

**RESTRUCTURING BIRTH: NEOLIBERAL SHIFTS IN MATERNITY CARE,
THE ROLE OF NGOS, AND THE IMPACT ON MIDWIVES AND
BIRTHPARENTS IN THE PHILADELPHIA COMMUNITY**

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ABSTRACT

Over the past twelve years, Philadelphia has undergone an unparalleled large scale shift in the way maternity care is provided, accessed, and considered. Key aspects of the changes to the landscape of birth in Philadelphia include: the closure of the majority of hospital-based maternity units, the activities of local women's health non-governmental organizations (NGOs), and the new set of pregnancy care and birth choices that parents navigate. One of the most striking results of the restructuring of Philadelphia's maternity care system is a drastic reduction in the number of hospitals with maternity units. While the birth rate in Philadelphia has remained consistent around 22,000 per year, since 1997 two-thirds of the hospitals in Philadelphia have eliminated their maternity services. During this time, numerous local women's health-oriented NGOs worked to established themselves in Philadelphia. The aim of each NGO has been to respond to inadequacies in the provision of maternity services that develop as hospitals, the dominant resource for maternity care, withdraw from the maternity care business. With only six hospital maternity units remaining and a couple of local nonprofit organizations attempting to supplement the dearth of services, the current system within which parents and health care providers maneuver is both unstable and inadequate for meeting the maternity care needs of the community.

In this research project, I explore the processes through which this new maternity care system is being established in Philadelphia with a particular focus on the influence of neoliberalism as an active force in the restructuring process. I examine the outcomes of this restructured system in terms of how lived experiences are influenced by the social,

political, and economic reconfiguration of birth. The case of Philadelphia is of particular value as the City's maternity care system has undergone an accelerated restructuring that is unmatched in other areas of the US. While a similar trend in restructuring can now be found in other locations, these changes happened earlier and have continued in a more extreme manner in Philadelphia, marking Philadelphia as a possible canary in a coal mine. Understanding the outcomes of this large scale change in the system of care provides a basis for contending with similar trends elsewhere.

My ethnographic work focuses on the experiences of particular individuals as they navigate Philadelphia's new system of maternity care. Within this restructured system of maternity care, the interests of parents and health care practitioners are increasingly devalued or disregarded, particularly for those whose philosophy of birth differs from dominant biomedical maternity care practices. Midwives, whose non-interventionist methods of care starkly contrast with the biomedical model of care, and parents who wish to have a low-intervention or natural childbirth struggle to achieve their goals within the confines of Philadelphia's maternity care system. Similarly, individuals running local NGOs strain to intervene in the process of restructuring, and often face the dilemma of remaining true to their mission on one hand or preserving financial security by meeting the imperatives of funders on the other hand. Therefore, I have made the stories of midwives and parents seeking alternatives to biomedical care central to my analysis in addition to conducting in-depth fieldwork with three local women's health-oriented NGOs.

This project adds to our understanding of how broad political and economic trends in health care translate into select cultural formations which inform the life choices

of individuals. In times such as now, when national policy regarding the provision of health care is under scrutiny, it is essential to connect the dots between the circumstances of individuals and the structure of systems of health care. This research project fuses analyses of civil society institutions, the politics of reproduction, national ideology, and local political and economic agenda to present a complex and inclusive assessment of the landscape of birth in the uniquely positioned city of Philadelphia.

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To my grandmothers
Mary Henrietta Knauer
and
Evelyn Alice Hull

But most of all,
to my beloved, Dave

ABBREVIATIONS

AFW	Alliance for Family Wellness
BAP	Birth Advocates of Philadelphia
C-section	Cesarean section
NGO	Non-governmental Organization
VBAC	Vaginal Birth After Cesarean

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CHAPTER 1

INTRODUCTION

The way people provide, access, and think about maternity care is changing in Philadelphia. This change has corresponded with a large scale shift in the way the landscape of maternity care is structured. Over the last twelve years, the majority of hospital-based maternity units have closed their doors, local women's health non-governmental organizations (NGOs) have taken an active role in providing maternity care, and parents have been navigating an new set of pregnancy care and birth choices. Obstetricians and midwives are encountering new standards in care practices, some of which threaten these providers' professional livelihood, while other practices reposition the relationship between provider, patient, and health care institution. Each of these interwoven components involves its own set of politics and policies, but their combined expression means one thing – a new set of human experiences and cultural patterns for a process that is as old as human existence: birth. In this dissertation, I explore how the birth experiences of individuals who live and work in the Philadelphia metropolitan area are connected to city-wide shifts in maternity care, and I will consider how this shifting landscape of birth reflects national ideological trends.

The diverse components of the newly restructured maternity care system are certainly linked by a set of political, economic and cultural processes attributed to neoliberal ideology. General shifts in policy, value systems and government function attributed to neoliberalism such as the privatization of public systems, the proliferation of NGOs, the expectation of personal responsibility, and the celebration of individual entrepreneurship can all be located within the new landscape of birth in Philadelphia.

Yet, it is the intricacies of how individuals and institutions within Philadelphia encounter and incorporate neoliberal practices into the existing maternity care system and the unique outcomes of this convergence that is of real interest.

Much of the anthropological work on the influence of neoliberalism on the lived experience focuses on financially disadvantaged or socially marginalized populations (see Lyon-Callo 2000; Maskovsky 2000a; Maskovsky 2000b). In this study, I diverge from this path by exploring the influence of neoliberal policies on a relatively privileged population of middle class people and communities. The majority of the parents, the midwives, the NGO staff, and the community activists who served as my informants for this research are white, lower-middle to middle class women (although it is important to note that some of my key informants are male). This analysis adds to the modest but growing literature that highlights the infiltration of neoliberal practices into all levels of US society and, in specific or distinct ways, influences the experiences and practices of individuals from all social classes (see Hardy 2007; Hyatt 2001).

In this dissertation, I draw on years of ethnographic research to illustrate the processes through which this new system was established in Philadelphia and the outcomes for families, health care professionals, and communities resulting from this reconfiguration of birth. Three interconnected aspects of this new system of maternity care are the focus of my research: the dramatic shifts in hospital maternity care, the birthing choices available to parents, and the activities of local non-governmental organizations (NGOs). My concentration is on human experiences and specific cultural patterns that emerge within and from these three aspects, yet an inclusion of the broader processes impacting these aspects is essential. As I explore these culturally contingent

processes I draw on work representing three significant areas within cultural anthropology: medical anthropology, North American anthropology, and the anthropology of policy. A fourth area of research stems from these theoretical topics, the impact of neoliberalism on the lived experience.

This dissertation begins with a brief historic overview of maternity care in North America with particular attention on time points in which significant shifts occurred in the provision of care. This general synopsis provides the opening for the core premise that maternity care is a uniquely appropriate cultural construct for an analysis of the impact of national ideology on numerous levels since the provision of maternity care is at once an economic, political and social pursuit as well as a deeply personal experience through which new life is brought into the world. My fieldwork location, Philadelphia, Pennsylvania is the microcosm through which I observe these dynamics. However, while Philadelphia serves as a case study of the nuanced interactions between daily life and national ideology, this city has a unique and fascinating history of maternity care. Therefore, while conclusions drawn from the research presented in this dissertation may speak to national circumstances, the details of Philadelphia's story and the stories of the city's people are distinct.

Brief History of US Maternity Care

Childbirth and Cultural Eras

Childbirth historians note three distinct periods in the culture of birth in North America (Dye 1986; Wertz and Wertz 1977). The term "social childbirth" (Wertz and Wertz 1977) characterizes birth culture from the early 1600s to the mid-1700s. Historical evidence shows that in colonial America, women within a community would attend and

assist, along with a midwife, in one another's labor and birth. Standards of social decorum and decency along with the experience-based knowledge that women developed by fulfilling their community responsibility of attending other women's births kept childbirth within the territory of women during this time period (Dye 1986; Wertz and Wertz 1977). Religious views that only God could control the outcome of pregnancy combined with the notion that labor and birth were natural and normal processes were demonstrated in midwives' generally non-interventionist management of childbirth (Dye 1986; Wertz and Wertz 1977). While physicians did sometimes provide care for women during pregnancy, they did not provide care during childbirth (Dye 1986). Having held the position of birth attendant throughout recorded history, the midwife remained the definitive resource on childbirth during this time period (Litoff 1978).

Historians mark the 1750s to the late 1800s as the second distinct era of North American childbirth practices. During this time period, the profession of medicine began to develop cohesiveness within its structure and doctors' status within society began to increase. Links between the medical industry and the fields of law, politics, and business added to the power of the growing biomedical system and added to the professionalization of the medicine and the technologies of physicians began to hold more value in the public mind (Starr 1982). Perhaps the most important change in birth practice that occurred during this "transitional stage" (Dye 1986:22) was childbirths' "inclusion within the medical practice of men" (Wertz and Wertz 1977:29). During the second half of the eighteenth century, physicians (the vast majority of whom were male) gained new scientific knowledge of the anatomy and physiology of gestation and developed technology that quickly became commonly used in childbirth, such as

obstetrical forceps and anesthesia. These advances were transmitted throughout the medical community through educational institutions and medical societies, such as the American Medical Association (Dye 1986; Starr 1982). This “new” area of medicine, which focused on a human event that was hitherto considered outside of their expertise, caught the attention of physicians who began to imagine assisting in childbirth as a gateway to the establishment of their whole practice (Wertz and Wertz 1977:55).

The new professionalism regarding birth care caught the interest of upper and middle social class women living in urban areas. These “women of means” began to select physicians as their care provider during childbirth believing that physicians’ knowledge and technologies could make labor and delivery both safer and less painful (Dye 1986; Wertz and Wertz 1977). While rural and lower social class women continued to rely on midwives through much of this time period, by the 1870s physicians had become the primary birth attendant in North America (Dye 1986). However, it is important to note two facts: first, throughout this second era of childbirth, birth continued to be accomplished in-home; and second, even with advances in knowledge, medical practices regarding labor and delivery were often misguided and wanting, as was the overall quality of medical education (Dye 1986; Leavitt 1986; Wertz and Wertz 1977).

Whereas the second era of North American childbirth marked transitions in care providers and in the social notions of birth, the third period noted by childbirth historians marks a complete transformation in the performance of childbirth. Physicians merged obstetrics with gynecology, a step which defined obstetrics as a surgical specialty (Dye 1986). Stricter medical educational regulation and licensing requirements added to obstetricians’ authority while concurrently marking midwives as inept and forcing

midwifery out of the birth landscape (Dye 1986; Wertz and Wertz 1977). In addition, medicine's improved antiseptic and aseptic techniques held enormous ramifications for the location of and the procedures conducted during labor and delivery (Jordan 1993; Wertz and Wertz 1977). With improved ability to prevent infection, obstetrical operations became more successful and birth could be moved out of the home (a location which inconvenienced obstetricians) and into hospitals (Wertz and Wertz 1977). Social understandings of childbirth shifted during this time period as well, as social reformers on public health crusades subscribed to the redefinition of birth as a "pathologic process that demanded active management" (Dye 1986:39) and advised women to birth in hospitals with the assistance of a medical doctor (Dye 1986). The combination of these various developments confiscated women's and midwives' authority and control over labor and delivery and situated obstetricians as the de facto maternity care provider.

The shift in the way childbirth was performed from the early 1600s to the mid-1940s was immense, and the changes in birth care mirrored social changes, medical advances and technological discoveries that touched all aspects of daily life. The usurpation of childbirth was just one part of the establishment of biomedicine as the dominant healing modality in North America. And, as part of the biomedical system, obstetrical maternity care incorporates the key structural attributes of biomedicine: physician oriented, interventionalist, hospital-based care.

Medicalization, Biomedicine, and Childbirth

Analyzing the tactics and processes that enabled physicians to increasingly dominate women's health care from the 1870s on, the influence of medicalization on pregnancy and birth care is apparent. Situated by Foucault in his theories on modernity

as a way to understand how government structures and enacts policies designed to control citizens, medicalization of the body is a grouping of processes that subvert oppositional social and cultural beliefs and promote beliefs and value systems that agree with the ideology of the governing body (Barry et al. 1996). An intrinsic part of the construction of the medical profession as all-powerful and all-knowing, the operation of medicalization as a form of social control served to not only reduce the legitimacy of other health practitioners but to bolster the authority of the physician. Western biomedical practices in regard to labor and delivery became normalized while the non-interventionalist model of care practiced by midwives was demoted. This shift was largely facilitated by the gaining general social acceptance of biomedicine due to the insidious processes of medicalization and through the support of politically powerful institutions such as the American Medical Association (AMA), a professional organization founded by physicians which has influentially advocated for the interests of physicians from the mid-1800s to current day (Starr 1982; Berlant 1975; Fishbein 1947; Friedman and Friedman 1990).

The consolidation of the biomedical industry combined with the process of medicalization and the political and economic backing of influential institutions and associations enabled the designation of physicians as the ultimate healers (Barry et al. 1996). At the same time, this hierarchical structuring of biomedicine, which placed (almost exclusively male) obstetricians at the top of the childbirth provider pecking order, devalued the variety of healing modalities utilized by different “healers”, “doctors”, or midwives. Exchanging female dominated midwifery for male dominated obstetrics brought broader issues of Western gender role divisions into the practice of maternity

care and therefore altered the experience of pregnancy and birth care for women. The designation of the obstetrician as “the authority” of labor and delivery also resituated the relationship between childbirth provider and mother; women no longer questioned the authority of the obstetrician. During childbirth, the obstetrician called the shots.

As mentioned above, the move from home-birth to hospital-birth was a significant win for biomedicine. Not only was the move convenient for obstetricians logistically, as all their charges were now in the same place, but it reaffirmed the new relationship between obstetrician and mother. In accordance with the social view of the hospital as a place for the sick, the movement of birth from home to hospital marked women as patients and childbirth as a problem only to be solved by the skillful medical intervention of the obstetrician. This deference to obstetricians facilitated the continued and increased use of aggressive interventions during labor and delivery (Scully 1986). Instruments such as forceps, perforators, and hooks used to extract a fetus (alive or dead), procedures such as episiotomies and cesarean-sections, and drugs from opiates to epidurals and anesthesia became standard resources for obstetricians during the early and mid-20th century (Scully 1986).

By the 1940s, the provision of health care was re-structured to the general system that exists in North America today (Starr 1982). While multiple competing discourses and practices regarding maternity care still exist in North America, the biomedical model of care has dominated the provision of all health care, including maternity care, during the 20th century. This trend continues into the 21st century. At present, we see the continuation of the multifaceted support system that benefits the biomedical model of

care which, in turn, maintains the dominance of androcentric, medicalized maternity care provision.

Doctors Versus Midwives

With respect to maternity care, the establishment of biomedicine meant a shift in practitioner, the patient's relationship with that practitioner, and a corresponding change in procedures implemented during pregnancy and birth. The technologies of health care providers are informed by ideological notions, and the shift from midwife to obstetrician truly resulted in a redefinition of childbirth. Although there are always individual exceptions any rule, overall, the approach and mindset of obstetricians and midwives differs so fundamentally as to necessitate further discussion of the two types of providers.

In contrast with obstetricians, who are surgeons trained to intervene during labor and delivery, midwives approach delivery in a non-interventionalist manner. Midwives have held the position of birth attendant throughout recorded history (Litoff 1978), and while changes in the profession have occurred, the perspective and practices associated with midwifery have remained much the same. In the English practice of midwifery, brought by British settlers to North America in the early 1600s, midwives were community based and well known for their skills and ability to manage trying situations (Litoff 1978; Wertz and Wertz 1977). Midwives also provided emotional support, spiritual support, and help with domestic chores for up to two weeks after the delivery (Sullivan and Weitz 1988). Usually trained through the apprenticeship model (Susie 1988) these midwives were frequently referred to as "lay midwives." Having gained their knowledge by watching the practices of other midwives within their community, "new" midwives tended to remain in their original communities, providing their services

to relatives, friends, and acquaintances. Truly rooted in the communities they served, midwives and their work were regarded as normal parts of the community and every day life. In accordance with midwives non-interventionalist practice, tools, such as forceps, were not usually used to speed along delivery. Instead, relying on the natural processes that occur during labor, midwives carefully monitored the woman's body for signs of readiness for delivery, allowing the woman's body to direct the course of the birthing process. This meant that deliveries could take a long time, during which time the woman's needs were responded to by the midwife. While long labors were exhausting for the woman, they were accepted as a natural part of childbirth (Susie 1988).

With the establishment of the biomedical system, the profession of midwifery and its associated practices were devalued and delegitimized. As obstetrics advanced, midwives were gradually excluded to the point that by 1935, only 11 percent of births were delivered by midwives, and by the early 1950s only 3 percent of all births in the US were delivered by midwives (Sullivan and Weitz 1988:14).

While midwifery's respect of the natural processes of childbirth validates the importance of a woman's input during labor and delivery, the biomedical procedures of obstetricians nullify both the pregnant woman's knowledge and the natural processes of the body (Shaw 1974). As previously discussed, the perspective and procedures of obstetricians are biomedically informed. Therefore, obstetricians designate childbirth as a pathological condition requiring intervention on multiple levels. While some of the practices and procedures of early obstetrics have been discontinued due to the harm they caused, many of the original technologies continue to be used and other techniques have been developed.

Recent Changes in the Practice of Obstetrical Procedures

Cesarean section, episiotomy, vacuum extraction, forceps, and various drugs - used both as a method of pain reduction and to alter the process of labor (usually to induce labor) are currently standard tools of the obstetrical trade. Some of these procedures are slowly losing popularity, whereas others are increasingly employed by obstetricians; all continue to be used on some level in the US. The use of cesarean section to deliver infants has reached an all time high in the US. The Centers for Disease Control's national data for 2008, the most recent data available, indicates that 32.3% of infants are delivered by cesarean section, meaning that one out of every three infants born in the US is delivered through the use of a surgical procedure in which infant, placenta, and membranes are extracted through an incision in the maternal abdominal and uterine walls (Martin et al. 2010). This is a 56 percent increase since 1996 when the cesarean section rate was at its most recent low of 20.7% (Martin et al. 2010). The current rate of cesarean section differs dramatically from the rate of 4.5% in 1965, when it was measured for the first time in the US (Taffel et al. 1987). A quick comparison between the US 2008 rate of 32.3% and the World Health Organization's suggested cesarean section rate of 10%-15% reveals the current excessive use of this procedure by US obstetricians (WHO 1985).

Along with the increases in the use of cesarean section to deliver babies, the rate of artificial induction of labor has risen. In 2008, 23.1% of all labors in the US were induced, up from 18% in 1997 and 9% in 1989 (Martin et al. 2010; Curtin and Park 1999). This rate means that over 1 out of every 5 women have their labor artificially induced, and concern over this high rate has recently motivated national physician

organizations to revise labor and induction guidelines (see American College of Obstetricians and Gynecologists 2009). The artificial induction of labor includes medical or surgical methods used to initiate active labor. Methods include utilization of synthetic hormones such as Pitocin, and other drugs, like Cytotec, as well as amniotomy or the artificial rupture of membranes. Among the consequences of labor induction is a heightened risk of cesarean section delivery compared to spontaneous onset of labor (Denk et al. 2010; also see Wagner 2006; Martin et al 2010).

Some obstetrically-based practices have decreased in recent years. Deliveries involving the use of forceps decreased from the 1995 rate of 3.5% to 0.7% in 2008. Births involving the use of vacuum extraction also decreased from 5.9% in 1995 to 3.2% in 2008 (Martin et al. 2010). Compared with 1996 practices, the use of episiotomies decrease 55% by 2006 (Russo et al. 2009). The reduction in utilization of these interventions, which can have severe negative health outcome for infants and mothers, is considered a positive move by the maternity care community in general (see Eakins 1986; Armstrong and Feldman 1990 for discussion of complications and use of these interventions). Yet, some researchers caution that the decreases in the use of these procedures are a result of the increase in the practice of cesarean sections (Russo et al. 2009; Martin et al. 2010).

In a similar vein, the decrease in VBACs (vaginal births after previous cesarean section) is currently under scrutiny particularly by providers who are concerned with the high rate of cesarean sections; fewer VBACS means more cesarean sections. National data shows that the rate of VBACs dropped to 9.7% in 2006 from 35.3% in 1997 (Russo et al. 2009). This 73% decrease in just nine years means that many women undergo

cesarean sections not just for their first delivery but for subsequent deliveries as well.

The ever increasing rate of cesarean sections is attributed, in part, to this drastic decrease in VBACs (Martin et al. 2010).

The Persistence of the Midwifery Model

In light of the national trajectory of applying increasingly interventional techniques to the practice of childbirth, namely through the artificial induction of labor and delivery by cesarean section, it may seem that the non-interventional methods of the midwifery model are obsolete. Interestingly, while the use of midwives declined drastically in the first half of the 20th century, the debate over the usefulness of midwifery was never completely erased from academic discourse (Litoff 1978). Although the use and practicality of midwifery was an ongoing debate in academia during the first half of the twentieth century, it was the Feminist and Women's Rights social movements of the 1960s that made space in broader social discourse in which proponents of midwifery could be heard. Advocates for women's birth rights and for natural birth espoused midwifery-based childbirth practices. It was through these social movements of the 1960s that midwives reemerged in the healthcare scene with enough force to receive acknowledgement from society at large and to strive for legalization as medical professionals (Litoff 1978).

The reemergence of midwifery was aided by a model of midwifery training that incorporated nursing (Kennedy 2009). Certified Nurse Midwives (CNMs) boosted the profile of midwives by incorporating biomedical certification and, perhaps more importantly, by enabling nurse-midwives to attend hospital births. Yet, the profession of midwifery is multifaceted and newer paths to midwifery are becoming legally recognized

in some states. Certified midwives (CMs) have equivalent training and practices as do CNMs, but do not hold a nursing degree (Sakala and Corry 2008). CMs are not currently legally certified to practice in Pennsylvania, however, according to midwifery lobbyists, licensure of CMs is imminent. Once CMs are licensed to work in Pennsylvania, they will have the same standing as CNMs, who are able to work in all settings, but primarily attend hospital births (American College of Nurse Midwives 2005). Certified professional midwives (CPMs) are educated in the discipline of midwifery and have been certified through an accredited midwifery agency (Kennedy 2009). CPMs are trained through a more classic model of apprenticeship, self-study, and primary experience. CPMs attend births in out-of-hospital settings, such as at home or in a birth center (North American Registry of Midwives et al. 2008). However, Pennsylvania law does not currently recognize CPM's, so in the state, CPMs currently only attend home births and do so outside of the law. Traditional midwives (TMs) do not hold a formal degree, are not recognized by any certifying body, and attend only home births without legal sanction (Natural Attachment 2006). In this dissertation, CNMs and CPMs are the types of midwives that are the focus of analysis as they actively provided care for women in Philadelphia, Pennsylvania during my dissertation fieldwork.

From the 1960s to present, midwives of all certifications have worked against social constraints to position themselves as respected providers within a variety of health care settings (Kennedy 2009). Today, both the biomedical model and the midwifery model of maternity care co-exist, yet the practices associated with biomedicine continue to dominate maternity care. Perhaps most telling of the continued dominance of biomedicine in the provision in maternity care is the fact that 99% of all US births in

2008 were hospital births. Furthermore, 92.2% of these hospital births are attended by physicians; midwives attended 7.4% of hospital births in 2008 (Martin et al 2010).

Why Study Philadelphia?

A Canary in A Coal Mine

Overall, the structure of maternity care in Philadelphia mirrors the national trajectory regarding pregnancy and birth care. Throughout the second half of the 20th century, obstetricians and midwives practiced in the city. The majority of births occurred in hospitals under the biomedical model of care, with some significant movements countering this model of care taking place at various time points, a topic to be detailed further below, under the subsection Activism in Philadelphia. By and large, Philadelphia can serve as a “typical” case study for the organization of maternity care in the US. However, in little over a decade, extensive shifts have occurred in the landscape of maternity care in Philadelphia that diverge from the national norm. Maternity care has undergone an accelerated restructuring that is unmatched in other areas of the US. While a similar trend in restructuring can now be found in other locations, these changes happened earlier and continue in a more extreme manner in Philadelphia, marking Philadelphia a possible canary in a coal mine with respect to changes facing obstetrics in the United States.

The structural shifts that have directed the recent restructuring of maternity care in Philadelphia began in the 1960s. Prior to the 1960s, health care in Philadelphia was largely provided through a public health system that was community based and consisted of many independently administered health clinics located in easily accessible local settings (Maskovsky 2000a). However, since the 1960s, most health care institutions

have been privatized. This privatization has gradually forced the closure of independent, community-based health centers and access to preventive and direct care has diminished (Maskovsky 2000a). This transition from a public to a private health system has been particularly devastating for maternity care. Now owned by out-of-state, large business conglomerates, or competing with hospitals that have been privatized, the independent and community hospitals located in neighborhoods throughout Philadelphia have closed maternity units – and in some cases, the entire hospital closed. As of 2010, not even one community hospital or independent hospital in Philadelphia has a functioning maternity unit. All of the remaining maternity units are housed in large teaching hospitals centrally located in the city of Philadelphia. These six remaining maternity units are all within just a few miles of one another, with the furthest distance between hospitals approximately 7 miles, and the shortest distance .6 miles. This concentration of the location of hospital-based maternity care into one small area within the sprawling city of Philadelphia reduces access for parents who live and work in geographically peripheral sections of the city.

The closure of so many hospital maternity units signifies a large scale change in the system of care. Beyond the geographic centralization of hospital-based maternity care, the closure of independently run and community-based maternity units also means fewer available healthcare providers and fewer options in type of provider (midwife versus obstetrician). While many of the now-closed hospitals housed midwifery groups or had both obstetricians and midwives on staff, the vast majority of the remaining teaching hospitals have only obstetricians on staff and do not grant privileges to midwives. The biomedical training of obstetricians combined with the fact that the hospitals in Philadelphia, by and large, only staff their maternity units with this type of

provider, translates into a maternity care climate in which highly interventionist maternity care is both the norm and, in most cases, the *only* option for parents who want a hospital birth.

Now, while hospitals are not the only places to give birth they are absolutely the dominant resource for maternity care in Philadelphia and in North America. Hospital-based maternity care is so familiar that it is difficult for other maternity care institutions to succeed. Birth centers, maternity centers, and homebirth are all positioned as alternatives to hospital-based maternity care in popular culture in the US. However, as of January 2010 the city of Philadelphia does not contain a single birth center or maternity center that is separate from a hospital. There are two small birth centers located outside Philadelphia County, one to the northeast and the other to the northwest. They are most easily accessible by car and they do not have the capacity to take on the increased number of prospective clients due to hospital closures.

Homebirth continues to be a controversial choice for women, yet providers are available in Philadelphia. Very few CNMs in the Philadelphia area choose to include homebirth as part of their practice, although a few (three) currently do so. By law, local CPM's assist only in homebirths. However, there are only a handful of CPMs currently working in the Greater Philadelphia area and their lack of legally recognized status as birth attendants adds to the already politically and socially fraught choice of homebirth. Essentially, hospitals hold such a monopoly on birth in Philadelphia that the loss of so many hospital-based maternity units leaves the community with a lack of existing alternatives to the remaining large private residency hospitals.

Activism in Philadelphia

Another reason for locating my research in Philadelphia is the city's long history of community activism and grassroots organization. Regarding health care and women's movements, the efforts of Philadelphians, particularly during the 20th century, have been well documented. From the "activist mothering" of Philadelphia women community workers hired in the mid- to late-1960s by Community Action Programs (CAPs) (Naples 1998) to the 27 year existence of the Elizabeth Blackwell Health Center and the establishment of Booth Maternity Center in 1971, later renamed John B. Franklin Hospital and Maternity Center, Philadelphia has long had a vibrant history of women's health activism. At the same time, while these activist attempts find success in the short term in countering the social inequalities in the provision of women's health care, many ventures have ultimately succumbed to the competition inspired by the privatization of health care facilities and the structural mechanisms that favor the continued dominance of the androcentric, biomedical model of care. The stories of the Elizabeth Blackwell Health Center and Booth Maternity Center (as I will refer to it in this dissertation due to the fact that most of my informants referred to it by this original name) illustrate this dynamic of activism in Philadelphia.

The Elizabeth Blackwell Health Center opened in 1975 and represented a culmination of many of the advances made in women's health care by the women's health movement of the 1960s. Offering gynecological and sexual-health services, including abortions, this female-operated, woman-centered health clinic often found itself center stage in national and local abortion debates (FitzGerald 2002). Holistic in approach, the Elizabeth Blackwell Health Center encouraged women to take charge of

their health and fought continuously to ensure that women's services that were not socially or governmentally supported, like abortion, remained accessible to low-income and disabled women (FitzGerald 2002). The Elizabeth Blackwell Health Center remained open for 27 years, providing abortion services to about 1,500 patients and offering gynecological care to 4,000 patients during its last full year open in 2001. Lack of need for services was not the motivation behind the closure of this facility. Instead, the political economic and societal constructs forced the Elizabeth Blackwell Health Center to shut its doors. Quite vocal about the causes of the closing, the executive director of the Elizabeth Blackwell Health Center, Jennifer Vriens stated, "the financial situation and the changes in the health-care landscape did what the anti-abortion protesters could never do to us – shut us down" (FitzGerald 2002:1).

Booth Maternity Center had a similar business trajectory. Established in 1971, Booth existed for 18 years before it closed in 1989. Like the founders of the Elizabeth Blackwell Health Center, the women's rights and feminist movements of the 1960s informed the mission and style of health care provided by Booth Maternity Center. Unlike the Elizabeth Blackwell Health Center, Booth's services focused primarily on prenatal and birth care. Booth incorporated a family-centered model of care with the notions and practices of the midwifery model of care. Most of the prenatal and birth care at Booth was provided by midwives, yet the facility strove to be comprehensive in nature and therefore also had obstetricians, nurses, and other health care providers on staff (Wilf 2003). All types of birth care were available at the facility, from natural birth and water birth to cesarean sections and epidurals; the facility was self-contained. Additional services, such as pediatric care, mental health services, and patient-initiated parent

support groups were integrated into the facility's offerings (Simmons 1989; Wilf 2003). The 1989 closure of Booth upset staff and patients alike, and is attributed to the same structural forces that were ascribed to the closure of the Elizabeth Blackwell Health Center: the privatization of health care facilities and the competition this inspired, and the political, economic, and social mechanisms which maintain the dominance of strict biomedical interpretations of maternity care (Simmons 1989). Many of the midwives who were my informants during my dissertation fieldwork had worked at Booth as some point during its existence, and they all expressed nostalgia for the facility and pride at having once been part of the institution.

Although these particular institutions closed, the spirit of activism for women's health remains intact in Philadelphia. Three such activist responses to perceived inadequacies in the provision of health care to women, which take the form of women's health oriented NGOs, are examined in-depth in this dissertation. These organizations, to which I have assigned the pseudonyms "Birth Advocates of Philadelphia", "Alliance for Family Wellness", and "Parental Support Center" take on issues in the community that have arisen as a result of long term social inequities as well as the more recent neoliberal shifts in the landscape of maternity care. Aware of the structural forces that shape the provision of women's health and maternity care, these three organizations nonetheless focus most of their attention on the people affected by the limited resources, dearth of options, and gaps in care which are the consequences of the current structure of the maternity system in Philadelphia. As I argue throughout the body of this dissertation, both parents and providers, particularly midwives, have been marginalized in the process of restructuring maternity care which has occurred over the past two decades. Many

people have literally been displaced due to the changes in the maternity care landscape: providers have lost jobs and parents have lost access to community-based maternity care facilities and practitioners. Each of the NGOs examined in this dissertation works to support individuals who are navigating the restructured Philadelphia maternity system. While these NGOs have had varied levels of success in achieving their missions, together their passion, persistence, and action provide evidence of a continuing legacy of women's health activism. The strength, variability, and creativity of these organizational and individual actions make for a fascinating study of the dynamics of social change.

Use of Pseudonyms: Protecting Informants

As do many ethnographic researchers, I have chosen to use pseudonyms to protect the anonymity of those who graciously served as my research informants. I adhere to this practice for all the names of the people with whom I conducted in-depth interviews and who provided personal anecdotes which I reference in the body of this dissertation. As mentioned above, the names that I use for the three NGOs are pseudonyms, as is the name of the birth center discussed in Chapter 2. Yet, due to the location of this research in the city of Philadelphia, and being that the specific history, politics, economics, and institutions of the city are essential to the issues explored in this dissertation I do reference some things by their actual name. Overall, hospitals are referred to by their real name. There are a few exceptions to this rule, such as the discussion in Chapter 6 under the subsection "Complicated Relationships", for which I use pseudonyms for the two hospitals discussed. When I apply this practice, it is noted in the immediate section. I did this to obscure the identity of the NGOs and informants who are included in this analysis,

as using the true name of a hospital in this circumstance may too easily lead to disclosure of a true identity or actual NGO name.

Theoretical Approach

The reader of this dissertation will interpret the theoretical emphasis of this work according to her own analytical standpoint. I perceive this work as primarily adopting a critical medical anthropological approach to understanding the current structure and enactment of maternity care in Philadelphia. Critical medical anthropology attends to a wide variety of issues including: the deconstruction of naturalized institutions, the role of the state in the shaping understandings of health and the performance of health care, health policy and health resource allocation, social relations among interacting medical traditions both nationally and transnationally, the intertwining of medical systems with their political economic context, and the location of individual experience within a framework of power, oppression, and resistance (Singer and Baer 1995). In addition to political economic, and Marxist perspectives, contemporary critical medical anthropology employs poststructuralist and Foucauldian perspectives (Sargent and Johnson 1996).

In my analysis of the restructured system of maternity care I connect with the key foci embedded within the critical medical anthropology approach. A main focus of my dissertation research project is the relation between the current status of political and economic policy construction in the US, the position of NGOS as providers in the maternity care system, and the care decisions made by pregnant women and new mothers. I am particularly interested in how national agendas and discourses are embodied within the choices women have with respect to care during pregnancy and delivery and the decisions women make with respect to their care options. I follow the

theoretical directives now firmly established within the contemporary critical medical anthropological approach by integrating theories put forth by political economic, Feminist, Marxist, and Foucauldian perspectives into my theoretical outlook.

Childbirth by design is a woman's issue, and although maternity care became androcentric in the US during the 20th century (and remains so during the beginning of the 21st century) the fact remains that the *experience* of pregnancy and birth are the realm of women. Yet, the findings of my research in Philadelphia demonstrate that whether through 'quiet' or 'subtle' coercions (Foucault 1995:137), outright intimidation, or undeniable disregard, women's interests in childbirth are largely subjugated due to the structural, institutional, and political practices which dominate the current landscape of maternity care. Furthermore, my findings indicate that even women who have a comfortable socioeconomic standing, who have a high level of knowledge about birthing options and practices, and who have the support of their families are often unsuccessful in having their wishes adhered to during labor and delivery. The structural and institutional factors that pattern where and how women give birth are immense forces that direct even the savviest woman's birth experience.

Situating my analysis of my informants, mostly lower-middle or middle class women, I turn first to feminist theory. The feminist theoretical position that gender is a universally socially and culturally constructed idea (Mead 1935) and its focus on the role of gender in defining human experience, serves as an initial and lasting influence on my research on women's experiences regarding childbirth. Yet, I extend my use of feminist theory to incorporate notions of gender inequalities and oppression as it relates to the subordination of women. Both the Marxist critique of class oppression and Foucault's

theorizations on the ‘quiet coercion’ of social discipline (Foucault 1995) inform Feminist anthropologists’ analysis on the universal subordination of women, and my own theoretical perspective adopts this feminist model by focusing heavily on these less overt forms of oppression.

I have found that the potency of situating pregnant women as “oppressed” amplifies inequities in power relations (both informal and formal) that are embedded in the US practice of childbirth. The feminist viewpoint that within the gendered hierarchy of Western civilization women are “the oppressed” (Rosaldo 1974; Personal Narratives Group 1989) may seem an extreme position, particularly regarding my research on the social landscape of birth in a 21st century North American city. That many of the interviewed participants are lower-middle to middle class women might make some question the validity of situating these individuals as “oppressed” since they have more social resources at their disposal than many other, less privileged individuals. There is no doubt that the specific constraints encountered by the lower-middle to middle class women who were the majority of my informants for this study differed from the obstacles and experiences of other women who have less social and economic mobility. Yet, as the data presented in this dissertation show, the limited choices available to women and the extreme difficulty my informants faced in their efforts to have control over their experience of labor and delivery highlight the unequal power relations implanted in the current provision of maternity care in Philadelphia.

This “oppression” holds true not just for the pregnant women and mothers interviewed but also for the care providers, the midwives who participated in this research. While these occupations may attract a few men, the professions of midwife and

doula in North America are dominated by women. My findings show that their work is just as restricted by structural, institutional, and political forces as is women's control over their birth experiences and that these are as gendered as the experiences of women facing child birth in many ways. The fact remains that regardless of social class, as members of the female gender operating within a culture of male privilege, the choices of all women are constrained.

Any analysis of "oppression" must include a core focus on power relations. Moving from a Marxian analysis of oppression to a Foucauldian conceptualization of power, I implement a Foucauldian perspective that power is a driving force behind social relationships and that power is fluid (Foucault 1990). I examine the role of power in my analysis of the "multilayered and contradictory processes" (Rapp 1993:60) through which a restructuring of maternity care emerged in Philadelphia. Recognizing that power relations exist interpersonally as well as on the level of national ideology, I consider the role of power on multiple levels: the interactions parents have with care providers and institutions, the structural landscape of birth options in Philadelphia which inform the choices available to parents and providers alike, and the established policies of the city, state, and national government that maintain the biomedical model's dominance over birth care.

While examining power on each of the levels described above is essential in understanding the structure of specific relationships, it is difficult to overstate the importance of positioning power as fluid process which does not act just within the arbitrary boundaries we create for the purpose of analysis. Not only are power dynamics of interpersonal interactions under constant re-definition and negotiation, but the

relationships between societal structures, such as civil society institutions and the state, are constantly shifting and reacting to new changes. Importantly, power must be imagined as acting in a bidirectional manner “across” all societal structures both simultaneously and constantly, though not necessarily uniformly (Ferguson 2004; Gledhill 2004). Incorporating the varied theoretical viewpoints employed within the critical medical anthropological approach, I add to the literature of this theoretical camp by probing the connections between national ideology, particularly neoliberalism, the structure and provision of maternity care in Philadelphia, and the pregnancy and childbirth experiences of individuals as they navigate the institutions and organizations which form the landscape maternity care.

Key Literatures

As mentioned above, the key theoretical framework that shapes this dissertation draws on numerous areas within the discipline of anthropology. Firmly situated within the boundaries of cultural anthropology, my work rests on theories developed within the sub disciplines of medical anthropology, North American anthropology, and the anthropology of policy.

This research adopts theorizations of neoliberalism which situate it as a mode of governance that in practice is contradictory, limited, and unevenly distributed (Maskovsky and Kingfisher 2001; Gledhill 2004; Harvey 2005; Kingfisher and Maskovsky 2008). Understanding neoliberally informed policies and values as cultural formations that combine with various other forms of governance and belief systems disposes of the view of neoliberalism as an impenetrable force that acts upon societies, over-riding any prior form of governance (Comaroff and Comaroff 2000; Kingfisher

2002; Kingfisher and Maskovsky 2008). The conceptualization of neoliberalism as a process articulated and appropriated differently in distinct places requires a focus on “concrete projects that account for specific people, institutions, and places” (Kingfisher and Maskovsky 2008:118). This project will add to ethnographic accounts, such as Goode’s 2006 examination of the activities of faith-based organizations in Philadelphia, that document the ways individuals and organizations selectively incorporate neoliberal ideology and the effect on lived experience and structural practices. In addition, this study builds on the literature that emphasizes the ways in which marginalized and disadvantaged populations are affected by neoliberalism (see Lyon-Callo 2000; Maskovsky 2000a; Maskovsky 2000b; Morgen 2002; Morsy 1995). My analysis extends the insights of these authors’ to reveal how neoliberal practices are also compromising the well-being of lower-middle and middle social class people and communities, specifically parents, midwives, and NGO staff in Philadelphia neighborhoods.

An incorporation of anthropology of the body into the literature that informs my work is of particular importance as my core focus of study is the shifts that have transformed the landscape of birth. Research recognizing that cultural constructions of the body occur on the level of the individual, the social, and the political situates the body as a unit of analysis that is helpful in understanding other cultural models in a society (Scheper-Hughes and Lock 1987; Martin 1992; Rapp 1993; Kaufert and O’Neil 1993). Similarly, analyses of the cultural construction of childbirth, a sub-focus of the anthropology of the body literature and a key topic of interest in my research, also inevitably reflect gender role organization, clarify social and political power dynamics, reveal factors that inform “ritual behaviors”, and illuminate the structure of ethnomedical

systems (Browner and Sargent 1996). Key concepts and issues highlighted within this area of work include power and authority and their impact on decisions related to childbirth procedures (Ginsberg and Rapp 1995; Jordan 1997; Craven 2005), critical analysis of various models of childbirth and pregnancy (Susie 1988; Davis-Floyd 2003), and the relationship between individual practices and beliefs related to pregnancy and childbirth and national or state ideology (Anagnost 1995; Rivkin-Fish 2004). My work incorporates each of these key concepts and adds to this literature by eliciting parents' birth experiences with particular respect to the recent reorganization of birth care in Philadelphia.

My examination of the role of local NGOs and their navigation of neighborhood and national policy and ideology builds on previous research on how non-governmental and local level organizations are situated within the larger political context. Recognized as key institutions in providing multiple types of support during social transitions, NGOs often compensate for a loss of local or community level of care by the direct provision of healthcare, by offering of educational instruction, or by acting as advocates for the individuals they serve (Gill 2000; Paley 2001; Hemment 2004). With the support of community members and with connections to other social institutions (Ferguson 2004), NGOs can have a powerful impact on policy and on the lives of individuals (Hyatt 1997; Naples 1998; Morgen 2002). Yet, as the literature theorizing the opposition between the state and civil society asserts, NGOs are subject to the same ideological influences as are both individuals and governments and, therefore, they can neither be viewed as impervious to ideological influences nor as entities that are separate from the state (Paley 2001; Ferguson 2004; Gledhill 2004; Goode 2006). I intend to add to this conversation

by examining the discourses and activities of local women's health-oriented NGOs as they navigate local politics and national ideology and attempt to offset the changes resulting from the restructuring of birth care in Philadelphia.

The location of my project in the city of Philadelphia obligates an integration of scholarship in the area of North American ethnography. This area of research provides guidelines on how an analysis of a US neighborhood and the circumstances of individuals living in the neighborhood should be undertaken. The circumstances of individuals and of neighborhoods must be viewed as a reflection of historically and geographically contingent processes (Goode and Maskovsky 2001) that are influenced by economic restructuring and political change, by state policies and social ideologies, and by individual agency and market relations (Mullings 1996; Naples 1998; Goode 2001; Hyatt 2001; Goode and Maskovsky 2001; Goode 2006; Maskovsky 2006). Most essential to the framework applied by these North American ethnographers is the centrality of power in structuring the conditions of late capitalism, and it is this core understanding of power as a fundamental focus in US Anthropology that I incorporate into my framework.

