

BIRTHING THE DIASPORA:
TECHNOLOGIES OF RISK AMONG HAITIANS IN SOUTH FLORIDA:

By

LAUREN FORDYCE

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To Leonie Hermantin and Gepsie Metellus.

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Abstract of Dissertation Presented to the Graduate School
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By

Lauren Fordyce

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My research examined the links between the technologies of risk and the making of subjects, with Haitian migrant women providing an important case study in the biopolitics of risk and responsibility. The biopolitical legacy of HIV/AIDS has constructed Haitians in the United States as a biosocial collective, no longer simply defined by nation, race, or history, but one also shaped by the shared experience of stigma, political violence, diaspora, and notions of risk. To this end, my project examined these narratives as means to get analytical and theoretical leverage on the conceptual categories, such as “mother” or “fetus,” which remain self-evident within contemporary biopolitical discussions about reproduction in the United States. Using Haitian pregnant women’s narratives of their own local moral worlds, I presented a feminist analysis which illuminates both the collective and individual nature of pregnancy experiences.

This research contributes to discussions about biopolitical forms of governmentality, particularly within contemporary neoliberal policies on maternal and child health. I focused on the narratives of “subjectification,” the strategies through which individuals are compelled to modify their behavior, or work on themselves, as expected in prenatal care clinics. These strategies are informed by notions of ideal liberal subjects – who possess self-discipline, assume responsibility for refraining from actions that may harm themselves or others, and take

responsibility for managing their own risk. Individuals, using “technologies of self,” conform or modify their lives or behavior in order to avoid perceived risks. In order to situate these practices in everyday lives, I illustrated the biopolitics of risk and responsibility within the local moral worlds of Haitian pregnant women living in South Florida. In this way, my project critically examined these intersections between local and global, and the making of maternal and fetal subjectivities in the contemporary United States.

CHAPTER 1 INTRODUCTION: WRITING RISK

When I began my dissertation research, I did not imagine writing about risk. This was going to be a project about reproduction and fetal citizenship and how these ideas intersected with the contemporary politics of abortion in the United States. Yet when clinic after clinic prohibited me from doing research, and the Haitian women I interviewed were more interested in talking about kidnappings and violence in Haiti than issues of citizenship, I was forced to reframe my thinking about these issues and re-evaluate the prospect of a clinically-based ethnography. From the beginning of this project, my research has been situated within particular narratives of risk. “Risk” was the reason cited by each clinic and hospital network for denying me access to their sites. It was a risk that my witnessing patient-provider interactions would violate HIPAA regulations. It was a risk that if something went wrong during one of my observations I could be sued for malpractice along with the physician, clinic, and hospital. My interviews with Haitian women could put them at risk for deportation. And finally, by singling out Haitian women for my research, I was designating them as HIV positive within clinical spaces. This was assumed because research on HIV within South Florida clinics overwhelmingly focuses on Haitians. According to these multiple constructions of risk, my Institutional Review Board protocol was becoming heavily weighted on the “risk” side, and very light on the “benefits.”

Narratives of risk are intricately interwoven with narratives of responsibility, as I found when measures were taken to reduce the “risks” of my research protocol. I was denied access to clinics that could not reconcile the risk for malpractice suits with my interest in observation; I could be assumed “responsible” in a case of patient harm. One clinic allowed me to observe but not to take notes, and specified that I observe only at a “low risk” clinic, where there would be

no HIV-positive patients, and therefore no assumptions about the HIV-status of the Haitian women I recruited.

In conversation after conversation, health researchers and Haitian advocates inevitably asked, “So what does your research have to do with HIV?” That HIV/AIDS was not the focus of my research became irrelevant. I imagined that when I moved to South Florida I would find a community bounded by a shared culture, language, and pride in the legacy as the first Black republic. I also imagined that this community would be fractured by notions of race, class, and gender. What I did not expect was that this community was created by much more than a shared experience of Haiti; being “Haitian” in the United States is increasingly shaped by the biopolitics of HIV/AIDS.

