNN). This represents the classic narrative of the “welfare queen.” Medicaid data shows that this is entirely false. 40% of enrollees are white while only 21% are black. Additionally, most Medicaid users are under the age of 18, and the majority live in rural areas (Kaiser Family Foundation). Although the public perception of Medicaid users and poverty in general is highly feminized, the data indicates that the percent of men and women are very similar, with women only being slightly higher. Thinking even more simply than looking at data, it is difficult to see this stereotype as logical. How is the “welfare queen” unintelligent but smart enough to scam the US government? Sure, having more children will qualify her for more money but she will also have the added expense of another child? Just like the ideas and questions of life in rural America, this is an unfinished thought.

The cliché “think global and act local” is very relevant to this dissertation and rural health. During a Zoom call with Megan, a labor and delivery nurse who is also engaged in a task force working on rural obstetric accessibility, the ceiling to her shared office in a rural hospital would fall in chunks every time someone behind her opened or closed the door. This was slightly distracting during our conversation as Megan would have to keep checking her coffee cup for pieces of vinyl coming down from above.

Megan talked about the challenges of working in public health in a rural community. She grew up in a nearby area, went to school to get her degrees, and returned to her home to work. She has a lot of personal investment in the health of the area but this tie comes with many challenges. She experienced the consequences of obstetric care closures herself and had negative birth experiences because of it. A lot of her work with high-powered political figures makes her feel like she is shouting in the void. She also feels like she is doing the best she can but is letting her patients down as there is only so much she can do in her position with the resources she has.

Megan explained the importance of people coming back to live and work in rural communities. She sees a future of improvement, but the key to that is getting people to find enough value in their rural roots to honor them and stay throughout their lives. As I discussed in other places in this dissertation, medical schools and systems work hard to recruit physicians to practice in rural areas to combat the necessity of closing medical services. Additionally, public health interventions need compassionate and committed professionals to provide support and nuanced knowledge in rural communities and validate the experiences women have accessing rural care. Megan frames this as an obligation of people with privilege to use that in a way that benefits their community. Her words stick with me and I return to them often when imagining my own future.

Megan explained how she is a middle class, highly educated woman living in a county where most people do not have a high school degree and the median income is well below the poverty line. "The problem is," Megan continued, "people like me, I mean the type of person who is from a small town or has these deep family connections to these rural counties waits their whole life to get out and never come back. People like you and

me, we go and get our degrees and then we leave these places, our homes, where our families are and have been for generations, we leave those in the dust and set out for bigger cities where we can thrive and make more money and get our kids a good education. We leave for more opportunities. But you know, it is the responsibility of people like us, people who are middle-class and highly educated and committed to our communities, **it is our responsibility to not stay away**. It is our responsibility to make these places better and that means returning to them. It's hard work, but it's fulfilling" (emphasis is my own). The problem here that Megan identifies relies on the stereotypes of rural America that dub it a bad place to live. As she asserts, it is the responsibility of people with privilege, like myself, to complete the unfinished thoughts and commit to places and push better understanding of the rural United States. I plan on returning.

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