With respect to birth in the US context, work which summarizes US cultural constructions of childbirth and critiques the biomedical model of birth (Susie 1988; Davis-Floyd 2003) and work that examines the variability of women's views of childbirth by race and class (Martin 1992; Colen 1995) are starting points for my related project. Other ethnography in North America recognizes that the type of healthcare restructuring that has altered the landscape of birth in Philadelphia, and that is taking place nation wide, is linked to the practice of neoliberal economic policy (Kingfisher 2002; Maskovsky 2000b; Morgen 2002). This body of literature documents that policies

derived from neoliberal ideology as well as the privatization of public hospitals result in reduced access to health care (Maskovsky 2000a; Morgen 2002) and disproportionately affect women, particularly low-income women (Kingfisher 2002; Craven 2005). My research adds to this discussion on how the control of neoliberal ideals over the market and the utilization of neoliberal concepts to rationalize policy decisions have created shifts in health care practice that limit access to care and often jeopardize women's lives (Kingfisher 2002; Morgen 2002).

Research Questions

The data presented in this dissertation are the findings that follow from my two primary research questions. The first question is: What key components are driving the restructuring of birth in Philadelphia? This research question attends to the forces driving change on two levels. The first is the city-wide level on which I examined the local structure of maternity care. As will be detailed in this dissertation, I determined three intertwined components acting to restructure birth locally: hospitals, NGOs, and parents and providers embedded in the maternity care system. The second level of analysis stemming from my research question examines the broader component of national ideology. More specifically, I endeavor to understand the role of neoliberalism in the restructuring of birth in Philadelphia and how local articulations can extend our understanding of the impact of neoliberal policy and ideology.

Stemming from my first research question, my second research question is: How are people impacted by the restructuring of Philadelphia's maternity care system? In asking this question, I endeavor to understand what the changes in the system of care mean for parents as they make their choices regarding pregnancy and birth care,

and how their birth experiences demonstrate the consequences of the new landscape of maternity care. I also explore the implications of the restructuring of maternity care on health care providers. While the implications for obstetricians are considered, my research focuses on the professional ramifications for midwives. As providers who are politically portrayed in current birth culture as “outside” mainstream care, midwives’ professional livelihood is more precarious than that of obstetricians and their positionality is more easily affected by shifts in care standards. The third level of inquiry for this research question is the impact on individuals involved in the running of local NGOs. My research findings for this research inquiry point to the increased need for local initiatives and a corresponding response, yet a political economic environment that dissuades NGOs from engaging in the work that differs from the traditional definitions of work expected of NGOs.

Fieldwork and Data Collection Methodology

This study contains ethnographic data accumulated during my fieldwork in Philadelphia, Pennsylvania from spring 2006 to summer 2010. As the above research questions suggest, my research interests required the use of multiple methodologies in order to collect data that reflected the complex and interwoven relationships between the variety of individuals and institutions involved in the restructuring of maternity care. Long-term participant observation, in-depth interviews, and the collection of public records and media coverage served as the means through which I collected data; the method employed varied depending on the research question and the subject at hand.

My fieldwork began with my interactions with three NGOs located in Philadelphia, all of which focused on aspects of maternity care and wished to provide

either educational or direct services relating to pregnancy and childbirth to local parents. My participant observation began with the first of the three NGOs, which I have given the pseudonym “Parental Support Center”, in early fall of 2006 when I was invited to sit in on a childbirth class and simultaneously volunteered to help with the organization’s daily operations. I continued to serve as volunteer staff at this organization, with the exception of one year off half way through, until its closure and dissolution in spring of 2010. My interaction with the second NGO, the pseudonym for which is “Alliance for Family Wellness (AFW)”, began in summer 2007 when I was awarded an internship through Samuel S. Fels Fund Internships in Community Service. My brief internship with this organization inspired a deep interest in the organization’s practices. I remained connected to individuals within the organization and attended the meetings of one of their committees throughout the course of my fieldwork. It was through my connection to AFW that, in fall of 2008, I began attending meetings of the third and final NGO that is part of this dissertation research, which I will refer to in this dissertation as “Birth Advocates of Philadelphia (BAP).” I continued to attend the monthly meetings and intermittent workshops offered through BAP until my fieldwork drew to a close. My activities with each of the three NGOs varied based on the needs and interests of the NGOs themselves, yet throughout my fieldwork, I collected meeting notes, reports, handouts, and brochures distributed by each of the NGOs. I also kept descriptive field notes (Bernard 2006) tracking daily operations or meeting activities and changes in policy or procedures.

As my interactions with these three NGOs were initiated prior to the finalization of my dissertation research proposal, there is no doubt that my consciousness of the

changes occurring in maternity care and my research interest in the various components of this shifting landscape of birth grew out of the NGOs' keen awareness of the existing services for maternity care and how gaps in care were impacting parents in Philadelphia. Understanding the role of NGOs was one part of my ethnographic fieldwork; the other pieces included capturing peoples experiences of accessing and providing maternity care and detailing the flow of the system of care, particularly the direct care provided by area hospitals.

In addition to my observations, I relied on in-depth interviews with NGO founders and staff, with parents, and with midwives to collect data. This data illustrates how personal experiences of accessing or providing maternity care reflect both the shifting environment of care in Philadelphia and broader ideological trends. Interviews were conducted from fall 2009 through summer 2010.

Public records and media coverage (Bernard 2006) of hospital maternity unit closures and of the community response provide documentation on the timing of the changes occurring in Philadelphia as well as offer additional perspectives and interpretations of the shift in birth care. The natural biases present in this archival data add to the richness of this data and are critically evaluated and included in my analysis as contextual views (Brettell 1998).

The integration of the various forms of data collected, from newspaper articles to my participation in rallies and NGO meetings to the personal stories shared by parents and midwives, presents a portrait of the dynamic and complex interactions which together are reshaping the landscape of birth in Philadelphia.

Overview of Chapters

This project explores three key aspects of the newly restructured system of maternity care in Philadelphia. As such, the body of this dissertation is organized into three parts, with each part focusing on one of the three aspects examined in my fieldwork. Chapter 2 is a detailed examination of the process of the closure of hospital maternity units and of the impact of these closures on midwives and parents. Chapters 3-6 focus on the activities and influence of three very different local women's health non-governmental organizations (NGOs), and Chapter 7 assesses the ways in which parents navigate the current system of maternity care as they make decisions about pregnancy and birth care. Together, these chapters encompass the entirety of the research done during my fieldwork and the data collected. The addition of Chapters 1 and 8 (Introduction and Conclusion) completes this dissertation.

The first chapter introduces my research topic and situates my project within the broader history of US maternity care. I define the recent restructuring of Philadelphia's maternity system as the focus of my project, and present the main variables I examined: the closure of hospital-based maternity units, the activities of local women's health non-governmental organizations (NGOs), and the new set of pregnancy care and birth choices that people must navigate. Within this chapter, I detail my theoretical approach and discuss the key literatures from which my research stems. In addition to providing in-depth description of my research location and the politics and dynamics of the city of Philadelphia as they relate to my project, I introduce my research questions and describe my fieldwork and data collection methodology.

Chapter 2 focuses in on the location of my research, Philadelphia, and presents one of the three aspects at the center of my research: the dramatic shifts in hospital-based maternity care. In the first part of the chapter, I document the steady stream of hospital maternity unit closures that have occurred since 1997, providing details of each closure as well as discussing the politics within and between hospitals. Next, I detail the current situation in Philadelphia with respect to the number of remaining maternity units and the lack of alternative places to birth (such as birth centers), and discuss capacity for the remaining maternity units to provide the care the community requires. The second part of Chapter 2 provides a discussion and ethnographic data on what Philadelphia's hospital closures mean for people in the community. In addition to presenting the main themes uncovered through data analysis, I incorporate stories of midwives and parents who have faced challenges in providing or accessing maternity care due specifically to the shifts in hospital-based care.

Chapters 3-6 form the second section of this dissertation manuscript. Chapter 3 introduces the second focal point of my research: the activities of local non-governmental organizations. In the first two sections of the chapter, I engage the historical understandings of and the theoretical arguments on the location of NGOs within the social structure. I examine the influence of national ideology and policy, specifically neoliberal economic policy, on the structure and function of NGOs. The third part of Chapter 3 is designated to introducing each of the three NGOs that were part of my fieldwork.

Chapters 4, 5, and 6 are dedicated to the in-depth description and discussion of each of the three NGOS studied. In Chapter 4, I relay the story of Birth Advocates of

Philadelphia (BAP). BAP is the youngest of the three NGOs studied, and I have followed the organization from its beginning, documenting the successes and struggles BAP encountered as it worked to establish itself in Northeast Philadelphia. The Parental Support Center, the second NGO, is the topic of Chapter 5. While the Parental Support Center existed for only four years, the start-up organization located in Northwest Philadelphia served thousands of individuals even as internal and external tensions reshaped the structure of the organization. Chapter 6 focuses on the third NGO, the Alliance for Family Wellness (AFW). This established NGO provides a contrast to the recently founded BAP and Parental Support Center. Having provided resources and programs for families in the Philadelphia area since the early 1980s, AFW's breadth of programming and political sway far surpasses that of the other two NGOs I studied.

I designated a full chapter to each of the three NGOs studied so that I could examine the NGOs individually and in-depth, teasing out the circumstances unique to each organization. I also examine the relationships of the NGOs to one another and to the larger maternity system in Philadelphia. My in-depth analysis of each of the three very differently structured NGOs draws on theoretically established understandings of NGOs as entities intimately connected both to state apparatus and to fluctuations in policy that are derived from national ideology (Hula and Elmoore 2000; Goode 2006). I see these organizations as actively engaging with other social structures and as integral parts of a broader system, not as separated units that are solely acted upon (Gledhill 2004; Nugent 2004; Ferguson 2004).

In Chapter 7, I focus on the third main area of my research: the new set of pregnancy and birth care choices that people must navigate. In this chapter, I attend to

the situations encountered by parents as they navigate the current maternity care system. Pulling from my interview transcriptions, I present the stories that highlight the challenges, barriers, and issues that parents confront due to the recent restructuring of the system of maternity care. I also examine how the beliefs, choices, and actions of parents are part of the maternity system. I question how the decisions made by parents add to, challenge, and transform the system of maternity care in addition to documenting their attempts to control their birth experiences.

In Chapter 8 I summarize my findings and present my conclusions. In the first part of the chapter, I assess the connections between neoliberalism and various aspects of my work: the structure and function of NGOs, the interests of and choices made by parents and health care providers, and the shift in hospital-based maternity care. I also look at the system of maternity care in Philadelphia as a whole and draw conclusions on the influence of neoliberal policy on the system's structure. I reserve the second part of Chapter 8 for a review of my key results and I discuss ways in which the outcomes of my project add to our understanding of the relationship between political and economic trends in health care and the personal and professional experiences of individuals.

CHAPTER 2

PHILADELPHIA'S CRISIS

Introduction

In June of 2007, Carmen Paris, acting Commissioner of the Philadelphia Department of Public Health declared that the city was in the midst of a “maternity care crisis.” Backed by local health care providers and maternity care advocates, Commissioner Paris reached out to the Governor and State Legislature to provide financial relief for hospitals struggling to make ends meet and called for a task force to “...identify the right solutions” to the crisis occurring in maternity care (McGlasson 2007).

Like Commissioner Paris, the media focuses on the financial difficulties faced by hospitals in its coverage of the problems with maternity care in Philadelphia. News stories of the “maternity care crisis” are found most often in the financial section of the newspaper, and while television news reporters may make reference to the impact on parents and babies, the problems with maternity care are most often explained as a situation affecting hospitals, which are forced to close maternity units supposedly due to the financial burdens caused by high malpractice and low monetary compensation for prenatal care and births. This portrayal of the changes occurring in maternity care is blindly simplistic, to say the least, as I discovered almost immediately with the initiation of my dissertation field work. The role of hospitals in the provision of maternity care in Philadelphia is significant, as are the financial burdens of the *type* of maternity care provided by these hospitals. Yet, these issues are really only pieces of the maternity care situation in Philadelphia.

While a focus on the financial problems of hospitals may be an easy angle to approach the changes occurring in maternity care, this financial angle also glosses over the people involved. As described in Chapter 1, hospitals have become the mainstream location for maternity care and particularly for labor and delivery care. The scarcity of other care options that has resulted from hospitals' monopoly on birth means that the closure of so many hospital-based maternity units has an immense impact on people's daily lives. Among those affected are parents, babies, and health care providers including doctors, nurses, midwives, doulas, ultrasound technicians, and others whose line of work involves the provision of maternity care. Not only are people's jobs jeopardized, but the choices they are faced with in accessing and providing maternity care are limited, complex, and often double-edged.

The research presented in this dissertation focuses in on parents and midwives and their experiences navigating the shifting system of birth care in Philadelphia. The following sections detail the impact of hospital closures, specifically, on the lived experience of midwives and of parents. However, before engaging in those discussions, I provide a detailed description of the process of the hospital closures in Philadelphia and the consequences of this reduction for the provision of maternity care.

Details of Hospital Maternity Unit Closures

It is true that one of the most conspicuous results of the restructuring of Philadelphia's maternity care system is a drastic reduction in the number of hospitals with maternity units. Within twelve years, thirteen out of the nineteen hospitals in Philadelphia closed their maternity units. More accurately, five of the thirteen hospitals closed entirely, while the other eight remained in business but simply ceased providing

maternity services. In 2010, six hospitals in Philadelphia County continue to offer maternity care. While the loss of two-thirds of Philadelphia's maternity units over a dozen years is alarming, it is only in retrospect that the complete consequences of this string of closures become apparent. As only one closure occurred per year, on average, the beginning of this process did not catch the attention of the media, health care advocates, or the Philadelphia community at large. Only when the number of hospitals that had closed their maternity units began to equal the number of hospitals with maternity services in use did the impact of these closures become so obvious that the Philadelphia community began to take notice of the changes occurring.

In 1997, the Medical College of Pennsylvania hospital closed, and with its closure, Philadelphia lost the first of many maternity units. In 1998, Germantown Hospital followed suit; as Germantown hospital closed, Philadelphians lost a second maternity unit. The same year, Nazareth Hospital discontinued maternity services. In 1999, City Avenue Hospital closed entirely, and Roxborough Memorial Hospital ceased providing maternity care. The loss of these five hospital-based maternity units within three years was only a glimpse at what was on the horizon. In 2001 Episcopal Hospital discontinued maternity services, followed by Mercy Philadelphia Hospital and Methodist Hospital maternity unit closures in 2002. Parkview Hospital closed entirely in 2003. Frankford Hospital in 2006, Jeanes Hospital in 2007, and Chestnut Hill Hospital in 2008 all discontinued maternity services. In 2009, the last of the thirteen hospital maternity units closed as Northeastern Hospital ceased providing services.

Some of these hospitals are owned by larger health systems that chose to consolidate maternity services. For example, Episcopal Hospital, Jeanes Hospital, and

Northeastern Hospital are all part of Temple University Health System. Temple University Health System officials discontinued maternity services at these three hospitals located, respectively, in the far north-eastern tip of Lower North Philadelphia, in Near Northeast Philadelphia (located closest to central Philadelphia), and in the Richmond neighborhood of Philadelphia. Temple University Health system plans to compensate for the closure of these maternity units by expanding the labor and delivery unit of Temple University Hospital, located on Broad Street, the main thoroughfare of Upper North Philadelphia. Nazareth Hospital, located in Near Northeast Philadelphia, and Mercy Philadelphia Hospital in West Philadelphia, are members of the Mercy Health System. Other hospitals that closed maternity units were owned by conglomerates located far from Philadelphia. For example, the majority owner of Chestnut Hill Hospital, located in northwest Philadelphia, is Community Health Systems Inc., a conglomerate based in Nashville, Tennessee, that has a stake in 110 hospitals country-wide (Hoffman 2008).

The locations of these closed maternity units are significant in painting the picture of the result of this reduction of services. All of the thirteen hospitals that ceased the provision of maternity care are located in more geographically peripheral neighborhoods of Philadelphia. These closures have left some sections of Philadelphia with no hospital that will provide maternity care. Northeast Philadelphia, a sprawling section of the city that is home to nearly one-third of the entire population (U.S. Census Bureau 2000) of Philadelphia County no longer has a single hospital with a maternity unit. Northwest Philadelphia is also now without a local maternity unit. Conversely, the six hospitals that continue to provide maternity care are located in the city center or in immediately

adjoining sections of the city. Therefore, over the past twelve years, maternity care in Philadelphia has been concentrated geographically as well as institutionally.

Maps of Philadelphia maternity unit locations in 1997 and 2011 displayed below, with the permission of the author, illustrate this geographic concentration of maternity care. Figure 1 shows the location of hospitals with maternity units in Philadelphia in 1997. From this depiction, it is clear that all 19 hospitals in the city had operating maternity units and that the maternity units are located throughout the city, providing easily accessible local care for the individuals living in nearly every sector of Philadelphia. Figure 2 provides a visual of the location of hospitals with open maternity units versus hospitals with closed maternity units (or, in a few cases, the hospital closed entirely) in 2011. Figure 2 is helpful in illustrating the geographic concentration of maternity units within a small area in the city's center. Figure 3 displays the location of hospitals with maternity units in 2011. When considered in this visual format, the shift in the geographic location of maternity care in Philadelphia, in less than a decade and a half, is arresting.

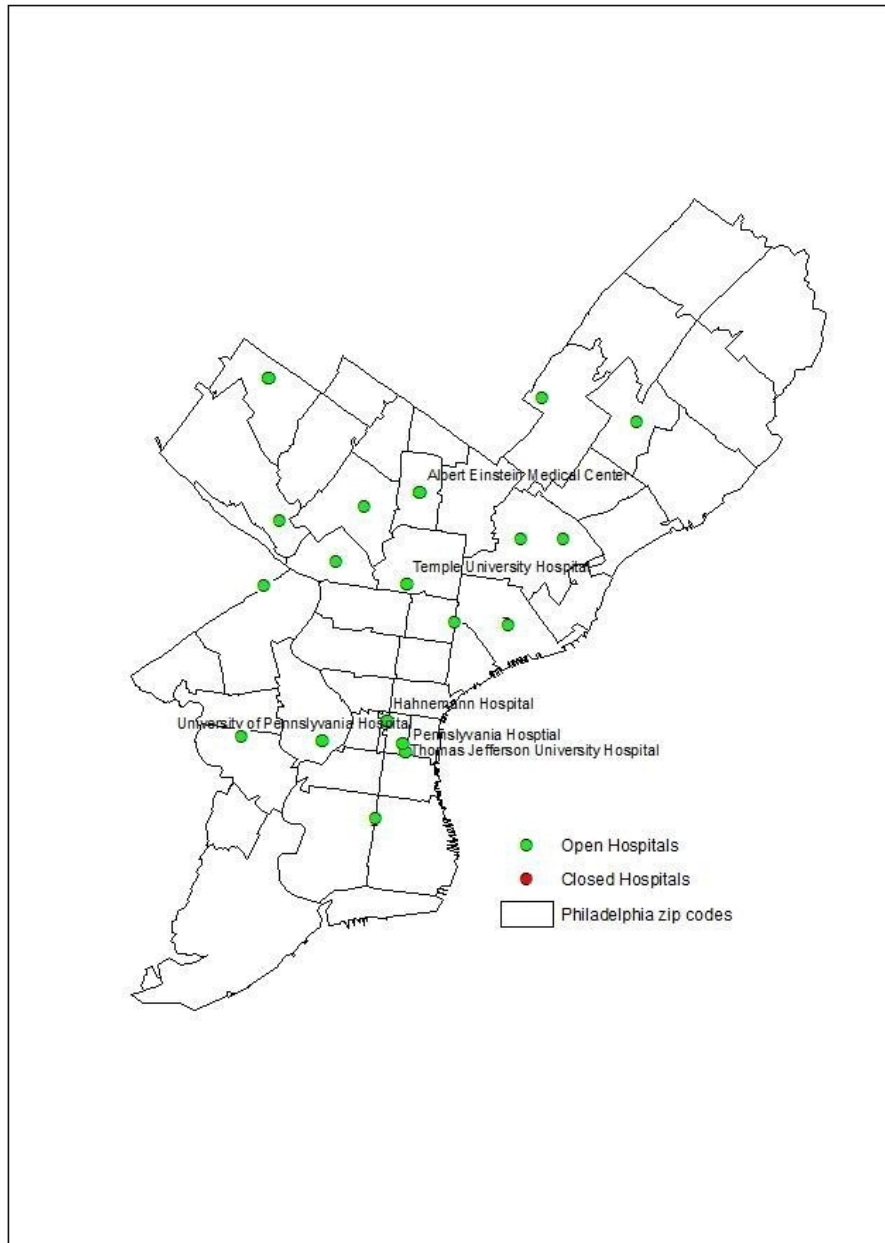


Figure 1: Location of hospitals with maternity units in Philadelphia in 1997 (Jadhav 2010)

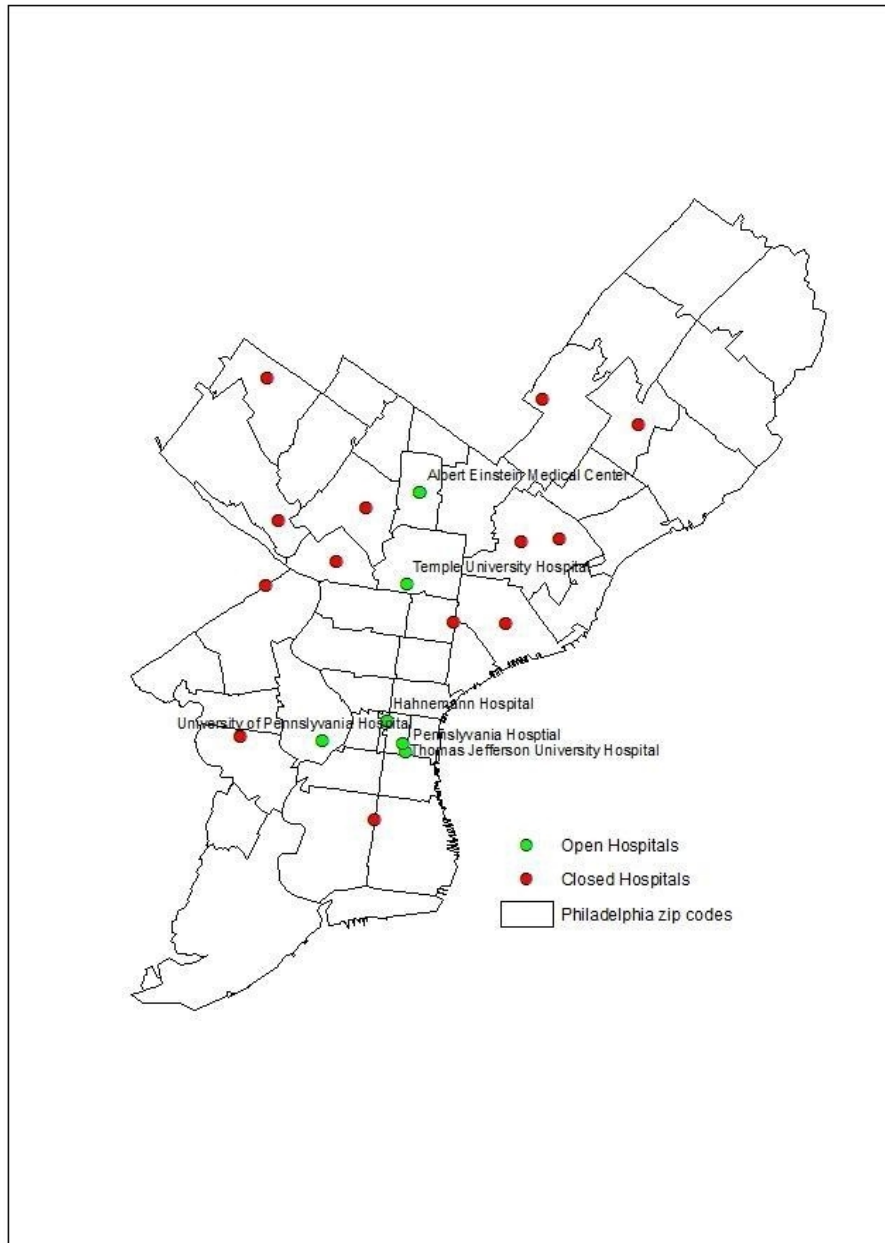


Figure 2: Location of hospitals with open and closed maternity units in 2011 (Jadhav 2010)

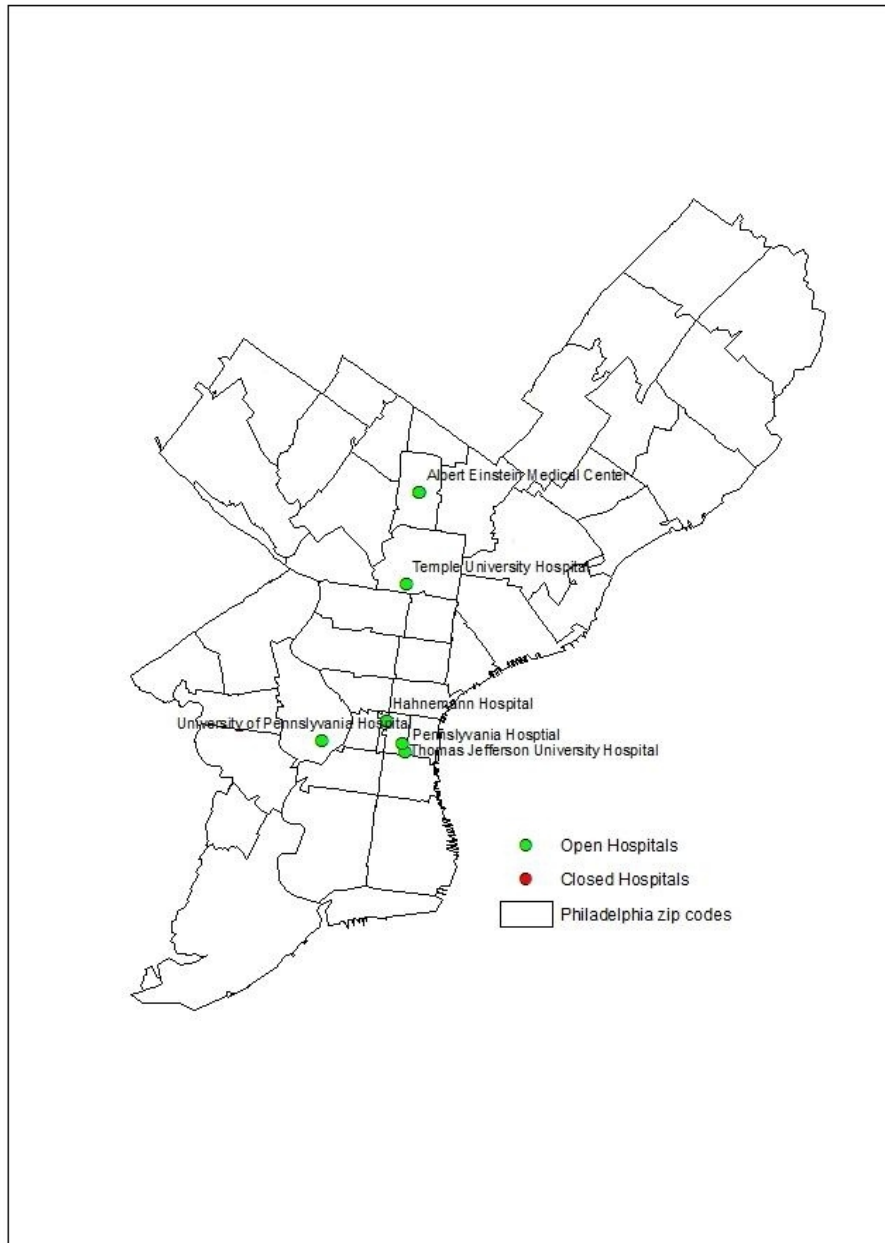


Figure 3: Location of hospitals with maternity units in Philadelphia in 2011 (Jadhav 2010)

Yet, it is not just the number or location of hospitals that is part of this consolidation process. The type of hospital providing maternity care has been reduced as well. All of the six hospitals that continue to offer maternity services are teaching

hospitals. They are: Albert Einstein Medical Center, Hahnemann University Hospital, Hospital of the University of Pennsylvania, Pennsylvania Hospital, Temple University Hospital, and Thomas Jefferson University Hospital. As part of a university system, these six hospitals have obligations to continue to offer maternity care in order to train their students. At the same time, these institutions are selective in the type of training provided. In the case of maternity care, this means that physicians are trained in the obstetric model to treat birth as a condition requiring medical intervention. The only exception to this educative hegemony is the nurse midwifery program at the University of Pennsylvania.

Shouldering the Burden: Impact of Closures on Remaining Maternity Units

The closure of two-thirds of Philadelphia's maternity units in a dozen years has greatly impacted the hospitals that continue to provide maternity care. With each additional maternity unit closure, the remaining hospitals' maternity units shoulder the burden of providing care for more and more births. Yet, when originally built, these hospitals were just one of many available to serve the maternity needs of Philadelphia parents, and the number of beds, number of maternity staff, and the hospitals' budgetary allocations reflect this. Remaining maternity units do not have the capacity to comfortably absorb the maternity patients left dangling by other hospitals' closures; they simply were not designed to provide care for so many births. And yet, the high rate of maternity unit closures has left remaining maternity units with no other option and the result is a dramatic escalation in the number of births at remaining hospitals which has pushed occupancy rates above the accepted standard. As Table 1 illustrates, the seven

maternity units that remained in late-2008 saw a drastic increase in births from 1997 to 2008. In just eleven years time, five out of the seven remaining hospitals experienced more than a 50% increase in the number of births, with three of these hospitals seeing increases of over 98%.

Table 1: Number of Births and Percent Increase from 1997 to 2008 by Hospital with Maternity Unit in 2008

Hospital	Number of births in 1997	Number of births in 2008	Percent (%) increase in births from 1997 to 2008
Albert Einstein Medical Center	1535	2810	98.50%
Hahnemann University Hospital	454	1936	373.70%
Hospital of the University of Pennsylvania	2578	4326	82%
Pennsylvania Hospital	3801	4986	42.90%
Temple University Hospital	1806	2493	51.90%
Temple East-Northeastern Hospital**	736	1820	165.60%
Thomas Jefferson University Hospital	2083	2123	11.20%

** Closed in 2009

Standards for maternity units suggest an ideal capacity of 75%, meaning that no more than three-quarters of beds should be occupied at any time, due to the unpredictable nature of labor and delivery. However, as Table 2 shows, the dramatic escalations in the number of births at remaining hospitals pushed occupancy above the recommended capacity.

Table 2: Obstetric Unit Occupancy Rate 2007-2008 by Hospital Maternity Unit

Hospital	Obstetric occupancy rate 2007-2008
Albert Einstein Medical Center	98.8
Chestnut Hill Hospital	N/A
Hahnemann University Hospital	68.1
Hospital of the University of Pennsylvania (HUP)	67.2
Pennsylvania Hospital	80.6
Temple University Hospital	98.9
Temple East-Northeastern Hospital	N/A
Thomas Jefferson Hospital	59.3
County total	79

This data, pulled from the Pennsylvania Department of Health’s Annual Hospital Questionnaire reports on obstetric unit occupancy rates from July 2007-June 2008. This data shows that at the time of collection, three out of the six hospitals for which data was available had obstetric occupancy rates above the accepted standard, some with dangerously high rates; Albert Einstein was at 98.8% capacity, Temple University Hospital at 98.9% and Pennsylvania Hospital at 80.6%. Interestingly, at the time this data was collected, Chestnut Hill Hospital and Northeastern Hospital still had functioning maternity units, yet no data was available for either hospital’s obstetric unit occupancy rate.

Outcomes of this strain on the capacity levels of maternity units are visible in the quality of care patients receive and in the methods of delivery employed by providers. Statistical data collected (and shared) by hospitals narrowly revolves around the number of vaginal deliveries versus the number of cesarean sections conducted, and tools used during these procedures. Even this limited data shows the shifts in practice that parallel the rise in occupancy rates. As more Philadelphia maternity units close, the rates of

cesarean sections (c-section) increase while the numbers of vaginal births and vaginal births after a previous cesarean section (VBAC) decrease. According to the Department of Health Statistics of the Commonwealth of Pennsylvania, in 1997, 19% of births in Philadelphia were delivered via c-section and 4.5% of births were VBACs. By 2008, 29.5% were c-section deliveries and 2% were VBACs. These statistics translate into a 55% increase in the number of c-sections performed in a span of eleven years, and a 55.5% decrease in the number of VBACs. Other data sources demonstrate an even higher c-section rate of 32.8% in 2008 (PA Department of Health 2008), a rate far above the recommended “safe-range” for c-section rates of 10-15% for industrialized nations (World Health Organization).

While this statistical data serves as a powerful indicator of the practice shifts that correlate with high occupancy rates, its focus is on the number of procedures conducted not the experiences of patients or care providers. During my dissertation fieldwork, I encountered many parents, midwives, and doulas who shared personal stories and anecdotes of others’ experiences that point to the diminishing quality of maternity care. Stories of women birthing in hospital hallways because no rooms were available, of women birthing unassisted because hospital staff was spread too thin, or of women birthing at home because their local hospital maternity unit closed and they felt uncomfortable or unable to access other options are among the many anecdotes shared with me during my fieldwork, yet hospital records and public health data do not document such occurrences. Patients also experience extremely long wait times for appointments, sitting in packed offices for hours for a brief appointment with a rushed obstetrician (see section titled “Bad Reputations” later in this chapter or “Audrey’s and

Mark's Story" in Chapter 7). Or, people may avoid practices and hospitals that are known to be overcrowded or "rushed" in their provision of maternity care, further reducing their options for care in an already limited environment (see "Betsy's Story" in Chapter 7). While politicians or corporate owners of local hospitals who favor the consolidation of maternity services may argue that the closure of maternity units across Philadelphia does not jeopardize parents' care experience or the well-being of providers, the data collected from my informants plainly suggests otherwise. The connections are clear between the closure of maternity units and the drastic increases in occupancy rates among remaining hospitals, and the shifts in the provision and experience of maternity care. Below, I pull from in-depth interviews conducted with midwives and parents to detail how their experiences have been shaped by the transformation in hospital based maternity care.

Midwives and Maternity Unit Closures

The thirteen maternity unit closures have impacted the midwifery community in a variety of ways. As discussed in Chapter 1, there are multiple segments of the midwifery profession, yet currently, only CNM's can practice legally in Pennsylvania. CPM's do practice in Pennsylvania, but do so without legal sanction. Because CNM's and CPM's have differing legal status and degree-level training, they assist births in varying settings. Whereas CNM's are legally permitted to attend hospital births, birth center births and homebirths, CPM's are not legally recognized in Pennsylvania, and therefore only attend homebirths. Due to these distinctions in legal standing, practice location, and individual professional circumstances, hospital maternity unit closures have had distinct repercussions for the diverse segments of the midwifery profession. For reasons of

clarity, I will discuss the impact of maternity unit closures for CNMs and CPMs separately, focusing first on midwives with a CNM degree.

The Many Work Settings of CNMs

The work environment of CNMs has been directly affected by maternity unit closures. Before the closure of 13 maternity units came to pass, CNMs worked in a variety of medical settings and locations in Philadelphia. Those who actively attended births at hospitals as part of their work were either on staff at hospitals as part of the maternity unit, or they had agreements with hospitals granting them privileges. In this situation, the midwife could have their own private practice in which they would provide prenatal care in an out-of-hospital setting and then planned in-hospital births for which they were the principle care provider. Or a midwife might have worked at a birth center, an independent health facility at which prenatal and birth care was provided and which had an agreement with a local hospital that allowed patients to be transferred to the hospital only in an emergency situation. Many CNMs in Philadelphia also worked in other capacities, such as providing prenatal care full-time at city health centers or even at hospital clinics – giving up their ability to attend births (due to time constraints) but instead trying to ensure that women received high-quality care during pregnancy. Although some midwives have been able to continue to work in these various settings after the closure of 13 of Philadelphia’s maternity units, the transitions that have occurred in the structure of the hospital maternity care system have greatly impacted the work environment and professional viability of many local CNMs.

As hospital maternity units continued to close, the number of work place options declined. Now, CNMs who wish to work as hospital staff find very few remaining

hospitals willing to hire them as full-spectrum practitioners, able to provide prenatal care, preside over patients' births, and offer post-partum care. Instead, many remaining hospitals flat out refuse to hire midwives as staff. Or, if they do hire CNMs, hospitals usually do so in ways that diminish or negate the professional training these midwives receive. For example, hospitals will severely constrain the independence of midwives through strictly regulating the patients they can see and procedures they are permitted to conduct, or by limiting their job descriptions to capitalize on the nursing skills of CNMs, having them provide prenatal or postpartum care, but substituting an obstetrician as the birth attendant. In these ways, midwives are constrained in their practices, are excluded from actually attending births and are treated more often as auxiliary staff instead of as primary care providers. In addition, midwives who have their own private practice but simply require a contract granting them hospital privileges find that most area hospitals refuse to award these contracts. Furthermore, shifts in the standards of maternity care provision that have corresponded to the disappearance of maternity units enable hospitals to exert power over birth centers, restricting the practices and procedures of these independent facilities and the midwives who work there.

As is delineated in the following discussion, the epidemic of maternity unit closures in Philadelphia has eliminated CNMs jobs, reduced their future employment prospects, complicated their current work environment, and constrained their professional autonomy. The outcome of the restructuring of hospital-based maternity care has been to further isolate, alienate, hinder, and control these health care providers who due to historic medical and social practice are already estranged from “mainstream” maternity care. The sections that follow provide details on the impact of the restructured maternity

system on the professional livelihood of various types of midwives (first CNMs, then CPMs) who work in various settings.

“Hospital” CNMs: Job Loss and Dwindling Work Prospects

For midwives on staff at a hospital, maternity unit closures mean the loss of a job. While physicians and nurses were similarly affected, the stakes were higher for midwives as not all hospitals are midwifery friendly. While an obstetrician or ob-nurse can theoretically apply for a job at any hospital with a maternity unit, midwives are restricted as many hospitals refuse to hire midwives as staff or grant them privileges. For example, of the 19 maternity units in Philadelphia in 1997, all had some type of midwifery service incorporated into their maternity care services, according to the recollection of my informants who are CNMs. Of course, all 19 hospitals also had obstetricians and ob-nurses on staff. In 2010, six maternity units remain. Only three of the six maternity units allow midwives to attend births – albeit in limited capacity. All six of the remaining maternity units have obstetricians and ob-nurses on staff. This situation holds true for hospital maternity units in counties surrounding Philadelphia, and nationwide. Essentially, the availability of jobs for CNMs who wish to work as hospital staff has been exponentially reduced in Philadelphia by the flood of maternity unit closures.

To complicate the fact that only three hospitals in Philadelphia will consider hiring CNMs, each of these three hospitals severely limits the scope and flexibility of their midwifery practices. Hahnemann University Hospital has a handful of nurse midwives on staff under their Obstetrical Department, yet their contract stipulates that the nurse midwives can only attend births during the regular work day. The nurse midwives are also given the task of gathering clients from the clinics associated with Hahnemann

and referring them to the Hospitals Ob/Gyn Department. The Hospital of the University of Pennsylvania has a private practice constituted of four nurse midwives. However, these nurse midwives are limited to providing care to patients in their practice; the nurse midwives are not allowed to provide care in the hospital's clinic. Pennsylvania Hospital, part of the University of Pennsylvania Health System, houses a nurse midwifery group. This group of seven to eight midwives is run under a "laborist" model, essentially meaning that the nurse midwives work in shifts to ensure that there is continuous on site coverage of the midwifery labor and delivery unit. However, the use of this model, which is now commonly used in obstetrical groups, by midwives has been criticized as breaking the continuity of care that is considered to be a hallmark of the midwifery model. This is because the use of the "laborist" model means that the nurse midwife who provides your prenatal care is unlikely to be midwife who attends your labor and delivery. So, while in-hospital nurse midwifery care is still obtainable in Philadelphia, it is limited considerably and has many constraints.

Concurrent with the maternity unit closures in Philadelphia, some hospitals in the counties surrounding Philadelphia also closed their maternity units. Although the total closures for all the surrounding counties combined does not near the number in Philadelphia, the closures added to the instability of CNMs professional livelihood. As one maternity unit closes, laid off midwives search for another hospital, either inside or outside city limits, willing to hire them. The serial nature of the maternity unit closures, however, has reduced job security, and midwives find themselves looking for a hospital that will support them every few years. The timeline of one CNM's professional career is a particularly telling example of the relentlessness of this process.

Gwen, one of the CNM's with whom I conducted an in-depth interview, explained in detail how her professional life has been affected by hospital closings. As a midwife who prefers practicing in a hospital and in fact refers to herself as a "hospital midwife", Gwen has always sought work in a hospital setting. Having graduated from nurse midwifery school in 1995, Gwen began her practice in Philadelphia in 1997. She recalls:

I got a job at Temple. Temple had started up a little midwifery service with 4 midwives and – in a North Broad office, and they had sort of a clinic population. That was a long time ago. So I worked there, and then, I had a contract, they wanted me to change my contract, I didn't want to, and they laid me off about 8 months into it...I got laid off. And they eventually closed that midwifery service.

And I got hired by Woman to Woman, I think it was called then. Which was Richard Jennings' practice...[He was] very famous in the midwifery world back in the 80s and 90s. He was running the Pennsylvania Birthing Suite; he started it. He was the suite – when it was independent, before it was owned by the hospital, and it was actually run by a private person. And he ran that with his wife who was a childbirth educator. Anyway, he got a good deal from Allegheny, which was that big organization that took over a bunch of hospitals. And he left. It was a big to-do. When I signed on, he had already moved to Allegheny. ...[T]hey were delivering babies when I was there at City Avenue Hospital. It used to be MCP, when MCP was still delivering babies. We had a clinic and a private practice there, and I worked with him for, oh, maybe a year, until Allegheny went bankrupt, Tenet took them over, evaluated everybody and laid us all off. So his private practice was actually owned by Allegheny, so the whole thing was in flux, so I got laid off a second time.

And right around the time that I was going to get laid off, I got a phone call from the private midwife...who had been around as Franklin Associates, which were the people who were in the Booth's – Booth Maternity Center, back then. When Booth sort of disappeared, all those midwives set up their own practices. She had a practice out of Blue Bell, in her home. She called me up and said, I'm looking for a partner. Do you need a job? And I said yeah, I'm about to lose my job, actually. And I jumped from sort of the clinic population – big, big practices – to a privately owned practice. She then three years later decided to retire, and we hired – she started to phase out, we hired another person, and then she retired and handed me and [the newly hired midwife] the practice. And then, [the newly hired midwife] moved. And that's how I got to be solo. It went from like an 8, to a 4, to a 3, to a 1.