Within the biopolitics of the contemporary United States, Haitians can be imagined as a specific “biosocial” community, one structured around this shared history of “risk” for HIV/AIDS (Rabinow 1996; Rabinow and Rose 2006). To this end, I argue that an analysis of contemporary discourses of risk and responsibility in pregnancy can provide an optimal lens through which to examine the construction of maternal and fetal subjectivities. By focusing on Haitian pregnant women and their association with a biosocial “risk” group, we can critically examine the technologies¹ of risk at work in the contemporary United States. Narratives of risk are inherently gendered, and the narratives of responsibility which have become implicated in contemporary constructions of maternal subjectivity can be linked to biopolitical policies around fetal rights. Situated within a historical moment of changing fetal subjectivities, a focus on the everyday practice of prenatal care allows us to examine the assumptions around “Haitians,”

¹ I utilize “technology” as a means to describe, not simply tools and machines, but the techniques of quantification, systematization, and routinization, or other techniques which aim to manipulate and control the issues at hand, in order to produce an effect assumed to be beneficial to individuals and society (Escobar 1995; Lock and Kaufert 1998).

“pregnant women,” and “fetuses,” and assists us in getting analytical and theoretical leverage on the conceptual categories that are treated as self-evident within these public debates.

An Anthropology of Risk

In a project focused on examining contemporary technologies of risk, it is important to ask how risk is conceptualized and imagined within anthropological analyses of pregnancy and reproductive health. There are a number of ways in which risk is defined and operationalized by various scholars. Probably the most widespread utilization of risk suggests that there are true, real dangers that exist in nature, which can be measured independently of social and cultural processes. These dangers and risks can be measured and quantified and used to transform a series of individual disease states into a single group measure (Trostle 2005). For epidemiologists and clinicians, science is understood to be best suited to produce knowledge about risk, because it is assumed to be neutral and objective, and not predetermined by social or cultural frameworks of interpretation (Lupton 1999a).

A number of social scientists have argued that risk is culturally constructed. Perhaps best known is the cultural/symbolic framework of Mary Douglas, which argues that risk is a contemporary western strategy for dealing with danger and “otherness.” Highlighting the cultural relativity of judgments about risk, she emphasizes the political use of risk in attributing blame for danger to a particular social group (Lupton 1999a). Yet for Douglas, risk is a socially constructed response to “real” danger that objectively exists out in the world: “the reality of dangers is not at issue. The dangers are only too horribly real, in both cases, modern and pre-modern. This argument is not about the reality of dangers, but about how much they are politicized” (Douglas 1992: 29). Her perspective provides an important counterpoint for those interested in looking beyond the realist perspective, which generally ignores the political, social, and moral influences on risk judgments (Lupton 1999a).

In the sociology of risk, Ulrich Beck has become a prominent figure with his perspective on the “risk society,” in which the concept of risk is related to the conditions of late modernity. While risks have always existed, the magnitude of risks today is different because of the global scale of industrialization, overproduction, and environmental degradation (Adam, Beck, and Van Loon 2000; Beck 1992; Caplan 2000). Beck argues that the overarching problem within contemporary western societies is not the production and distribution of wealth but instead, the prevention of risk – as evidenced by debates and conflicts over risks which now dominate public, private, and political arenas. For much of Beck’s work, as in Douglas’s, risks are realistic entities (Lupton 1999a). It is assumed that “risk” exists out in the world, but our understanding of them is mediated by social and cultural processes: “It is not clear whether it is the risks that have intensified, or our view of them. ...because risks are risks in knowledge, perceptions of risks and risks are not different things, but one and the same” (Beck 1992: 55). His later work seeks to integrate both a realist approach to risk with a more cultural relativist approach – arguing that contemporary western societies face and conceptualize risk in ways that are different than in previous eras (Lupton 1999a).