When I was with [this practice], we delivered at Lankenau. So I was at Lankenau for 10 years, in this private practice, delivering in Lankenau. My Lankenau docs, different docs changed around, and at one point some of the docs

who were not interested in having midwives and backing up midwives, they called a meeting, it was a tie score, someone broke the tie, they said, you know what, we're ready to sort of stop the midwifery thing, we've covered you for 15 years, it's enough now. We induce all our patients, we don't need you to come in, but we'll help you find somewhere else. I said, I'm fine, I got Chestnut Hill. I contacted [people at] Chestnut Hill.... So I was there for, you know, a year and a half, and then it closed. Somehow I landed on my feet every time, it's a miracle. It's a complete miracle. And even the Montgomery thing is a complete miracle. And if that didn't happen, I probably wouldn't be doing it now. I wouldn't be a midwife.

As she mentions above, Gwen is currently working at Montgomery Hospital, in Norristown, and has been there since Chestnut Hill Hospital closed their maternity unit in 2008. In the thirteen years that Gwen has practiced, her practice has suffered two layoffs, one hospital ceasing to provide midwifery services, and one hospital closing its entire maternity unit. The frequency with which Gwen has had to secure a new work place has taken its toll:

I feel like there's a lot of uncertainty. I think when I went – you know, I lived through 2 or 3, those layoffs, and...everybody closing hospitals, like, whatever. When I changed hospitals from Lankenau to Chestnut Hill, and then the subsequent stuff, now everything feels really tenuous to me. Like, anything could happen. Someone could sue me, I could lose my insurance; I won't be a midwife anymore. The hospital could close tomorrow; I won't be a midwife anymore. And I didn't have that for a long time. I didn't feel that. So it feels really uncertain. Like I don't – I don't know if I ever imagined being a midwife until I'm 60, but I'm not so sure that – it feels like I do it on a year-to-year basis. I get my insurance coverage for a year. They insure me for another year, okay. They're insuring me. The hospital usually has to give you 90 days' notice. So I feel like it's much more tenuous now for me. ...But, so that's been really hard for me, to feel like any day, I have to come up with a new career.

Gwen's career path illustrates the instability and insecurity that midwives face as hospitals close maternity units and phase out midwifery care. Over 13 years time, Gwen has worked in some way, either as staff or as a midwife with privileges, with five different hospitals. As she explains it, she never moved between hospitals on her own account, but was instead forced to relocate due to contract terminations and maternity

unit closures. While Gwen has been able to recover after each layoff, the restructuring of the maternity care landscape has altered Gwen's practice dramatically. At one time, she was able to secure staff positions at various hospitals. Yet, as hospitals repositioned their priorities regarding maternity care, this type of employment became more difficult for Gwen to obtain. Steered away from this work environment, Gwen joined a small midwifery practice that provided prenatal and postpartum care in a private office and had hospital delivery privileges. With the loss of her two partners, Gwen began a solo practice. She said, "It went from like an 8, to a 4, to a 3, to a 1." Professionally, Gwen has been increasingly isolated from other health care providers and from the hospital-based maternity system.

Currently, Gwen runs her practice entirely alone, without the direct support of other midwives, physicians, or even an administrative assistant to help with appointment scheduling and insurance payments. She provides prenatal and postpartum care in an office she rents, and has delivery privileges at the closest hospital she could locate that still has a maternity unit and is willing to allow her to be the primary practitioner when her clients give birth. This hospital is about a 30 minute drive, without traffic, from her private practice office. Gwen says it's a miracle that she has been able find a new arrangement each time she is left without a place to deliver. Unfortunately, Gwen will soon need another miracle; I recently learned that the hospital at which she currently holds privileges, located in Montgomery County, will close its doors in 2012.

CNMs Who Work in Birth Centers

In a city where approximately 22,000 births occur every year, it seems reasonable that a freestanding, independent birth center would exist. However, there is not one

freestanding birth center in Philadelphia County. There are two birth centers located not far from city limits, though. One of the birth centers is located to the northwest of Philadelphia; the second birth center is located northeast of Philadelphia. The two centers are designed and run in remarkably different manners, yet both confront similar barriers due to legal stipulations and the ability of hospitals to exert increasing control over the practices and procedures of these birth centers.

Pennsylvania law has specific licensing requirements for birth centers. While a birth center may be owned and operated by a midwife or a community of midwives, the birth center is required by law to have a Physician Director of Medical Affairs. This physician must be board certified and must practice obstetrics. In addition, birth centers in Pennsylvania must secure a written transfer agreement with a physician who has admitting privileges to a hospital-based obstetric service for when complications or emergencies arise (Commonwealth of Pennsylvania 1998). The Physician Director of Medical Affairs and the physician with whom the birth center secures a written transfer agreement can be, and is indeed likely to be the same individual. The legal requirement that a birth center have an obstetrician as Medical Director and must secure a written transfer agreement with an obstetrician can pose as an obstacle since in the US maternity care system obstetricians and midwives are positioned at odds with one another and midwives are often seen as “competition” by obstetrically trained physicians. In addition, the requirement that birth centers have a written transfer agreement with an obstetrician who has privileges at a hospital with an active maternity unit connects independent birth centers with hospitals. This connection may be fairly distant if the obstetrician with whom the written transfer agreement is negotiated owns their practice themselves.

However, if the obstetrician's practice is owned by the hospital, which is more and more frequently the case due to the skyrocketing cost of malpractice insurance, the obstetrician does not have the power to directly negotiate a written transfer agreement with a birth center. Instead, it is the hospital that has final say regarding a written transfer agreement with a birth center. This situation establishes a dependency between birth center and hospital that favors the hospital. It is the birth center that needs an agreement with a hospital, not the other way around.

As one might imagine, the relationship between birth centers and hospitals is fragile and unstable. The restructuring of the Philadelphia maternity system has made this relationship even more tentative. The closure of two-thirds of the city's maternity units has reduced the number of options for birth centers in need of a written agreement. In addition, the maternity unit closures condensed the power which hospitals hold over birth centers into the hands of just the few hospitals that have maintained their maternity services. In Philadelphia, all six of the remaining maternity units are run by teaching hospitals - nearly all of which adhere to strict biomedical, obstetrical prenatal care and delivery methods. The closure of 13 of the city's maternity units has severely limited to options of birth centers. Not only does this inhibit the creation of birth centers within Philadelphia city limits, but it also reduces the flexibility of the two birth centers located to the northeast and northwest of the city. These two birth centers have found themselves increasingly dependent on their "collaborative" hospitals and are subject to the whims of hospital administrators. The dominance of both the biomedical model of care and of hospital control in constructing how care is accessed is apparent in the interactions between birth centers and hospitals. Hospital management is keenly aware of this

unequal power relationship and, as the situations of both birth centers show, hospitals take full advantage of their position of power by controlling the procedures and access of birth centers, and the autonomy of the midwives that staff the birth centers.

The story of Woman's Way Birth Center (pseudonym), one of the two birth centers located in a suburb outside of Philadelphia, illustrates the level of control that hospitals have over birth centers and the impact that hospital maternity unit closures can have on the operations and success of independent birth centers. In line with Pennsylvania state law, Woman's Way Birth Center had a Physician Director of Medical Affairs who was also the obstetrician with whom they had a written transfer agreement. This obstetrician's private practice was located at a hospital in Montgomery County, and it was to this hospital that Woman's Way Birth Center clients were transferred in case of a complication or emergency. The relationship between this obstetrician and the midwives who ran Woman's Way Birth Center was very positive and neither the obstetrician nor the midwives wished to alter the arrangement that had been negotiated. However, the obstetrician determined that he would sell his practice to the hospital in which he had worked for many years. The midwives at Women's Way were informed of this and, like the obstetrician, did not anticipate any alteration in the written transfer agreement that the two parties had negotiated. However, the hospital administrators had a different idea, and once the hospital owned the obstetrician's practice, Women's Way was told in short order that their written transfer agreement was nullified. Women's Way had to find either another private practice or a different hospital that would consent to a written transfer agreement.

For three months, Women’s Way closed as the midwives who ran the center located a new hospital with which they could secure a written transfer agreement and then underwent the credentialing process that was necessary before the new agreement could be finalized. This hospital, Lifescape Hospital (pseudonym), happened to be located in Philadelphia and was known to be midwifery friendly. Unfortunately a short while after Women’s Way received transfer privileges Lifescape Hospital announced it would close its maternity unit. Again, Women’s Way had to find a new “collaborator” for their written transfer agreement. Luckily, Women’s Way was able to do so fairly seamlessly this time, without having to close while it made arrangements. The new collaborating hospital, Hutchinson Hospital (pseudonym), is located in a county outside of Philadelphia. This hospital is located further than the two hospitals with which Women’s Way had written agreements; it is over a 30 minute drive from Women’s Way Birth Center, but as it is one of the few remaining hospitals in the area that will consent to a written transfer agreement with a birth center, Women’s Way has little choice but to gratefully accept the hospitals collaboration.

Within just a handful of years, Women’s Way has had three different agreements at three different hospitals. While the midwives who run Women’s Way tell me that they rarely need to transfer patients to a hospital, the simple fact is that the birth center must have a written transfer agreement in order to operate legally. This independent birth center has been lucky enough to rebound from the recent challenges faced, but its long term success is uncertain. If the current collaborative hospital nullifies the written transfer agreement or closes its maternity unit (it is rumored the hospital will do so within

the next few years) Women's Way will again have to search for a new collaborating hospital or private practice, and the options are getting leaner and leaner.

As the story of Women's Way Birth Center reveals, the very existence of independent birth centers relies on the support of obstetricians and hospitals. The current landscape of birth in Philadelphia and the surrounding counties does not bode well for the stability, the proliferation, or ultimately the survival of birth centers. For the midwives who are the primary staff at birth centers, the shifts in the standards of maternity care combined with restrictive legal stipulations create an environment of insecurity.

Vulnerable to the whims of hospital administrators and reliant on the continued existence of maternity units that are within reasonable driving distance, birth centers have become increasingly dependent on support from the very institutions which uphold the model of maternity care that midwives and birth centers challenge.

Homebirth Specialists: The Impact of Maternity Unit Closures on CPMs and CNMs Who Attend Births at Home

In this portion of the chapter, my focus is on describing the situation for CPMs who work in the Philadelphia area. Since Pennsylvania law does not recognize CPMs as licensed birth attendants, those working in the state only attend homebirths. Therefore, the following subsections relay stories and examples regarding how the practices of these homebirth specialists are affected by the closure of hospital based maternity units.

However, it is important to point out that CNMs may also choose to include homebirth as part or all of their practice, and therefore may encounter the same, or similar, issues as do CPMs.

Due to the lack of legal recognition, CPMs cannot secure the formal contracts that CNMs develop with hospitals. Although the relationship may differ slightly depending on the individual midwife, hospital, and community, by and large CPMs are unable to attain professional support from obstetricians or hospitals due to malpractice concerns. This lack of support means that CPMs have no alternative but to arrive unannounced with their patients at the emergency room if a serious complication occurs during labor, for which they are admonished by hospital staff. Of course, this system is undesirable for all those involved, and responsible CPMs do everything possible to prevent such occurrences: screening prospective clients to ensure they understand the medical limitations of homebirth, accepting only clients with a low-risk pregnancy, offering well-woman care throughout pregnancy, and ordering screening tests when necessary.

While CPMs prepare for and are able to handle some complications during labor and delivery, there are times when circumstances necessitate medical care beyond what can be provided in an in-home setting. These situations require the CPM to transfer their patient to the closest hospital for emergency care. Since CPMs are not recognized in PA as birth attendants, once their patient is on hospital grounds the CPM is unable to provide any further care. The patient becomes the charge of the hospital's nurses and obstetricians.

Unlike CNMs and other state licensed health care professionals, CPMs are not integrated in any way into the hospital system. Therefore, the scenario regarding hospital maternity unit closures has different nuances for CPMs than for midwives with different credentials. For the few CPMs serving the population of Philadelphia, maternity unit closures have complicated the already difficult interactions with hospitals.

Some issues that have arisen with the closure of maternity units have to do with the geographic concentration of functioning maternity units in central Philadelphia and the high occupancy rates of these units. As CPMs go to their clients homes to assist with births, the loss of “neighborhood” hospitals with maternity units has become an added safety issue. Whereas in the past, it may have been a 15 minute drive from a clients home in, say, Northeast Philadelphia to a hospital maternity unit, it can take double that or more to transport a client to one of the six remaining maternity units in Philadelphia or to hospitals in surrounding counties. Many of the midwives I spoke with say that in most situations in which they must transport a client to a hospital, they have between a 20 minute and 40 minute window of time to safely get a client to a hospital. However, the added distance to a hospital combined with the unknown variables of traffic conditions and the hospitals current level of occupancy (which, as discussed earlier, is likely at or above the recommended capacity) increases the likelihood that an emergency transfer to a hospital ends in tragedy. A CPM named Sylvia bases her practice out of a neighborhood in the lower-central part of the city. During our in-depth interview, she noted that driving time to a hospital with a maternity unit is not often a concern for her particular practice since most of her clients are local and are therefore within a few minutes drive to one of the six remaining maternity units in Philadelphia. However, she did point out that the high occupancy rates of these maternity units, and the overcrowding that results, is a concern:

We did recently have to go to a hospital and I was more just seeing overall from a public health perspective, they were full up. They had to have people on different floors for the recovery because their post-partum was full. And so they still have to take you, but it's just...as a public health crisis and just as that factory mentality being promoted more and more. So it's more that I see, it just scares me that, you know, it just promotes the get-em-in, get-em-out mentality, when people are

under the gun of like, “Are we even going to have enough beds for getting through the night?” and that kind of thing...Certainly, we are always kind of mindful, definitely if we do births up in the Northeast, it's like, well, we're pretty much going to be coming to Center City.

While distance to a maternity unit is usually not a problem for Sylvia due to the location of her practice and her client's homes, the overcrowding at maternity units and the overburdened staff have become a cause for concern. Having to be “mindful” that in the event a homebirth requires an emergency transfer, the receiving hospital maternity unit will likely be above capacity is a burden that no midwife should have to carry, particularly in an urban area where hospitals (though, now without maternity units) abound. For CPMs who practice in less central sections of the greater Philadelphia region the concern may differ; distance to a hospital may weigh more heavily on their practice than overcrowding.

The closure of “neighborhood” maternity units impacts CPMs in other ways as well. In some instances, the now further distance from home to an active maternity unit steers potential clients away from hiring a CPM. For example, Jessica, one of the parents I interviewed whose story is discussed in more detail later in this chapter, seriously considered birthing her second child at home with the help of a CPM. However, Jessica discovered that since the hospital located closest to her home had closed its maternity unit, she would be transferred to a hospital at least 25 minutes away from her home if an emergency situation arose during her delivery. Although Jessica felt it was unlikely she would have a complication during delivery, the amount of time it would take for her to arrive at a maternity unit if an emergency did occur was too long for her comfort. Because of this, she decided against hiring a CPM and birthing at home and instead opted for a hospital birth under the care of an obstetrician. So, while CPMs do not work in a

hospital setting, the loss of maternity units can deflate their practice. The closure of “neighborhood” hospital maternity units that would serve as an emergency back up can sway parents away from attempting homebirth and hiring a CPM to assist.

The closure of maternity units and the restructuring of the provision of care in remaining hospitals certainly present new obstacles to CPMs, but these shifts also exacerbate existing issues. For instance, as their credentials are not recognized by the state, CPMs are seen by hospital administrators and staff as civilians and therefore their knowledge regarding childbirth is often dismissed and their activities related to maternity care are often painted as irresponsible and dangerous. In light of this, developing a positive rapport with hospital staff can be extremely difficult for CPMs. Yet, in an attempt to alleviate the agitation that can erupt for all parties involved in the case of an emergency transfer, most CPMs work hard to build a positive relationship with hospitals. This relationship is usually built slowly over many years as the CPM dispels the negative stereotypes and proves herself a respectful, knowledgeable, responsible provider. In other words, CPMs must become “known” and trusted by hospital staff based on their skills, not their credentials.

Of course, some hospital staff will be more supportive of CPMs than are others. Even after developing a positive rapport with particular provider, CPMs may find that a department head or the institutional politics of the hospital remains a problem. Sylvia, who has worked as a CPM in Philadelphia for the past eight years, discussed her approach with hospital staff and pointed out that the support of one provider may not be enough to ease the tension between midwife and hospital:

I mean, my approach has generally been to present myself as a competent, trained professional and be treated as such. But sometimes that doesn't work....

Sometimes it works, sometimes not. Sometimes people are like, “Ah, no. You don't really count here.” But often, it's been really helpful, and I would say the majority of time, we are received well. I went to this hospital this morning, and the doctor saw me. I'd gone to the appointment with the client, and she was like “Sylvia!” ... You know, but out of one side of her mouth, she's like really accessible and supportive and everything else and then the next part of the conversation was how the head of her practice was like, “Stop seeing these people's clients.” So we're still trying to work through that.

For a CPM who has garnered support, or at least limited negative receptions upon arrival at a hospital by proving her skill and her respect for hospital staff over a long period of time, the closure of a maternity unit can be a blow to the stability of her practice. Maternity unit closures scatter health professionals and result in a loss of the diligently developed and delicate relationships that CPMs build with hospital staff. These individuals served as “inside” contacts who helped ease the often tension filled emergency transition from attempted homebirth to hospital care. This type of positive relationship benefits all: parents, hospital staff, and midwives. With the closure of a maternity unit and the dispersal of “inside” contacts, midwives must begin the arduous process of building a positive rapport with different hospitals, usually located further from the area in which she practices, and new health care providers who are unacquainted with her or her clients.

The situation in Philadelphia is doubly difficult for CPMs. Not only have the string of maternity unit closures negated the hard won support of staff at particular hospitals, but the repositioning of hospital maternity care as even more biomedical (the counterpart to the drop in number of maternity units) makes bridging the barriers between ideologies of care even more challenging for CPMs. Since all of the remaining six hospitals with maternity units in Philadelphia are teaching hospitals that train obstetricians (and a few CNMs) to view the hospital as the only appropriate location for

labor and delivery, the fundamental ideology of the hospitals and of CPMs is opposed. Although CPMs continue their efforts to build relationships with hospital staff, their work is an uphill battle.

Another issue with which CPMs must contend now that there are so few hospitals offering maternity care is access to prenatal testing. The majority of prenatal care for a homebirth is done by the midwife either at their office or at their clients' homes. However, certain tests and procedures, such as ultrasounds, require the expertise and technology of other professionals who are based in hospitals. For these kinds of tests, CPMs prefer to refer their clients to practices or specialists with whom they have built a positive relationship and who are sympathetic to the needs of parents and midwives who conduct homebirths. Yet, when necessary, CPMs will refer to any hospital, usually the one that is most convenient for their client. However, the closure of maternity units has made locating quality prenatal testing increasingly difficult as midwives find they can no longer send clients to any hospital (with or without a maternity unit) and expect the same level of care.

This issue impacts all midwives who conduct homebirths, both CPMs and CNMs. While those who are employed by hospitals (with maternity units) or birth centers have direct access to fully-functioning maternity units and the auxiliary staff who specialize in all aspects of prenatal care, homebirth midwives lack contracts with hospitals, and therefore when their client's health care needs necessitate special prenatal tests they must locate a hospital to which to refer their clients. Often, this will be the hospital located in closest proximity to the client's home or a hospital that accepts the client's insurance. Before the closure of maternity units became popular among hospitals, finding a location

where clients could access high quality prenatal care was not too difficult a task. Even if a CPM was not familiar with the hospital that their client wished to use for prenatal testing and as their emergency back up they could confidently send their clients to any hospital for testing, knowing that the maternity care professionals who worked at the hospital had sufficient expertise needed to conduct tests and interpret the results.

However, as hospitals cease the provision of maternity care, staff specializing in various aspects of prenatal and birth care are let go. The closure of maternity units results in a loss of jobs not just for midwives, but for doctors, nurses, and screening specialists as well. The departure from hospitals of professionals who specialize in maternity care leaves a void for parents who seek any level of maternity related services. For example, a woman in labor who arrives at the hospital nearest to her home is increasingly likely to find no maternity unit, no obstetrician, no midwife, no OB nurse, and no health care professional who has any skills regarding labor and delivery care. Likewise, a woman who arrives at the same hospital looking for a prenatal ultrasound will likely find that there is no longer a technician whose primary focus is pregnancy/fetal health and no longer an analyst skilled in reading and interpreting fetal ultrasounds and preparing ultrasound reports. The repercussions of this deficit of knowledge regarding basic prenatal care and fetal health can be severe, as midwives have discovered. During two different interviews with midwives who conduct homebirths, one a CPM, the other a CNM whose practice is 50% homebirths, each midwife pointed out this issue of access to quality prenatal testing as an unexpected challenge that developed with the closure of hospital maternity units. In particular, both of these midwives share stories about the difficulty of sending clients for ultrasounds, and the “misses” of ultrasound technicians.

Here, I will share comments made by Hannah, who discussed the issue of prenatal testing in detail during our in-depth interview. Hannah practiced for 20 years as a CPM before earning her CNM degree. She has attended homebirths for 30 years and began attending hospital births ten years ago. Hannah had obtained privileges at Chestnut Hill Hospital, when it still had a maternity unit, and sent many of her homebirth clients to the hospital for prenatal tests. Reflecting on the challenges presented to the homebirth aspect of her practice due to maternity unit closures, she points out this issue of prenatal testing:

Now we even have problems with testing. It's hard to send women for their ultrasounds now. Before, they went, I was at Chestnut Hill [Hospital], you went to Chestnut Hill [Hospital], you got your testing. I collaborated more with the perinatologist. She told, okay, this is the problem, this is what we're gonna do, this is how often we're gonna have testing, this is the, you know, the medication or whatever. It was all easy. Now it's like, "I don't know. I don't know where you're gonna go. Your insurance says you have to go there. They don't have internal fetal medicine, but you're higher risk and I want you to see, you know, a perinatologist as opposed to just a radiologist who's gonna do an ultrasound." It's terrible.

I had two [clients who birthed babies born with] cleft lips this year, not picked up on regular, what we call, anatomy scans. That would have never happened at Chestnut Hill [Hospital]. Never, ever, ever. So I already see the quality of care is going way down. Way down. I had an ultrasound the other day, didn't even mention the baby's face. Didn't mention the baby's face! What else was it? The femur length and the genitalia. Even if [the parents] don't want to know [the fetus' gender], they usually say, "normal genitalia present." Nothing. Didn't even know! Oh, it doesn't have any? Are we ambiguous here? It was just terrible. So the quality of care, you know, where to send women, is just all falling apart, it really is. You know, for us, since Chestnut Hill [Hospital's maternity unit] closed, it has been a nightmare of where to send people, and trying to find perinatologists, and who's high-risk, and who's not.... The cleft lips - that shouldn't have happened. That's a major anomaly. These moms should have been prepared that this was going to happen. They both did good. One didn't do as good as the other. But, you know, it's shocking, to have [the cleft lip] all the way up and it's shocking. They should have known, had some psychological preparation, maybe chose not to have home births. You know, not that it was a problem. Both babies breastfed well. But they might have chosen not to [birth at home]. And then of course in your mind you're thinking, "oh my gosh, what else are we missing here? Are we missing major heart anomalies? What else are we missing?"

....Older women [who are pregnant], trying to get them in for their testing, it's just impossible. It's impossible trying to get the ultrasounds. And their testing has to be done within certain [number of] weeks. [Hospitals say,] "Oh, we're overbooked, we can't schedule it for then." It's like, well she'll be too late for then. "Oh well. Sorry." It's like, if they want this testing, it should be available to them. So it's really bad.

....But this kind of stuff is [getting] even worse. Trying to get them their ultrasounds and their testing, and if there's a problem, where to go. It's, yeah...big problems, where to go, it's really been hard. That's really, really been hard. [I had a client who was pregnant with a] really anomalous fetus that mom chose to terminate – it wasn't compatible for life. And trying to find her somewhere to go, it was like, "oh, we can't see her for 4 weeks." It's like, well, she can't wait 4 weeks. She's got to end this today, or before the end of the week, it's Wednesday. Because there's time periods with weeks and stuff like that. It's like, "No. You're going to force this woman to do something if we don't deal with this by the end of the week. Carry to term, and deliver a baby that she knows is going to die, because it's not compatible for life." Where that didn't happen at Chestnut Hill [Hospital]. We had a perinatologist and it was all just handled right there. We identified, genetic counselors and counselors were brought in and it was discussed and it was just all handled right there. Kept the same provider. So now it's like, okay, you have this particular incident, terrible anomalous fetus, not compatible for life. Now we've got to find you new providers, and you've got to go through that whole thing of the trauma of that, and where, how can we terminate this pregnancy, and we've got 4 days to do it. It just, those kind of things are horrible. It is hours and hours and hours and hours on the phone, trying to figure it out and work it out. And we're sending them to 2 states away. Or another woman had to go, oh my gosh, I can't even remember... Indiana or something. We were sending her way states away. Because it was identified, they weren't sure. The next test, the amnio, by the time they got it, she was too late for Pennsylvania, and there was only one state that she could terminate that late. And it just is like, this kind of stuff, it shouldn't happen. Women shouldn't be traumatized like this. It's horrible. It really is. And that's, again, because of less places to provide care.

The one ultrasound with the terribly anomalous fetus, they didn't even pick that up earlier on. I mean, his organs were not on the right side of his body. They were – he was missing things. And it was like, how did you not see that earlier on? It wasn't like they were there and then they weren't there. I mean, really poor, poor – because it's just regular ultrasound people. You know, they're going to radiology now, instead of a perinatologist who's reviewing this and [will notice], "wait a minute here, that's not right." [Now, clients who go to] any hospital, any random hospital, that's not [the radiologists] specialty. They're doing gall bladders, and then they're doing a fetus.... it's all this – it's so impacting the quality of care for the women for sure. Absolutely.

Hannah brings up multiple components of the problem of accessing prenatal testing for her clients who want a homebirth. The main theme within Hannah's narrative is the decrease in the quality of care given by hospitals to her clients. She alludes to the closure of Chestnut Hill Hospital's maternity unit, stating that since that closure, she has extremely limited options regarding where to send clients for prenatal testing, particularly for ultrasounds. She points out that the closure of maternity units exacerbates insurance stipulations and has also resulted in overcrowding and excessive wait times for appointment scheduling at remaining maternity units. She relays her experience of having to send clients to other states for care due to the overloaded capacity of area hospitals and their inability to provide patients with timely appointments. Hannah also relates stories of clients who have received ultrasound reports that are missing basic information or that completely overlook major anomalies, due to the inexperience of the radiologists at hospitals that have closed maternity units and therefore no longer employ maternity specialists. She focuses on the trauma that these inadequate ultrasound reports cause to parents, and adamantly argues that this poor quality of care is unacceptable and should not happen. Yet she also says that she is personally impacted by the lack of access to quality prenatal testing as she spends many hours researching locations and trying to schedule tests with overbooked providers.

Hannah's narrative highlights the important point that the closure of maternity units does not just effect the provision of labor and delivery care; the loss of maternity units reduces access to and the quality of prenatal care as well. Furthermore, her discussion underscores the fact that the restructuring of hospital-based maternity care has significant consequences for parents and midwives involved in homebirth – not just for

individuals who seek hospital-based childbirth settings. The lack of access to quality prenatal testing most directly impacts parents and babies, yet it also effects homebirth midwives. The increasing difficulty Hannah has encountered in arranging for prenatal testing for her clients along her decreasing trust of the quality of the care provided at hospitals complicates her work as a homebirth midwife and adds to the barriers encountered in her out-of-hospital practice. The closure of maternity units has led to overcrowding among remaining units and to below standard prenatal testing, both of which have a variety of implications for the work of homebirth midwives and the childbirth outcomes for their clients.

What Maternity Unit Closures Mean For Parents

The parents I interacted with during my fieldwork each had their own plans and ideas for the way they wanted to bring their baby into the world. From type of practitioner wanted to the setting desired for labor and delivery, from natural birth enthusiasts to those who sought pharmaceutical pain relief, the interests and wishes of parents regarding their care during pregnancy and birth was extremely variable. This variation held true among the parents with whom I conducted in-depth interviews, all of whom had at least one child prior to our meeting and had made decisions during their second pregnancy based on their previous experiences. I also found that frequently, there was a distinction between parent's plans and expectations for care and the actual experience of care, an issue examined further in Chapter 7.

With the great diversity of preference among parents, it corresponds that the closure of hospital maternity units would impact some parents in different ways than others. Yet, regardless of personal preferences, the closure of so many maternity units

increased feelings of uncertainty among parents who were in the midst of navigating the maternity care system. The unrelenting series of closures meant that parents could not take for granted that their maternity unit of choice would continue to offer care. While the specific circumstances differ, I found commonalities within the decisions made by parents when selecting a hospital. Depending on personal preferences, I found that some parents try to follow their health provider as they move their practice to a different hospital. Other parents, concerned less about having a particular provider, select another hospital based on reputation or distance from their home. Additional issues that surfaced in my data analysis of the impact of Philadelphia hospital closures on parents include: the uncertainty caused by unexpected relocation, and the option, for some, to search for a hospital outside of Philadelphia.

Distance: How Far is the Hospital?

Distance from people's homes to the nearest maternity unit is one of the common issues that developed with hospitals' closures. All of the parents I spoke with, whether they had planned a hospital, birth center, or a home birth wanted to have a hospital within reasonable distance. The most common amount of travel time parents said they were comfortable with was 20 minutes. This distance factor was so important to parents that it frequently played a part in their decisions regarding which provider to go with and what setting they chose for labor and delivery (home, hospital, or birth center). As hospitals with maternity units became geographically concentrated in the city's center, parents, particularly those living in peripheral neighborhoods, increasingly factor distance to a maternity unit into their decision making process.

One of the mothers who participated in the study, Betsy, was considered to have “high-risk” pregnancies due to her high blood pressure and as a result had to have hospital births. She discussed her choice of specific hospitals for the births of her two children. Betsy’s first child was born in 2006 at Chestnut Hill Hospital, located just a few miles from her home. Betsy admits that, given the choice, she would have liked to return to Chestnut Hill Hospital for her care and delivery during her second pregnancy, but by that time, the hospital had closed its maternity unit. After calling to confirm that no obstetricians or midwives were still on staff at Chestnut Hill Hospital, Betsy was forced to look for another practice and location to birth. She chose Lankenau Hospital, located in a suburb west of Philadelphia. Lankenau Hospital is over twice the driving time from Betsy’s home than is Chestnut Hill Hospital. When I asked if she would consider returning to Lankenau Hospital in future pregnancies, her response was:

Well, we’ve talked about that actually, because we thought about having a 3rd [child]. And my husband’s attitude is like, I was happy with Lankenau, generally. And I would go there, but for the drive. We were driving by Abington [Hospital], and he was saying, this is very close. So I think I would try them and see what I thought.

Distance to the hospital is a key factor for Betsy and her husband. Even though they felt that the care received at Lankenau Hospital was generally acceptable, the extra time it takes to get to the hospital is a chief reason they would try a different, closer hospital. The full story of Betsy’s experiences in navigating the maternity system is shared in-depth in Chapter 7.

The story of another mother, Jessica, shows how distance to a hospital can play a role even in the decisions of parents who would like to birth at home. Jessica believed that the caesarean section she had with her first child was unnecessary and wanted to

deliver her second child vaginally. During her second pregnancy, she was seriously considering birthing at home with a midwife. Note that during this conversation she uses the term “VBAC”, meaning vaginal delivery after caesarian section, to describe the type of birth she wants to have.

Jessica: But for me, it really—I didn't want to be hooked up. I was on the wall of home birth versus [hospital]. There were two certified professional midwives [who] were the only ones that said they would deliver me VBAC at home. But, if you think about the political field and everything, you know, there was this whole thing like if you have to transfer, like I can't be your midwife, all this stuff. At that same time, Chestnut Hill Hospital actually closed their maternity ward down, so if we were gonna have to transfer, I could no longer be taken there, because they would have just sent me somewhere else, because there were no OBs on staff, there was nobody to deal with the high risk.

Interviewer: Do you know where else you'd be transferred to?

Jessica: Well they would have, in an emergency situation, we would have gone to the closest place, and we discovered probably that would have been...HUP [Hospital of the University of Pennsylvania]. Which, if you could drive on the side in a traffic jam, that would take about 25 minutes from here. Which for me was a little bit on the edge. Like if I was 10 minutes away, you know, less than 20 minutes away, I think I would have felt okay about that.

Ultimately, Jessica decided against attempting a homebirth because she felt there was no hospital with a maternity unit close enough to her home for her to transfer to if an emergency arose during her labor and delivery. Essentially, the closure of local maternity units removed the option of homebirth for Jessica, and she ended up having a hospital birth. However, Jessica remained committed to her desire to delivery vaginally, and this wish, after an intense search, led Jessica to an obstetrician who agreed to support Jessica in her hope to have a vaginal birth. The complications for Jessica did not end here, however, and we will return to her story later in this chapter when discussing the unanticipated consequences that can occur when parents follow their provider to a new hospital.

Unexpected Relocation

While the possibility of closure for some maternity units was known long before the closure actually occurred, hospital management often delayed announcing closure until absolutely necessary. In spring of 2007, for example, Chestnut Hill Health Systems made its review of Chestnut Hill Hospital's maternity unit public knowledge. At the time, the hospital's chief executive officer declared that future of the hospital's maternity program was uncertain (Pazulski 2007). It was not until September 2008, after a year and a half of press releases, community rallies and evaluation, that the hospital announced it would close its maternity program in early November 2008. While parents had been aware of the instability of the hospital's maternity unit, they were only given two months notice of the closure. Like the similar announcements made by twelve other hospitals in Philadelphia, Chestnut Hill Hospital's announcement of closure left parents in the lurch. The short notice of closure typically given affects parents planning to birth in all settings: in hospital, birth center, and at home. For parents who are actively receiving care at a maternity unit when a closure is announced, the notice can be traumatic. Local news station 6abc's reporter Lisa Thomas-Laury points to this issue in her coverage of the closure of Chestnut Hill Hospital's maternity program:

Michelle Vicks of Elkins Park, has a 4-yr-old son born at Chestnut Hill; she says the news is devastating. She told Action News. "I think it will be very disheartening for parents-to-be, especially the young ones."

That includes new mothers like Jamillah Gordon, of Mt. Airy, who is 5 months pregnant with her first child. She learned about the closing at her pre-natal appointment at Chestnut Hill, earlier today:

"It was really stressful, because I don't know what I'm going to do," she told us. "It's kinda like they left me high and dry." [Thomas-Laury 2008]

As this news interview points out, the closure of a maternity unit, particularly mid-way through a pregnancy can be upsetting and stressful for parents. Those who had planned to deliver at the hospital must scramble to determine where they can go to give birth. As more maternity units close, fewer options remain, and the available maternity units are overburdened and largely over capacity. For parents whose maternity care was interrupted by an announcement of closure, the task of quickly choosing among dwindling options can leave them feeling lost.

“Bad” Reputations

Another factor that strongly influences parents’ choice in hospital is the hospitals reputation. Simply put, some hospital maternity units are more popular than others. Although one hospital may be closer than another, a poor reputation may eliminate a maternity unit as a viable option for some parents. The frank comments of one of the parents interviewed demonstrate what I found to be common opinion among many individuals with whom I talked:

You know, midwives—there are midwives downtown, but they're in Pennsylvania Hospital. And the atmosphere inside the big teaching hospital is really different. . . . So, [for my first pregnancy] I just went to my regular OBGYN. He worked with Pennsylvania Hospital. And I went there for my blood tests and my glucose tests, and all this different stuff, and I waited for *hours* to get them done. I think I waited for... for the 20-[week] ultrasound, the one where they tell you the baby's sex? I think we waited there for 4 hours. . . . And [during my first pregnancy] I still would have had to wait hours for my care. Like, all of the care that I received during [my second] pregnancy, like 20-week ultrasound, that was done at Lankenau Hospital, which is out on the Main Line, and it was like we waited for 20 minutes for the 20-week ultrasound, as opposed to 4 hours [waiting for the same procedure during first pregnancy]. I mean it was totally, totally different. And they gave us—they took a million pictures. It was just a really different experience.

So, yeah, being downtown is a bad place to have a baby, because there's so many people, and there's not a lot of choices. Like, there's a lot of different hospitals, but everybody goes to those hospitals downtown, from all over the city,

because there's only Einstein in North Philly, and Temple, and who wants to go to either of those shit holes?

The study participant quoted above is not alone in her evaluation of the remaining six maternity units in Philadelphia. All of my participants expressed similar dissatisfaction with the city's current hospital-based services. The continual loss of maternity units in Philadelphia has limited parents' choices to the point that many make their decision on which hospital to birth at based on what they perceive to be the best choice out of a group of bad options. In addition to the drastic reduction of maternity units, the reputations of the remaining six hospitals offering maternity services further reduces the number of viable options for parents.

Searching the Suburbs

One option for some parents who are disenchanted with the hospital-based maternity care in Philadelphia is to travel to hospitals located outside of city limits. Many of my research participants, all of whom had access to a car, would drive 20 to 40 minutes into suburbs surrounding Philadelphia in an effort to avoid the "downtown" hospitals. However, it is important to remember that most of my research participants were of a socioeconomic standing that enabled them to access services that not all Philadelphians are privy to. The fact that all my research participants had access to a car made it possible for them to consider venturing into surrounding counties for maternity care. While distance or the type providers available or the hospital's reputation may have played a role in which hospital study participants chose, the simple truth is that "searching the suburbs" is an option for them, whereas it is not for Philadelphians without a personal means of transportation.

For parents like those who participated in this research, these suburban hospitals may add to the variety of choice: some grant privileges to nurse midwives, and they may be less crowded than the “downtown” hospital. Yet, hospitals in counties surrounding Philadelphia have been part of the process that has shifted the landscape of maternity care in the region. Six hospitals located in counties adjacent to Philadelphia have closed their maternity units over the past nine years. Others, such as Lankenau Hospital, mentioned by the participant quoted above, have terminated their midwifery programs and provide only obstetrical based care. While hospitals outside of Philadelphia add to the now meager options, they are under the same economic and political forces that have impacted Philadelphia hospitals.

Following a Health Care Provider

As mentioned in the discussion of the impact of closures on midwives, the closure of hospital maternity units and the discontinuation of midwifery services disrupts the care these professionals are able to provide their patients. Midwives are not the only healthcare professionals who have had to secure positions at new hospitals due to closures, however; obstetricians as well as nurses must also reestablish themselves in new locations and must navigate different sets of rules and regulations in the process.

This process of uprooting providers affects parents in a variety of ways: it may add to the uncertainty of where they will deliver their baby during the time that their provider searches for a new professional home, it may force parents to change providers if their provider of choice moves their practice out of the area or if the provider’s new location restricts the procedures they are able to perform. For parents who feel strongly about receiving their care from a particular provider, following their provider to whatever

hospital necessary can come with consequences that are unanticipated by both parents and providers. The this type of “musical chairs” that providers are forced to perform adds to parents stress and in some cases leads to birth experiences that are drastically different than planned.

Returning to Jessica’s story, part of which was discussed above in the section on the issue of distance to hospitals, we are provided with an example of how the relocation of a provider to whom a patient is dedicated can yield unexpected issues which can negatively impact the patient’s experience. Determined to birth her second child vaginally after having had a c-section for the delivery of her first child, Jessica weighed the limited options available to her and chose to birth in a hospital with an obstetrician who was willing to conduct a VBAC and who is known for her “unorthodox” style of care, which is in many ways more similar to the midwifery model of care than the biomedical model. According to Jessica:

And so, I found, through the recommendation of some midwives, a doctor. And she was great, and she's a big supporter of natural childbirth, but she doesn't take insurance, because she doesn't want to deal with any of that. So I had to pay out of pocket to be with her, on top of paying my regular insurance. And we paid her a lot of money....We were like, you know, counting pennies to try to have this birth the way we wanted it, because we had such a bad experience with [my first child’s c-section birth], and we just thought it was really worth it....And what was cool about her is that you just see her, she's the only one in the practice, you have her cell phone number; you can call her. I mean, all the things that you would want from your healthcare provider when you're pregnant, trying to have a VBAC, she was providing....We thought that if anybody could do it, she could do it, because she really was so supportive. And I told her I didn't want to be on a monitor, she said fine. I want to go in the shower, I want to eat. I want to basically use the room, freestanding, but not—you know, if something goes wrong, then we can hook me up or whatever....And she was totally cool with it.

What Jessica did not consider was whether the hospital where she would birth would be “cool with it.” She assumed that it was between her and her obstetrician as to

exactly what procedures would (or in the case of Jessica's wishes, would not) be incorporated into the labor and delivery process. However, her obstetrician's relocation to a different hospital just prior to Jessica's birth brought a third unpredicted player into the mix. The obstetrician had been able to act with a great deal of independence at her previous hospital, and based on her assurances to Jessica, seemed to anticipate the same level of autonomy at the new hospital. Jessica was the first patient of the obstetrician's to deliver at this new hospital, and as they both discovered, hospital policies and the mindset of its staff did not make for a welcoming reception. As Jessica remembers:

And it came down to the day of the birth, and I went in [to the hospital], and I was sitting there with the nurse, and my doctor and the head of the nursing staff, who was threatening to bring down their lawyers or whatever. Yeah, because I was refusing [treatment], because I didn't want to be on the [monitor]. They gave me so many problems. It was really, really difficult. . . . I didn't realize it [at the time], but I really had the legal right at that point to tell them that they can bring as many lawyers as they want, if I refuse, or I consent to no treatment, then I get no treatment. [But] what it sounded like was a threat to say like, "we have the ability not to serve you if you do not agree to hook yourself up to this monitor, and the only reason you can get off of it is to go to the bathroom." I was like, "what about if I did that, and then the last 20 minutes, if everything's okay, when things get really, really intense, you let me go into the shower? Because I know I'm gonna need that water. I know I'm gonna need to create some kind of relaxed environment for me, you know, I need a small space." I just knew what I needed. I knew it. And, no, [hospital staff said I] gotta stay on [the monitor] the whole time. And I got them to turn off the sound and to throw like a blanket over it or something. But yeah, they acted as though, if the lawyers were to come down, that I would be basically escorted out of there if I didn't agree to what they were doing. It was a really threatening couple of minutes there. And the doctor, I thought maybe she would have this kind of insulation, which is kind of what she had said she would have, that no matter kind of what they do that since she's the doctor, she would dictate what was going on, but it wasn't like that at all.

And there I was, you know, I had been laboring at home for a while before I came in [to the hospital], and everybody finally left, and the doctor sat down with me and she's like, "Here are your options. You can go home right now, and just I'll call [a CPM] at home, you can birth at home." And this was in the middle of labor. [Then doctor said], "I can call [another hospital] and see if there's a doctor there who's willing to take you there who has agreed to not have you on the monitor, and to let you do what you want to do, or you can stay here and

follow their rules.” I was like, “I'm not going anywhere.” But it was awful. It was so awful. The whole experience.

They also wouldn't let me eat. And I swear, because they wouldn't let me eat, I was sick after the birth. I went in there eating a banana. I think that was the last piece of food I had the entire time I was there. This woman, this nurse came up to me and she was like, “You can't eat, you know, you're pre-surgery.” I'm like, no I'm not. I'm not gonna have an operation today, hopefully.

And it was the same thing after he was born. I don't want him taken out of the room, “I don't want him taken out of the room.” [Nurses said], “We have to take him out.” And I had refused all these tests, but then I ended up getting them, because they kept telling me that I needed them, and I remember feeling like I was so helpless. And every time we would want to go to sleep, like somebody—every nurse's shift, every two hours, they had to redo all these vitals with him, just because it was procedure. Finally, [to] one nurse at the end, we were like, “please do not take him. Like, bring whatever equipment you need in here to do it in here, or you're not doing it.” And she finally said she could. Which was so funny, because like the 50 other nurses that came in had all said that it was impossible to do the tests that they needed to do on him in that room. That they couldn't—the equipment was not portable, and they needed to take him. [But the last nurse brought the equipment into the room] and it was a freakin' scale, a thermometer—you know, like really they weren't doing anything. And, yeah, it was just, it was hard. And there was a point, I mean, if I wasn't so physically debilitated, I probably would have taken him and walked out of there within two hours after my birth, but I was really weak, and really tired, and I had a pretty—and I tore, and I was in a lot of pain. It was just, it was just like pulling teeth, everything I wanted and everything I had envisioned for me—the pregnancy, the birth, and postpartum. I just could not wait to get out of there.

I remember this one thing where I said I didn't want a Pitocin shot. [The Hospital], they've been giving a procedural Pitocin shot in the leg, right after birth, so that you're...it just helps the uterus to start to clamp back down, and prevents hemorrhaging. But you know, my baby nursed right away, he was right on the breast. I felt like, you know, they kept feeling, saying, okay, it feels okay. But I remember this one nurse who I fought with the most at the beginning...I remember her, not even asking me, and coming up to me and like, hard, injecting this needle into my leg. And they said it was a Pitocin shot.

But if I wasn't physically debilitated afterwards, I for sure would have taken him and gotten out of there. But I felt really helpless, and really just tired of the—just felt like it was a big machine that was against me, and did not care at all about my wishes or desires or anything like that. If anything, they were annoyed and bothered by the whole idea that we would even ask any questions, or request any kind of special care. Which was really just, “leave us alone. Just leave us alone.” That's what we wanted.

I ended up having a great birth, I mean, I ended up having a natural, vaginal birth, but the only reason I did was because [my doctor] was there, and I just kind of gave into, you know, the medicalization of it....All in all, it was good to have [my baby] coming out the right way....It was healing in the sense that,

you know, my body worked, it did was it was supposed to do. And my water didn't break until I was like 9 centimeters, and I slowly progressed into this intensity, and then I could feel—you know, everything about it was good. My body did a really good job, and that was really, really healing. The only problem was the external forces that were making it a really unpleasurable experience. I was a total prisoner in that hospital. And I was a total prisoner to their policies.

Through Jessica's narrative, we are given a powerful example of how following a provider as they re-establish their practice at a new hospital can come with unexpected barriers and complications which can greatly affect a parent's care experience. As they move from one hospital to another, providers and parents are confronted with new regulations and procedures as well as institutional and personal politics that can restrict their autonomy and nullify previously agreed upon care plans, as Jessica's experience illustrates. While a provider may choose to relocate their practice for personal reasons, the rash of maternity unit closures in Philadelphia left providers no choice in the matter. Maternity unit closures do not just dislodge providers from their existing and often carefully negotiated agreements with hospitals; they force providers, along with their patients, to navigate the modus operandi of a new institution.

As discussed previously, the dynamics of the changes to the system of hospitals in the Philadelphia area not only drastically reduced the number maternity units but also pushes hospitals that continue to provide maternity services into adopting an increasingly extreme biomedical model of care. Very few remaining area hospitals will tolerate, never mind support, parents and providers whose views and practices regarding childbirth differ from biomedically informed protocols. Also, because there are so few options left as the number of hospital maternity units has shrunk, units that remain wield an increased amount of power and control over the practices and procedures implemented into

maternity care. As the third party in any hospital-based birth, the interests of the hospital outweigh the professional opinion the provider or the parent's wishes.

For Jessica, following her provider to a new hospital resulted in the denial of her desire for a childbirth experience devoid of monitors, superfluous tests and unfounded rules. Her control over her labor and birth was confiscated, not by her provider – who had approved Jessica's requests, but by hospital staff who asserted hospital protocol and carried out practices that were unnecessary, even abusive, and counter to Jessica's wishes. Jessica's story illustrates some of the negative and unanticipated consequences that can occur when a parent follows a provider to a new location. Her story also shows how complicated and layered the actual provision of maternity care can be and how difficult it is for parents whose wishes are counter to biomedical views to have their interests upheld. As Jessica noted regarding the actions of the hospital staff, "It's a shame, because they could have done what I wanted them to do. They could have so easily. That's all I wanted - just "hands-off" until there was a problem." Of course, not all parents who follow their provider to new locations encounter the same hostile situation, yet Jessica's experience serves as a caution that within the restructured hospital system, finding just a provider to support you is not necessarily enough.

Summary

As the discussion above illustrates, the "maternity care crisis" in Philadelphia extends far beyond the issue of the financial burden on hospitals, which is the most common focus of politicians and news media coverage. Instead, I have argued that the true focus regarding the closure of hospital maternity units should be on the impact of this shift on the people involved. The restructuring of Philadelphia's maternity system

has led to a drastic reduction in the number of maternity units available, a geographic clustering of care in the city's center, and a decrease in the type of hospital that provides maternity care which has resulted in the proliferation of a distilled, extremely biomedical version of prenatal and delivery care. Area hospitals that maintain maternity units attempt to manage the increasing patient loads as their occupancy rates reach, and rise above capacity. Patients' experiences of long waits for care, crowded waiting rooms and labor and delivery wards, and a reduction in quality time with providers exposes hospitals inability to sufficiently compensate for loss of two-thirds of the city's maternity units.

Midwives who work in hospitals, birth centers and who conduct homebirths find increased constraints placed on their professional autonomy. While midwives have long been estranged from "mainstream" maternity care, the reduction in maternity units and the corresponding fortification of strict biomedical, obstetrical prenatal care and delivery methods further isolate, destabilize, and hinder midwives' professional practices. Parents also find they must contend with new variables as they navigate the maternity care system. The closure of local, community-based hospitals has led to the unexpected relocation of prenatal and delivery care, has narrowed parents' choice of care provider, and has reduced the ease with which parents can control their experience of childbirth – particularly if their wishes counter biomedical care practices. Distance to a hospital maternity unit and the reputation of that hospital are holding increasing weight regarding the care decisions made by parents, regardless of whether they intend to birth at home, in a hospital or at a birth center.

The relentless process of maternity unit closures in Philadelphia has not only pushed providers and parents from one institution to another, it has led to the further

alienation of providers and parents whose interests counter or contradict the dominant biomedical practice of maternity provision. Midwives and parents interested in low-intervention or non-intervention based maternity care are faced with new challenges as they attempt to navigate the maternity care system. The loss of so many hospital maternity units and the structural constraints placed on different sources of maternity care provision (birth centers, homebirth, maternity hospitals) has led to a multitude of negative results. The closure of maternity units has not only affected the general provision of labor and delivery care, but it has complicated the experiences of parents by reducing access to a variety of care modalities and decreasing in the quality of maternity care received at hospitals.

Neoliberalism and Maternity Unit Closures

The influence of neoliberal policy and ideology on the shift in hospital based maternity care in Philadelphia is undeniable and visible on numerous levels. As documented by Maskovsky (2000a), the privatization of public hospitals initiated the neoliberalization of health care in Philadelphia. With this transition from public to private came government deregulation of health care practices and services. These processes of privatization and of deregulation go hand in hand with other neoliberal practices, such as reducing public expenditure on social services and the devaluation of working for “the public good” (Martinez and Garcia 2000:2). All of these aspects of neoliberalism interfaced with Philadelphia’s hospital system, transforming hospitals into products of the neoliberal free market and repositioning of the purpose, structure, and rationale of hospitals. Instead of acting as a public service interested in meeting the needs of the community, hospitals have become privately run businesses, either owned by out-of-state

conglomerates or by large healthcare systems, operating according to a corporate business ethic which places financial gain as the utmost priority.

Repositioned as enterprising businesses within the neoliberal political economy, hospitals evaluate services offered based on efficiency and financial profits, not the needs of the community or their influence on “the public good.” Maternity care, with its high time-demands and its relatively low financial profits, compared with other services, does not make business sense to hospital owners. In Philadelphia, the reaction to this realization has been to cease providing this service if at all possible, regardless of the needs of the community. As discussed in the beginning of this chapter, all of the hospitals in Philadelphia that had the option to close their maternity unit have done just that; 13 out of 19 hospitals have unapologetically ceased providing maternity services (to be fair, five of those 13 hospitals closed altogether). The six hospitals that continue to provide maternity care do so because they have to – as teaching hospitals, they must train physicians in maternity care. Just as the practices and ideals of neoliberal economic policy facilitated the closure of maternity units, neoliberalism also guided the restructuring of how maternity care is provided in the six hospital maternity units that remain.

These six hospitals’ increasing concerns with efficiency and capital gains as well as their increasing occupancy rates have inspired a reformulation of maternity care practices to encourage time-management and high financial reimbursements for the hospital. This “new” style of maternity care systematically reinforces dominant biomedical procedures, as this highly interventional model of care can be used to control the timing of labor and delivery and also reaps the highest financial rewards. The result

is the extreme version of biomedical maternity care found in Philadelphia's six maternity units, which translates into practice shifts in the methods of delivery employed by providers that promote overuse of interventions, such as c-sections, decreases in the quality of care received by patients, and the virtual purging of "alternate" models of care, such as midwifery from hospital practices. As the outcomes highlighted by the stories of midwives and parents show, the incorporation of neoliberal policy and ideology into Philadelphia's hospital system has resulted in significant alterations in the provision and experience of maternity care.

CHAPTER 3

WHY NGOS? AN EXPLANATION OF THEORY AND AN INTRODUCTION TO THE THREE NGOS

Introduction

This chapter introduces the second focus of my research: the activities of nongovernmental organizations (NGOs) as part of the shifting landscape of maternity care in Philadelphia. Three sections form the body of this chapter. First, I delve into a theoretical and historical discussion of the social role of NGOS in order to make clear the importance of incorporating this “third sector” in my study of the landscape of birth. Next, I address the scholarly literature on neoliberalism so as to situate my analysis which follows in Chapters 4 through 6 on the impact of neoliberal ideology and policy on the structure and function of the three NGOs. Finally, I provide an introduction to the three NGOs which are examined in-depth in the following three chapters.

In my review of the literature and in my analysis of the three organizations, I employ the term “NGO” as well as the term “nonprofit” in my discussion of these civil society institutions. I alternate between these two terms depending on the context of my discussion. NGOs (nongovernmental organizations), as a global phenomenon, characterize the social science literature, especially the anthropological literature. Yet, in the US literature and in common usage, these organizations are usually referred to as “nonprofits” or “nonprofit organizations.” As an Anthropologist, I generally use the term “NGO” except when citing literature on nonprofits and their particular US legal context or when applying the emic term “nonprofit” as it is used by the three organizations,

themselves. As such, in this chapter, and in the following chapters in which I detail the three organizations studied, I frequently use the term “nonprofit.”

History and Theory on NGOs

Introduction

It is well acknowledged that nonprofits play an important role in US society. Nonprofits work to improve the quality of human life by providing services and advocating for the rights of others. They have been heralded as embodying two values at the heart of the American experiment: individual initiative and responsibility to the common good (Salamon 2003:2). They are imagined as organizations which build community and inspire individuals to participate in the structuring of public affairs (Smith 2000:9). Nonprofits not only respond to social change, they are also integral vehicles in prompting change. Yet, these organizations are so embedded in our societal structure that many people encounter nonprofits, and benefit from their work, on a daily basis without even realizing it.

For all these reasons, it is essential to include an analysis of the role and activities of nonprofits in any social survey of daily life in North America. I would have been remiss had I failed to incorporate an analysis of nonprofits, essential institutions within the “civil society” sector, in my study of the landscape of birth in Philadelphia. If, for example, I had considered only hospitals in the provision of maternity care in Philadelphia, I would have seen just the diminished care options for pregnant women caused by maternity unit closures; I would have missed the varied service options provided by nonprofits as they attempt to compensate for the deficiency in hospital services. Understanding how nonprofit organizations are situated - as service providers,

as advocates, as businesses - within the social schematic is necessary if we want to comprehend the dynamics of social issues.

Brief History of the Shifts Within the Nonprofit Sector

How to theoretically situate nonprofits within US society is an ongoing topic of discussion in the academic community. In part, this continual discussion is due to the fact that the role of nonprofits has changed over the last one hundred years with the most significant changes occurring since the 1960s. Part of civil society, nonprofits are socially constructed institutions, and as such they are susceptible to shifts in national and local ideology and policy.

In the 1960s, the ideals behind the civil rights movement inspired federal support of community based nonprofits with the intention of empowering the disadvantaged to take action to improve their communities and increase their political voice (Smith 2000; Naples 1998; also see Marris and Rien 1982; Morone 1990; Stone 1999). The decade of the 1970s brought with it an increase in federal funding allocated for health and social services organizations, yet a corresponding move away from community participation. As nonprofits increased in number and size, they also became more professionalized. The right-wing conservative government of the 1980s brought another change in course for civil society institutions. The national government cut spending for social services and promoted the notion of free market enterprise by encouraging competition among civil society institutions. Government oversight and funding of public programs were withdrawn, thereby advancing the privatization of once public institutions. Although this privatization increased contracting between civil society organizations and the

government, federal deregulation of services brought about concern regarding the efficiency and effectiveness of nonprofit organizations (Smith 2000).

Growing concern over the inefficient provision of health and social services, increasing distrust of government control, and the rising popularity of the ideological notion of “individual responsibility” directed yet another shift in the nonprofit sector starting in the late 1980s and lasting through the 1990s (Smith 2000; Martinez and Garcia 2000). A return to the 1960s notion of community engagement, yet within the context of the now neoliberal political economy, has led to increasing numbers of nonprofit organizations that emphasize partnerships with citizen coalitions and community stakeholders (Smith 2000; also see Boyte 1989; Healthy Cities 1995). Nonprofits operating within today’s neoliberal political economy face a series of challenges due to the ideals and policies that stem from this “formula of rule” (Rose 1993). Fiscal insecurity, the need to compete with other organizations, the requirement to demonstrate effectiveness and organizational legitimacy, the pressure to incorporate new technology into operations and programs, and the necessity to attract and retain employees in light of expanded expectations and insufficient resources are all challenges faced by nonprofits today (Salamon 2003). It is undeniable that during the second half of the 20th century and into the beginning of the 21st century there has been a close relationship between the expected role of nonprofits and national ideology.

Theorizing the Relationship Between Nonprofits and the State

Recent theories on the position of nonprofits take into account the ever shifting relationship between the state and civil society. Analyses which consider the nonprofit sector as separate from the rest of society, impervious to outside influences, are not

longer recognized as valid. Contemporary understandings situate the connection between civil society institutions and the state as unstable, shifting, and interconnected.

David Nugent's (2004) work offers an example of the current debate of how the relationship between the state and civil society should be theorized. Nugent describes the processes in Peru that resulted in governance by an underground political movement, the Popular American Revolutionary Alliance (APRA), instead of the "legitimate" state. Nugent presents this case study as evidence against the Weberian notion of the state as a "closed" system, unshakable and unchangeable in its composition. Instead, Nugent points to the vague boundaries between the "state", "civil society", and "outside" or international governments and asserts that many interconnected forces, including particular historical trajectories, the political economy, and influence of "outside" governing bodies makes for many different categories of "the state", all of which are under constant reconfiguration.

James Ferguson's (2004) work complements Nugent's analysis of the relationship between the state and civil society. Ferguson argues against the "common sense" state/civil society opposition, exposing the false notions of separateness and hierarchy that formulate the concept of the state as the "top" or "highest" apparatus of society and civil society as the "bottom" or "lowest" level. Terming this "leveling" as the "vertical topography of power", Ferguson argues that the "space" that is structured by this formulation is imaginary and therefore this perspective is misleading in the analysis of the relationships of power between the state and civil society. Ferguson asserts that instead of examining the actions of the state or civil society as "top down" or "bottom up", respectively, the actions of both should be viewed as acting "across" since

transnational relationships of power structure, enable, and hinder both types of action. Ferguson concludes that civil society, or the “local” and the state should be examined using the same measurements previously used only to verify state power: spatial reach, vertical height (location in a power hierarchy), and “superior generality of interest, knowledge, and moral purpose” (Ferguson 2004:397).

Apparent in Ferguson’s “rethinking” of the state and civil society is his Foucauldian perspective on power as fluid. Indeed, Foucault’s work is influential in shaping current anthropological perspectives of the state and civil society. Two aspects of Foucault’s work are particularly helpful in situating analyses of civil society and the state. First is a general ethos with which Foucault approached his analysis of the present as a series of questions formulated from historical problematizations, and *not* as an epoch or as a linear, inevitable “culmination of some grand historical process.” Second is Foucault’s recognition of liberalism as a political rationality of government under which state reason and politics are to be critiqued (Barry et al. 1996:5). In fact, Barry, Osborne, and Rose (1996) argue that the emergence of liberal theory is responsible for the creation of the notion of “society” since the liberal way of thinking about government requires the state to be responsible for ensuring an arena (i.e. civil society) for the critique of the state while safeguarding that arena’s (civil society’s) autonomy from the State.

Documenting the shifting nature of governance, Nikolas Rose (1993) compares the form of governance he calls ‘advanced liberalism’ with the techniques of the prior form of governing, liberalism. Rose argues that although some similarities, particularly in terminology, exist between different “problematizations of rule” the techniques of rule vary. Using “expertise” as an example, Rose explains that under the liberal welfare state,

expertise as a mode of authority was a technique for governing through society. Under advanced liberal rule, however, expertise is employed as a tool to govern through the regulated choices of individual citizens. Rose argues that this shift in focus redesigned the relationship between the state and civil society. Whereas under the liberal welfare state, the state was to be actively ‘re-inventing community’ while guaranteeing individual and economic freedom, under ‘advanced liberalism’ the state is imagined as sidelined and the market is seen as the driving force which instructs and regulates the “choices of autonomous agents – citizens, consumers, parents, employees, managers, investors” (Rose 1993:298). Rose’s analysis supports the current anthropological view of the “state” and “civil society” as concepts that are constantly under negotiation. In addition, Rose calls attention to the fact that individuals’ relationship with “society” is also constantly changing since as modes of governance shift, so does the manner in which citizens are constructed.

Susan Hyatt’s (2001) work provides an example of how citizens’ relation to the state is reconfigured when there are changes in the form of state governance. Furthermore, Hyatt details how different categories of citizens, based on race, class, and gender, are expected to fill different roles as citizens. Hyatt argues that the philosophies of the free market have reconfigured the relationship between the US state and its citizens through political practices which promote self-governance through community service and volunteerism as a superior option to state services. Hyatt’s differentiation between the expectation that middle classes volunteer their time versus the demand that the poor work in low-wage jobs highlights the fact that the restructuring of state services affects all citizens – not just the poor. Of special interest is Hyatt’s discussion on the “call” to all

citizens, middle class and poor, to step up and rebuild “civil society” and her assertion that in responding to this call citizens simultaneously mark themselves as “good” citizens and (consciously or unconsciously in a Foucauldian way) support the government’s current model of social order (Shore and Wright 1997:6).

Echoing Rose’s (1993) and Hyatt’s (2001) contention that techniques of governance vary with different problematizations of rule, John Gledhill (2004) takes the argument further by asserting that there can be diversity within one form of governance. Gledhill discusses this diversity of governance using examples from Latin American countries with specific historical and community-based movements to support his argument that both diversity and unity are apparent in the way “neoliberalization” is expressed. Pointing out that state power, under past “roll back” neoliberalism and more recent “roll out” neoliberalism, is not exerted uniformly, Gledhill details the means through which the state maintains power: through dissemination of “audit culture”, by funding “civil society” institutions like NGOs, and by attaching morality to market economy involvement. Although Gledhill’s ethnographic examples are of Latin American events, his discussion of the means through which state power is employed in the structuring of NGOs (and other “civil society” institutions) is applicable to examinations of the connections between “state” and “civil society” institutions in North America as well.

The above works are very influential in informing my examination of the three women’s health oriented nonprofit organizations. Viewing the connections between nonprofit organizations and state apparatus as fluid, unstable, and shifting relations of power enables a more holistic understanding of the complicated position of nonprofits

within society. Embedded firmly within the national political economy, nonprofits are essential and active components of our social and market systems.

The Impact of Neoliberalism on the Structure and Function of NGOs

All the above works represent current theorizations on the position of civil society institutions within the neoliberal state, some more expressly than others. A key point that runs through each of the above theorizations is that under the current form of neoliberalism, the state continues to intervene in the civil society market in a variety of ways. Counter to earlier depictions of neoliberalism which portrayed the state as withdrawing from the market, recent analyses highlight that neoliberalism has inspired “critical shifts” in the ways government regulates civil society institutions, such as nonprofit organizations (Kingfisher and Maskovsky 2008:117).

I adopt this viewpoint in my analyses of the three NGOs I studied. Early on in my fieldwork it became obvious that the NGOs are entwined in complex relationships with the state and that neoliberal policy and beliefs were responsible for structuring their social environment. Not only are these NGOs’ external interactions influenced by neoliberalism, but their internal structure and programming is as well. There is no doubt that these three NGOs are impacted by neoliberalism and that they play an active part in the neoliberal political economy.

Yet, as the discussions in the following in chapters will illustrate, neoliberal policy and ideals affect each NGO differently. Although the three organizations are all health-related service nonprofits in Philadelphia, each organization addresses this issue from a unique standpoint and all three have their own structure, mission, and positionality within the Philadelphia landscape. As such, each NGO’s actual experience of neoliberal

policy and their appropriation of neoliberal cultural beliefs are as unique as the NGOs are from one another. In Chapters 4, 5, and 6 I follow my detailed description of each NGO with a discussion of the unique ways the organization is influenced by neoliberal policy and ideology. As a means of introducing the discussions that follow in the next three chapters, I will highlight here the characteristics of neoliberalism. I will then provide a review of the literature that explores the consequences of neoliberal policy which has guided my analysis of the three NGOs.

Characteristics of Neoliberalism

The theory behind neoliberal economic policy holds that freedom of the market and of trade practice guarantee individual freedoms and that human well-being will be advanced through this “liberation” (Harvey 2005). In practice, neoliberalism encourages the removal of state intervention (or responsibility) in individual’s lives and supports the “rule of the market”: free enterprise, privatization, and reduction in public expenditure for social services (Martinez and Garcia 2000). The reasoning used to support these measures is based on the notion that people must fend for themselves, therefore, the notion of “individual responsibility” is promoted over the notion of “community” or the concept of “the public good” (Martinez and Garcia 2000:2). State intervention could leave citizens dependent and unproductive which would mean that they are not “good” citizens; hence deregulation is one of the characteristics of neoliberalism (Kingfisher 2002a; Martinez and Garcia 2000). Corresponding to the values of neoliberalism, constructions of “good” and “bad” citizens have been developed. Characteristics of a “good” citizen include: autonomy, self-governance, independence, empowerment, personal knowledge, individual choice, and an entrepreneurial work ethic (Hyatt 1997;

Kingfisher 2002a). It is these notions of how society should function and what characteristics make up a “good” citizen that inform social policy.

Anthropologists have noted that the policies of the “culture of neoliberalism” disproportionately affect women, particularly low-income women (Kingfisher 2002b). The neoliberal model of governance places increased strain on women by demanding that through their “infinite elasticity”, women both participate in the public market through volunteer and low-wage work and continue, simultaneously, their private reproductive labor without state support (Kingfisher 2002c). Furthermore, the control of neoliberal ideals over the market and the utilization of neoliberal concepts to rationalize policy decisions has created shifts in health care practice that limit access to care and often jeopardize women’s lives.

Consequences of Neoliberal Policy

Articles that touch on a variety of topics with the literature on the consequences of neoliberal policy have informed my analytical perspective: assessments of the differential impact of neoliberalism on various institutions and geographic locations, critiques of the impact of neoliberal policy on nonprofit organizations, analyses of the effect of neoliberalism on the health care landscape, and examinations of the implications of neoliberal policy on individual’s lives. Combining the insights gleaned from these areas of study within the literature on policy is extremely helpful in positioning my analysis of three health related-nonprofit organizations that serve individuals in the Philadelphia area.

As academics continue to monitor the influence of neoliberalism on societies worldwide, the differential impact of the institution of neoliberal policy and ideology on

societies and institutions has become a topic of interest. Based on its positionality, an institution or organization may be directly or indirectly impacted by neoliberalism in a variety of ways. The same may be true for countries; Third world countries are impacted by different mechanisms of neoliberalism than are developed countries. In his article on neoliberalism, cited above, John Gledhill (2004) argues that various parts of the world are impacted differently by neoliberalism in part because there are different types or forms of neoliberal governance. This argument highlights the instable, shifting nature of neoliberalism as a form of governance. Other researchers focus on additional aspects the differential impact of neoliberalism, such as the unevenness of the spread of neoliberalism, how neoliberal ideology is articulated on local levels, and ways that neoliberalism intersects with existing forms of rule (Goode 2006; Kingfisher and Maskovsky 2008; also see Morgen and Gonzales 2008; Nonini 2008; Ruben and Maskovsky 2008; Wilson 2008).

As mentioned in the above section, nonprofits operating in the current neoliberal state face a series of challenges, primarily the need to compete for limited funding against other organizations. These challenges are a direct result of neoliberal practices which include such measures as cutting public expenditure for social services, deregulating the market for the delivery of such services, and privatizing as many of the remaining services as possible. In order to survive in the highly competitive market, nonprofits link to a variety of market and state institutions for financial and social support. Yet these linkages inhibit the autonomy of nonprofits and can lead to shifts in internal structure, operating methods, and mission.

This issue is the focus of Judith Goode's (2006) analysis of services offered by faith-based organizations. Her analysis documents concrete ways in which neoliberal policy restructures the services offered by nonprofits. Goode details how the requirements connected to program funding and the neoliberally informed cultural expectations of individuals led to shifts in the organizational structure and philosophy of faith-based organizations. External pressure to prove effectiveness and efficiency resulted in "assembly line" style programs that differed dramatically from the previous community oriented programs. The neoliberal emphasis on "individual responsibility" motivated a shift in the organization's "mission from community empowerment to individual uplift" (Goode 2006:229). Organic collaborations, and collective understandings based on the nuances of the community gave way to an adoption of the corporate business model and paternalistic attitudes toward program recipients. These shifts contrasted with the original purpose of the organization's programs, and ultimately resulted in alienation of community members and the organization's demise.

Providing an overview of the effect of neoliberalism on the health care landscape in Philadelphia, Jeff Maskovsky (2000a) argues that neoliberally informed economic restructuring processes have reduced access to health care in Philadelphia. Maskovsky describes health care in Philadelphia prior to the 1960s as largely provided through a public health system that was community based and consisted of many independently administered health clinics located in easily accessible local settings. However, shifts in the health care system since the 1960s, particularly the privatization of health care institutions, reflect the tenets of neoliberal economic reform. Maskovsky argues that the continued privatization of health care has gradually forced the closure of independent,

community-based health centers. Acknowledging that the public health system was by no means ideal, but that Philadelphians did have immediate access to health care services, Maskovsky asserts that under privatized health systems, Philadelphians, particularly the poor and those afflicted with serious illness such as HIV/AIDS, suffer inordinately as access to preventive and direct care has diminished. Maskovsky's analysis remains salient as community hospitals and health clinics continue to close at an alarming rate in Philadelphia due to economically driven restructuring that gives control of health care services to private out-of-state conglomerates.

Sandra Morgen's (2002) historical account of the changes in women's access to reproductive care supports Maskovsky's argument. Morgen's book describes how the policies of the New Left in the 1960s and 1970s, which supported the Civil Rights Movement and notions of community awareness and togetherness, nurtured the women's health movement leading to dramatic increases in health care access. Yet, Morgen also details the destabilization of the women's health movement and the consequential decrease in care options that resulted from the adoption of neoliberal policies in the 1980s and 1990s.

While the analyses of Maskovsky (2000a) and Morgen (2002) discuss the impact of neoliberal policy on health care institutions and health-related social movements, other work critiques the role of neoliberal policy in structuring lived experiences. As part of his comprehensive analysis of the history of neoliberalism, David Harvey (2005) argues that neoliberalism has been used as a tool to manipulate class relations. Although neoliberal theory relies on the notion that all citizens are equal actors, in practice neoliberalism has led to increasing social inequalities. Neoliberal theory, Harvey

asserts, is manipulated in practice to further add to the wealth of an elite sector of the world's population while placing constraints on all other classes (i.e. middle class and poor). This has polarized world classes; the "new" upper class consists of CEO's and business entrepreneurs who control international markets in ways that protect their privileged lifestyle and the "lower class" is comprised of everyone else. This elite capitalist class has affected a shift from production to finance, a shift which marginalized laborers both economically and socially. Harvey's critique highlights the need for an analysis of this redistribution of wealth and the recognition and examination of class forces that are guiding the global market, particularly in countries like the US where the class is ignored as a catalyst of power. Harvey's analysis illustrates the impact that shifts in ideology and policy can have on how individuals are categorized by class.

Other works take a more intimate perspective of the influence of neoliberal policy on the individual and focus on how neoliberally informed health care policies operate as a means of control by defining the ways individuals think of and care for their bodies. For example, Soheir A. Morsy (1995) explores the impact of state policy on reproduction in her analysis of maternal mortality in Egypt. Morsy extends her analysis beyond the boundary of the state by linking current state policy orientation to the interests of international financial institutions and economic shifts that reflect these institutions' partiality to privatization over public economies. This adds another dimension to the dispersion of health policies as it shows how the global economic and political negotiations of a government can force national policies that are known by state officials to be misguided. Morsy determines that the concept of population control, imposed by international institutions as an aspect of Third World development strategies and

therefore considered to be of state concern, orients state approaches to women's health which narrowly focuses on maternal mortality, a measure that is quantifiable and therefore can be used to prove effectiveness, instead of on improving living standards. Morsy concludes that these health policies, which emphasize the neoliberal notion of "individual responsibility", actually further endanger the livelihood of women by placing the responsibility of "saving the nation" squarely on women's reproductive decisions.

It is important to note that not all of the literature on the implications of neoliberal policy focuses on the unidirectional impact of policy on individuals. Some analyses highlight the influence of individual agency on policy. Indeed, considering the role of individual agency (or in Foucauldian terminology, technologies of self), in restructuring and applying health policy to daily life is essential in developing an overall picture of policy. For example, Sandra Morgen's (2002) work, discussed above, demonstrates that while national interests may force shifts in policy, the actions of individuals also impact policy. Morgen details how the grassroots planning of activist women both motivated the social policies of the 1960s and 1970s that nurtured the women's health movement, and also resisted the neoliberally informed policies of the 1980s and 1990s that jeopardized the women's care by adjusting their work to compensate for lack of funding. Morgen's illustration of the impact of the women's health movement on both the medical field and on US policy shows the power of individual agency and indicates the importance of continuing to document the relationship between health movements, and neoliberal policy ideology.

Taken together, the above works offer instruction on how to examine the various ways neoliberal policy influences civil society institutions and individual's life

experiences. The works discussed are examples of the breadth and depth of issues examined within the critical policy field; these articles greatly influence my analysis of the connections between neoliberalism and the challenges and successes of the three health-related NGOs I studied. These works illustrate that neoliberal policy is not apolitical and that in its implementation the interests of the elite and “the rest” are further polarized. Neoliberal policy restructures and redirects the provision of social services by eliminating the importance of community representation and the notion of “the public good”, instead substituting the efficacy standards of corporate business models and the worth of “individual responsibility.” The above articles show that not only do neoliberal policies impact the functions of civil society institutions, such as nonprofits and health care establishments, but they can structure even our most personal reproductive decisions and limit access health care. The issues underscored in these critical policy analyses and the concepts outlined in the recent literature on the relationship between the state and civil society will guide the discussion that follows in this chapter and in Chapter 4 through Chapter 6.

The Three NGOS

Originally, I planned to condense my discussion of all three of the NGOs with which I conducted my ethnographic fieldwork in just one chapter. As I analyzed the data collected on each NGO, however, I realized that the amount of data was simply too large to be contained in a single chapter. I had spent four years as a participant-observer at the Parental Support Center, over three years collecting data on the Alliance for Family Wellness, and more than two years studying Birth Advocates of Philadelphia. The richness of the data and the uniqueness of the organizations warranted each its own

chapter. Therefore, Chapter 4 is dedicated to the story of Birth Advocates of Philadelphia, just as Chapter 5 focuses on the Parental Support Center, and Chapter 6 details the Alliance for Family Wellness.

Although all three organizations are health service nongovernmental organizations that focus on pregnancy and childbirth, each organization attempts to address the issue of access to prenatal and birth care in Philadelphia from a distinct angle. Birth Advocates of Philadelphia (BAP) wishes to establish a facility that will provide direct OB/GYN health care services. The Alliance for Family Wellness (AFW) addresses access issues to prenatal and birth care through education and social service programs for low-income families as well as through advocacy efforts on state and national levels. And the now closed Parental Support Center situated itself as a citizen-led community resource center that also offered classes and treatments centered on a holistic wellness model.

The different approach taken by the three organizations is the result of the formal and informal leadership of each NGO. Distinct social movements shape the forms of advocacy and the missions adopted by the leaders of all three organizations. BAP's present mission of establishing a health care facility that will provide woman-centered childbirth care reflects the interests of the current leadership; BAP's President elect and nearly all of the organization's officers are either midwives or doulas, or they have worked in healthcare facilities in some capacity. The organization consists of individuals representing numerous generations, from people who are in their late-20s to people who are in their 80s. Although personal philosophy differs between individuals, on an organizational level, BAP's mission is directed by the notions embedded in the modern

midwifery movement (for an in-depth discussion of midwifery, see Chapter 1 of this dissertation). AFW's mission of advocating for low-income families, on the other hand, reflects the public health activism that developed out of the Civil Rights Movement of the 1960s and which was bolstered by federal support of health and social service organizations through the 1970s. With a degree in social work, AFW's Executive Director has been an advocate regarding women's health issues among disadvantaged populations in the greater Philadelphia area for the past 30 years. The co-founders of the Parental Support Center, two women who were in their 30s when the Center was established, were influenced by New Age holistic health and wellness models as well as by the community activism and the liberal sensibility that flourish in the neighborhood in which the Parental Support Center opened.

Just as the three organizations started out of different movements and address the issue of access to pregnancy and childbirth care in Philadelphia from a distinct angle, each organization also has a distinct trajectory and constituency. In addition, each is connected to different sources of funding. The Alliance for Family Wellness (AFW) is by far the most established of the three organizations studied. With a 30 year history, AFW is now well-known in the Philadelphia area for its outreach programs and has gained considerable attention among legislators through its advocacy work. It is also the largest of the three NGOs I examined, with a total of ten locations, including the main site near the city center. The organization offers services in nearly every section of Philadelphia and has locations in surrounding suburbs as well. Boasting a paid staff of 70 and countless volunteers, and it has developed intimate and mutually beneficial connections with nonprofit and for-profit businesses, corporations, and public institutions. AFW

receives significant amounts of government funding from national and local agencies as well as grants from private foundations, corporations, and service organizations. As the organization's focus is on serving the disadvantaged, its service population is individuals with low-income. The Alliance for Family Wellness represents what many would consider a successful, fully established organization.

In contrast, when I began studying Birth Advocates of Philadelphia it was not yet an "organization", it was merely a group of individuals who shared an interest in and concern over the limited access to maternity care in Philadelphia. This group of people met for over a year before applying for status as a nonprofit, and it was yet another year before status as a 501(c)(3) was awarded. During the two and a half years I observed and took part in its activities the focus was largely on determining the organization's mission and debating how to proceed to fulfill this mission. Without strong, or lasting, connections to other organizations and without a business location of its own, Birth Advocates of Philadelphia met wherever free space was available: at libraries, churches, health centers, or in members' homes. Lacking funding, the handful of members volunteered their time and energy to define the parameters and goals of the organization. The organization developed due to concern over the lack of hospitals with maternity units in the northeast part of the city, and therefore is focusing its efforts on establishing a maternity center that is located in the center of Northeast Philadelphia. The expectation is that the maternity center will provide comprehensive care to individuals from all income brackets and backgrounds. BAP's goal is to provide pregnancy and postpartum medical care to all women, without exclusion. As I concluded my dissertation research,

this organization still had a lot of preparation to do before it would be ready to provide services to its constituency.

For much of the time I studied the Parental Support Center, the organization fell somewhere in the middle of the spectrum between the brand new Birth Advocates of Philadelphia and the firmly established Alliance for Family Wellness. I first connected with the Parental Support Center just a few months after it received 501(c)(3) status and had quickly obtained a business location. Although the Parental Support Center struggled with its internal structure throughout the four years I had contact, this young organization provided an array of well-received services to families in the community. While, at times, the Parental Support Center received small grants from local foundations which enabled the organization to hire a few paid staff, the Parental Support Center was run mostly through volunteer labor. Combining the Board of Directors, the co-founders, and paid staff and volunteers, approximately ten to fifteen people were involved in operating the organization. Instructors brought in to teach classes and run support groups added another fifteen or so individuals who were part of the organizational structure. The Parental Support Center primarily served individuals from the surrounding neighborhoods in Northwest Philadelphia, although individuals from Center City and from the suburbs surrounding Philadelphia utilized the Center as well. Like Birth Advocates of Philadelphia, the Parental Support Center was interested in attracting pregnant women and new parents from all income levels and backgrounds. Yet, this nonprofit's core constituency was the highly educated middle and upper-middle class families who reside in the area immediately surrounding the Parental Support Center. As

further detailed in Chapter 5, the Parental Support Center ceased operations in early 2010, thereby drawing my work with the organization to a close.

These three organizations differed in the obstacles and challenges encountered as they navigated the terrains of nonprofit service provision and of health care in Philadelphia. As the detailed discussions in Chapters 4 through 6 reveal, each of the three NGOs struggled with distinct external pressures and internal limitations due to the structure of the organization, its approach to service provision, and its position within the community. Just as each organization bears weaknesses, all three boast particular strengths that set them apart from one another. For example, one of the most impressive strengths of the Parental Support Center, for much of its existence, was the organization's devotion to its patrons and the community in which it was located. The Center let community opinion direct decisions regarding services offered and adamantly designated its location as "community space." Neither the Alliance for Family Wellness nor Birth Advocates of Philadelphia possesses such an intimate relationship with the community, yet both organizations have strengths of their own.

All three of the NGOs examined in this dissertation are health service nonprofit organizations located in Philadelphia, Pennsylvania that focus on improving access to care for pregnant women and their families. These organizations all navigate the same set of local issues relating to recent changes in maternity care provision, and they all must negotiate national cultural, economic, and ideological trends. While most of the literature defines and discusses US nonprofits in terms of their official legal context, I examine the three organizations considered in this study as they informally and actually operate as social and cultural entities. As the in-depth discussions in Chapters 4 through 6 illustrate,

not only do the internal structures and services provided by these organizations differ but the external challenges encountered and their responses to these challenges is unique to each organization.

CHAPTER 4

STARTING UP: THE STORY OF BIRTH ADVOCATES OF PHILADELPHIA

A Confession

Elaine's doe-eyes misted as she said to Dimitri and me "I've realized that I can't keep this up." It was just the three of us, the only people who showed up Birth Advocates of Philadelphia's (BAP) bimonthly meeting that the organization opened to the public. Not that it mattered that it was an open meeting; the three of us were all on the Board of Directors. Elaine is the organization's vivacious, generous, and optimistic President elect and a Certified Nurse Midwife (CNM). Dimitri, also a CNM, is Treasurer. I am the reluctant Secretary of the organization, elected due to a dearth of other candidates and because I sat scribbling away in a notebook at nearly every meeting, anyway. We sat around a cafeteria style table, two on one side, one on the other, taking up only an ounce of space in the cavernous meeting room. Our table was pushed close to the wall, as near to the exit door as possible. Behind us, the community meeting room BAP reserved every other month for their public meeting was set up theater style in preparation for some other groups' meeting: brown metal folding chairs with their backs to us faced the stage and a big-screen TV decorated for the holiday season with a red bow perched on its corner.

Dimitri, an ever-stoic male midwife, seemed to cease breathing at Elaine's confession. I, on the other hand, exhaled in a flood of relief. For months now, I had noted frustration building among other members of the group. Finally, it seemed we were all on the same page. Miranda, the Vice-President elect of the organization, had been vocal during previous meetings regarding her dissatisfaction with BAPs seeming lack of

progress and her feelings that the group had been spinning its wheels over the same set of basic issues during the past few years. Alice, the matriarch of the group and a lifelong health activist in Philadelphia had been elected public relations officer, but rarely attended meetings during the second half of the year 2010. Alice did, however, stress the critical need for BAP to develop connections with health providers and to garner the interest of community members during phone conversations with Elaine. With the annual election of the Board of Directors quickly approaching, the group had no new members to elect as officers. I, too, had increasingly felt the apathy caused by inertia over the past year, and had felt a tinge of relief on the few occasions I had been unable to attend group meetings. Yet, while other members of the organization voiced their frustrations and acted on their dissolving interest, Elaine had remained positive, determined, and unaffected by the barriers the organization had encountered. By sheer strength of leadership she had continued to hold monthly meetings for dwindling numbers of people, guilted the rest of the officers into attending, and in completing a few small organizational related tasks. She had been pulling the rest of us along millimeter by millimeter for months now, and I was exhausted by watching her.

Elaine continued to explain to Dimitri and me, unnecessarily, that she felt overwhelmed. When she was unable to complete a grant she had been working on by the due date, she finally admitted to herself that she simply did not have enough time to dedicate to the organization. In order to move BAP forward, it needed to be her full-time job. But, Elaine already had a full time job as a prenatal care provider for a large healthcare NGO in Philadelphia. For that matter, everyone connected to BAP worked another job; the time they gave to BAP was on a volunteer basis. Elaine's declaration

that her work for BAP needed to be full-time wasn't a request for the job, however. It was an admission of defeat. As a start-up NGO, the organization had only a few thousand dollars in its treasury and no immediate grant prospects. Elaine needed income, but BAP couldn't pay.

As I sat listening to Elaine's confession, I reflected on the organization's history. The current feelings of resignation hadn't always been there. In fact, I had once marveled at the energy and momentum with which the organization had been created. What had happened? How did we get here, in this little corner of a big, empty room, listening to the remorse and exhaustion in our fearless leader's voice? It wasn't just about time. It wasn't just about money. Since the group's first meeting, long before it acquired the legal status of a 501(c)(3), BAP had encountered a myriad of obstacles and complications, some expected and some unanticipated, that had thus far distracted and disabled the organization from developing into a thriving NGO able to meet its goals and the needs of the Philadelphia community.