Other analyses of risk within contemporary theory take a Foucauldian perspective, one which integrates the theory of governmentality in order to investigate the ways in which specific discourses, strategies, practices, and institutions help bring risk into being, and subsequently, construct it as a phenomenon (Lupton 1999a). Notions of risk are grounded within ways of thinking about the future, and the interventions and calculations which work to prevent this outcome (Rose 2007). While there are some major differences between the various theories of risk detailed above, there are also some similarities which are central to all three perspectives: notions of risk have become dominant within western societies; risk is a central aspect in the

construction of subjectivity; risk is understood as something which can be managed through intervention; and risk is associated with notions of choice, responsibility, and blame (Lupton 1999a: 25). My own research is situated in a more Foucauldian analysis of risk –examining Haitian pregnant women’s interactions with the various discourses, practices, and institutions of risk and responsibility that govern the everyday management of pregnancy in the contemporary United States. This perspective will allow for an investigation of the maternal and fetal subjectivities shaped by these narratives of risk, and the subsequent notions of choice and responsibility which accompany these narratives.

From the Government of Population to Individuals

During the eighteenth century, disease became understood as an economic and political problem for societies, not just as an individual concern but one which could compromise the social body as well. To this end, “different power apparatuses [were] called upon to take charge of ‘bodies,’ not simply to exact blood service or levy dues, but to help and if necessary constrain them to ensure their own good health. The imperative of health: at once the duty of each and the objective of all” (Foucault 1980: 170). In accordance with the labor and economic needs of the emerging capitalist system, the “population” became constituted as an “object of surveillance, analysis, intervention, modification, etc.” (171). This led to a host of attending technologies – the management of cities, demographic estimates, marriage and fertility statistics, life expectancy tables, and mortality and morbidity rates (Foucault 1980; Lupton 1995).

Central to this control of population is “governmentality,” a strategy and rationale that has dominated Western political authority since the eighteenth century (Foucault 1991). Foucault describes these domains of government:

The things with which in this sense government is to be concerned are in fact men, but men in their relations, their links, their imbrication with those other things which are wealth, resources, means of subsistence, the territory with its specific qualities, climate,

irrigation, fertility, etc.; men in their relation to other things, customs, habits, ways of acting and thinking, etc.; lastly men in their relations to that other kind of things, accidents and misfortunes such as famine, epidemics, death etc. (1991: 93).

In the nineteenth century, governmentality manifested as “liberalism,” whereby expert knowledges came to provide a number of solutions for managing populations. These experts’ authority arose through their reliance on science and objective facts, claiming neutrality and efficacy. In the late nineteenth and early twentieth centuries, liberal governments were perceived as failing, unable to control the economic, social, and moral consequences of increasing industrialization, wage labor, and urban existence. A strategy to remedy these consequences was the formula of the “welfare state,” in which the state relied on various technical devices to reinvent the community, installing and empowering professionals to act as experts and assist in the government of the population (Foucault 1991; Rose 1993, 1996).

In the past fifty years, a series of criticisms of the welfare state – its cost, its bureaucracy, its paternalism – resulted in a contemporary form of liberalism, what Nikolas Rose (1993) terms “advanced liberalism” or, as it is more commonly known, “neo-liberalism.” As Rose explains,

[N]eo-liberalism managed to reactivate the sceptical vigilance of classical liberalism and link it up with a series of techniques – none of them in itself particularly new or remarkable – which could render them operable – techniques such as monetarization, marketization, enhancement of the powers of the consumer, financial accountability and audit. ... ‘Advanced liberal’ government entails the adoption of a range of devices that seek to recreate the distance between the decisions of formal political institutions and other social actors, and to act upon these actors in new ways, through shaping and utilizing their freedom (1993: 294-5).

An analysis of the governmentality of neo-liberalism is relevant for my research as we take a closer look at some of the other features which accompanied this shift from the welfare state. A key point is the transition from the regulation and disciplining of citizens as an aggregate to a focus on autonomous, self-regulated individuals (Lupton 1999a; Rose 1993). No longer are

citizens simply policed by the state, but instead they are expected to police themselves, behaving as normalized subjects interested in their own self-improvement (Gordon 1991; Lupton 1999a).