The Birth of BAP

It was late 2007 when a Town Meeting was held in Northeast Philadelphia in response to hospital maternity unit closures. At the time of the meeting, 14 hospitals in the greater Philadelphia region had already closed their obstetrics units; 11 of those 14 hospitals were located in the city of Philadelphia. The closures of Jeanes Hospital maternity unit earlier in 2007 and of Frankford Hospital's maternity unit in 2006, along with the closure of Nazareth Hospital's obstetrics unit in 1998 left a gaping hole in the maternity care available in the vast section of Philadelphia simply referred to as "the northeast." The Town Meeting, co-sponsored by civic associations, religious institutions,

local NGOs and health centers, was presented as a forum for the community, health care providers, and legislators to discuss the recent loss of maternity units and to explore solutions. However, the politically savvy Alliance for Family Wellness (AFW), the chief organization behind the Town Meeting, also intended to use the event to draw attention to the “childbirth crisis” among the media and legislators and to spark activism in the community.

On the evening of the meeting, I sat in the audience surrounded by about 125 other attendees and listened to the directors of NGOs, elected officials, midwives, nurses, obstetricians, and doulas share statistics, information, and experiences related to the reduction of maternity services in the area. Insurance reimbursements, malpractice insurance, travel time for women in labor, over-burdened remaining maternity units, and health insurance coverage were among the topics discussed. The Alliance for Family Wellness presented a short film that reiterated the key issues as they saw them. Elected officials made impassioned promises, and healthcare providers expressed their outrage over the lack of services available. A local news station and a few local newspapers covered the event. Looking around the room, it became clear that only a handful of what I would have considered to be true community members attended: that is, individuals who lived in Northeast Philadelphia, who had attended because of their interest in the topic at hand, and who did not have an intimate connection to one of the organizations sponsoring the event. Instead, the vast majority of attendees were connected to one of the many groups that had co-sponsored the meeting or were professionals who are part of what is frequently referred to as the “birth community”, that is, health care providers and activists who had a vested interest in maternity care in Philadelphia.

The Town Meeting was generally considered a success by the organizers. The co-sponsors had filled the room with enough supporters to ensure a nice turnout. The event had been covered, though somewhat minimally, by media reporters. A few public officials and legislators partook in the conversation and declared their commitment to the issue. Aside from these acute results, the most lasting and tangible outcome of the meeting was the formation of a small group which eventually became the organization called Birth Advocates of Philadelphia (BAP).

The Alliance for Family Wellness (AFW) played an important role in the creation of BAP beyond its role as the chief organization behind the Town Meeting. AFW nurtured the idea of creating an organization that would advocate for the availability of maternity care choices and birthing options in the community of Northeast Philadelphia. Motivated by the activism of community members, AFW took charge of organizing the initial meetings of BAP, inviting a select group of activists, health providers, politicians, and religious leaders to take part in the group's meetings. It was AFW's Community Engagement Coordinator, Drina, who managed BAP in its infancy, setting up meetings, providing meeting agendas, distributing meeting notes, presiding over meeting discussions. In fact, it was through Drina's invitation that I attended a BAP meeting in September of 2008, and henceforth became involved in the organization.

Defining Objectives

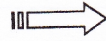
From fall of 2008 into spring of 2009 meetings were scheduled monthly, drawing about twelve attendees, with some meetings having as many as fifteen participants and others with as few as eight attendees. Those who attended came from many walks of life: nuns, nurses, midwives, doulas, employees of managed care companies, politicians,

students, mothers, activists, and directors, board members and chairpersons from a variety of large healthcare NGOs both local and national. Chaotic and inspiring, the discussions were a mixture of information sharing, advocacy planning, and outreach preparation.

Imagined as an advocacy group, members developed a list of broad organizational objectives which ranged from establishing a maternity care facility, to education and facilitating community involvement, from improving the availability of services by collaborating with existing Philadelphia providers to impacting public policy relating to maternity care. These objectives were quickly printed in a recruitment flyer which was distributed by members to friends, local businesses and organizations. Figure 2 is a copy of this flyer, front and back, with sensitive, traceable information blacked out. While these objectives were certainly lofty, attainment seemed possible based on the projects planned during meetings and the activity of members between meetings. For example, during the first meeting I attended, a visit to a maternity center located outside of Philadelphia was planned. The purpose was twofold: to provide the group with a blueprint of a functioning maternity center to aid in designing a similar type of facility in Philadelphia, and to gather information on the services offered by the maternity center in order to refer parents in the community, as appropriate. By the next meeting, having visited the center and met with the director, group members reported on the services offered and the general structure of the maternity center.

Another example relates to the organization's objective of public education and facilitating community engagement. The group planned an event at which baby onesies (a one-piece body suit) would be decorated by parents from the community and then

Learn More and Get Involved!
Come to our next meeting!



September 23rd 2008
Time: 6:30-8:00pm

Philadelphia PA

Bring Birth Back!

Join

We are grassroots community organization addressing the withdrawal of birthing options and women and family healthcare from our area.

We seek the development of maternity care choices for the women and families of the Northeast and the surrounding community that are safe, comprehensive, sustainable and mother-friendly and inclusive.



For More Information:

Our mission is to advocate for the availability of maternity care choices and birthing options for all women in the community of Northeast Philadelphia.

Our Objectives

- ◆ The establishment of a facility in the community to serve maternity care and related health and social service needs of area residents.
- ◆ Conduct public education and facilitate grassroots community engagement.
- ◆ Identify and collaborate with providers and resources in the Philadelphia area to develop availability of services.
- ◆ Develop and support public policy in support of these objectives.

Figure 4: BAP Recruitment Flyer

exhibited together. This event was designed to get parents involved in the organization, to provide an opportunity to educate parents on the changes occurring in maternity care, and to serve as a visual display of community solidarity at a rally in opposition to the imminent closure of the twelfth hospital maternity unit in Philadelphia in eleven years time.

As spring 2009 continued on, BAP members persisted in their effort of achieving the group's broad objectives. Yet, month by month, the group's focus shifted, I believe imperceptibly to some, favoring certain objectives over others. One objective began to take clear precedence over the rest: the establishment of a healthcare facility in the community to serve the maternity needs of residents of the northeast. The preference for focusing on this particular objective arose out of numerous developments. The difficulty BAP faced in making progress on the other three organizational objectives was no small factor in the groups increasing focus on the establishing a health care facility.

Objective 1: Public Education and Grassroots Engagement

Although one of BAPs original objectives was “to conduct public education and facilitate grassroots community engagement”, group members found this local activism difficult to implement. One problem was the limited time group members had to search for and then meet with residents of the northeast community. Although one BAP member, Solange, a mother of three young children, had connections with local parenting groups, her already busy schedule kept her from dedicating time to engaging the mothers and fathers associated with these parenting groups and, often, kept her from attending BAP monthly meetings. Likewise, as mentioned before, the rest of the individuals associated with BAP held jobs that kept them unavailable during the day, leaving only

evenings or weekends open for community outreach work. While discussions on the need for BAP members to volunteer evenings and weekends to conduct outreach activities occurred during monthly meetings, the actual planning and implementing of such activities was generally avoided. Even when outreach activities were planned, volunteers were few.

On the other side of the coin, BAP was unsuccessful in its attempts to draw individuals from the community to its monthly meetings. Very early on in BAPs existence, the group established a listserv partially in an effort to reach community members and draw them into the organization. While the number of listserv members eventually reached 70, little interaction occurred through the listserv. Individuals who consistently attended BAP's monthly meetings were encouraged to bring friends and acquaintances along, yet this request went unanswered. As the year 2008 turned to 2009 and 2009 became 2010, the number of attendees at BAP meetings steadily decreased.

Those who continued attending meetings expressed their frustration with the lack of community engagement, often from a perspective that placed blame on the community, itself. Some were of the opinion that the people of Northeast Philadelphia were too conservative or too set in their ways to become activists. Others drew the conclusion that while Northeast Philadelphians were capable of activism, their lack of knowledge or different values prevented them from being open to the changes in maternity care that BAP advocated. Still others suggested that BAPs focus on birth related issues was too narrow a topic to draw the attention of the general population; only families expecting children or those who had recently given birth were directly impacted and those individuals had too much on their plates to make room for community

activism. For whatever reasons, the reality was that the organization found itself unable to engage community members on a long-term basis.

Adding to the complexity of the situation, members of the “birth community” frequently applauded BAPs efforts. There were multiple instances when a midwife, doula, NGO or business professional would praise BAPs “vision” and offer to assist in any way needed. While BAP would invite these supporters to attend monthly meetings, the organization was at a loss regarding concrete projects to assign in order to employ these people’s abilities. Almost without exception, the individual would not attend a BAP meeting, and was told that BAP would contact them sometime in the future, at which point communication was suspended. BAPs objective of educating the public on the changes occurring in maternity care and of initiating activism had met with limited efforts and scant success, and the organization frequently missed the chance to involve supporters at the crucial point when their interest was piqued. For all these reasons, this first objective lost its allure and was quietly shifted to the background.

Objective 2: Develop and Support Public Policy

BAPs objective to develop and support public policy relating to maternity care was also unsuccessful. During monthly meetings in 2008 and in early 2009, lists of Senators and district Representatives in Northeast Philadelphia were distributed, and BAP members were urged to contact legislative leaders regarding a variety of issues. These issues were often brought to the attention of BAP by the few members whose day jobs involved legislative advocacy. In other words, the policy advocacy that BAP members were asked to do was actually to support the work of others such as lobbyists and NGOs. BAP, as an organizational entity, did not attempt to create or independently

influence public policy. The issues brought to the group included state reform of adultBasic health insurance coverage, requiring hospitals to increase notification time before closing OB units, and increasing accountability among hospitals that receive public support to serve underprivileged populations. While these issues are certainly aspects of the problems with maternity care, these topics relate only tangentially to the core focus of BAP. It is important to note that BAP members were asked individually to contact legislators. To my knowledge, BAP never contacted a legislative leader as a unified entity advocating for change.

Perhaps the reason that BAP did not address legislators as an organization could be that until 2010, BAP did not obtain legal status as a nonprofit organization. The decision to apply for status as a 501(c)(3), however, was made in relation to the gradual shift in BAP's focus to the establishment of a maternity care facility, not the group's objective of influencing public policy. At the time that the legislative issues discussed above were presented to BAP, the group had not yet determined if it would in fact apply for legal standings as a nonprofit organization. Yet, it is certainly possible for a group of individuals to band together and approach elected officials as a unified assembly without legal standing. However, in addition to legal standing BAP also lacked the strong political influence that an established NGO, such as AFW, with a proven track record and close ties to the community, would have over legislators. It is likely that the absence of a visible power base is what kept BAP from asserting itself as a cohesive organization in the legislative arena.

Objective 3: Collaborate with Existing Providers to Develop

Availability of Services

BAP members also found that their objective of collaborating with existing providers and resources to increase the availability of maternity care services would not be easily accomplished. The possible options for collaboration were fairly obvious: local NGOs, two birth centers and a maternity center located outside of Philadelphia, and hospitals. BAP investigated these organizations' willingness to provide additional maternity services or to dedicate resources such as staff, money, and time toward the development of services. The responses lead to a collaborative dead-end. Existing organizations were either not interested or were unable to join in BAPs efforts.

The hospitals that remained were not interested in adding the type of maternity care BAP supported into their services. That is to say, while a few of the remaining hospitals in Philadelphia, all six of which were teaching hospitals, were increasing their patient capacity regarding maternity services, none of the hospitals showed interest in altering their maternity care model to enhance patients' choice of provider, to make natural or low-intervention birth a viable and acceptable option, or to re-center maternity care around the needs of women instead of provider or institutional needs. Hospitals argued that they made little money as it was from the provision of maternity care, and therefore did not view the addition of maternity services, particularly the non-interventionist type of services BAP supported, as a fiscally wise decision. Hospitals and BAP were speaking different languages: hospitals spoke the language of business while BAP spoke the language of human rights. Neither one could understand the other.

The two birth centers verbally supported BAPs efforts. However, as non-mainstream maternity care providers, both centers had to dedicate their time and limited resources to the maintenance of their own facilities and services. Neither center had the

capacity to add to the services they were already providing. The maternity center happily accepted any referrals BAP sent, yet as it was connected to a hospital outside of Philadelphia and had plenty of patients, the maternity center was self-sufficient and, like the birth centers, had enough on its plate as it was. While there seemed to be no ill-will between BAP and the birth centers and maternity center, a collaborative agreement between these organizations was not feasible.

Partnering with NGOS or with other activists was the last possibility. The most obvious collaboration would be with AFW, since AFW held such a prominent role in the creation of BAP. AFW had considerable political influence and was already working to increase the availability of certain maternity services through their public policy efforts and through their outreach program which provides education and referrals for low-income families. The problem there was that the relationship was unequal in that BAP needed AFW, but AFW did not require BAP's assistance in achieving their goals. There was also the difference in focus. Even though AFW had directed the construction of BAP, the two organizations concentrated on different aspects of maternity care. BAP's focus was specific to pregnancy and birth and the direct provision of prenatal and delivery care. AFW responded to broader social and health issues mainly through educational programs for parents. Certainly, the two organizations supported one another's goals, but there was enough of a division in focus and in power that the two organizations were not ready to collaborate on the same issue. It also became clear, during the spring of 2009 that while AFW had helped establish BAP, AFW did not intend to make BAP part of their organization. The two organizations were seen as separate entities and AFW did not wish to wish to maintain management over BAP. This fact was

made very clearly by Drina, AFW's Community Engagement Coordinator, as she ceased acting as BAP's administrator and, by the end of summer 2009, stopped attending meetings.

BAP also considered joining forces with activists within the "birth community" who, like BAP, were trying to address the dearth of locations, providers, and options available to Philadelphians for childbirth. During one BAP monthly meeting, members excitedly discussed the discovery of a group consisting of a midwife, acupuncturist, doula, and massage therapist who were planning to open a center in South Philadelphia that would offer a variety of services to pregnant women. BAP also learned that a group lead by a doula in Delaware was planning to open a center that would offer "one-stop shopping" for pregnancy and birth care. BAP members were thrilled to hear of others who were working on a similar issue in their geographic area, and hoped to meet with these groups to see if collaboration was possible. No meeting ever occurred, and the topic was never revisited by BAP. Just as with other BAP objectives, the plan to collaborate with others to increase the availability of maternity services was not realized due to a variety of external and internal barriers.

Member Attrition: Losing People and Their Skills

Gradual attrition of BAP members also played a role in determining the focus of the organization. As mentioned above, Drina, the original manager of the group, slowly but surely cut direct ties with BAP during the first half of 2009. By fall 2009, she no longer attended meetings, and it was understood by the remaining BAP members that while Drina still supported the group's efforts and could be contacted with questions, she was no longer a "part" of BAP. With Drina's departure, BAP lost more than a dedicated

motivating force. Drina's skills were in community outreach and in brokering alliances. Her work with AFW also kept her informed of state and national health care policy initiatives. Drina's areas of expertise dovetailed with BAPs objectives to engage the community, to develop collaborations with providers, and to influence public policy. Her withdrawal from BAP meant a reduction in the skill set BAP possessed to achieve its stated objectives.

There had been others as well who, although they did not hold as central a role in the organization as did Drina, did bring strengths that would have aided in the achievement of BAPs four objectives had they sustained their involvement with the organization. As it was, the attendance at BAP meetings fluctuated greatly from its inception through summer of 2009. The skills and interests brought to the group by individuals who attended only one or two meetings before losing interest fed BAP a multitude of ideas and projects that were started and, in the end, were not completed because the person who had inspired the project was no longer there. Simultaneous with the appearance of temporary additions to the group, established members, such as Drina, discontinued their involvement. The result of this constant fluctuation of group members during the first half of 2009 was chaos, false starts, misdirection, and a lack of progress. As the year wore on, the number of attendees gradually began to decrease. By late summer 2009, a core group of six individuals, including myself, had surfaced.

As a freshman organization, BAP had set out to achieve four key objectives. Circumstances both internal and external to the organization transpired that restructured the group's focus from addressing all four objectives simultaneously to focusing on just one objective while the others were largely dismissed. Instead of concurrently addressing

four different objectives, BAP repositioned its focal point to working toward the establishment of a health care facility that would serve the maternity care needs of area residents. Attrition of group members, difficulty engaging the community and possible collaborators, and the disarray caused by lack of organization and having numerous multi-pronged objectives all had a role in re-shaping the focus of BAP. In addition, the skills and interests of the remaining group of six individuals complemented the direction BAP had taken. Most of the individuals who remained with BAP as the singular objective of establishing a facility took hold were health care providers, either midwives or doulas, or were activists whose professional experiences had highlighted the need for more birthing options and more locations for giving birth in Philadelphia.

Last One Standing: Objective 4

The first year of BAPs existence was spent eagerly developing expansive objectives only to turn around and pair down the organizations goals. Yet, as BAP emerged from this process of subtraction, the organization claimed progress toward its remaining objective, now the group's central focus, of establishing a healthcare facility to serve the maternity needs of Philadelphia residents. Though the steps taken toward the fulfillment of this objective had been largely exploratory, investigation of structural options and current politics were seen as an essential first step by BAP members. While BAP now focused its efforts on the establishment of a facility, the exact services to be provided and type of facility had yet to be determined. Would the facility be a resource and education center or would it provide direct health care services? If the facility would provide health services, what kind of services would be offered? What type of practitioners would provide the care? Would the facility be independent or an off-shoot

facility for another institution, perhaps a hospital? These were just some of the questions with which BAP members grappled. Surveying the design and services of institutions that already offered women's services provided BAP with a basis on which to evaluate current practice and to design the facility most suitable for fulfilling the needs of local women and their families.

The group's earliest activities relating to the objective of establishing a healthcare facility were also among its most external, meaning they were activities for which BAP turned to the community or to outside institutions for opinions and information that would guide BAP's actions. In late 2008 a trip was taken to a birth center in Washington D.C. A visit to a maternity center located in Bucks County followed soon after in the early months of 2009. Both trips were arranged to learn about the structure of the organization, the model of care used, and the relative success of each facility in order to see if the model might be a fit for northeast Philadelphia.

Concern over whether people in Northeast Philadelphia were supportive of the establishment of a facility that would provide an alternative to hospital care led to the development and the distribution of a survey. The survey focused specifically on the creation of a birth center. A dozen survey questions along with a description of what a birth center is were distributed through an online survey tool, at community health fairs, and at a local city health center. The survey assessed people's knowledge of, feelings toward, and experience with birth centers as well as what was appealing and not appealing about receiving care at a birth center. Nearly 350 surveys were ultimately collected, 260 of which were completed by residents of Philadelphia, and with 216

completed by residents of Northeast Philadelphia (residency was determined by the zip code of participants).

BAP focused on the survey responses of residents of Northeast Philadelphia since that was the location under consideration for building a facility. The results were largely positive, with most respondents showing interest in and support of the establishment of a birth center in Northeast Philadelphia. Some concerns were raised, however, about the possibility of complications occurring during labor and delivery. Since birth centers do not usually have obstetricians on staff and do not have operating rooms, patients who require heroic intervention due to unforeseen complications during labor and delivery, such as an emergency cesarean section, must be transferred to a hospital. The lack of an obstetrician's presence at a birth center, the need to transfer the mother to a hospital should complications arise, and the proximity of the birth center to a hospital in case of complications were listed by survey respondents as reasons why giving birth at a birth center might not be appealing. These issues mirrored some of the barriers that the Washington D.C. birth center faced, as a large percentage of their patients requested hospital deliveries, and BAP took these concerns into consideration.

The solution, BAP decided, was to build a maternity center instead of a birth center. The most important distinction between a maternity center and a birth center is that a maternity center is a level 1 hospital while a birth center is not. As a level 1 hospital, maternity centers not only have the capacity to safely attend low-intervention or natural births, but they include the additional benefit of having operating rooms in-house should complications arise. In addition to a staff of nurses and midwives, a maternity center has obstetricians on staff. This switch in focus from establishing a birth center to

building a maternity center provided resolution for the issues raised by the feasibility survey and the visit to the Washington D.C. birth center. Patients receiving care at a maternity center would have access both to midwives and obstetricians, and operating rooms were available in the case of complications, thereby rendering transfer to a hospital unnecessary.

The decision to establish a maternity center also put to rest some of the barriers BAP had encountered when the organization's focus was on building a birth center. For example, in Pennsylvania, birth centers must have a "written transfer agreement with physicians who have admitting privileges to a hospital obstetric/newborn service for the mother and infant when complications or emergencies arise" (Commonwealth of Pennsylvania 1998:501-10). As BAP discovered, however, the current politics of maternity care in Philadelphia made such agreements difficult to obtain as both the physician and the hospital to which the physician has privileges must support the agreement. BAPs preliminary inquiries regarding the establishment of a birth center had not revealed any physician or, perhaps more importantly, any hospital in Philadelphia that had a sincere interest in connecting with a birth center in Northeast Philadelphia. Thus, the later decision to build a maternity center that was a level 1 hospital, instead of a birth center, negated this legal stipulation as an issue to contend with.

Detractors of BAP's decision to establish a maternity center certainly existed. Practitioners and politicians who had seen the demise of Booth Maternity Center, a similarly structured maternity center, argued that any new attempts would meet with the same fate. Midwives employed by birth centers, and who had supported BAPs prior idea of establishing a birth center in Northeast Philadelphia, expressed shock at BAPs new

concept of establishing a maternity center and argued that it would not be a successful venture. A few BAP members also stopped attending meetings once it became clear that the organization's goal was to establish a maternity center. This fall-out did impact BAP by forcing the group to second guess its decision and by causing some long-term confusion among group members. However, as spring of 2009 drew to a close, BAP moved forward, although unstably, with its objective of establishing a maternity center in Northeast Philadelphia.

Part of the process of moving forward was a shift in leadership within BAP. While Drina had managed the group during its infancy, by now she was gradually relinquishing her leadership role. As Drina stepped back, Elaine became more involved in the managerial aspects of BAP. By mid-summer 2009, Elaine was the unofficial and unopposed leader of BAP. The shift in leadership corresponded with the changing focus of BAP; Drina's expertise had supported three of BAP's original, now discarded, objectives. Elaine's interests matched the revised goal which focused on the establishment of a maternity center. In fact, Elaine's enthusiasm and ideas had played a large part in swaying the group's decision toward emphasizing the need for a maternity center. Her eagerness to accomplish BAP's objective was apparent in the work she did and the activities she planned for the group.

A flurry of activity occurred from summer 2009 through May 2010. First, Elaine's agenda was to incorporate BAP as a nonprofit organization and to apply for status as a 501(c)(3). The reasoning for this was twofold: first, to give the group authenticity and independence from having to rely on other established organizations to speak for BAP; second, to enable BAP to fundraise and apply for grants. Elaine began

the nonprofit application paperwork in July 2009. The requirements of the application process prompted the creation of a mission statement, bylaws, a vision statement, and a general budget. Elaine and Alice organized a two-part workshop, run by a foundation, on grant seeking and proposal writing. In September of 2009 officers were voted in, bylaws were voted on, and possible recruits for the Board of Directors were discussed. Elaine was now the official President of BAP, Miranda was Vice-president, Alice now held the position of Public Relations Officer, Dimitri was elected Treasurer, and I was elected as Secretary. Within the next few weeks, a fundraising letter was drafted and distributed to BAP members who, in turn, disseminated the letter to friends, family, business contacts and acquaintances. The letter campaign raised about \$6,000 for the treasury by February of 2010. In the same month, with the volunteered help of a friend of Dimitri, creation of BAP's website began and Elaine informed BAP that she had applied for a marketing grant for BAP, which the organization had won. The grant provided free design help with BAP's choice of marketing materials, such as a brochure, business cards, or a logo. BAP was unsure how to best use the grant and put off a decision.

With the bulk of the treasury savings, BAP decided to hire a nationally known organization to present a workshop on beginning a birth center, even though by this time BAP had decided to establish a maternity center/hospital, instead of a birth center. While the cost of the workshop usurped two-thirds of BAP's treasury, members felt that the information to be provided and the connections forged through the workshop would be helpful in guiding their efforts to establish a maternity center. BAP planned to defray some of the cost of the workshop by inviting others from the "birth community" to attend for a nominal fee; not wanting to exclude any interested parties, BAP also decided to

offer a few “scholarships” to individuals who wanted to attend but could not afford the fee. Arranged largely by Elaine, the workshop took place over two days in April and, again arranged by Elaine, included a visit to a birth center located northwest of Philadelphia. While BAP had expected up to twenty outside registrants, only one non-BAP member registered, and that registrant was rewarded a scholarship. Disappointed but not daunted, BAP went ahead with the workshop.

While the workshop was informative and did have a temporary energizing effect on BAP, the long-term impact of the workshop on BAP is questionable. One of the reasons BAP willingly spent two-thirds of its small treasury savings on the workshop was because of the standing of the nationally known presenting organization. The national organization that performed the workshop had the capacity to provide information, resources and support as well as to secure relationships with other centers and organizations that could aid BAP in achieving its goals. To BAPs surprise, however, with the conclusion of the workshop the national organization informed BAP that in order to benefit from an ongoing relationship, BAP would need to join the national organization’s association. Although BAP was not opposed to the idea, the cost of membership in the national association was simply too prohibitive. Therefore, one of the most anticipated outcomes of the workshop, to establish a network of support with and through an association with a national organization, was not accomplished.

In addition to depleting the financial resources of BAP, the main topic addressed in the workshop nurtured ongoing confusion among BAP members. Even though by this point in time BAP determined to establish a maternity center instead of a birth center, confusion abounded among BAP members due to a general lack of adhesion to

terminology and concepts during BAP meeting discussions. The terms “birth center” and “maternity center” were often used interchangeably, most frequently by Elaine, even after group members took pains to clearly distinguish one from the other. In addition to the “maternity center vision statement” that had already been created, BAP members discussed plans to develop a “birth center vision statement” even though BAP had no intention of establishing a birth center. This confusion existed among BAP members prior to the workshop, yet the workshop, presented by a national birth center organization with the topic of “how to build a birth center” rekindled this confusion among BAP members. While some information provided at the workshop was applicable as it related to starting any business (not just a birth center), the focus on birth centers revived the confusion among BAP members resulting in frequent revisiting of the issue during subsequent BAP monthly meetings.

Loss of Momentum and Interest

By this point in time, the number of individuals still involved in BAP had dwindled to six, including myself. Five of the six members were elected officers. Elaine was active in work related to BAP: applying for grants, organizing a workshop, applying for nonprofit 501(c)(3) status. However, from our first meeting of 2010, I noticed a substantial decrease in interest and activity by most of the other members. Miranda, the Vice President of BAP and a native of Northeast Philadelphia, moved from northeast to south Philadelphia, and her interest and involvement in BAP decreased as the inconvenience of attending group meetings increased. Alice faced family issues and health problems which prevented her from dedicating time to BAP. Kevin, a long-time member, expressed his frustration with BAP's lack of organization and focus and ceased

his involvement with the organization. Yet, just as Kevin cut ties, Solange, a doula and mother from Northeast Philadelphia rejoined the group after a year long hiatus. An attempted theft from the BAP treasury, although not perpetrated by a BAP member, proved divisive for the group as it brought issues of trust and integrity to the surface. All of these factors combined to result in extremely low turnouts for BAP meetings with just 2 or 3 members attending some meetings. Elaine, however, remained dedicated and, therefore, another outcome of the drop in involvement by the rest of the group was the increased responsibility shouldered by Elaine. In addition to planning the birth center workshop and orchestrating monthly BAP meetings, Elaine obtained status for BAP as a 501(c)(3) in April of 2010 – a project a year in the making. Elaine also worked with Dimitri and his friend who voluntarily constructed the BAP website. The website launched in May 2010.

So, through Elaine's persistence some projects were completed in the first half of the year 2010. Yet, considering the palpable loss of motivation and interest among the rest of the group, Elaine's enthusiasm could only carry BAP so far. The monthly meeting agendas became carbon copies of each other; the same business was discussed month after month with various members repetitively voicing the same opinions and ideas without accomplishing anything. The small tasks assigned to members went unfinished and any progress regarding the group's immediate and long term goals was imperceptible. The lack of progress meant that the same projects were rehashed each meeting, filling the agenda and the available meeting time, and preventing new projects from being initiated. BAP was caught in a vicious cycle: members' loss of dedication halted progress, and the lack of progress increased members' disinterest in BAP.

Inward Orientation

Since BAP's inception in 2008, the organization has undergone changes in leadership, changes in membership numbers, and changes in objectives. In 2010, concomitant with a loss of interest among the majority of members and Elaine's increased responsibility, BAP's focus changed from outward to inward. Originally imagined as an advocacy organization, BAP's initial goals held the needs and interests of the community central. With this outward focus BAP conducted its community survey on birth centers, drew a kaleidoscopic group of attendees to meetings, and connected with other organizations and individuals from which BAP learned a great deal. Over time, the focus of BAP shifted until, by late spring 2010, the concentration was decidedly focused inward on organizational needs.

During this time period, topics of discussion at BAP meetings repeatedly centered on the marketing of BAP as a brand, although the term "brand" was never explicitly used. Members did, however, discuss the need to define BAP's "product" in such a way that businesses would find appealing. Frequently deliberated matters included: the procurement of business cards, the obtainment of an "official" organizational calendar, the design of a logo and graphics, and the development of a brochure and information packet for distribution. Fundraising made the agenda every month. Every meeting, members explored the idea of holding a large fundraiser, discussing possible locations, the guest list, and the intended fundraising goal. Yet, no progress was made in organizing this proposed fundraiser and, every meeting the date for this possible fundraiser was pushed back. The need to apply for grants was another popular topic of discussion on which no actual action was taken by BAP members, except for Elaine who

attempted to apply for grants on her own, only informing other BAP members of her submissions afterward.

Perhaps most telling of BAPs inward focus was the decision to begin to hold separate public and private meetings. In May of 2010, BAP officers determined it necessary to designate select meetings as private meetings during which organizational issues would be dealt with. At the time of the decision, this meant that all six of the standard meeting attendees would be invited to private meetings: the five BAP officers and Solange. So, the establishment of private meetings was not an attempt to separate the existing group. Instead, private meetings were intended to provide officers with time to attend to clerical and business-related issues. On the other hand, public meetings would be open to anyone interested in attending and BAP planned to invite community members, members of the “birth community”, and legislators. Public meetings were imagined as opportunities to inform and inspire others to join in BAP efforts. While the establishment of private meetings was not an attempt to exclude existing BAP members, the separation of public and private meetings defined the core group of six members as “BAP” and separated that “private” group from the broader community.

This was more a change in mindset than practice, however, as meetings designated as public did not draw outside members. Occasionally, a BAP officer would announce that they extended an invitation to an outsider, but these invitations went unanswered. The same core group of six people attended both the public and private meetings. Furthermore, while the agendas for both public and private meetings were originally envisioned as essentially different documents, in reality, the agendas for public and private meetings were identical and dealt with the organizational related topics

deemed “private” by BAP. However, in addition to the shift in mindset conjured by this designation of public and private meetings, one other important difference did exist. Public meetings continued to be held in the community meeting room of a local library while private meetings were held in the homes of BAP officers. Holding “private” meetings in a private space and keeping “public” meetings in a public space symbolically solidified this division between BAP insiders and others.

Summary

Almost exactly three years after the first meeting of the group that would become BAP, the past 2 years and 4 months of which I had been involved, Elaine quietly announced her despair to Dimitri and me in a room we had hoped would be populated with an assembly of enthusiastic BAP members, impassioned community members, and determined legislators. A bevy of occurrences had brought us to this moment in which the future of this start-up NGO was so uncertain. The attrition of members, the volunteer basis, the lack of funding, and the limited amount of time and energy members had available to dedicate to BAP are among the most obvious of the issues impeding the group’s progress. These issues are certainly not unique to BAP as such barriers have been noted as common among many start-up NGOs (see Salamon 2003). Nor are these the only issues that have affected the progress of BAP. In considering the story of BAP, some less apparent influences surface as significant in steering the group in the directions taken.

As it worked to define and establish itself within the civil society sector, BAPs interactions with other organizations and institutions (private, public, for-profit and nonprofit) had a considerable impact on the profile of and focus of BAP. The close

connection with AFW at the group's outset had tremendous influence on the individuals associated with BAP, even after that initial union dissolved. Even the multipronged model of programming AFW applied to its own organizational efforts was adopted in the design of BAP's original four objectives. This explains the broad reach of the four initial objectives, which included the development of public policy, community outreach and education efforts, direct provision of health and social services, and collaborative agreements with other institutions and organizations. All of these areas are prongs of the AFW organization and can easily be found in the programming of this established NGO. Whereas we can see the influence of AFW in the blueprint of BAP, the later withdrawal of AFW also shaped the direction in which BAP proceeded. Drina's departure from BAP marked the disengagement of the two organizations. As mentioned before, with the loss of Drina's presence, BAP also lost her skills and BAP's champion for maintaining all four objectives. With no one actively advocating for these objectives, which were proving difficult to achieve, these objectives drifted from view and were pushed out to sea with the changing tides of the organization.

The loss of the intimate support of AFW also meant a loss of resources for BAP. Although BAP members continued a friendly, distanced relationship, AFW no longer provided direct support in helping BAP achieve its goals. For example, in 2010, BAP contacted AFW asking for help in writing a seed money grant. BAP hoped that AFW, seasoned in grant writing and successful in obtaining funding, would be willing to temporarily allocate some time and staff to help develop a grant application along with BAP members. AFW declined the request citing the need, in difficult economic times, to center all efforts on self maintenance. So, even though AFW motivated the BAP

objective of collaboration with area organizations, the gradual distancing between the two organizations made it acceptable for AFW to decline collaboration in projects that would be meaningful to BAP.

While the complicated relationship with AFW was influential in structuring BAP, AFW was not the only organization or institution that shaped BAP's trajectory. As BAP explored the paths of possibility with regard to their original four objectives, encounters with other nonprofit agencies, birth centers, maternity centers, hospitals, and universities steered BAP toward or away from certain courses of action. In the end, it was the lack of support from this variety of civil sector institutions and the difficulty faced in engaging in meaningful collaborations that channeled BAP's efforts toward establishing an independent maternity center facility. Even after BAP narrowed its focus to the singular objective of building a maternity center, its appeals for guidance and assistance from more established organizations and institutions, both local and national, were stonewalled by solicitations for financial reimbursement or by lack of interest or inability among these institutions to reach out to the startup NGO. Let loose from the parental structure provided by AFW, BAP struggled to develop new relationships with supportive collaborators, finding civil society to be a lonely sector full of false starts and verbal, but not actually tangible, support.

In response to Elaine's confession, which left the future of BAP dangling by a thread, Dimitri and I put on brave faces. We convinced Elaine that a reevaluation of BAP's goals, along with guidance from an outside source on how to achieve said goals, would help to get BAP back on track. Elaine responded well to this idea, and within the next few weeks had contacted a consulting group specializing in organizational

development and grant writing. The following monthly BAP meeting was attended by four BAP members and a representative from the consulting group. After listening to the explanation of BAPs current situation, the consultant shared her prescription for BAP in general terms, and reviewed a handout on steps for successful grant writing. Before departing, the consultant explained that at a cost (the amount she would not yet disclose), BAP could hire the consulting group to guide BAP in the direction of success.

Much of what was covered by the consultant was, unbeknownst to her, repetition of what BAP had on its agenda over the past three years. The documents that needed to be developed and the regulatory steps to be taken that were suggested by the consultant were not new ideas to BAP. This work had been on BAPs agenda; BAP had just not been successful in completing these tasks. Convinced that the guidance of the consulting group would be the means to success, Elaine announced that she didn't care how much they cost, she would raise the funds necessary to hire the consultants. As the meeting adjourned, I wondered if, in fact, the help of the consulting group would make a difference. Could the supervision of a consultant reanimate the waning dedication of BAPs members or help attract new members? A consultant group might be able to aid BAP in clearly and consistently representing its mission, values, and plans, but could it help this startup NGO establish itself as a vital part of Philadelphia's civil society sector in which meaningful collaborations with other institutions and organizations had as yet been elusive? As of the moment, a follow up meeting has yet to be scheduled, so the future of BAP remains in the balance.

Neoliberalism and the Birth Advocates of Philadelphia

Chronicling the progression of Birth Advocates of Philadelphia brings to the surface one of the more intangible results of neoliberalism. Through the implementation of neoliberal policy and the incorporation of neoliberal ideology into the social framework, this form of governance restructures the social environment. The neoliberal celebration of the unfettered free market combined with policies that cut public expenditure for social services, diminish the importance of community conscientiousness, and support the privatization of once public ventures has changed the national climate. Corporate business ethics rule over a social atmosphere in which competition, efficiency, and financial gains guide interactions. The neoliberal political economy enforces a dog-eat-dog attitude in which the interest of the individual is valued over that of the community.

It should not come as a surprise, then, that a small nonprofit organization like Birth Advocates of Philadelphia (BAP) would encounter difficulty in its efforts to connect with other civil society institutions. The neoliberal social climate dissuades both individuals and businesses from joining forces unless there is a direct personal, and most likely financial, benefit. In a highly aggressive market where organizations must compete with one another for the limited funding available, who would be willing to collaborate on a project like the one BAP had proposed? The establishment of a facility like a maternity hospital requires huge financial allocation up front before any hard statistics on the efficiency and effectiveness of the facility can be provided. Yet, funding agencies currently prefer the security of projects with easily quantifiable outcomes. Furthermore, the population BAP intends to serve does not quite match the target

population of interest for many funders; BAP wishes the maternity hospital to provide care to all women, not just the disadvantaged, but to the middle class and the financially elite as well. BAP's vision is too community centered, too altruistic, too time-consuming, and too much of a financial gamble to appeal to other organizations as a valuable partner and to appeal to funders as a sound investment.

The story of Birth Advocates of Philadelphia highlights the repercussions of the neoliberal structuring of the social climate. The ideology and policy inspired through neoliberal governance force social actors to adopt a competitive business model which cautions against engaging in social or financial collaborations "for the public good." One result of this type of social climate is the isolation encountered by BAP. For this organization, the neoliberal political economy has had the indirect impact of disabling the development of meaningful and essential connections with community members and other civil society institutions.

CHAPTER 5

YOU CAN'T LOSE HERE: THE PARENTAL SUPPORT CENTER

Introduction

It was fall of 2006, a few weeks before Halloween. I had been scoping out a new NGO, called the Parental Support Center, that had opened earlier that year at a busy intersection in the neighborhood called Mt. Airy in Philadelphia. I was looking for a field site for my dissertation research and this place looked promising. The magnetic pull of its powder blue banner and big storefront window lured a handful of people through its front door as I watched from across the street.

Having perused their website, I knew that the Parental Support Center offered an array of services and resources for pregnant women and new parents. I wondered how all those services and people fit into such a small space. Only one way to find out, I goaded myself. With a gust of wind and confidence I was off the sidewalk and in the Center, and in the presence of a woman who fit the physical description of the mythicized Amazon. I stammered as I introduced myself to her, feeling unsure of myself as I was new at “finding” field sites and I worried that my confession of being an Anthropologist who wanted to “study” the Center would scare her off. Daring an upward glance at her expression as I finished my speech, Maureen’s eyes sparkled, surrounded by a mass of dark curls, as she smiled, “Oh, my sister’s an Anthropologist!” And that was that. I began volunteering the following week and was invited by Maureen, one of the two co-founders of the Parental Support Center, to attend a childbirth class she instructed.

I quickly learned that while the Parental Support Center, which I will hence forth refer to as the Center, opened in its current location in spring of 2006, the organization

had begun two years prior. In fall of 2004, in rented space from a healing-arts cooperative, Maureen and her co-founder Jessica – both mothers with young children – began offering services they felt were missing in their own experiences of pregnancy and birth. Their mission was “to support, educate, and empower women and families during their transition to parenthood.” The community response to their birth education classes, psychotherapy services, and new moms group was immediate and unrelenting, inspiring them to find a larger space and to register for nonprofit status.

The process of procuring a new space had been challenging. Both residents of Mt. Airy, Jessica and Maureen wished to keep the Center in the neighborhood. Without outside funding, Maureen and Jessica took out personal loans to finance their venture. Although these personal loans were small, they marked the women’s big investment in the Center. After a few months of searching, Jessica discovered a site located in the heart of West Mt. Airy with a rent they could afford. During an in-depth interview, Jessica reflected on finding their chosen location:

So I found this space, where it is right now, and it was like this completely dilapidated, really run-down space. It was like a makeshift daycare center, so it was like, mold on the walls....And that front wall, which is a retail window now, was brick. [But] it was reasonable rent.... So we just did it, and the landlord agreed at a certain cost to renovate it a certain way. But if we wanted special things that we would have to pay extra. But it was totally renovated to our specifics, how we wanted it. And we just did it.... We just opened. I was like, it's across the street from the co-op, and it's right next door to [a] café. Just like, you can't lose here.

Two dozen birth education classes and support groups were offered as well as massage therapy, psychotherapy, acupuncture, and yoga. A small retail section offered a range of products for pregnancy and parenthood, with much of the merchandise coming from local artists and businesses. I was one of a handful of volunteers who ran the small

retail section of the store, explained services and enrolled clients in classes, cleaned and organized the space, and interacted with the parents, grandparents, children, and intrigued passersby who streamed into the Center. Profits from a small retail section were combined with service fees to help with operational costs and to help fund their program for low-income women – which enabled women-in-need to attend classes for free. Pulling from a holistic model of birth education, the tone of the center was non-judgmental, and the focus was on empowering women to make informed choices. However, the political and personal leanings of the founders, volunteers, and instructors were toward natural, non-biomedical pregnancy care and birth. Adopting the community's inclination toward flattened hierarchies, the two women named themselves co-founders and actively involved the community. As Jessica said, “when we opened, it was like, whatever, you want to teach a class here, go ahead. We gave kind of this free will to the community to do what they wanted.” The structure, the operation, and the offerings of the Center reflected the values of the West Mt. Airy community and resonated with residents. As Jessica recalls:

And the moment we opened the doors it was like this rush of women... It was like, this amazing thing. ...it was so needed, and nobody could pinpoint really why.... I remember the first couple months we were open, there were three different women that walked in there, just soon as they stepped through the door they just start crying. “Are you okay?” “Yeah, I just, I just feel so good to be in here.” It feels like such a healing space. Or this grandmother came in ... and she said, “God, I really could have used something like this when I was a mom.”It was this safe haven for people to come in and breastfeed, or meet there. It was really amazing. It seemed to really fill a void in a lot of women's lives who were pregnant and new moms. You could see them coming in just like so disheveled, and so emotionally exhausted, and just to feel like they could come in and relax there.

To a cynic, or even a realist, Jessica's memory of the immediate, insatiable response to the Center might come across as embellished. However, my own experience

as a volunteer during the Center's first year supports Jessica's recollection. My shifts, four hours in length, one to two days a week, were always whirlwind experiences as I tried to simultaneously answer the constantly ringing phone, greet people as they wandered into the Center, chat with the new mom breastfeeding on the couch who was desperate to talk with an adult, ring up purchases of onesies, baby slings, herbal teas, and salves, direct clients to the massage therapy room, the bathroom, or the psychotherapist's room, enroll parents in classes, and refer people to resources in the community not offered through the Center. By the time my shifts ended, my head was spinning, my voice was hoarse, and I felt the sense of contentment that stems from the intimate connections formed when you are part of a community. Though chaotic and sometimes frustrating due to the Center's lack of structure and organization, volunteering was a rewarding and fulfilling experience during this time period.

As I review my field notes and interview transcriptions which reference that period of the Center's life, two characteristics stand out as noteworthy in making the Center an immediate sensation, beyond the products and services offered and the contagious enthusiasm of Maureen and Jessica. One characteristic was the Center's adoption of the values of the community, the neighborhood of Mt. Airy, and the Center's corresponding relationship with the community. The other characteristic of note was the internal structure of the organization and the consequent daily business practices. These two characteristics overlap one another in some ways, yet, I will discuss each separately beginning with a focused discussion on the adoption of community values and the Center's close relationship with the Mt. Airy community.

Location, Location, Location

The geographic location of the Center is an important aspect of this NGO and it makes for a particularly interesting case study. The Center is located in the West Mount Airy section of Philadelphia, and I will begin with a description of this neighborhood. The West Mount Airy section of Philadelphia has been noted by researchers and the news media as a uniquely diverse community since the late 1950s. Located in the northwestern section of Philadelphia, West Mt. Airy is acknowledged as one of the few stable, racially integrated communities in the United States (Ferman et al. 1998). Additionally, this segment of the city is recognized for “its rich institutional history and its reputation as a viable community with a strong sense of community identification” (Ferman and Kaylor 2000:94). This sense of community identification is visually found throughout the neighborhood, from “I like Mt. Airy” bumper stickers to the festive banners on the tree-lined main thoroughfare that read “Mt. Airy: Shopping, Dining, Happening.” A very tangible sense of community is apparent as well in interactions with residents involved in any of the 85 to 100 organizations in the neighborhood including a long-standing food cooperative, a very active civic association, and various religious, environmental, educational, and artistic organizations (Stern and Seifert 1998). This community has no dearth of examples of thriving local organizations or of ways to get involved. If there is a place where you’d bank on a local-nonprofit taking off even in difficult economic times, this is it.

The way these organizations are run has been suggested to be key in perpetuating the image of the community. Largely founded and staffed by local residents, organizations push for a sense of “community ownership” and their non-hierarchical,

participatory demeanor reinforces this sensibility (Ferman and Kaylor 2000). It is important to note that residents of West Mt. Airy are well-educated (22% hold a bachelors degree or higher vs. Philadelphia's overall 10%) and they are comparatively affluent (the median household income for 2000 was \$49,721 vs. Philadelphia's \$30,746) (Cartographic Modeling Lab 2005). These attributes make it easier for the community to support this cooperative ideal. In fact, it is very common, to the point of being expected, for existing organizations to offer support to startups, particularly if the new organization's mission reflects the established values of the community.

This was very much the case for the Parental Support Center, nestled in a bustling stretch of this neighborhood, that is known for its liberal sensibility, community activism, and influential neighborhood organizations. As residents, Maureen and Jessica were well aware of the benefits of locating their nonprofit in this supportive neighborhood in which individuals, organizations, and businesses were driven to give what time, money, and advice was available to others within their network – all with the sense that these communal efforts lead to the betterment of their neighborhood. Jessica's remark, cited above, that "...it's across the street from the co-op, and it's right next door to [a] café. Just like, you can't lose here" is not just a statement about the literal geographic location of the Center. Her statement also implies that the Center would benefit from the sphere of influence of these neighborhood institutions.

Maureen's and Jessica's approach to operating the Center mirrored the business values of the community. Jessica and Maureen stressed their perspective that the Center was simply a new addition to the many resources the community had at its disposal. The Center welcomed the public to use the space almost as an extension of their homes.

Parents running errands would come in just to use the bathroom to change a diaper, new moms would bring their visiting parents in just to sit on the couch and drink tea; the door was open to all every day during regular business hours, no retail purchase or class enrollment required. Most evenings, the Center was lit up, filled with the activities of classes or workshops.

The types of classes and workshops offered fluctuated based on community requests, with the core set of offerings resonating with the interests and parenting views of the diverse population. In its first year of business, the Center offered thirteen free support groups, each focused on the needs of a specific category of residents, including, but not limited to: a new mom's support group, a new dad's support group, a lesbian parent's support group, a multi-racial support group, an adoptive parent's support group, a single mother's support group, and a home birth network. The approach taken in the classes also melded with the view of many in the community that the dominance of biomedicine over the provision of pregnancy and delivery care should be questioned and alternate modalities should be explored. Education and empowerment were a top priority for class instructors and clients alike, and while the full range of options and procedures relating to birth care were discussed, there was a strong emphasis on the benefits of low-intervention and non-intervention birth, breastfeeding, and the importance of making self-aware, well-informed choices.

Jessica's and Maureen's proclivity for a laissez-faire model of business that supported a sense of community ownership harmonized with the values of the West Mt. Airy community. This fit between the Center and the broader community garnered local support for the center and made collaborations with other organizations and businesses in

Mt. Airy nearly effortless. Because the ideals promoted by the Center reflected the established standards of the neighborhood, individuals incorporated use of the Center into their daily lives with ease. The approach taken in the classes, support groups, and workshops offered by the Center connected with the needs and interests of parents whose political sensibilities and life choices had them searching for something more in their childbirth experience. According to Maureen, in its first year the Center served over 1000 people through its classes, workshops, and support groups. Not only did the Center fill a need within the community, but it also complemented existing values of this unique community. The location of the Center in the neighborhood of West Mt. Airy made for a nearly seamless match in ideals and needs and fostered the positive community response which made the Center an initial, immediate success.

Internal Structure

Maureen's background is in social work and she holds a certificate in childbirth education. She had always somehow worked with pregnant women as her population. Jessica has experience in running a small for-profit women's center that offered holistic practices, like acupuncture, yoga and massage. Yoga is Jessica's area of expertise. The vision, passion, and drive of the two women guided them to the decision of making the Center a nonprofit organization. The fact that neither had experience or knowledge related to running a nonprofit was no hindrance. What little they did understand about nonprofits was enough to make their decision, as Jessica remembers:

Neither one of us had much experience opening businesses, and especially not nonprofit businesses. So we didn't really have a business plan.... And we didn't really investigate too much into how to start and run a nonprofit except like the basic things that you need to do. And the only difference for me was that living in a city now, where—and this is where [Maureen's] passion came in, also, is that we wanted to be able to give this to people who couldn't afford it. And in my

mind, it's like, okay, we become a nonprofit because then we can get things like grants, and you know, solicit money from people. That was the reason that we became a nonprofit. And that was the component of the nonprofit that we were familiar with and that we felt like we understood a little bit. But [we] didn't really understand a lot of the bureaucratic [aspects], and understand a lot of administrative stuff.

Even without a business plan or personal experience running a nonprofit, Maureen and Jessica had a strong conviction of how they wanted their organization to be structured. Both women were adamant that no one person should hold the highest position of power. Instead, they adopted the idea of a flattened hierarchy, which also happens to be a popular format within the Mt. Airy community. As Maureen explains:

One of the things that we always said was that we wanted to be co-directors. Like, we wanted sort of a flattening of the organization. Even on the Board, we didn't have a president, we had co-chairs. Because we felt like, we didn't want to repeat that hierarchical structure that's already present on the maternity ward. Like, I'm the doctor, you're the nurse, you're the nutritionist, and you're the lowly patient at the bottom of the totem pole. Like, we wanted to kind of flatten that out.

And so, Maureen and Jessica took the title of “co-founder”, and as alluded to by Maureen in the above quote, took on the task of developing a Board of Directors. The co-founders built their Board with the same sense of passion and abandon with which they had signed the lease on the store and applied for status as a nonprofit. That is not to say they did not put thought into who they wanted on the Board and what type of role the board members would fill. With a goal of having seven board members, Jessica and Maureen reached out to friends and acquaintances in the area who they knew were interested in maternal health issues and who would be supportive of the Center’s mission. All of the board members were women, but they did represent the diversity of the neighborhood and their composition reflected the values of the Center. As one of the

goals of the Center was to provide equal services to the financially privileged and to those in need, the co-founders reserved two seats on the Board for women who had been clients of their program for low-income parents. Board members also represented the neighborhood's diversity regarding race and sexual orientation. While the co-founders built a Board that supported the goals of the Center, they did overlook some important issues in its construction. Looking back, Maureen and Jessica reflect on the original Board of Directors:

Jessica: So we compiled a bunch of our friends. We knew we needed a couple board members, so we compiled a bunch of friends, and we're like, "You don't need to do anything, you just need to like, be there, we need to write your name down or whatever."

Maureen: I feel like our board was a bunch of moms that cared about maternal health... I mean, our initial board was like, calling on people we knew, like a woman I used to work with in the teen parent program, like, yeah, that we had a connection [with]. At that time we didn't think [about issues] like finance, like how [I] think now. We were like: maternity stuff. So we just called them up and asked them. Honestly, our board initially, they would just be like, oh, you're doing that? That's great. And kind of walk away. And Jessica and I would be left to do everything.

Without prior experience in constructing a Board of Directors, the co-founders overlooked some common requirements. Their board members were not expected to provide any guidance or commitment to the Center, other than attending quarterly meetings. Instead of building a well-rounded Board in terms of the professional skills members could bring to the table, such as financial acumen or grant-writing experience or familiarity with running a nonprofit organization, the co-founders focused on recruiting individuals based on their interest in maternal health. The negative result of this was that Maureen and Jessica carried the burden of running the bureaucratic and administrative aspects of the nonprofit themselves for over a year. However, there were some positive

results of this type of Board. First, Maureen and Jessica were able to have final say regarding all decisions, since it was a titular Board. Second, the Board really did represent the community of Mt. Airy and the local roots of the board members served to strengthen the Center's connection to the neighborhood.

While Maureen and Jessica took on all the work that a Board would normally help with, they did not benefit financially. The co-founders established their nonprofit with speed, but had done so without a business plan that incorporated salary. Working 40 to 60 hours per week, Jessica and Maureen ran the center for years without a single paycheck. The Center's staff did so as well; the Center relied on volunteers to remain open during the day. Most volunteers were either mothers with young children or students at area colleges; the demands of motherhood and academia meant a high turnover rate among staff.

The co-founders belief in community involvement and dedication to equal care for people of all income brackets did trickle down into the way services were provided. Community members as well as instructors had a say in what services were provided and in the class schedule. Administrative procedures and guidelines were kept to a minimum, giving instructors near total autonomy. The Center charged a fee for all classes except support groups, as well as for the other services offered: psychotherapy, acupuncture, massage, yoga classes and nutritional consultations. Some of the income garnered from these services and the retail section of the Center was put toward the initiative for low-income parents so that they could attend classes and receive psychotherapy, massages, or acupuncture treatments for free or for a reduced charge. Importantly, all clients, whether paying or not attended the same classes:

Maureen: Our intentions were to always integrate our clientèle, whether they were fee-based or not. Because of course as you know, we charge. So if you can afford to pay for services, we charge for our services. That's part of the way that we keep ourselves afloat. If you meet income guidelines, then you're eligible for the [low-income] initiative program, and services are free. We're low-cost, but we tried—initially the idea was that they would all be free. And our plan was never, like, this is the [low-income] birth class. This is the [low-income] yoga class. It was always like, this is *the* birth class, this is *the* yoga class. And so everyone would come in together.

In Maureen's and Jessica's view, this "integration" represented a core value of the Center: that the entire community deserved access to every resource available during pregnancy and early parenthood. While the internal structure of the Center was certainly not without its flaws, many of these structural problems were masked by the energy and momentum of the Center's first year. Indeed, even though the lack of organization and established procedures made things challenging for volunteers, the same easygoing mentality appealed to the sensibilities of clients and the broader Mt. Airy community. Without strict rules, without the paperwork and procedures so often associated with NGOs, individuals felt comfortable embracing the Center as an authentic part of their community. The non-hierarchical, unautocratic structure of the Center dovetailed with the established value of community ownership within the Mt. Airy Community and marked the Center as an immediate neighborhood institution.

All Good Things

The Center seemed to fit seamlessly into the neighborhood. Mirroring the values of the community and providing services that connected with the interests of parents, the Center had quickly become another neighborhood boasting point. Patrons settled into the notion of the Center as a fixture on the busy corner, yet even as the daily activity in the Center continued unabated, issues related to the internal structure of the organization

began to surface. Finances became a looming problem for the co-founders. Although class enrollments were high and retail products sold, business costs were just being met. Having gone into debt to open the Center, the co-founders were still not taking a salary for their work weeks, which averaged 50 hours. Add to that the increasing interest in the initiative for low income parents, which took its funding from the Center's profits. In year one, the initiative for low-income parents reached 35 enrollees. By the end of year two, the number of enrollees grew to 50; by year three it was 75. While the co-founders were pleased by the response to the initiative, the Center's profits were not enough to cover the increasing demand for the low-income program. Maureen and Jessica applied for grants in order to supplement the Center's finances, and did receive a few small grants from local businesses and charities, but the amount of funding received did not ameliorate the financial deficit.

While the Center had always been open to developing relationships with other organizations and business that also worked on issues related to women's health, pregnancy, and childbirth, Maureen and Jessica intensified their coalition building efforts during this time of financial insecurity. One of the organizations the Center reached out to was the well known and established Philadelphia-based nonprofit, the Alliance for Family Wellness (AFW). Although the two nonprofit organizations approached their service to expectant and new parents from different perspectives and on different scales, the Center's co-founders hoped that AFW might collaborate on some sort of mutually beneficial project. After some difficulty connecting, the Center and AFW did eventually meet. But, no partnership was formed. During Maureen's and my discussion regarding

the attempted partnership with AFW, her comments pointed to the underlying competition for funding that can dissuade joint endeavors between nonprofits:

[With AFW], we've tried. Like, they opened their office up here, and I know they've sent us some people.... But it definitely has felt like they are the big player on the block. And then when they opened their office up here, one of our major funders gave them a whole bunch of funding, and deferred our grant. And it did—there was just a piece of it, like, wow. I mean, I guess if you're going to provide [funding for] services for moms, you're gonna choose one group, and they went with them.

The Center did build some alliances with a handful of organizations, many of which worked with at-risk teens. Yet, partnerships with these organizations were outreach work located at area high schools and health clinics, and they were all dependent on the allocation of outside funding. These ventures were particularly exciting for Maureen, as they realized her vision of providing childbirth education to underserved populations. However, the financial resources received for these programs only funded the designated venture; these alliances did not provide financial security for the Center itself.

By 2008, the internal stressors of the NGO began to affect the daily operations of the Center, and by 2009, fewer classes were offered and certain services were eliminated. During the same time period, a shift occurred in the Center's relationship with the Mt. Airy community. With respect to the change in the Centers connection with the community, Maureen remarked during an interview:

Well, I think that,... this community - I feel like we were really embraced by it. I think for our initial growth...this is a great place to be. Because there was a lot of interest, people were seeking out our services—they still are. And I really think...the way we envisioned ourselves, and even the way I see ourselves now even though we're not really doing that, is [as] a community-based resource center...a [place you can just] drop in, like come in, get a book, breastfeed your baby, have a cup of tea, talk about your sleep deprivation. That's what we do. And

I feel like the neighborhood did use us, and the neighborhood has definitely supported us.

You likely noticed Maureen’s use of past tense – “the neighborhood *did* use us”, and her comment that although she sees the center as a drop-in community resource, “...we’re not really doing that” now. Her phrasing during that interview is telling of the structural, operational, and clientele changes that occurred. The decisions made and actions taken in response to both internal and external pressures inspired a shift in focus from the interests of the community to the financial needs of the Center.

Structural Changes

Internally, a key change occurred in summer of 2008 – when a new board member, Gretchen, concerned about the financial stability of the Center advocated for adopting more of a business model in the operation of the Center: for example requiring clients to complete paperwork before accessing the Center in order to better track the Center’s efforts; shifting business hours and reducing classes offered to make running the Center more manageable; and putting more focus on grant writing (one of Gretchen’s professional specialties) in order to reduce the Center’s reliance on class registration numbers. The overall response to these suggestions was positive – they seemed to be common sense, after all. However, Jessica felt the changes were so counter to the ideals of the Center which she had co-founded, that she abruptly resigned. When asked to share her reasons for leaving, Jessica said that in addition to the emergence of some personal issues at that time, she felt that in searching for a solution to the Center’s financial problems, a transition had occurred in the Center’s priorities:

And I think there was, to some level, some disagreement about, you know, for me it was the creative side of it and the clinical side of it and the kind of, I don't know, [the creative side is] what really drives me. And I felt that was directly

connected to the vision, mission of the center, and the profitability and the success of the center. It's an interesting thing, as a nonprofit. I feel like, unless you're an arts nonprofit....When you're a service nonprofit, like serving pregnant women, or whatever, especially poorer populations.... There seems to be this idea that it should be this like, dull, paperwork-laden, like, fluorescent-lit agency, or something. And I felt like we were blazing a path to say, it doesn't have to be that way. Just because we're serving poor people or just because we're providing health needs for people, it doesn't have to be this kind of empty space where we're just like, okay, here's your paperwork. You know, I just really didn't want it to be like that. I wanted it to feel like this vibrant, alive, energetic place. And I really believe that that is what created its long-term sustainability, profitability. What would attract people to [the Center]. And you couldn't really put your finger on it, but it was something about the essence of the Center that came from the creativity and from the vision.

And it was very hard for, I think, [Gretchen], and some of those other [new] people that they recruited to be on the Board to see how those two are connected. So it got kind of frustrating, because it began to become a lot more about, you know, appealing to the granters, and how are we going to create ourselves as this very together, very organized, you know, just, a different type of organization. And as that happened more and more, I think the Center started to lose its—whatever was special about it. And more effort was being put toward that kind of stuff than all the fun programs we were gonna do, and all these interesting ways we were gonna stimulate our community.

.... So yeah, [at] that point it started to shift. And you know, we never even got, while I was there, any really big grant money. So there was never really this cancellation of classes or anything going on [then], but more it was just about the style, and just the focus, that felt like it was going to be going in the more conventional direction.... I just felt like it was changing and it was time for me to go.

In the aftermath of Jessica's resignation, a consultant was hired to help reset the direction of the Center. Overwhelmed and frustrated, Maureen and the Board agreed to the consultant's recommendations: that an executive director should be appointed, and that applying for grants should be a top priority. Also, whereas the founders had never received a salary for their work, it was decided that both the executive director and the remaining founder should begin receiving a salary. In February 2009, Gretchen, largely due to her grant writing experience, was appointed Executive Director, and Maureen, now limited to the 15 hours per week of paid work that the Center's finances could

afford, took the title of Program Advisor. While the original Board offered loyalty and support to the founders in their vision of an organization that was in and of the community, their skills did not reflect the organization's new shift toward a corporate business model. Gretchen, the executive director, reasons:

The [original] board, like so many start-up nonprofits, are people who are committed to the mission, but have no skills.... You know, they don't have board background, they don't have funding background. They don't have the things that you really need a board to have. That... board was completely ill-equipped to be able to handle any kind of forward, proactive thinking. Completely ill-equipped to support the directors in any way, shape, or form. You know, they felt good about the agency, but they didn't know what to do. And there was no way that they could know what to do, because they had no previous experience.

Over a 6 month period, the original board, composed of local residents who mirrored the ethnic diversity and values of the neighborhood, was replaced with new members. The new board - hand-picked by the executive director for their individual skills and professional accomplishments - is composed of: 2 lawyers, 1 member with strategic planning and board development experience, 2 members with strong fundraising experience, 1 member who works for a foundation, 1 member who works in public relations. All but one have previous board experience. All but one are white.

The structure of the Center had gone from a flattened hierarchy, that was locally run and community oriented to a hierarchical agency following a corporate business model with - in the executive director's words - "an institutionalized structure." Unlike the two founders who lived in the community, the executive director lives 40 minutes outside of Philadelphia, is unfamiliar with the Mt. Airy neighborhood and never even sat in on one of the Center's classes or support groups.

Locking Up The “Space”

While the structural changes certainly began the process of distancing the Center from the local community, the major shift in community involvement came at the same time as the transition in leadership. In February 2009 the Center’s daily drop-in hours and the retail section were eliminated in order to enable more resources to be allocated toward securing funding. Instead of being able to sign-up for classes in person, clients instead had to sign up for classes using the new online service. The Center was now only accessible during times that classes are offered - the rest of the time, the doors were locked. It was no longer possible to just drop in, have a cup of tea, or relax on the couch while chatting with other parents. To community members, this change signified more than a shift in operation. To many, the inability to access the space meant that the Center, itself, had closed. This became apparent to me one day when a Mt. Airy resident mentioned that she was saddened to hear of the closure of the Center. When I explained that the Center was in fact still operating but that the space was just not accessible for “dropping-in”, her response was, “Oh. Well, same thing.”

With the neighborhood viewing the Center as closed, class registration dropped by over 50%. The executive director and board saw this drop as a result of the difficult economic times and family’s corresponding belt-tightening, and intensified their efforts to write grants and fundraise. Their efforts were successful as they were awarded two large grants – out of the many for which they’ve applied. However, the two that were funded were for outreach programs developed in partnership with other agencies which target low-income teen mothers living in other areas of the city. I do not wish to diminish the good intentions and hard work of the new Board or to demean the likely positive

effect that this kind of programming would have on those who access it. My point here is that the sort of projects for which the Center has been able to secure funding shift the focus to a new type of programming and to a new type of client, and positions the Center in a very different provider role - one that fits within the more classic expectations of the type of work done by nonprofits. None of the grant money would be used to reopen the “space” of the center; for the neighborhood that once eagerly incorporated the organization into its community, the Center was now a loss.

Volunteering for a New Administration

Fall of 2009 brought another change in leadership. Maureen gave up her role as Program Advisor, having acquired a full-time job outside of the Center, and by mid-October had transitioned out of the Center completely. The position of Program Advisor was filled by a former staff member named Brianna, who returned to the Center after a two year hiatus. With neither of the original co-founders still connected to the Center, and a Board that was entirely different from the original one, the Center was under an entirely new administration.

Having continued my volunteer work through all of the Center’s changes, I had an intimate understanding of their impact on daily operations. As a volunteer, I held the position of “middle man” between the administrators of the Center and the community. While I knew more of the internal politics and changes than did the community, I only knew what the administration shared with me. On the other hand, unlike the administrators, I interacted with clients and community members on a daily basis, and therefore, I had a thorough understanding of their interests and needs regarding the

Center's services. From my perspective, there was a clear disconnect between the Board's and Director's "restructuring" and the wishes of the community.

Although from February 2009 going forward, I was no longer needed to work the retail store or open the Center for drop-in hours, I continued to visit the Center once a week for an hour to return phone calls, direct people to the website so they could register for classes online, and refer people to resources in the community. I came to dread returning phone calls, as my conversations often dissolved into my apologizing to annoyed clients that it took nearly a week for their phone call to be returned or that we no longer offered a class or support group they wished to attend. Without exception, someone walking by would see the lights on and knock on the door, asking why the Center was no longer open during the day or expressing frustration that they could no longer reach an actual person when they telephoned the Center. Parents who had become accustomed to accessing the Center as a community gathering place expressed feelings of sadness, resentment, abandonment, and wistfulness at no longer being able to use the Center for their enjoyment. Yet, the correspondence I received from the Center's management celebrated the increased reliance on the internet and the switch to online class registration.

Just as the Center receded from the community, I felt the Center's administrators' withdrawal from contact with their staff. With Maureen and Jessica as co-directors, I had always been able to call them with a question or an issue that arose during my volunteer hours and, in fact, I had been trained to do so. I assumed the same protocol under the new administration. However, my calls to Brianne often went unanswered, and the tone of Gretchen's responses, while cordial, made it clear that she would rather not be

subjected to my calls. Likewise, Maureen and Jessica had informed staff through emails and phone calls of even small changes in programming. Yet, under the new administration, I frequently only learned of changes in programs, fees, and class instructors by chance. As a volunteer, I become increasingly isolated from both the community and the Center's administration. Unlike the hectic but fulfilling work I had done for the Center in its first two years, I now dreaded the time I spent at the lifeless Center.

I was saddened but relieved, then, when I received an email from Brianne in March 2010 informing volunteers and instructors that the Center would cease all operations the following month. This announcement and the formal public statement that followed highlighted the national economic downturn as the root cause of the closure. In her letter, sent out over the Center's listserv, the Executive Director correlated the economic recession with the drop in enrollments for the fee-based programming and the limited grant funding awarded to the Center for fiscal year 2010. The dissolution of the NGO was painted as the singular, yet regrettable, option available to the Board and the Executive Director.

Summary

During the four years it functioned as a nonprofit, the Center underwent a dramatic structural transformation. What began as a non-traditional organization with a flattened-hierarchy that was entrenched in the community became a traditionally structured hierarchical organization which focused on internal logistics and fundraising. In just a couple years' time, the lively, organic, yet disorderly run Center changed into a desolate but extremely organized establishment. Both internal and external pressures

informed the bureaucratic and administrative choices made by those who were in charge during various phases of the Center's life. Those who made the decision to close the Center point to the national economic downturn as the root cause for the Center's dissolution. While the economy likely did play a role in the financial fragility of the NGO, it was surely not the sole trigger. My analysis of the Center highlights the shifts in tactics and perspective which ultimately disconnected the Center from a neighborhood that was uniquely supportive and from the individuals in the community whom the nonprofit was meant to serve. Over its four year run, the focus turned increasingly toward securing large endowments instead of sustaining the community's support. Along with the Center's shift in focus came a reform of its values and structure which mimicked the traditionally accepted model of a health-related service oriented nonprofit organization. In their efforts to make the Center a success the administrators followed established protocol for nonprofit achievement, and in doing so, the Center's once intimate connection with the community was lost.

The story of the Parental Support Center serves as an example of the type of unanticipated results that reliance on government contracts and foundation grants for funding can have on the structure and function of an NGO. As the internal structure and programming of the Center was reorganized to better fit with the model of productivity acknowledged by funders, the social distancing that occurred left a gaping hole in clientele that was once filled by community members who viewed the Center as their own resource. According to market standards, this agency should have been a success – they received funding for unique programming that would serve those in need. But, this success meant the displacement of the original vision of the Center: to have a

community-run space sustained by personal relations, activism, diversity, and liberal ideals. Although the physical location of the Center within the neighborhood of Mt. Airy nurtured the organization, the subsequent shifts in internal structure, in business focus, and in philosophy resulted in the Center's ultimate dissolution.

Neoliberalism and the Parental Support Center

The story of the Parental Support Center is remarkable in that it allows us to see “in real time” how the incorporation of neoliberal policy and ideals can entirely change an organization. Originally designed as a community organization that was intended to resist external neoliberal influences, the Center's shift provides an extreme example of the snowball effect of neoliberalism. Over just a few years time, the Center adopted more and more of the structural and operational processes that are reinforced by neoliberal policy and ideology. In the end, the Center had transitioned so completely from a community-based organizational model into a corporate business model that the final result was nearly unrecognizable.

Reviewing the story of the Parental Support Center, we can see that the Center's transition began in earnest in 2008 as financial problems motivated the organization to increase efforts to obtain government and foundation funding. However, the neoliberal policy of cutting public expenditure for social services has resulted in a highly competitive funding market in which applications that appeal to the business model standards of funders are favored. So, concomitant with the organization's new emphasis on grant writing came the need to provide statistics to funders on the efficiency and effectiveness of the Center's programs. Knowing that funders expected this type of hard data in grant applications, the decision was made to revise some of the Center's internal

operations to enable better tracking of the Center's efforts. To achieve this goal, the Center adopted more of a business model and altered operations to better suit the interests of the organization itself instead of maintaining its focus on the needs of the community. Business hours were condensed, extraneous classes were cut, and questionnaires and enrollment forms were developed and distributed in order to track clients.

These operational shifts inspired structural changes that "professionalized" the organization. Now that community participation was less of a focus, the Center needed stronger internal management. The flattened-hierarchical model was disbanded and replaced with a traditional hierarchical internal structure that was more aligned with the corporate business model. The original Board of Directors which had represented community interests was replaced with a Board that had the professional skills to advance the organizations goal of achieving financial stability through external funding sources. The organization's interest in appealing to funding agencies prompted the Center to alter its focus, internal structure and operations and to adopt the professional business attitudes that align more easily with the neoliberal political economy.

As the Center became more dedicated to its new focus, we see the organization shift its priorities and position regarding the community. The elimination of the concept of acting for the good of the public or to support the community was incorporated into the mindset of the revamped Center. Replacing the original community-oriented Board was a start to the Center's shift away from the community. The transition from in-person class enrollment to online enrollment was another move away from the community. The most blatant alteration was the Center's decision to cease its daily drop-in hours. The original emphasis of the Center as a "community space" had positioned the interests of

the community over the interests of the Center. These drop-in hours required staff to remain at the Center throughout the day. Yet, most of the staff was volunteers, and so the true financial cost of maintaining the Center's drop-in hours was minimal. However, under the Center's new business mentality, these drop-in hours were a waste of resources. Although the community had grown to rely on the ability to access the Center, the decision was made to only open the Center for classes. Suddenly, the community was no longer welcome to use the Center's "space" as their own. Being embedded in the community, being open and available "for the public good" was no longer a priority to the inwardly focused organization.

As a nonprofit, the Center was a participant in a neoliberal political economy, and therefore it is understandable that over time the organization adopted procedures and ideals that supposedly correspond with financial success within the neoliberal market. The misfortune in the Center's incorporation of these neoliberally inspired processes is that it was a component in the organization's ultimate demise. The Center lost its connection with the community through the combination of various developments: internal alterations, such as the complete transitioning-out of the original co-founders and Board of Directors; the organization's financial precariousness and its resulting attempts to attain stability; and the Center's increasing engagement with ideas and practices related to the neoliberal economy. The shift in focus, values, operations, and internal structure were initiated with the expectation that these changes would strengthen the organization. Those who were in charge of the Center anticipated these changes would open a door to a world of funding opportunities that would enable the organization to further its mission. Yet, overhauling the entire structure of the organization to fit the

current model of a successful nonprofit only made the organization more vulnerable to external forces. In the end, the Center isolated itself from the very community it was established to serve and, in doing so, lost its unique and powerful support network.

CHAPTER 6

SURVIVAL SKILLS: THE ALLIANCE FOR FAMILY WELLNESS

Introduction

By the time I applied for a summer internship in 2007 with the Alliance for Family Wellness (AFW), the NGO was in its 27th year and had served over 60,000 low-income families in the Philadelphia region. I went into my interview knowing very little about AFW, except what I had learned from their website and from some of their brightly painted outreach program vehicles around the city. The internship, which involved surveying and reporting on the availability of prenatal care sites for low-income women in Philadelphia, excited me because it was proof that others in Philadelphia were interested in the same women's health and childbirth related topics that I was. In accepting the internship, I anticipated learning the ins and outs of accessing prenatal care for women on Medicaid. I did not expect that I would find the inner workings of AFW so fascinating or that I would develop a lasting connection with the organization.

Attracting Others

Looking back on my now four year relationship with AFW, it is clear that it was not just my interest in the organization or the causes it champions that sustained my connection to the NGO. AFW has a knack for reaching out to others and including them in organizational activities. Once my internship was over, I was asked to return to present my report to AFW's nearly thirty member board. I was also invited to continue to attend the committee meetings I had been included in during my internship, an invitation which I happily accepted and I continue to attend these meetings to date. Soon after the conclusion of my internship, I was recruited to help in organizing a Town

Meeting in Northeast Philadelphia. I took part in planning sessions and distributed fliers announcing the Town Meeting to eight schools in Northeast Philadelphia. It is worth noting that it was out of this Town Meeting that the NGO Birth Advocates of Philadelphia (BAP) began, the details of which I have expounded upon in Chapter 4. In late fall of 2008, at the suggestion of Drina, AFW's Community Engagement Coordinator, I attended meetings of community activists attempting to intervene in the impending closure of Northeastern Hospital's maternity unit. Soon after, Drina and her supervisor enlisted my help in drafting testimony to be read at the Mayor's 2009 Budget Meetings that detailed the impact of city-wide maternity unit closures on childbearing families and city health centers. A few months later, I was contracted by the Deputy Executive Director of AFW, followed by the Director of Program Operations and Community Development, to prepare part of a grant to which AFW was applying.

Apart from my paid internship, which was funded by an outside foundation, the only work for which I was financially compensated was the last bit, the preparation of a grant proposal. This lack of pay was not an issue, as my participation in AFW's activities became part of my dissertation research and as such, I preferred not to have the issue of money involved in my interactions with the organization. Yet, it is important to note that my experience with AFW is not unique. While the organization does have a large paid staff, AFW is gifted at obtaining the pro bono help of individuals from all walks of life in regard to their numerous and varied programs and causes. AFW's mission statement says it all: "...to improve maternal and child health and wellbeing through the collaborative efforts of individuals, families, providers and communities."

Structure and Programs

Internal Structure

AFW is structured in a classic hierarchical model. The large Board of Directors is extremely active and has gender, racial, and professional diversity. The organization's leadership team is headed by the Executive Director who oversees the day-to-day running of AFW. Second in command is the Deputy Executive Director, followed by directors who manage the ten internal branches of AFW, for example there is a Director of Programs, a Director of Finance and Administration, a Public Policy Director, a Director of Operations and Community Development, and so on. Each of the nine satellite sites has a Program Manager or Site Coordinator who supervises daily operations. With nearly 30 members on the Board of Directors and a staff of 70, AFW is a thriving organization that continues to expand.

AFW Programs

One of the main ways AFW has worked to “improve maternal and child health and wellbeing” is through its outreach programming. Initially, AFW focused solely on decreasing infant mortality rates in the Philadelphia area. Within a decade of its establishment, AFW expanded programming to include broader issues encountered by low-income childbearing families, such as education and housing. While the main office is located near center city, AFW currently has nine auxiliary sites located throughout the city of Philadelphia and in surrounding counties. It is from these nine satellite sites that AFW's six outreach programs are based.

Staff positioned at these nine sites work as advocates for the families they serve, acting as educators and also connecting families with outside resources. Currently, AFW

has six different outreach programs which offer individualized case management either at the client's home or at the nearest satellite site. The programs are all designed to intervene in the perceived lack of appropriate parenting knowledge held by families living in "neighborhoods affected by poverty, infant mortality, and changing patterns of immigration" (AFW publication). As such, the programs offer education and training on a variety of issues including: prenatal health needs, safe sleeping practices, breastfeeding, family planning, lead poisoning prevention, smoking cessation, healthy eating habits, HIV/AIDS awareness and testing, child development, and positive discipline skills. In addition to referring women to health services and tracking their appointment attendance, AFW staff also helps enroll families in state and national social service programs such as job training, health insurance, food assistance, and housing aid.

In addition to its outreach programs, AFW has active research and policy groups. With a focus on drawing the attention of legislators, the public policy program works to heighten the visibility of issues faced by childbearing families that are considered noteworthy by AFW. This often requires increasing the public's awareness in addition to informing policymakers of AFW's variety of concerns. Just as AFW's outreach programming addresses many topics, the public policy arm of AFW attends to a wide array of issues encompassed under the umbrella of healthcare reform and public benefit programs. Examples of issues addressed by the policy group include: Medicaid and CHIP funding, the closure of hospital maternity units, assurance of timely prenatal care, the treatment of pregnant incarcerated women, subsidy of domestic nutrition programs such as Food Stamps and WIC, and mandating the allotment of paid sick days for everyone employed within Philadelphia.

In order to rally public interest and passion, AFW's policy group employs numerous strategies. On a weekly to biweekly basis, AFW's policy group disseminates notices of legislative developments, usually through an email listserv. Embedded in these notices are details of upcoming bills and how votes in one direction or another could impact the lives of pregnant women and babies. Recipients of the notices are encouraged to contact policymakers or to sign an attached petition, depending on the issue at stake. The policy group also organizes rallies and demonstrations and recruits public participation for these events. AFW's policy group engages the public on the grassroots level as well, attending and participating in meetings of community activists and providing direction and guidance to groups that form as a result of AFW's activities, as was the case with the Birth Advocates of Philadelphia, the NGO which was the focus of Chapter 4. In addition to increasing public awareness, policy group staff visits with county, state, and national legislators, presenting these policymakers with data and information related to AFW's causes in an effort to influence policy.

AFW's research group has a dual focus regarding the projects adopted. One area of interest to the research group is the effectiveness of the organization's programming. The effectiveness of the outreach programs is scrutinized and programs are updated as deemed appropriate. The research group also holds the responsibility of identifying and examining new or, at least, previously unexplored issues. Recent projects undertaken by AFW's research group include the topics of perinatal depression, HIV rapid testing, sexual practices among young adult minority groups, and the use of community health workers to conduct research.

The research group is designed to work in conjunction with the public policy and outreach divisions of AFW, with all sectors of the organization supporting one another. As such, there is considerable overlap in the projects of each group. For example, the research group may learn from outreach program coordinators of a need within the community and develop a research project to survey and document the need. The data compiled by the research group may then be passed on to the policy group which translates the data into a legislative issue to be brought to the attention of policymakers.

Nearly all of AFW's programs are working collaborations with other institutions. Research projects are developed and undertaken in partnership with local universities and hospitals as well as with nonprofit organizations and government agencies. Many of the outreach programs offered through AFW are either partnerships or are subcontracts with other federally funded program providers. For example, for years, AFW was a subcontractor for the Montgomery County Head Start program, which is federally funded. Just recently, AFW became a grantee, instead of a subcontractor, and now receives direct federal funds to provide the Early Head Start Program in some of its satellite locations. It is through these partnerships with other institutions and organizations that AFW is able to provide such a wide-range of programming.

Money Matters

Even with AFW's aptitude for enlisting the pro bono help of area professionals and for inciting community interest, AFW would not be able to maintain its extensive programming without the financial support of other institutions. Interconnected with the state apparatus, AFW receives significant amounts of government funding from national agencies, such as the US Department of Health and Human Services, and from local

government agencies like the Philadelphia Department of Public Health. Grants from private foundations, corporations and service organizations also form a large part of AFW's funding, with foundations based in southeast Pennsylvania awarding the largest singular grants.

An array of businesses, from supermarket chains, banks, and brokerage firms to hospitals, health care networks, and providers of managed care health plans give financial donations to AFW. Yearly fundraisers are organized by AFW as well, some of which are high-profile events which boast the involvement of media and sports celebrities; other fundraisers are letter writing campaigns that capitalize on the connection between the organization's service population and holidays like Mother's Day and Labor Day. Individual donations are regularly solicited from AFWs immense list of contacts; the number of donations from individuals for the 2008-2009 fiscal year exceeded 550. Even AFW staff, however temporary the position, are encouraged to invest in the organization by making financial contributions.

Utilizing Media

In addition to recruiting the help of volunteers, acquiring funding, and maintaining an array of programs, AFW excels at tapping media outlets to increase the profile of their campaigns. AFW reaches out to print and online newspapers by writing Letters to the Editor, by inviting reporters to attend rallies and public demonstrations, and by issuing press releases. Statements made by AFW staff have served as the cornerstone for articles published in the Philadelphia Inquirer, Philadelphia Weekly, Philadelphia Daily News, Northeast Times, The Norristown Times Herald, Philadelphia Tribune, The Philadelphia Business Journal, Al Día, and Centre Daily Times to name a few, as well as

in numerous University newspapers. AFW makes its causes known to local news stations as well and the organization's willingness to comment on camera about local issues and events has made AFW popular among the press. As a savvy recipient of this media attention, AFW uses these opportunities to publicize its programs, most often its outreach programming, which correlate with the topic of the news coverage.

AFW's reach has expanded over the past few years as the NGO has been noticed by reporting agencies with broad audiences. Radio interviews with WHYY as well as with the BBC bolstered the visibility of AFW, as did mention of AFW within BBC feature reports which aired internationally. Like many other organizations, AFW has an active website and subscribes to the social network site Facebook. Their use of this internet based networking tool has connected AFW to a new community: bloggers. In recent months, a handful of blogs have discussed AFW and have featured a link to the organization's website or Facebook profile page. By using numerous types of media as resources to promote the organization and its programs, AFW continues to expand its visibility.

As a well-connected, highly visible organization within the Philadelphia community, AFW is often contacted by other organizations, businesses, and activist groups with requests for support. Depending on the organization and the request, AFW's response varies. Yet, to its credit, AFW often uses its connections and visibility to promote the activities of others. Notices of other organization's upcoming meetings, fundraising events, conferences, and rallies are often spread word-of-mouth and over AFW's listserv. AFW's willingness to provide these notices for others serves as an additional promotion of AFW itself; through its endorsements, AFW's name reaches new

groups of people associated with these other organizations. In using its social capital to connect others in the community, AFW simultaneously increases its own profile.

A Closer Look: Limitation Within Strengths

The strengths of AFW as an organization are clearly numerous. Over the organization's 30 years, it has developed extensive programming which has served thousands of low-income families. The ties AFW has developed with other institutions and organizations are almost too numerous to count. AFW is able to obtain large federal, state and local grant funding as well as acquire a great number of individual donations. The organization's ability to connect with community activists and area professionals and to inspire these individuals to volunteer their time to further AFW's mission is remarkable. And the media literacy demonstrated by the organization has no doubt helped to cement AFW as an authority on maternal and child health. Yet, the strengths of the organization are also, under certain circumstances, limitations of AFW.

Beginning with my internship and continuing with the meetings I attended, the pro bono and paid work I completed, and the social relationships I formed with AFW staff, I was exposed to the internal dynamics of the organization which revealed forces that would not be apparent with just a cursory examination of AFW's structure. Over the course of my four year connection to AFW, I encountered moments when what seemed to be a strength of the organization from a structural perspective was revealed as restricting AFW's options. As I conducted my dissertation fieldwork, staff and community member's experiences, as well as other NGO's interactions with AFW gave a complex perspective on the organization's positionality within the community.

Complicated Relationships

Partnerships with institutions and organizations enable AFW to undertake research projects that would be too cumbersome to take on alone. Yet, connections with so many institutions can also prove problematic, particularly with respect to AFW's advocacy work. In addressing an issue of policy or health care practice, AFW is often faced with the dilemma of how to publicize the problem without alienating other institutions, as these very institutions are also in partnership with AFW. An example of this is AFW's entrenched relationship with one of Philadelphia's hospitals, which, for purposes of this discussion, I will give the pseudonym "American Hospital."

The relationship between AFW and American Hospital is complex and multi-leveled. Representatives from American Hospital sit on AFW committees, offering input on the organization's strategic planning and advocacy initiatives. Collaborations are common between American Hospital and AFW; for example, American Hospital is one of the numerous businesses that recently agreed to take part in an AFW initiative to help employers make the workplace a "breastfeeding friendly environment." On another level of association, American Hospital, itself, and the larger healthcare network of which the hospital is part, give sizable monetary donations to AFW. There is no doubt that AFW relies on its relationship with American Hospital for advice, program participation, and funding and that AFW has an interest in maintaining a positive rapport with the hospital. Yet, the recent surfacing of a local maternity access issue proved challenging for AFW as the organization found itself caught between following its mission of advocating for improved maternity care for low-income families and preserving its good relationship with American Hospital.

The situation escalated with the 2010 closure of a hospital maternity unit in a suburban hospital located slightly Northwest of Philadelphia County. This closure left a large population of low-income families, many of whom are undocumented immigrants, with extremely limited options for accessing maternity care. Just one hospital, which I will refer to as “Verbena Hospital”, continued to provide maternity care in that geographic area. With only one hospital remaining in the area, wait times at Verbena hospital for prenatal care appointments increased to unacceptable levels and hospital staff quickly became overworked. Verbena Hospital strained both physically and financially to provide for the increasing volume of births, as over one-third of the 1,500 births were to undocumented families.

American Hospital came into play when, seeing an opportunity for expansion, its healthcare network joined with Verbena Hospital to construct a new healthcare facility in order to serve this suburban Philadelphia population. The venture was publicized as an equal union between American Hospital and Verbena Hospital, and the new facility, which houses a 20-bed maternity unit, is slated to open in September 2012. The problem with this, as AFW saw it, was that in the interim, the available services were inadequate for meeting the maternity care needs of area residents. The overcrowding at Verbena Hospital forced pregnant women to wait more than three months for their first prenatal appointment. Yet, American Hospital, which was slowly incorporating Verbena Hospital beginning in January 2011, had taken no action to ameliorate the situation. A local Federally Qualified Health Center (FQHC) was willing to help alleviate the congestion if Verbena Hospital provided the financial assistance necessary to do so. Verbena physicians were unwilling to relinquish money to the FQHC and negotiations stalled.

Incensed that the parties involved seemed to have happily given up on finding a resolution to the problem, AFW fiercely advocated for the immediate rectification of this deficiency of care by writing an open letter to the hospitals and physicians involved in the new venture. AFW beseeched all of the involved parties – American Hospital, Verbena Hospital, the hospital’s physician group, the FQHC - to attend to, not ignore, the families who needed maternity care between the Fall 2010 and Fall 2012. In their open letter, AFW stated:

Women have to wait a full 11 weeks (a third of a pregnancy) for an initial prenatal-care appointment. Waiting a full trimester for initial care is completely contrary to accepted standards of care and increases the risk of serious health problems for mothers and babies. How can women receive timely prenatal care to ensure that babies are healthy and strong? [George 2010:2]

The response received was both defensive and deflective. None of the institutions involved took responsibility for the insufficient access to care. Instead, both hospitals, the key institutions in the matter, took advantage of the fact that the venture was publicized as joint undertaking by placing the blame with the other hospital. When confronted with the unwelcome query, Verbena referred questions to directors at American Hospital, and American Hospital shirked accountability by stating that as a partner in a collaborative effort they only had partial control over decisions. By diffusing and obscuring the locus of power, American Hospital and Ventura Hospital effectively blocked AFW’s initial attempts to hold either institution accountable or to resolve the problem.

In their effort to address the situation AFW had, however, upset their relationship with American Hospital. After initial direct and pointed statements from both sides, American Hospital disengaged from the conversation by attempting to withdraw from the

arena of culpable institutions. Officials from American Hospital had previously proffered the fact that they would be incorporating Verbena Hospital over the course of a year and a half, and therefore, over time, they would have increasing control over the prenatal care situation. Yet after AFW's confrontation, representatives of American Hospital censored themselves by refusing to provide a timeline of American Hospital's incorporation of Verbena Hospital and even backtracked on previous statements that the new healthcare facility would be run by the American Hospital healthcare system.

Realizing that American Hospital's withdrawal revealed the need for conciliatory action, AFW adjusted its tactics. Delicately circumventing American Hospital's role, AFW focused on the other parties involved, namely Verbena Hospital but also the FQHC and the Department of Public Welfare. This shift in tactics also included discussions on how to involve other institutions that would draw attention to the situation, possibly reducing AFW's need to lead the attack. While AFW certainly did not yield in its efforts to increase access to prenatal care for the families in need, the organization did make tactical concessions in order to protect its relationship with American Hospital.

This account is just one example of the how AFW's relationships with other organizations and institutions posed obstacles to AFW's advocacy work, even as the connection benefitted other branches of the organization. Negotiating boundaries and how far they can be pushed is very often part of the strategic planning done by AFW, particularly with regard to the organization's advocacy work. The need to maintain positive connections with other institutions, connections which AFW worked hard to establish, complicated and restricted the options available and sometimes forced AFW to re-chart its tactical course.

Pleasing Funders

AFW's need to please others is not restricted to its advocacy work, however, as the organization is dependent on outside funding from a variety of sources. In order to receive funding from government sources, foundations and corporations for their programming, AFW's proposed projects must meet with the funder's expectations. Funders offering donations to family service nonprofits like AFW require the organization to meet certain criteria. The organization, itself, is expected to have the standard characteristics of a "human-service nonprofit", such as serving disadvantaged populations, often through the adoption of an authoritarian perspective which situates the "disadvantaged" as lacking the education and drive to remedy their own situation. Regarding the programming offered by these nonprofits, funders are interested in programs that meet niche needs unmet by public programs – in other words programs that fill in the (ever increasing) gaps. Funders also demand that programs have a provable impact; government and foundation based donors fund services that have measurable outcomes and are shown to be highly efficient (Smith 2000). In addition, certain amounts of innovation, such as the use of new methods and technologies, draw funders in and increase the likelihood of donations. Programs which meet most or all of these criteria are most successful in attaining funding. Therefore, nonprofit organizations in need of donations shape their programs to match funder's models.

In its ability to develop programs which fulfill the expectations of funders, AFW is certainly a "high capacity organization" (Eisinger 2000). The organization is a model for continual growth as the breadth and depth of issues engaged swells with each passing year. The angle from which AFW approaches the provision of most of its services fits

the accepted standard of practice among health and service-oriented NGOs. Their outreach programming focuses on uplifting the disadvantaged through education and access to personal advocates who couple clients with social service programs. While AFW programs meet the classic standards, the organization is also adept at developing programs which respond to funding trends. For example, in response to recent national interest in obesity prevention, AFW developed a program that promoted breastfeeding in workplaces and tied this initiative to data correlating breastfeeding with lower obesity rates. The target population for this program differs from AFW's usual focus on low-income individuals, yet the project addressed a topic of current interest so well that it received federal funding.

Just like all nonprofit organizations, AFW must compete for the support of funders to order to survive. In this light, AFW's talent for creating programs that are awarded funding is an enormous organizational strength. Yet, considered from another angle, the organization's dependency on outside institutions and corporations to continue currently funded programs and to be able to offer new programs can limit the organization's flexibility in designing and adopting programming. The organization may select certain projects, campaigns, or approaches over others based not just on the needs of the community but also on how well they mesh with the interests of funders. Although AFW may wish to pursue a project within the community, if the topic, target population, or approach does not appeal to funders the issue is likely to be sidelined.

This explains, in part, AFW's selectivity in joining working collaborations with other organizations. The organization's 30 years of experience with funders has honed AFW's sense for which topics and projects are likely to be awarded funding. The

experience of the Parental Support Center with AFW is an example of AFW's careful selectivity. As discussed in-depth in Chapter 5, the Parental Support Center was a startup nonprofit which offered childbirth education classes, support groups, and supportive therapies both to paying customers and to low-income parents. The Parental Support Center's co-founder, Maureen, shared with me her frustrations regarding her unanswered attempts to entice AFW to collaborate with the Parental Support Center in its efforts. From Maureen's perspective, the two organizations had similar goals and similar target populations, just different levels of resources. Collaboration with AFW, a large, established nonprofit would be a boon for the young and struggling Parental Support Center. Although a meeting between the two organizations eventually did occur, no collaborative agreement was struck. Adding (I believe unintentionally) insult to injury, AFW soon after established a satellite office in the Parental Support Center's catchment area and the funds granted this satellite office took away from the Parental Support Center's already feeble funding.

While AFW's decision not to collaborate with the Parental Support Center seemed an unexplainable slight to Maureen, from the perspective of a nonprofit experienced in attracting grant funding, collaboration may not have seemed judicious. While no doubt AFW would support the concept of providing well-rounded education to new parents, neither the structure of the Parental Support Center nor the design of its programming fit into the expected mold of funders. Not only was the Parental Support Center organized in a flattened hierarchy instead of as a classic hierarchy, but the Center's heavy emphasis on community involvement combined with a largely non-functional Board of Directors made for a loosely structured, non-bureaucratic business

model. In addition, the Center's perspective altered from the traditional view adopted by service nonprofits by insisting that all individuals of every income bracket be eligible to utilize their services. Following a non-traditional design, the Center used revenue from paying customers to fund services for low-income or disadvantaged clients and mixed and mingled clients from all income brackets in classes and support groups. The fact that much of the Parental Support Center's programming lacked measurable outcomes even further lessened the chance that these projects would appeal to funders. To a nonprofit like AFW, which has successfully navigated the restrictions presented by the neoliberal economy through a series of strategic responses, collaboration with the non-traditional Parental Support Center was a gamble not worth taking.

Extreme Work Ethic

One of AFW's strengths is the number of dedicated staff and volunteers the organization draws. Countless volunteers and a paid staff of 70, which continues to grow, enable the organization to accomplish its extensive range of undertakings. The individuals who make up the organization are champions of its mission who believe in the organization and its goals. This is certainly not a characteristic unique to AFW; this "purposive incentive" (Cordes et al. 2000:59; Wilson 1973:34), the sense of personal fulfillment and commitment to a group cause that nonprofits provide, is well documented as a key enticement to working in the nonprofit sector (see Salamon 2003; Cordes et al. 2000; Wilson 1973). It is this very sense of purpose, however, that can be taken advantage of and used to push employees and volunteers to extend themselves above and beyond reasonable and fair work hours.

This expectation of extreme work ethic can be found on all levels of the organization, and therefore can affect anyone – from volunteers to the executive director. Since paid staff has the added component of relying on their job for a salary, however, the drive to perform carries an extra burden. I experienced this exploitation most powerfully as I first joined AFW, during the time of my internship. My personal familiarity with this largely unspoken yet tangible expectation opened my eyes to the behaviors and attitudes of others. In the actions of AFW employees, I saw the same pressure that I had felt to prove dedication to the organization; employees worked many more hours than they received financial compensation for. In the four years I have studied AFW, I have had conversations with individuals who have left the organization and with those who remain employed at AFW regarding the towering work load expected of them. These conversations take one of two tones. Either the person is sheepish in their confession, as if admitting their experience is a betrayal of the organization and its mission, or the individual shares their story in a resigned, matter-of-fact manner, as if this extreme work ethic is simply par for the course.

Early on in my internship with AFW, I noticed that lunch breaks were frowned upon. While it was understood that people would eat in the middle of the work day, leisurely lunches were unacceptable. Staff who used the lunch room did so hastily, quickly returning to work as soon as their plates were empty. Many staff, myself included, ate as they worked at their desks perhaps only stepping away long enough to retrieve their lunch from the lunch room refrigerator or a nearby store. I also felt compelled to put in extra hours by staying late or taking work home with me. I noticed the same practices and more extreme behavior among other staff who seemed never to

stop working. Evenings and weekends were just extensions to the work week for employees as they used their nights to attend meetings and weekends to prepare for the upcoming week.

Considering the substantial number of programs and projects undertaken by AFW, this need for an extreme work ethic is understandable. The outreach arm of the organization offers six programs at nine satellite sites as well as at client's homes, the research group conducts examinations of community issues and monitors the organizations own program effectiveness, the policy division of the organization advocates on local, state and national levels, and the administrative branch manages the facilities, finances and operations. Add to all that the constant necessity to compete with other organizations for grants, donations, and gifts in order to survive, and AFW's staff of 70 suddenly seems altogether insufficient.

No one wants to be the weak link of the organization, to be the reason a project fails or a deadline goes by unmet. Driven by AFW's ideals, its mission, and the sense of personal accomplishment and ownership that connects them emotionally to the organization, employees endure the loss of personal time and inadequate financial compensation. The tragedy in this, of course, is that AFW is a human service organization that works to help the disadvantaged and to correct social inequalities, yet in order to achieve its mission the organization takes advantage of its own employees.

Summary

The oldest of the three nonprofit organizations I studied, AFW is also the most complex. Its 30 year lifespan, and counting, is a testament to its numerous strengths. Perhaps the most important of its strengths is that it meets society's expectations for what

a human service nonprofit organization should be. AFW serves the disadvantaged in ways that do not challenge existing social hierarchies. Its services and projects seek to fill the gaps in care that for-profit and public entities leave behind. Its programs follow trends in topic and innovation, meet funders' standards of effectiveness, and have measurable outcomes.

For all its strengths, AFW does have weaknesses and limitations as well. Dependent on community support and reliant on other organizations, businesses, corporations and the government for collaborations and for funding, AFW is susceptible to changes in public opinion, market shifts and the latest trends in research fashion. To survive, the organization must respond with fluidity and flexibility to these shifts and unexpected obstacles. This may mean backing off of an issue in order to preserve a relationship with a collaborator, ignoring a community need or project that would not appeal to funders, or exploiting the emotional ties of employees as well as their labor, health, and family life in order to meet increasing work load demands. The internal dynamics of AFW show just how complex the positionality of nonprofit organizations within our society and just how interwoven they are with other societal structures.

Neoliberalism and the Alliance for Family Wellness

Of the three nonprofits studied, the Alliance for Family Wellness has most seamlessly incorporated neoliberal processes and ideals into its organization. With its structure, focus, and programming AFW is an archetypal model for what a nonprofit "should be." AFW's internal structure is a classic hierarchical model, with an executive director with the most influence as the organization's leader, followed down the line by a deputy director, department directors, staff, interns, and volunteers. The Board of

Directors meets the standard of a “professional” Board, with active and highly skilled members who are connected to an array of public, nonprofit, and for-profit institutions. The three branches of the organization - advocacy, research, and outreach – cover all the bases with regard to the expected functions of nonprofit organizations.

Just like all nonprofits operating in the neoliberal political economy in which public expenditure for social services is limited, AFW must compete against other organizations for funding. In the highly competitive funding market, donors expect to receive grant applications that statistically quantify the efficacy and efficiency of nonprofit programs. AFW has all the bureaucratic procedures in place for gathering this type of data from program participants and the organization’s research department presents this data with aplomb. In addition, nearly all of AFW’s programs follow a public health model of care in which services are provided to disadvantaged populations through somewhat authoritarian measures, and this style of program continues to be well-supported by funding agencies. AFW understands exactly how the current system of funding operates and has demonstrated its flexibility by shaping its procedures and programming to mirror the system’s demands. The frequency with which AFW is awarded large endowments from federal and state agencies and from foundations is evidence of the organization’s success in meeting the expectations of funders.

Even though AFW has successfully navigated the neoliberal political economy, the same strategies that have helped the organization thrive also complicate its positionality and restrict its options. All of the limitations discussed above can be linked back to the institution of neoliberal policies. The practice of neoliberal theory has encouraged free enterprise and privatization, and has reduced public expenditure for

social services. One of AFW's responses to these political economic shifts is to develop collaborations. Collaborations with other organizations are necessary because funding limitations make it impossible for AFW to hire the staff necessary to conduct research and programs alone. Yet as the situation detailed above regarding American Hospital shows, these partnerships can be problematic as they can limit AFW's freedom. Another of AFW's reactions to the social realities that result from neoliberal policy is to pressure employees to display an extreme work ethic. By correlating individual's ideological support of AFW's mission with their willingness to be exploited, the organization is able to undertake projects that would normally be impossible. This "solution" is circular in nature, however, as employees are encouraged to show extreme work ethic so that AFW can receive funding to take on projects for which employees are expected to be excessively dedicated to complete. Finally, AFW strategically selects topics and shapes programs in ways that appeal most readily to funders. This practice limits the organization's creativity and autonomy in responding to true needs of the community, but AFW's reliance on the donations of others requires this funder placation.

This organization's experience navigating the neoliberal political economy shows that the absorption of neoliberal ideology into the fabric of a nonprofit can result in mixed outcomes. AFW's social and political acumen in its adoption of structural and organizational practices that are favored under neoliberal standards has enabled the organization to endure for 30 years and serve thousands of individuals and families. Yet, this incorporation of neoliberal practices comes with a price. The organization is restricted by the expectations of government agencies, corporations, foundations, and the donating public.

CHAPTER 7

CONSUMING CARE: “YOU MIGHT ACTUALLY HAVE TO FIGHT TO HAVE THE KIND OF EXPERIENCE YOU WANT”

Introduction

In this chapter, I focus on the experiences of parents as they navigate the shifting landscape of maternity care in Philadelphia, which is the third, and final, aspect of my research. I discussed in Chapter 2 the ways parents are impacted by hospital maternity unit closures in order to bring to light the frequently overlooked humanistic repercussions of the closure of hospitals, which remain the dominant resource for labor and delivery care. The focus of this chapter, however, is much broader. The purpose of this discussion is to describe the ways in which parents act within the social structure of the maternity care landscape in Philadelphia. What drives the choices made by parents regarding where and who provides their maternity care? Do parents even have a choice, considering the recent and drastic reduction in hospital maternity units and provider options? Does the existence of local NGOs, and their activities, make any difference in the experience of parents? What ideological expectations are thrust on new parents and what barriers and challenges do these parents face within the neoliberalized maternity care landscape?

The stories shared in this chapter engage the questions asked above. These are the pregnancy and birth experiences of just a few individuals who have interacted with the restructuring system of maternity care. Each story is unique, but taken together they illustrate “what it is like” to be a person in need of maternity care in the current system. Through an examination of the personal experiences of these parents, we are able to

observe how the current maternity care system, redesigned under the influence of neoliberal economic policy and its corresponding ideology, interfaces with the interests of parents. Similar themes and issues surface between these stories: a desire for a connection to other new parents, the usefulness of community resources, the lack of “alternative” providers, restrictions on the options available to new parents, and the dominance of biomedicine in the structure of maternity care provision.

The most significant theme running through these personal experiences is also the most seemingly contradictory. The current configuration of maternity care pushes parents into taking on the role of a consumer, yet as consumers, their options have been severely limited by the neoliberal reorganization of maternity care provision. The notion of childbirth consumerism has been discussed by others as an approach that “permits a woman to take direct action in changing current practices” (Rabuzzi 1994:72) related to pregnancy and birth care. Situated as an outcome of the feminist movement of the 1960s, childbirth consumerism is imagined as women taking action to protect their bodies from the oppression of physician-dominated models of care (Rabuzzi 1994). In the current neoliberal schematic, the term “consumer” is still relevant, yet it has taken on a different meaning, as have other popular terms that are used to describe the ideal neoliberal subject: independent, entrepreneurial, autonomous, self-governing, empowered, knowledgeable (Hyatt 1997; Kingfisher 2002a). The neoliberal view positions a “good” consumer as an individual who, out of a sense of personal responsibility and appreciation of the choices available through the free market, engages in an survey of all their options – evaluating price points and the quality of products – before making their selection.

Based on my fieldwork and the stories shared by the parents I interviewed, I offer

a different perspective on this childbirth consumerism. Instead of adopting the characteristic of “consumer” out of a wish to change current practice or to fulfill their role as a “good” citizen by eagerly evaluating their many options, parents are forced into becoming investigative, aggressive consumers due to the fact that the neoliberal restructuring of the maternity care system has limited the care options for parents. In Philadelphia, the neoliberal restructuring of maternity care had led to a reduction in the number of hospitals that provide maternity care, a decrease in the type of provider available, and a condensing of the geographic location where care is available. The result of these shifts is the presentation of an extremely biomedical model of maternity care at remaining hospitals. This extreme biomedical model of care does not necessarily jibe with parents’ needs and expectations regarding their maternity care, and, in fact, the practices and attitudes that prevail can alienate parents from the now standard biomedical maternity care of most Philadelphia hospitals. Parents adopt and express a consumerist attitude in different ways and at different times, depending on their personal experiences; some parents approach the maternity care system with caution and act as a consumer from the beginning of their first pregnancy while other parents “become” consumers in response to maternity care that they perceived as a bad experience. While individual agency certainly plays a part in parents’ decisions regarding their maternity care, this agency is a response to a system that is difficult to navigate and in which information is often not easy to obtain. For parents like those I interviewed for whom the new standard of biomedical maternity care does not meet their health needs or their expectations, becoming an aggressively active consumer is not a choice; it is a necessity.

The adoption of a consumerist identity is not exclusive to parents who are seeking out childbirth care. Under neoliberal policy, a consumerist orientation is forced upon all individuals (see Hyatt 2001; Murphy 2003; Maskovsky 2006; Rose 1993). And, certainly, parents in locales other than Philadelphia implement consumerist attitudes regarding their acquisition of pregnancy and birth care. I contend that the particularities of the recent restructuring of birth care in Philadelphia have exponentially increased the aggressiveness with which parents act as consumers within the landscape of maternity care.

It is important to acknowledge that the experiences of the parents included in this research do not represent the experiences of all parents. As discussed in Chapter 1, the parents with whom I conducted in-depth interviews have a lower-middle to middle class socioeconomic standing, have earned at minimum a bachelors degree or similar certification, and all are White. The uniformity of the racial classification was not deliberate, however, I was intentional in my efforts to hear the birth stories of individuals who did not face all of the class-based barriers to health care that impact those of low-income parents. I was interested in seeing more of a “best case scenario” of individuals who were navigating Philadelphia’s newly restructured maternity system; what are the experiences of individuals who are educated, who have access to resources such as a car, and who have (at least some) health insurance coverage? In addition, all of the parents with whom I conducted in-depth interviews either had two children or were expecting their second child at the time of our interview. Although I did not exclude first-time parents from my sample, I was particularly interested in conducting in-depth interviews with parents who had multiple children because I wanted to know whether parents would

make different choices for subsequent pregnancies based on prior birth experiences. I was lucky to find parents with multiple children who had the time and interest in talking with me. While the conclusions drawn represent the experiences of one small group of individuals and therefore are not directly transferrable to all parents, or even all parents in Philadelphia, I believe that the themes found in these stories highlight structural and ideological factors that in some way affect the provision of maternity care to all.

The Stories

Between fall 2009 and late spring 2010 I conducted in-depth, loosely structured interviews with five parents, focusing on their experiences navigating the Philadelphia maternity care system. Each of the five stories was distinct, yet analysis of the transcribed data uncovered remarkably similar themes running through each narrative. In order to capture the nuances of these parents' experiences, I believe that it is necessary to present parents' stories using their own words, as much as possible, instead of summarizing their narratives. This presentation style does, however, drastically increase the volume of text in this chapter. Therefore, in an effort to remain as succinct as possible, I elected to present here narratives that construct the stories of two couples' pregnancy and birth experiences which more than adequately display the common themes found in all the parents' birth stories. Below are the stories: Betsy's narrative of her two pregnancies and births, and the two stories of Audrey and Mark, a married couple whom I interviewed separately on different occasions and whose stories I have woven together for the purpose of this chapter.

At the time I commenced with conducting these interviews, thirteen maternity unit closures had already occurred in Philadelphia; only the six teaching hospitals

sustained maternity care services. This situation remains the same today; however, hospitals located in suburbs surrounding Philadelphia have continued to close their maternity units. Although each maternity unit closure affected the landscape of care, due to the timing of these parent's births and the geographic area of the city in which they reside the 2008 closure of Chestnut Hill Hospital's maternity unit most directly impacted their childbirth experiences. Therefore, Chestnut Hill Hospital, located in the Northwest section of Philadelphia, is referenced frequently by these parents as they share their stories. Parts of these parents' experiences may have been discussed in Chapter 2 in reference to the issues specifically related to hospital maternity unit closures. Here, the stories are presented in their entirety, as depicted by the parents to the fullest extent possible. Yet, for clarity and conciseness, I did take some liberties with reordering and omitting some text. To further clarify issues or to orient the reader, I also provide some narration and analysis with each story.

Audrey's and Mark's Story

Well, first of all, growing up, I had a babysitter who was a midwife. And this influenced my views on childbirth. I always thought, without knowing anything about it, that natural childbirth was best.... So I had an idea in my head that hospital births weren't that good. And it wasn't because of "interventions." It was because of—in my mind it got sort of connected to things like septicemia, which I guess, we don't really get anymore. But in general, [I believed] being surrounded by sickness when you're giving birth is not a great place to be.

Audrey began her story of her first pregnancy and birth by telling me this bit of information, I believe, to help me relate to her general mindset and belief system regarding childbirth. However, she went on to say that her relationship with this babysitter/midwife deteriorated and her annoyance with this woman led her away from choosing a midwife as a provider when she became pregnant with her first child in 2005.

Instead, she continued to use the OB/GYN practice at Pennsylvania Hospital, in lower-center city Philadelphia, which she had previously been using for her gynecological care.

So when I did get pregnant, because of [the babysitter/midwife], I decided not to go to a midwife. I already had an OB/GYN that I had been going to for 8 years. I didn't know them well, I didn't like them. But I didn't care. I was like, well, I'm young and healthy. There's no reason that I'm not going to have a healthy pregnancy and a normal delivery. And that was in my mind.

So, I just went to my regular OB/GYN. And he was an older man. It was, when I started going to that practice, it was two older guys, and I started with the one and I didn't like him and I switched to the other. So when I get out there again, pregnant, the guy said, "Well, I no longer do deliveries. So you can have either the other older guy that you don't want, or the new younger guy." So I took the younger guy. And he was nice enough. Very jocular, but not very personable. Uh, not very personal.

And, so that pregnancy did not go well. I was never satisfied with the care that I got, although I didn't dwell on it, and it was not even something I think that either [my husband] or myself fully realized, at the time. I did appreciate the ultrasounds, and the exams. I got tired of it after a while, listening to the heartbeat every week, and the last month you're just like, all right. Whatever.

The doctor's office was always really crowded. There was often like 3 appointments scheduled for the same time period, and he would, you know, rush in, rush out. I spent more time with the nurse who took my blood pressure. You know, I got to know her a little bit. She had a kid, so we talked. And [the obstetrician] had 3 kids, and we never really talked about that. So I mean, he just wasn't, you know, no small talk, no getting to know you. And I went there for my blood tests and my glucose tests, and all this different stuff, and I waited for hours to get them done. I think I waited for... for the 20-month ultrasound, the one where they tell you the baby's sex? I think we waited there for 4 hours.

So, I got through 40 weeks, and of course I didn't go into labor. And I was only 1 centimeter dilated... But I wanted to, I wanted to deliver. So I agitated for induction. And I read about it, and I read nothing linking getting induced to having C-sections. The only thing I read was, you'll have stronger contractions. And my thought was: pain is pain. Like, a stronger or less strong contraction, like what's the difference?

So, that was a horrible experience from start to finish. We got [to the hospital for the scheduled induction] in the evening. [My obstetrician] said, "Have a nice meal." So we went out and had Thai food with my parents, and then drove to the hospital around 10 or 11 at night. And then they gave me the Pitocin, and they told me I couldn't get up and walk around. That I had to lie in bed the entire time. And now I know, actually, that you can [get up]. You just say, no, I want to be monitored from time to time, and you cannot make me lie in this bed. But they were like, no, you have to.

And I wish I'd gotten up and left at that point. But I kind of wanted the baby. I wanted it out. I was so miserable. I mean I was a gigantic whale, I was

boiling hot all the time, and I could hardly poop, and when I did I couldn't reach my ass to wipe it. So yeah, I mean, everything was—like, I was done being pregnant. So, I basically had a couple hours of sleep, even though I couldn't roll over because the monitors—every time I would roll over they would come in and readjust the monitors. And then by the next morning I was in labor. And it was very mild at first, but then it was very bad. And because I couldn't get out of bed, there was nothing I could do to, like do any kind of pain management techniques. I couldn't walk around and distract myself, I couldn't take a warm shower, like I couldn't do anything. So it was really bad, and I ended up just writhing on the bed. And [my husband] begged me to get an epidural. And I kept refusing. And then finally I couldn't take it anymore. So I got an epidural. And then that was very undignified. Because they, um, I guess they put a catheter in you after that. And you know, I'm just not used to—you know, I'm a very active person, and I've never had a major illness. So I was not used to being taken care of at that level.

So, you know, [I am] still feeling like, I gotta get this thing out of me. Can't stand it anymore. And they came in and broke my water, and I felt like I was entering phase 2 of labor, which is I guess when you're fully dilated and ready to start pushing. You know, I wasn't sure though. And they're like, you feel like you have to push? And I'm like yeah, I think so. And I felt like they were going to send me back to that room if I was wrong. They're not very encouraging, really. So [I] got in there, [the obstetrician] comes in, I'm trying to push and I'm lying sort of slightly raised up, nurse is raising one leg up, [my husband] is holding the other, and I start pushing. And [the obstetrician is] yelling at me that I'm puffing out my cheeks, and that that's not proper pushing. And [the obstetrician checked] and said, “Oh, we got another 2 hours of pushing here.” Like, in this disgusted tone of voice! And I was kind of offended by that. Like, so what if I have two hours worth of pushing. Like, it's my labor. And I think it was then that the [baby's] heartbeat dropped, and [the obstetrician] was like, “Get her on the table!” And they rushed me off to have a c-section. And I said no, and I started crying, but they didn't listen to me. They paid absolutely no attention to the fact that I screamed, “No.” They didn't ask me, they didn't ask [my husband]. Nothing. It was just like, the baby's heart rate dropped. Throw her in the OR.

So, then they c-sectioned me. And they were talking about their vacation, while I'm there, being operated on! And they took the baby out, and they took it away. First they showed me its head, over the curtain. Like, they held him by the back of the head, and was like, oh look, here. And they took him away, and he cried for a long time while they weighed him and did all this stuff. And I was like, why is he crying? Can I have him? And I was kind of weak, and sort of like, [whispering] “Why is he crying? Can I have him?” And [my husband] finally brought him over to me, and so I got to look at his head.

And then, they put me in the recovery room. I nursed [my baby boy, Chris]. So, then I started shaking, because the effects of the anesthesia were wearing off. And I had [hospital staff] put the baby in the bassinet, but I didn't really want him over—like, I didn't want him in the bassinet, I kind of wanted to still be holding him. But I also wanted to be drinking water, and I was shaking, and I was—that's why I didn't want to hold him. Because I was shaking. So, I fell

asleep right away; he was born at 5:15 pm, and by 6:30 pm, I was in my room and asleep, and I slept until like 6 the next morning. And they just took him away, and I was like, whatever, I don't care, get rid of it.

And the next morning my doctor came in and said, "Well, we may never know why you needed a c-section." And I was like...okay. I tried to put a good face on it, but I was really disappointed, and I was in a lot of pain, and I couldn't move around. I didn't get up for 2 days. So taking care of Chris was really, really hard.

And then [my husband and I] had really different interpretations right after the event. [My husband] was like, well, you know, the important thing is that you guys are okay. And I said, I feel like no matter what we would have been okay. And I was like, no, my labor and my delivery were taken away from me, and I'm really disappointed. And it was really horrible for me, and now I'm upset. And [my husband said] no, the important thing is that you're okay, and the baby's okay. And I was like, no. that's not the important thing. ...The important thing is that my labor was taken from me. And I couldn't articulate really just that, I was really disappointed in the whole experience.

Well, when I got pregnant again, I just sort of assumed that I would be given another chance to deliver in a normal way. And we got to the doctor, and he said, no, because you labored all the way to 10 centimeters dilated, and because you have big babies, you are not eligible for a VBAC (vaginal birth after c-section). Some people here are eligible for a VBAC, but you are not one of them. So if you give birth here with me, you will have a c-section. So, I cried. And [my husband] was somewhat unhelpful about this. He was... he was like, well, you know, that's how it is. And I was like, no, it isn't. I'm not gonna do it.

And so I called the midwives, at Pennsylvania Hospital, and they said, no, whatever that particular doctor says, we also go by. I called Abington Hospital, I called these doctors offices all around this area. And the people I talked to on the phone had never even heard of the term 'VBAC'. Like, nurses who worked in ...women's doctors' clinics! And so I started getting really desperate. And then I contacted the [Parental Support Center], and they referred me to the woman who ultimately became my midwife. [When I first met with the midwife she asked] "well what did your doctor say?" And I said, "well I have big babies." And she said, "well, I just delivered a 10-pound VBAC. So that doesn't bother me." And I said, "well, he said, [I was not eligible for a VBAC] because I was 12 days late with Chris. And the doctor said because I labored until I was 10 centimeters dilated I wasn't a good candidate." [The midwife said] "I don't know what he's talking about there." And then she said that the only issue that I might have is because I was late the first time, I would probably be late the second time, and if you have a VBAC, you're not allowed to go more than one week past your due date. So you can only go 41 weeks. So, I was like, whatever, fingers crossed, I want to do it.

In addition to interviewing Audrey about her birth experiences, I also interviewed her husband, Mark, about his recollection of the birth of his two children. In general,

Audrey's and Mark's stories were very similar. At this juncture in the story, Mark echoes Audrey's comments, but provides additional information regarding a pivotal transition in the way the couple interacted with the maternity care system, so I turn to his comments here:

The real turning point for the whole process for us was when we got pregnant with [our second child], we went into the same doctor, to have an initial consultation, an initial ultrasound. And he said, he gave us the ultrasound, asked us all of the questions, and then said, "I know you were very interested in doing natural childbirth all the way, last time, and it sounds like you're interested in doing a VBAC." And he said, "you know, you're not gonna do it here. You can't do it here. We only allow them under very certain circumstances, and you don't meet them. So if you want to have the baby with this practice, you're going to have to schedule an elective c-section, and we'll just deliver it."

[Audrey] was extremely upset. And we sort of went home, and she said there's no way I'm going to have an elective c-section. And we immediately started reading. So, and that was another kind of, quite an experience for me, because immediately, I went to the AMA (American Medical Association) to see what they had on [VBACs]. And when you started reading about uterine rupture... and sort of the AMA hard line on it was that, they very much discourage VBACs. In the end, I was very lucky to have the resource, I ended up calling my sister, who is a pediatrician, and saying, you know, what is this? [My sister told me] essentially that if we decided to have a third kid, repeated c-sections made it more and more dangerous, and that essentially that it was even odds, and that there was really no reason to elect the surgery. Which made me feel much better. I didn't really want to elect for surgery. We also found out that, I learned that the nationwide [c-section] rate was 32%, basically a third of babies born in the United States were c-sections, that was above the average of the first world. A lot of interesting statistics.

But for me, it was very illuminating, one, to learn that [for the delivery of our first child] we had been in a hospital with a very high c-section rate. I think 42% at that point. We had—there was some doubt as to the absolute, the necessity of our c-section. Well, that it was suspicious in some ways. It happened at 6 o'clock in the evening, for example. It was sort of the first sign of, there was a contraction, the heartbeat dropped, dropped a little low, but it always drops in contractions, and it was sort of the first instance, it wasn't sustained necessarily. Labor had certainly stalled, but it hadn't been going on for hours—it had been going on for maybe 4 or 5 hours, it wasn't like it was 20, 30 hours. So, by some people's estimations, that was a little suspicious. You know, who's to say. If it was—we weren't objective at that point.

But yeah, [early in Audrey's second pregnancy] we were going through a lot of emotional turmoil because we were trying to find someone who would even consent to consider doing a VBAC. Because the resources in the area—the

midwives at Pennsylvania Hospital aren't under the same insurance as OB/GYNs at Pennsylvania Hospital, and they wouldn't touch [us] with a 10 foot pole. The Birth Center in Bryn Mawr, for insurance reasons, can no longer do [VBACs]. We finally found the midwives at Chestnut Hill [Hospital], the midwifery practice there, one of the independent midwives there, who certainly did VBACs. Ended up doing a lot of them. 'Course when we went to meet the midwife that we ended up having [our second child, Lauren] with, she met us in the lobby and told us they were closing the OB unit at Chestnut Hill Hospital. So that was a little fraught with peril, the whole beginning process. Very, very stressful, in the beginning....It definitely was mentally traumatic for us, without a doubt. Because here was [Chestnut Hill Hospital] right nearby our house, that, you know, is 8 minutes from our house if we went slowly. Probably more like 5. And then, all of a sudden our midwife and a bunch of our alternatives to her were all without a place to practice. And when our midwife did find another place, it was Montgomery Hospital, which is more like 25 minutes away. Which isn't a terribly long drive, I suppose, for most Americans, but when you have a screaming woman in the seat, you've just woken up your neighbors to drop your son off, and you're trying not to kill all of you so that one of you can be born, then it seems like a really long distance. So it was pretty stressful. [When Audrey was in labor] we got there—we seemed to get there in time. Going out there for the birth, going back there every day to visit [after the birth] was also very difficult. I felt like I had to travel, you know, I guess it's more like 30 minutes.

And [the close of Chestnut Hill Hospital's maternity unit] was kind of difficult for a lot of people around here. And you know, people would come, from other parts of Philadelphia to Chestnut Hill Hospital, from the surrounding suburbs, from New Jersey. So, I'm not so sure for the community around here, that there's more hospitals who use other alternatives, but I just sort of wonder as the numbers kind of dwindle. Your choices were pretty much, in Philadelphia, they are Chestnut Hill Hospital and Pennsylvania Hospital for midwifery. There seem to be less and less options. I suppose any—you know, Jefferson must have a maternity ward. I don't know anyone who's ever had a kid there. I suppose the Catholic hospitals usually maintain them because they're not for profit, and supported by the church.... Temple and Einstein... They have a reputation as a good place to get stitched up. You know, in fact the person who stitched up the cut I had in my leg at Chestnut Hill Hospital said she really enjoyed working at Einstein, because she got to do so much suturing.

As we return to Audrey's version of the story, she describes the care she received during her second pregnancy with a midwife, her labor, and the birth of her second child. Audrey's description, as well as Mark's, of the care she received during her second pregnancy and birth stands in stark contrast with feelings regarding the care received during her first pregnancy:

So I started seeing [my midwife] in her [private] office, which was very close by. And the prenatal visits were... I don't know, they were shorter but more satisfying. There was not really much machinery involved. Like, she took my blood pressure and she checked the heartbeat. And she talked to me about how I was feeling, and I could tell her any old thing. [Our midwife] was an extremely friendly woman, and very easy to talk to. And Mark went along for a lot of the visits. Really enjoyed them. Chris did not. That was hard, taking a 2 year old to a bunch of prenatal visits. But yeah, I really enjoyed the prenatal visits, and then we got to the end and she suggested I use evening primrose oil which anecdotally may ripen your cervix for delivery. So, I did that, and then she didn't really check me as often. Like in my 9th month at my other place it was every week, but she did it every two weeks, and I was constantly being surprised by stuff like that. Like aren't you gonna strip me down and check me? She was like, "Nah." Oh, good.

So she just, you know, she just didn't really check me physically, she really more checked me emotionally, it seemed like. It was a very different experience. And there was no nurse, it was just her doing the whole visit. So by the end I was really dilated. And she was really surprised, like she didn't expect me to dilate so much, but I was like 3 centimeters at 40 weeks. So she said I could go at any time. And she stripped my membranes 2 weeks in a row. So I went into labor that night [after the midwife stripped the membranes the second time], 2 days early.

Audrey labored at home for about twelve hours, unsure that she was in labor for most of that time, before calling her midwife. After hearing Audrey have a contraction over the phone, the midwife told her to go straight to the hospital, where the midwife met her:

So I got in my gown, and then the nurse checked my dilation and she was like, "3 centimeters." And I was like, "3 centimeters? No way. That's what I was yesterday." So [my midwife] came in and she found out that this nurse had—had uh, touched me in my, in my special place, and she was mad! And it was really great. She did an exam, and she was like, 7 centimeters, and I was like, that's what I'm talking about. So, I had hard labor. [My daughter] was born I think at 12:30. So, I was in labor from probably about 7:30 in the morning till 12:30, when I had her. I begged for pain relief at one point. [My midwife] reminded me, mercilessly, that this had been what I wanted....And she respected my wishes even when I was screaming for pain medication, and whatever else I was screaming about. Whereas my doctor [during my first pregnancy] never even knew what kind of labor I wanted. He never asked. He didn't know I wanted natural childbirth, I don't think.

I spent a large part of my labor [with my second child] screaming uncontrollably and I broke all the capillaries in my face. And I was very dramatic about the whole thing....But, at no point did [my midwife] say, "Uh, you have

another two hours.” She was like, “You can have this thing out in 20 minutes! Come on!” And I’m like, yeah, I’m gonna lie here and scream. So finally I started pushing. So, then the head was sort of sticking halfway out at some point, and I reached down and I felt it, and I was like, holy shit! It was all pointy. And I had to be monitored again, for the heart, the baby’s heartbeat, and that was another—I don’t know if that was—I think that was a VBAC thing. But [my midwife] was really cool. She followed me around the room with the monitor, and she took it off to let me go to the bathroom. It was totally different....I was being monitored for the entire labor for the baby’s heartbeat. Which is only one monitor. They didn’t have huge—they had one for my contractions, and one for the baby’s heartbeat at Penn, and then at Montgomery, just the one. And there was one nurse, and she was really nice. She never said anything. She was very unobtrusive.

I was really a trooper for the end of that labor. I pushed and pushed and pushed and I didn’t scream. And then I collapsed on my back, because the head was out, and then the rest came out, and I went, “Ahhh!” And then they threw this—a wet fish on my stomach, was what it felt like. It was all slippery and floppy and weird, and then they started like rubbing it and draining out all the mucus, and I was like, whoa, what’s going on? But then, you know, then she was clean and things calmed down. And yeah, it was great. I knew exactly what to do at that point. I nursed her, and she nursed really, really well, and then they weighed her, and my husband took pictures of her.

[After the birth] my vagina was swollen, enormously. I had three mountainous hemorrhoids. But I was up and walking around. And I didn’t feel that bad. You know? I actually was feeling pretty good. I felt really good, and I really enjoyed how much better I felt. Like, I was very conscious of it the whole time. There was, you know, massive vaginal soreness, but it’s only for 2 days. Which, you know, it sucks when it happens, but you’re just careful about how you sit, it’s not so bad. But it was just, you know, it was a quick and easy birth, and a really quick recovery. And then I’ve had one visit with [my midwife], and actually, I have yet to make a second, where she was—she is going to give me an exam, but I feel normal. And I have ever since. And it was really nice, because with Chris I couldn’t carry him, much less put him in a sling and carry him around for hours, but with her I did. I’ve had her, been carrying [Lauren] in a sling since she was born. And that has made managing her much easier.

Audrey’s and Mark’s narratives highlight a variety of issues related to the restructuring of Philadelphia’s maternity care system. The unexpected interventions of their biomedically managed first pregnancy and birth, the difficulty faced in finding a provider willing and able to conduct a vaginal delivery for their second birth, and the stress encountered due to the closure of the hospital where they planned to birth can all be

attributed as direct or indirect outcomes of Philadelphia's new landscape of maternity care.

Based on their descriptions, it is clear that the different models of care enacted by their two providers, one an obstetrician and the other a midwife, had a great influence over the way Audrey and Mark view each of their childbirth experiences. Audrey was particularly expressive about the way her interactions with each of the two providers made her feel. Her initial expectation that as a young, healthy woman, she would naturally have a normal birth, which to her meant a natural or at least a low-intervention birth, certainly played a large role in her dissatisfaction with the obstetrician's highly interventionist practices during her labor and the delivery of her first child. In this regard, Audrey's personal expectation of "what birth should be" is a guiding factor in her assessment of her childbirth experiences. She certainly made a point of asserting that her two very different births were not an outcome of her body's capabilities but instead were a result of the decisions made and interventions used (or not used) by each provider. Audrey's declaration that "no matter what we would have been okay" in her attack against the obstetrician's decision to deliver her first child by c-section speaks to this view that it was due to her doctors wishes, not her or her baby's health needs that she was c-sectioned. On the other hand, Audrey's statement that during her labor with her second child, her midwife resisted Audrey's requests for pain medication also underscores her belief that the decisions made by her health care provider dictated the type of delivery she had.

There is no doubt that there are obstetricians who practice low-intervention methods of labor and delivery just as there are certainly midwives whose methods would

not have appealed to Audrey's and Mark's needs and expectations. Yet based on the practical training of both types of providers, as discussed in Chapter 1 of this dissertation, it is possible to make the general statement that obstetricians tend to utilize more biomedical interventions than do midwives both during prenatal care as well as during labor and delivery. Furthermore, it has become increasingly difficult for parents to access midwives as providers in Philadelphia since hospital closures have drastically reduced the employment options for midwives. Just as the closure of hospital maternity units have effectively reduced access to midwifery care, the closures of two-thirds of Philadelphia's maternity units has also led to an overburdening of remaining units. This has increased patient loads and has resulted in the long waits for appointments, as mentioned by Audrey, and has increased providers reliance on interventions as a time-management technique. For parents, all these structural and practice changes increase the odds that they will have a birth experience more like Audrey's and Mark's first, not their second childbirth story.

The difficulty Audrey and Mark encountered in finding a health care provider who performed VBACs is a clear example of how the shifts in practice that have corresponded with structural changes in maternity care perpetuate a biomedical model of maternity care and its corresponding interventional techniques. The c-section used to deliver her first child automatically classified Audrey, within the biomedical maternity care system, as a woman who would need c-sections for all future deliveries. Had she believed her obstetrician's assertions that she was not a candidate for a VBAC, there is not doubt that Audrey would have had a scheduled c-section for her second delivery. This obstetrician's viewpoint follows the standard biomedical mantra of "once a c-

section, always a c-section” which serves the interests of the biomedical establishment, not the interests of patients. Audrey’s successful vaginal delivery of her second child is proof of the fallacy of this practice of herding women toward subsequent c-sections once they have undergone one of these procedures.

The fact that Audrey and Mark had difficulty finding a provider who disagreed with her obstetrician’s determination that she would have to have a c-section for her second childbirth is further illustration of the control of the biomedical model over the provision of maternity care. Audrey states that she contacted numerous hospitals and providers in her efforts to find someone who would even consider conducting a VBAC; she was incredulous to find that some health care professionals did not even know the term “VBAC” none the less provide that as an option. The fact that the only provider Audrey found who provided VBACs, and did so frequently, was a midwife is telling of the limitations that the biomedical model places on women’s maternity care options.

As we continue through Audrey’s and Mark’s story, we see that even after they found a provider willing to conduct a VBAC the restructuring of Philadelphia’s maternity system continued to jeopardize their choices regarding their maternity care. As discussed in Chapter 2, not all hospitals welcome midwives. In fact, few of the hospitals in the area that continue to offer maternity care hire midwives as staff or grant midwives privileges. Chestnut Hill Hospital was one of the few midwifery friendly hospitals in the Philadelphia area, and this is where Audrey’s and Mark’s midwife had privileges when they selected her to be their care provider. The closure of Chestnut Hill Hospital’s maternity unit during Audrey’s pregnancy was stressful for the couple not just because it was an unexpected relocation, but because their chance at having a vaginal birth hinged

upon the midwife's ability to find a local hospital that would grant her delivery privileges. As it turned out, the midwife had to look outside of Philadelphia to find a hospital willing to grant her privileges and she was lucky to find a hospital in a suburb to the northwest of Philadelphia County that was close enough to still be accessible to most of her clients. As this midwife was the only provider Audrey and Mark found who provided in-hospital VBACs, had the midwife not found a hospital at which to relocate, Audrey and Mark would have had to either submit to a c-section, to greatly expand the geographic area in which they looked for a provider, or to attempt a homebirth – all three were options with which the couple was uncomfortable.

Audrey's and Mark's story illustrates the process through which they "became" aggressive childbirth consumers. As Audrey clearly explains in the beginning of her narrative, she started her first pregnancy with the expectation that she would have a "normal" childbirth experience and simply continued to use the same practice she had been using for her gynecological care. She did not take any action at that time to look for a particular type of provider or to survey the various options available. She did not take steps to ensure that her expectations of a "normal" pregnancy and delivery would be met by this obstetrical practice. Nor did she question the prenatal care or the procedures performed by her obstetrician, until the very end of her labor, even though she was not satisfied with the care she received. Using her words, she just "didn't dwell on it." Unfortunately, the labor and delivery of their first child was an extremely traumatic birth experience in which their control over their labor and delivery were stripped from them and they (particularly Audrey) were left feeling powerless, oppressed, and mistreated.

Only once they were faced with a similar scenario for the couple's second birth did the couple adopt a consumerist attitude. However, as Audrey and Mark quickly found, the current structure of the maternity care system constrains the choices available to parents making the realization of their wishes a task which requires persistence and dedication. The limited options available to them, due to the neoliberal restructuring of Philadelphia's maternity system, forced the couple to adopt an aggressive consumerism: investigating on their own the choices available by calling numerous practices, hospitals, and independent providers; researching the data on standard practices and statistics related to VBACs and c-sections; contacting trusted professionals for their advice. The couple also briefly turned to the nonprofit sector for help, contacting the Parental Support Center (the nonprofit discussed in Chapter 5 of this dissertation) and it was through the guidance of this Center that Audrey and Mark found the midwife who ultimately enabled them to have the childbirth experience they wanted. Audrey's and Mark's interactions with the maternity care system during their first pregnancy and their second pregnancy were drastically different. They went from passively accepting the practices and procedures done to them to very actively and critically consuming care. This transition in positionality within the system of maternity care is accompanied by a new perspective as well, captured succinctly in Mark's response to my question of what he learned through his experiences with Philadelphia's maternity system: "That you might actually have to fight to have the kind of experience that you want to have. And you should be prepared to fight." Transformed from submissive participants to combatant consumers, Mark's and Audrey's story is an example of how the neoliberalized maternity care landscape can force parents to reposition themselves within the social structure.

Betsy's Story

Betsy and her husband moved to the Philadelphia area in spring of 2006 just after she became pregnant with her first child. Although she was not familiar with Philadelphia's maternity care system, she knew that because of her high blood pressure, a preexisting health condition, she would be considered a "high risk pregnancy" and that this classification limited her to birthing in a hospital. She selected a hospital-based obstetrical practice because of its high profile reputation. Eager to connect with other parents in the area and to increase her knowledge of childbirth related issues, she immediately began exploring the services and classes available:

And I was interested in a childbirth class that was more than one day, or two days. Because I wanted to meet other parents....I was looking for a way to make friends in the community, and I was really anxious about childbirth. ...And I kind of felt like, you know, one day didn't seem adequate given that my parents went to classes that were 8 weeks. So, I went to the [Parental Support Center]. I had searched for it online, and that's how I found it. And at first I started with the Bradley Class, but it was very um... anti-intervention. I mean it was militantly pro-natural-birth. And I have high blood pressure, which meant that I had a high-risk pregnancy, and I needed a hospital birth. So, I said I didn't think that that class would be working out, and I asked about other [classes], and Maureen (one of the founders of the Parental Support Center) called me, and talked to me, and said well why don't you try [the class] "Birthworks"? So, I went to that class and I found it to be very good. It was definitely...respectful of natural childbirth as an option. It's one that you may not hear as much about if you are with an OB, that kind of thing.... And that was one thing that I really liked – I felt like those Birthworks classes really gave me the ability to talk knowledgeably to the medical personnel. To be like, well, I want to try...can we try this? Rather than be like, what do you think we should do?

[For maternity care] I started out at the Women's First Clinic at Pennsylvania Hospital....When I had first started Bradley classes, I went to my OB and was asking her about what would happen. What was the birth plan? And she seemed really defensive when I asked about it. And she said we really don't talk about this stuff until you're in your third trimester. And so, I waited until I was in my third trimester, and when I went in for my next appointment after that time had passed, I said, okay, so when are we gonna talk about it? And she – I mean, she wasn't angry, but she was, as I say, defensive. And said, you know, I'm seeing a lot of red flags here. You know, it was sort of like, take it or leave it. I know what I'm doing. Your job is to come, show up, and I'll do my job. And, you

know, when people start talking about their preferences, and what they want, listen, we do what we have to do to make sure you and the baby are okay. But she didn't really want to talk a lot about what that was, and I felt like I was just being put off. So, I decided then that maybe a doula was in order. And I called around various doulas, and they were very hesitant when they were hearing my concerns. You know, I was like, I was hoping that you would kind of help me to make educated choices, and help me to make sure that this process isn't rushed. And one doula, who I really liked, said listen, if you want me to run interference with your OB, I don't want to do that, and I don't know who would want to do that. It's just, you need to be with someone that you feel comfortable with. And *then*, if you want a doula, you know. But you shouldn't be getting a doula as an antidote to feeling nervous about your healthcare provider. So, that's when I decided that I would use a midwife practice, rather than an OB practice. And I didn't want to use Penn, because I'd had such a bad experience with them before, at their Women First clinic.

And so, then I got involved with Chestnut Hill [Hospital]. At that time, Chestnut Hill was open, and they had a labor and delivery ward, and they had a midwife practice. And so for the rest of my pregnancy, I saw a nurse practitioner. And I really liked her....And the midwife practice, I had never met a midwife until I was actually going to go into labor. I had to be induced, because of the high blood pressure. I was due on the 23rd, and they kind of wanted me to be induced on the 24th, and I said, can we wait until the 26th? So I went in on the 26th to Chestnut Hill [Hospital]. And it was a very long and difficult labor. I went in [to the hospital] around 5 am, and I delivered at noon the next day. I mean, it was very long. And they were very respectful about not pushing me to try to do, you know, more drugs or more – they had me on Pitocin, because nothing was really happening. And I was trying not to have an epidural, and then there was one point at which I was basically lying on my side, sweating. And they had me hooked up to machines to monitor the baby. And I couldn't move well with them, so I wasn't able to do, you know, pacing, or sitting on a ball, all that kind of stuff that people can do.

So then, I decided that – at one point one nurse came in and said, “you know, there's somebody who wants to know how things are going.” You know, meaning the anesthesiologist. I guess he was leaving, or something. And so, I had asked them not to talk to me about it, and they were pretty respectful of that, although one person once said, “you know, I just hate to see you in pain, why don't you do this?” And I guess there came a point – they had given me a narcotic to let me fall asleep, and turned off the Pitocin, and then they crept in while I was asleep and then turned on the Pitocin just a little to see if I could – if it would help. And they I immediately woke up. Just feeling right back to the level I was at, you know, when they had turned it off. And I said, well, could you check and see how much I'm dilated, and it was like, 4 cm. I mean, it was not enough. Not nearly enough. It was going to be a long night. And I just decided at that point, well, you know, I'm going to go with an epidural now, because I want to be conscious, and with it, when this baby comes, and enjoy that moment. So I got an epidural, then, and it was a long time [before] you know, they had determined that

I was ready to push. But [they] asked me, do you feel like pushing, and I thought, you know, sure. I want this to be over. You know, I tried to push, but I was so tired, and so everybody kind of left the room. I said I can't do it, they said we'll leave you alone, and shortly after that I really felt the need to push. So I kind of started pushing, and a midwife sort of came in and was like, you know, oh my gosh! Very surprised. Ran back out and said, you know, get over here now! So everyone was right in, and the baby was coming. And, you know, they asked me, do you want to feel his head? I was like, okay. I decided what the heck, because they were like, really? You don't? Are you sure? Okay. So I decided to do it. And I remember – but I remember it being very painful. When finally – I guess I don't have the exact word for it, but the skin that [the baby] was coming through, I felt it tear. And that was very painful. And they sewed me up and everything. And the recovery was difficult. I mean, it wasn't – I was up and about, and my mother in law who'd had an episiotomy and three kids said, you know, you're doing so much better than I was doing. But I definitely had a lot of... I felt the scar a lot, for a year afterwards. And it kind of made intercourse difficult, since like, a reminder. So, that was that first [birth] experience.

I had gone to the Parental Support Center – their “new mom's group” before I had [my first child, David] to kind of meet the other new moms. And then after I had the baby, I went back, and some of the moms remembered me. I continued to go, every week, and then when a bunch of the kids who were about the same age got too big to fit in there comfortably, four of us spun off, and had a playgroup. We're still in contact today. We met once a week until, I would guess until the kids were like 2, and then just the schedules got a little bit more hectic, and people started doing other things with their lives that they couldn't, you know. But we still do a baby sitting exchange with one of the couples. David's best friend is one of those kids. So, and then I did use some of the other services [offered at the Parental Support Center]. I used the prenatal massage once, and I have gotten a couple of [regular] massages there. I thought about their counseling from time to time, but didn't ever use it.

I went to some other support groups, too. Like the breastfeeding support group at Penn. That's one that sticks out in my mind. But what I noticed was, it was very focused around breastfeeding. So someone would be like, “I don't know if I can handle this, I'm so tired, so upset.” And they'd be like, “And how does that relate to breastfeeding?” And stopping conversations in order to refocus on breastfeeding. And the nice thing about the Parental Support Center's group is that it was, you know, wide-ranging. Just people and talking about things, more about parenting, or the experience of motherhood. Sometimes birth. Spousal relations after. It was just more helpful because it was, you know, client directed and focused. I mean, I feel like [the Parental Support Center] was great – I feel like I got there in its heyday, and it was the reason why we moved to Mount Airy, in fact. Because I was like, well, if this is the community that has this kind of place, you know, this is where I want to be. So, anyway, I'm really sad that it is closing. I looked into other childbirth classes, and there really weren't any that I saw. I mean, there's prenatal yoga that's available in Fairmount, but I really didn't see anything – all the other classes were of the hospital 4-8 hour variety.

And in my opinion, it takes a little longer. Don't you want to meet other people? You know what I mean? So, I think that now, yes, there's a huge hole left by the Parental Support Center [closure].

Betsy is, of course, referring to the closure of the Parental Support Center, the nonprofit organization located in northwest Philadelphia that is the topic of Chapter 5 of this dissertation, and its imminent closure had been announced publically by the time I met with Betsy for our in-depth interview. The closure of the Parental Support Center was not the only closure that Betsy experienced. Chestnut Hill Hospital closed its maternity unit in 2008, two years after Betsy gave birth there to her first child, but before she became pregnant with her second child. I asked Betsy whether the closure of Chestnut Hill Hospital's maternity unit impacted her second pregnancy in any way and how she made her selection of which hospital to birth her second child. Betsy replied that she "definitely would have" returned to Chestnut Hill Hospital for her maternity care with her second pregnancy had the hospital not closed its maternity unit. In fact, she said that she had called the hospital in an effort to locate the nurse practitioner who had provided most of her prenatal care during her first pregnancy, but was unable to find her. Faced with finding a new provider and a new hospital at which to birth her second child, Betsy contacted various providers and hospitals and also turned to friends and community members for advice:

Well I guess when I was thinking of where to give birth, the second time, when I think of inside the city, all I could really think of was Penn. You know? And there's another hospital on the west side of Philly. There's Pennsylvania Hospital, and University of Pennsylvania. But they're affiliated. It's the same thing. So I don't really know where to go, other than that.

There's only one midwife practice that I know of, and that's Penn. And I have heard good things about it, but I just had such a negative experience at their [Women's First Clinic] – and I also have heard about Penn that it's kind of like – you know, they're rushed. They have an awful lot of people in there. I hear that

that's pretty – pretty, you know, quick. So I don't think there's adequate midwife – I mean I'm sure that there could be midwife practices that would do fine. The problem is, you know, if you want a midwife practice that's in a hospital. Like I talked to Gwen [a midwife who does hospital births]. And she asked the doctor, she was just starting working with Montgomery [Hospital]....And she said that they said no. Because I was high-risk. And she was like, "maybe if I'd been there for a while, I would push the envelope, but I don't feel like I can do that." And just to see, you know, independent, solo midwives, I was sort of scrounging around, asking for doctors to give them permission to do what they think that they can do....

There are some OBs in our [church] congregation, and they were all like, oh, Lankenau, you'll love it there. They treat you like a princess. And all the moms were saying, oh, Lankenau, you should see the birth suite, you know, it's like you can look out on the whole city. My friend who had her - David and her boy are best friends - she and I are very similar in temperament, and she really liked this practice [at Lankenau Hospital]. It was a perinatal practice. So, high-risk. And I just qualified. And I really liked the practice. It was right in [Lankenau] Hospital. And it was definitely different being seen by OBs. They made an effort to be available. There was one who I really clicked with, because he was kind of – I felt like he was sympathetic, you know, to the stresses that I faced, and that I was trying to do my best. There was one OB that I didn't like, because he was sort of jokey, kind of. My first meeting was with him, and he took me into their office to talk, and he said, "well I know you have birthed with midwives, so I want you to know, we do not do episiotomies, he smiled, we do not." You know, just really talking about how in-line with midwifery they were. Which is fine, but it was the way he was talking about it, I don't know. I didn't like it. There was no real talk about a birth plan, or anything. Other than the fact that I said I want to decide about interventions as long as it's reasonable to do so and won't put me or the baby at risk.

I was induced again [with this pregnancy]. So then this time it was much quicker labor, 12 hours. And the doctor I chose [from the practice] would come in periodically. And then right before – right when we were getting close to time, my doctor that I had specifically chosen, you know, to have the baby with, said, you know, I really am so sorry, but there's an emergency and I've got to go help this woman. And I called another person – who I had never met, and he said, but he's really competent and he'll do a great job. It'll be fine. Well, then "Dr. Jokey" came in. And he was like, yeah, I happened to be here, so I'm gonna help you.

And that experience was definitely different. I mean like, it was less respectful. Like for example, at one point I had a bowel movement when I started to push, and he was like, "well!" You know, like? And I said, you know, is that it? And he said, no, you haven't given birth yet. But clearly I sensed something like revulsion, which I can understand. You know, I didn't want to be like, well listen, I'm trying to do something here! And had I not felt like, well, buddy, you know, I'm trying to do something here, I might have felt embarrassed. And the main thing I remember about it is, he said, "let me know when you feel the urge to push." And then waited, you know, a minute, a minute and a half. And he said,

“well, just push.” So I thought about it, and I thought, you know, I’m okay with it. You know, I could just wait, but I’m okay with it. The thing that really stands out in my mind about the treatment is like, I could feel his hands pushing on the skin, all around [my vagina], and I tore very little. You know, from giving birth the second time. Had a great recovery. No scar tissue that I could really tell. It was a lot less of an effect on my day-to-day life.

Betsy went on to say that after the birth of her second child, she looked for support groups to join. She returned to the Parental Support Center’s “new mom’s group” as well as attended local breastfeeding support groups, mainly to meet other parents. Betsy’s use of local nonprofit agencies is a theme which prevails throughout her two birth stories. Because of this, Betsy’s narrative provides a wonderful example of the essential role nonprofit organizations can play within the larger maternity care system. Within her story, we can also see an example of how the consumerist attitude adopted by parents is expressed in different ways and times, depending on the circumstances at hand.

Having moved to the Philadelphia area newly pregnant with her first child, Betsy adopted the attitude of a childbirth consumer from the outset. Her focus was on the educational and community services provided, so she surveyed the types of childbirth classes and support groups available in Philadelphia. She researched the programs of a variety of institutions, including hospitals, before linking herself to the Parental Support Center. Betsy frequently utilized the Parental Support Center before and after the birth of both of her children. In addition, she accessed the Center to meet a variety of needs: for childbirth education, for personal services like massage, and to meet other new parents. Her connection to the Parental Support Center had an immense impact on her experience in Philadelphia; not only did the Center inspire her to move to the same neighborhood in which it was located, but it was her main avenue for developing lasting friendships. In

addition, the information she learned through the childbirth class in which she enrolled gave her confidence to assert her own wishes in her interactions with hospital staff and care providers. This small nonprofit agency grounded Betsy within a supportive community from which she navigated other aspects of the maternity care system.

Although Betsy acted as a consumer upon her arrival in Philadelphia with respect to the childbirth classes and support groups available, it is interesting to note that she did not initially adopt a consumerist attitude in selecting a practice to provide her medical care. She nonchalantly chose a health care practice based on the only requirement she thought was of primary importance due to her condition of high blood pressure: that the practice was hospital-based. Even as the dissonance between her expectation of care and the obstetrical practices approach to care became increasingly obvious, it was not until her third trimester – and at the prompting of a doula – that Betsy became active in selecting a different practice that better engaged with her care expectations.

As Betsy's story progresses, we see that due to the limited options available, she became increasingly aggressive in her efforts to obtain maternity care that suited her needs and expectations, particularly with the development of her second pregnancy. Structural shifts in Philadelphia's maternity system, particularly the closure of Chestnut Hill Hospital's maternity unit and the scattering of the nurse practitioner and midwives who provided her prenatal and birth care during her first pregnancy, forced Betsy to aggressively investigate where she might birth her second child and who might provide her care. It is at this point in Betsy's story, the beginning of her second pregnancy, that it becomes undeniable that her childbirth consumerism reaches a new level. She utilizes a bevy of resources in order to find a provider and a place to birth. She contacts

independent midwives and is turned down due to the instability of the midwives' work situations. She checks with Chestnut Hill Hospital's remaining gynecologists, knowing that they no longer provide maternity care, "just in case" and when it is confirmed that she cannot deliver at that hospital she inquires where she might locate the individuals who provided her care during her first pregnancy; she is unable to find these individuals.

Forced to birth at a different hospital, Betsy considers at what hospital she might access care for her second pregnancy. She can only think of two (out of the six remaining in Philadelphia): "There's Pennsylvania Hospital, and University of Pennsylvania. But they're affiliated. It's the same thing." While there is a midwifery practice that draws her interest at one of these hospitals, her previous negative experience with Pennsylvania Hospital combined with the reputation of the midwifery practice as "rushed" negates both of these hospitals as viable options for her. Ultimately, Betsy settles on an obstetrical practice in a hospital located outside of Philadelphia, based on the advice of friends and community members. From her narration, it is clear that Betsy did not become a childbirth consumer because she wanted to change current practice or because she felt the need to be a "good" citizen who evaluated all of the numerous choices available. Had she been given the opportunity, she would have revisited for her second pregnancy the same hospital and the same providers with whom she birthed her first child. It was the extremely limited options available, resulting from the shifting landscape of maternity care, which spurred Betsy into adopting an assertive consumerism.

Another issue worth highlighting in Betsy's story is her preference for the low-interventionist, unobtrusive yet communicative style of care that she correlates with the

midwifery model of care. The ability to openly and comfortably discuss her prenatal care and birth plan with her provider is clearly of high importance to Betsy; she left the original obstetrical practice she chose for her first pregnancy because she became distrustful of her obstetrician who was unwilling to engage in such conversation. Her choice of a midwifery group as a replacement is an affirmation of her inclination toward the type of care associated with the midwifery model. Indeed, she remembers feeling respected by the midwives and nurses who cared for her during her first delivery, while at the same time recalling feelings of annoyance toward the obstetrician, whom she remembers as treating her disrespectfully, during the delivery of her second child.

What is particularly striking about Betsy's emotional memory of her experiences is that the two births were very similar. She was induced for both births, labored in a hospital bed, and gave birth vaginally both times. In fact, her first birth, for which she was under the care of midwives, was much longer and the aftereffects of her delivery more painful than was her second birth with an obstetrician. Yet, it was the attitude and treatment of these providers that stuck in Betsy's memory. While her first delivery was difficult and she ended up having biomedical interventions, such as pitocin and an epidural, Betsy felt that she was part of the decision-making processes. She had an epidural because she *chose* to have an epidural, not because a medical practitioner decided she needed one. Likewise, Betsy remembers pushing in her own time, when she was ready. In fact, she recalls that her midwife left the room to in an effort not to pressure her to push before she was ready. Her experience with the obstetrician during her second birth was very much the opposite. She recalls the obstetrician's obvious disgust at her

accidental bowel movement and his impatience as he said, “well, just push” only seconds after he told her to push when she was ready.

Betsy’s feelings regarding her two births have much more to do with the way her provider related to her than with the ease of the labor, the interventions used, or her recovery. This issue surfaced in the birth stories of other parents as well; what was of fundamental importance to parents was that their provider was communicative, respectful, and non-judgmental. Parents wanted a provider who acted as a partner in their care, not a provider who directed their care. Interest in this style of care led many parents to seek out midwives instead of obstetricians since, whether fairly represented or not, the midwifery model of care is linked with this non-interventional, supportive style of care (for a deeper discussion of these issues, see Chapter 1 of this dissertation). And yet, just as the parents I encountered in my fieldwork sought out the care of midwives, the neoliberal restructuring of the maternity care landscape reduced parents’ access to midwives, forcing persistent parents to look even more assertively for maternity care that met their needs.

Summary

Although many of the details of these parents’ experiences differ, together their stories illustrate “what it is like” for some parents who are in search of maternity care in Philadelphia’s restructured system. Parents are confronted with an unstable and shifting maternity system that increasingly limits their options for care. While they may have begun their first pregnancy as passive participants in a system of care, these parents found their expectations of respectful, compassionate, and low-intervention care would not be easily met within the restructured, condensed, and biomedically driven maternity

care system of Philadelphia. Their dissatisfaction with this model of care motivated them to adopt highly consumerist attitudes and behaviors, aggressively investigating which hospitals, providers, and nonprofits organizations could meet their needs. Yet, the closure of maternity units, the deficit of alternatives to hospital-based care, the dispersion of care providers (particularly midwives), and the systemic reinforcement of biomedical procedures and attitudes toward birth presented an array of obstacles to parents.

These parents, as well as other parents I encountered during my fieldwork, were resourceful in their consumerism, turning to nonprofit organizations, community groups, professional publications, and trusted friends and experts in their community as they navigated the landscape of maternity care. Sometimes, parents are able beat the odds and piece together a birth experience that meets both their needs and expectations, as Audrey and Mark were able to do for their second pregnancy and birth. Other times, parents must forgo their ideal and settle for “good enough” care, as Betsy did for her second birth when she had to find a new hospital at which to birth and she was unable to arrange for care with a midwife. And yet, these “successes” are hard won and should not overshadow the barriers to care that frustrate, oppress, and alienate parents, forcing them to reposition themselves as aggressive consumers within the shrinking boundaries of the neoliberal maternity care landscape.

CHAPTER 8

CONCLUSION

In this dissertation, I have sought to critically analyze aspects of the Philadelphia maternity care system and the experiences of individuals who are embedded within this system. I have contended that the structure of Philadelphia's system of maternity care has undergone drastic reorganization, starting in force in 1997 and continuing unabated to the present, directed by the national application of neoliberal policy and ideology. Three interconnected aspects within this restructured system of maternity care have been the focus of my research: the shifts in hospital-based care, the role of local non-governmental organizations (NGOs), and the experiences of individuals as they navigate the maternity care system. I have situated these aspects as interactive components of the landscape of maternity care, each of which is constantly shifting and reacting to new changes in local circumstance and the larger political context. Examining these three aspects in depth uncovers the challenges, issues, and influences unique to each, yet also highlights the relationships and connections that exist between them. This detailed inspection is an ethnographic account of a specific place and community as it undergoes a significant structural and ideological transformation.

At the same time, this ethnography is an analysis of the influence of national ideology and policy on the lived experience of individuals. No part of society is untouched by national policy and ideology; institutions, businesses, both for-profit and nonprofit, and individuals are all directed in some way by the values and social boundaries assembled through the adoption of modes of governance. The current dominant practice of neoliberalism is no exception. As illustrated by the data presented

in this dissertation, neoliberal practices and values infiltrate the cultural patterns and human experiences of even the most personal of events: pregnancy and birth.

Yet, as recent scholarship on neoliberalism contends, the reach of this mode of governance is unequal, partial, and situational. The assimilation of the values and beliefs that stem from neoliberal theory, as well as the actual implementation of practices informed by neoliberal policy does not occur in a vacuum; neoliberalism is integrated into a sociocultural framework structured by preexisting historical, geographical, and ideological processes. As such, my analyses of the three aspects of the Philadelphia maternity care system (hospitals, NGOs, individuals), situates each as uniquely influenced by neoliberalism. It is the intricacies of how the individuals, organizations, and institutions studied encounter and incorporate select neoliberal practices that is at the heart of this inquiry. In this dissertation, I display the various aspects of neoliberal policy and ideology that confront and are articulated by three different NGOs, by the local hospital system, and by individuals, and I highlight the results of this convergence with neoliberalism. I argue that the outcome of the neoliberal restructuring of Philadelphia's maternity care system is a destabilization of the landscape of care that severely limits choice in the provision of maternity care, disperses and isolates providers, reduces the autonomy of NGOs, and positions parents as childbirth consumers. Instead of guaranteeing individual freedoms and advancing human well-being through a free market, as is portended by neoliberal theory, the actual effect of neoliberalism has been to constrain, oppress, regulate, and diminish the institutions and individuals embedded in the landscape of maternity care.

The discussion in Chapter 2 on the transitions in hospital-based maternity care highlights the snowball effect that the adoption of neoliberal values and policies can have on established social systems. As noted in Chapter 1, starting in the late-1800s physicians fought to define maternity care as a service best provided *by* physicians and *in* hospitals and it is unquestionable that from the 1940s on people have depended on hospitals and physicians as the dominant resource for maternity care in the US. The social movements of the 1960s reintroduced the woman-centered approach of midwives into popular discourse on maternity care, with the result that over the following three decades the midwifery profession experienced resurgence. Although the medicalization of maternity care instated obstetricians as the main providers of prenatal and birth care, the flexibility in the political economy of health care from the 1960s into the 1990s enabled a tenuous but genuine coexistence between physicians and midwives, even though midwives remained marginalized to some degree. This coexistence in Philadelphia during that time-period is confirmed by the establishment of Booth Maternity Center in 1971 and the fact that by the late 1980s and early 1990s midwives were incorporated in some way in the services nearly all area hospitals. However, as shifts in Philadelphia's hospital system from 1997 through 2010 show, the inclusion of neoliberal practices and beliefs in the operation of hospitals has resulted in dramatic changes in the structure of the hospital system in a very short amount of time, particularly regarding the provision of maternity care. Hospitals' adoption of neoliberal notions of the importance of efficiency, of substituting individual responsibility of patients for their own care in lieu of responsibility of the medical profession, hospitals, or the government to the community, and of marking financial gains as the ultimate objective combined with

national neoliberal policies of deregulation, social service funding cuts, and deference to “free” enterprise has created an environment in which it is justifiable for hospitals either to cease the provision of maternity services or to alter practices to serve hospital interests instead of the interests of patients. No longer considered a valuable service due to the low reimbursement rates and high time commitment required in the provision of prenatal and delivery care, maternity services, even obstetrically based maternity services, are now being summarily discarded by hospitals. The non-interventionalist midwifery model of maternity care, with its high time-commitments and low insurance payouts due to limited use of technologies simply is not valid within the new maternity care schematic. Neoliberal logic allows for this cursory dismissal of maternity care regardless of the community response or need, without consideration to the outcomes, and with no responsibility for ensuring that alternate sources of maternity care provision exist. The direct effect on Philadelphia hospitals of the incorporation of neoliberalism is a release of any and all accountability to the communities which they serve.

The dearth of alternatives to hospital-based maternity care in Philadelphia has made the closure of 13 maternity units and the extreme biomedical repositioning of the remaining 6 maternity units even more significant for individuals who are embedded in the maternity care landscape. The few hospital maternity units that remain are all centrally located teaching hospitals in which the biomedical model of care is practiced in an increasingly extreme manner. The very few midwifery practices associated with these hospitals are compromised by the limitations placed on them by their parent hospital. No birth centers or stand-alone maternity hospitals exist in Philadelphia. Although two small birth centers located in suburbs of Philadelphia attract parents who are socially mobile

and have access to transportation, the practices of these birth centers are restricted by the regulations of their “partner” hospitals. Even homebirth, an already a maligned option within the medicalized birth culture of the US, has become more challenging to coordinate as Philadelphia’s maternity care system has both shriveled and become extremely biomedical. These numerous and varied challenges and dilemmas faced by midwives and parents as they navigate the shifting hospital system are often ignored or whitewashed by politicians, media, and hospital executives, yet these issues are evidence that the neoliberalization of hospitals and health care in general has restructured maternity care in ways that directly, and largely negatively, impact individuals in Philadelphia.

As the radical restructuring of the hospital system widens the gaps in maternity care, NGOs strive to compensate by attempting to address a variety of maternity related needs. The increase in the role of NGOs is not unique to Philadelphia’s maternity care system or just a result of the withdrawal of hospitals, although the community’s dependency on the services provided by NGOs has been greatly intensified by the recent shift in hospital-based maternity care. Shifts in state governance since the 1980s have lead to the withdrawal of state-sponsored welfare programs and to an increase in reliance on nonprofits to provide the services once directly supplied by the state. In recent years, the nonprofit sector has expanded. Expected to “make up” for an ever increasing lack of services, nonprofits now attempt to provide social, health, and educational services as well as inspire community building, activism, and grass-roots democracy (Smith 2000).

Yet, operating within the current neoliberal political economy, nonprofits have become progressively more dependent on government contracts and foundation grants

(Smith 2000; Goode 2006). Even with their increasingly important role as comprehensive providers, nonprofits operating under current neoliberal rule often face a dilemma between remaining true to their mission and maintaining their community roots on one hand and preserving financial security and meeting the imperatives of funders on the other hand (Smith 2000). Furthermore, the cementing of neoliberal ideology into the structure of social interactions both within and between civil society organizations alienates individuals who staff nonprofits and restricts cooperation between organizations. Dependent on the approval of funding agencies and disengaged from the individuals and other organizations which could provide much needed support, nonprofits are both isolated and constrained in the current neoliberal political economy.

The neoliberal climate makes success difficult even for nonprofits that are supported by communities with longstanding track records of local activism, neighborhood organization and a sense of community ownership (Ferman et al. 1998; Ferman and Kaylor 2000; Goode 2006) as the case of the Parental Support Center illustrates. The topic of Chapter 5, this nonprofit received immense support from the community in which it was located and the services it provided were extremely valuable to the thousands of parents served. During the short time the Center was in operation, this nonprofit fulfilled an important need by connecting individuals with information, resources, and services that, due to the quickly shifting landscape of maternity care, were exceptionally difficult to obtain alone. For many, this small nonprofit was a lighthouse in a storm, providing direction and a sense of security as they navigated the choppy waters of the Philadelphia maternity care system.

Yet, financial pressures led to an internal restructuring which favored the corporate business tactics supported by neoliberalism, and the organization began to be influenced externally by funding agencies instead of the community that had nurtured the Center. In the end, the Center's appropriation of neoliberal ideals resulted in the demise of the organization. The gradual rejection of the interests of the community and the substitution of the interests of the Center as a business disconnected the organization from its roots. The competitive, self-interested nature of the neoliberal political economy was no replacement for the community support that once guided the organization, and the Center which had been a beacon for others became the ship caught by the storm.

In contrast with the results for the Center, the story of the Alliance for Family Wellness (AFW), detailed in Chapter 6, is an example of an organization whose assimilation of aspects of neoliberalism has met with a fair amount of success. This organization has survived for 30 years because of its ability to respond to shifts in the market and in public opinion. Its numerous outreach programs and its advocacy work have touched the lives of many of Philadelphia's underprivileged parents. AFW's structure and programming dovetail with standard expectations of the role of health-oriented nonprofit organizations, and its agility in traversing the challenging neoliberal political economy to further its efforts is remarkable.

Yet the apparent success that has come with the adoption of practices that are in line with neoliberalism is a double-edged sword. The very survival tactics that the organization employs can limit and constrain as well. The collaborations developed with other organizations, the grants bestowed by government and corporate funders, and the organization's high profile position in the community all direct the issues addressed in

AFW's programming. The organization's autonomy is restricted in that it cannot address issues that directly and purely respond to the needs and interests of the community; instead, the programs and topics addressed are structured to meet the expectations of funders. The independence of AFW has been undermined by its collusion with neoliberalism, yet it seems this exchange of freedom for security is one of the few options available to nonprofits operating in the current neoliberal political economy. Certainly, of the three nonprofits I have examined in this dissertation, AFW has managed to continue to achieve its goals, if in a concessionary way.

The youngest of the three nonprofits studied, Birth Advocates of Philadelphia (BAP) was created in direct response to the withdrawal of Philadelphia hospitals from the provision of maternity care. This nonprofit is struggling to flourish and it is too early to tell if BAP will achieve its long-debated goal of establishing a maternity hospital in Northeast Philadelphia, not to mention whether the organization itself will last the year. There is no doubt that, if successful, this organization would be providing a much needed service to the Philadelphia community in a way that supports the interests of a wide array of people. While all current hospital-based maternity care in Philadelphia approaches prenatal and delivery care with an increasingly extreme biomedical model of care, the BAP maternity hospital is imagined as espousing a "woman-centered" facility which favors the techniques and practices associated with midwifery but which also has all the biomedical options available for parents who choose or require them. A maternity hospital of this nature would increase the extremely limited options parents currently face, particularly parents like my informants for this dissertation who were disenchanted with the treatment provided at area hospitals and who struggled to find less interventional

care. This maternity hospital would also theoretically support midwives who have been alienated by the shifts in the landscape of maternity care by providing them with an additional, and much needed, option for employment and a hospital-based location where they can assist in their client's births. However, three years after the inception of BAP, significant progress toward establishing a maternity center has not yet been made due in large part to the barriers the organization has encountered as it has attempted to establish itself within the neoliberalized maternity care environment.

In addition to the managerial problems BAP faces, this nonprofit has encountered significant obstacles as it has attempted to engage with individuals and other organizations within the neoliberal political economy. BAP has tried to establish itself by reaching out to community members, other nonprofits, activists, and hospitals knowing that relationships and collaborations are essential components of their grassroots work. Yet, the national implementation of neoliberal policy and ideology has altered the social framework in which BAP is maneuvering. Due to the competitive nature of the free market, both community members and organizations place their individual interests over the interests of the greater good. The result of this shift in orientation for BAP, a small nonprofit with nothing but vision and passion to bring to the table, is an inability to garner the support necessary to achieve its goal. In a civil society sector in which detachment and self-interest impede social progress, the organization simply cannot get a foothold.

All three of these nonprofit organizations play a part in the landscape of maternity care in Philadelphia. Though the direct impact of these organizations on the lives of parents and providers varies, the missions of all three respond to the shifting needs of the

community. Each focuses on a different issue and approaches the provision of care in a unique way. Due to the distinct position of each within their local community and the maternity care community, the aspects of neoliberal policy and ideology that influence and impact each nonprofit are also unique. Yet, the long term, in-depth analyses of the nonprofit organizations presented in this dissertation uncovers the collective impact of neoliberalism on NGOs. While some nonprofits are able to creatively and flexibly engage aspects of neoliberalism for their benefit, overall the outcome of neoliberal practices and ideals on nonprofits is a reduction in autonomy and an increase in isolation. The neoliberal constraints placed upon NGOs has the effect of reducing these organizations ability to do the very thing we expect them to do – to “fill in the gaps” in community-based services that continue to widen.

The stories shared by the parents, midwives, and nonprofit staff who served as my informants for this dissertation portray the many ways in which the shifts in maternity care challenge individuals by repositioning them within the system. Through their experiences, we can see how people interact directly with the provision of maternity care and more generally with the larger health care system. The narratives leave no doubt that the neoliberal maternity care landscape currently in place in Philadelphia situates free market interests far above the interests of community members.

The stories of Audrey, Mark, and Betsy, detailed in Chapter 7, provide examples of how structural shifts in the provision of maternity care combined with a ideologically neoliberal social environment pushes parents into becoming aggressive childbirth consumers. Importantly, these parents are not attempting to consume “high profile” or extravagant childbirth experiences or even care that utilizes new technologies. In fact,

they are attempting to obtain care that uses the fewest number of interventions as possible and are searching for a provider-patient relationship which makes them feel respected and involved in their pregnancy and birth. Yet, the condensed and biomedically driven maternity care system currently in place in Philadelphia makes this humanistic style of care increasingly difficult to obtain. Parents find themselves struggling with basic issues, such as the amount of time it will take them to travel to hospitals or providers due to the closure of local maternity units, as discussed in Chapter 2, as they navigate a system that is constantly changing in ways that further reduce the availability of care options and social support. Midwives continue to be driven out of the hospital-based maternity care system, and their positionality as “alternate” providers further complicated, whether home, hospital, or birth center based. The supportive and supplemental services that nonprofits provide are constrained and jeopardized as these organizations are themselves jeopardized by the restrictions of the neoliberal climate. Taken together, these neoliberally informed structural and ideological transformations in the maternity care landscape have relentlessly diminished the options available to parents, midwives, and nonprofit organizations to the point that they are left with no “good” choice.

This project answers the call for placed based ethnographies which “account for specific people, institutions, and places” by “situat[ing] neoliberal cultural formations in their specific contexts of occurrence” (Kingfisher and Maskovsky 2008:118). In this dissertation, I examine the intricacies of how neoliberalism articulates with the preexisting configuration of maternity care in one location, exposing the shifts that occur as a result of this coalescence. The analysis presented here shows how the structure of the local landscape of care and the lived experience of individuals are influenced in

distinct and dramatic ways by the incorporation of certain neoliberal policies and ideals into the social environment. The specifics of the presentation of neoliberalism are unique to Philadelphia, based on the city's historic, geographic, and social composition.

However, it is important to point out that during the time in which I conducted my fieldwork and penned my dissertation manuscript similar shifts in maternity care occurred with increasing frequency in counties surrounding Philadelphia and in other states. In addition to the maternity unit closures in Philadelphia, six maternity units (soon to be seven) in four counties surrounding Philadelphia have ceased providing maternity services. In Allentown, PA, a city about 60 miles north of Philadelphia, a hospital revoked the delivery privileges of a midwife and limited the births attended by other midwives (Bennis 2009). In New York City, the 2010 closure of a midwifery-supportive hospital and the refusal of other hospitals left midwives who conduct homebirths without a written practice agreement, a document necessary for midwives to practice legally in New York State (Hartocollis 2010). These are just a few examples of the many shifts occurring in maternity care in various locales in the US that mirror those in Philadelphia. Nationally, the c-section rate has been climbing steadily since 1996 and in 2007 the c-section rate reached 32%, the highest rate ever in the United States and a rate that is nearly the same as Philadelphia's today (Menacker and Hamilton 2010; Grady 2010). The reasons for this rate may differ by state or even by town from those in Philadelphia, but this 53% increase from 1996 to 2007 is a record high (Menacker and Hamilton 2010) and certainly signals the existence of a transition in care that is broadly based and is deserving of the attention of researchers, public health officials, and policy makers.

I have endeavored to illustrate in this dissertation that the “culture” of birth is not separate or untouched by shifts in national and local ideology and policy. Just as the intersections and articulations of neoliberalism with numerous aspects of the Philadelphia maternity care system have resulted in a restructuring of the landscape of care that is unique to Philadelphia, there can be no doubt that neoliberalism has likewise influenced and compromised the provision of maternity care and the lived experienced of individuals in distinctive ways in other locations throughout the US.

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