In a contemporary analysis of biopower, Paul Rabinow and Nikolas Rose (2005: 197) argue that one of the key elements of the concept of biopower is “modes of subjectification,” that is, the strategies through which individuals are compelled to modify their behavior, or work on themselves. The ideal liberal citizen possesses self-discipline, and assumes responsibility for refraining from actions that may harm themselves or others. Individuals are understood to be responsible for managing their own risk (Ruhl 1999). These guides to behavior are the result of particular forms of expertise, in relation to a discourse of truth: “by means of practices of the self, in the name of their own life or death, that of their family or some other collectivity, or indeed in the name of the life or health of the population as a whole” (Rabinow and Rose 2005: 197). Population data, such as vital statistics or epidemiology, are used to develop norms, which in turn assists experts in advising individuals in how to conduct their lives. This advice also shapes particular kinds of subjectivities, and can be assumed to be part of “technologies of self.” These technologies of self comprise the ways in which individuals modify their lives or behavior in order to avoid perceived risks (Foucault 1988; Gordon 1991).

Central to these expert discourses are strategies to identify, treat, or manage individuals or collectives perceived as high risk. For those interested in an analysis of modern strategies of biopower, reproduction remains an important problematic, where the connections between individuals and the collective, the technological and the political, and the legal and the ethical provide a “biopolitical space par excellence” (Rabinow and Rose 2005: 208). For feminist scholars of reproduction, contemporary analyses of biopolitics focus on pregnancy to draw attention to the proliferating technologies of risk management. My project argues that an analysis

of risk and responsibility in pregnancy can assist us in examining the construction of maternal and fetal subjectivities. Situated within this historical moment in the politics of abortion, exploring the technologies of risk and responsibility among Haitian women seeking prenatal care in South Florida allows us to critically examine the categories and subject positions that are presented as self-evident.

Foucauldian scholars of risk and responsibility have argued that understanding changing notions of risk is more complicated than following its shifts from local to global contexts, as described by the thesis of the “risk society.” As Deborah Lupton (1999a: 102) argues, “changes in risk rationalities have occurred which have resulted in risk being conceptualized and dealt with in diverse ways that have strong links to ideas about how individuals should deport themselves in relation to the state.” Yet a growing number of scholars have criticized the Foucauldian perspective on risk as focused too closely on the discourses and strategies of governmentality with little attention to how these practices are experienced within everyday lives (Lock and Kaufert 1998; Lupton 1999a). To this end, this dissertation situates a discussion of the biopolitics of risk and responsibility within the local moral worlds of Haitian pregnant women living in South Florida, as a means to critically examine these intersections between local and global and the making of maternal and fetal subjectivities in the contemporary United States.

Investigating Local Moral Worlds

What are the links between risk and the making of subjects? Building on the governmentality literature, discourses of risk and responsibility contribute to the constitution of particular kinds of subjects, “an autonomous, self-regulating moral agent, who voluntarily takes up government imperatives” (Lupton 1999a: 105). Yet these are not passive subjects, who blindly adhere to the advice of experts. Instead, by situating the technologies of prenatal risk within pregnant women’s everyday lives, we can begin to explore the varied and dynamic ways

in which Haitian women respond to and experience these discourses of risk and responsibility. Arthur Kleinman (1995), in his research on pain and illness, argues that ethnography can provide a description of the microcontexts which mediate the relationship between societal and personal processes. For Kleinman, these contexts of belief and behavior are “moral worlds,” in which the experience of illness is constructed, and are “*particular, intersubjective, and constitutive* of the lived flow of experience” (123, emphasis in original). Haitian women’s experience with the technologies of pregnancy reflect not only their interests as individuals, but also the wider sociopolitical fields of shared engagements and interests (see also Gammeltoft 2007).

While Kleinman (see also Csordas 1994; Good 1994) utilizes experience from a more phenomenological perspective, my own project seeks to situate Haitian women’s narratives of local moral worlds within a slightly different articulation of lived experience. What are the social, historical, and political contingencies that create particular kinds of experience? Building off the work of Joan Scott (1992), I argue that it is not simply Haitian women who *have* experience, but that they are also subjects constituted through these experiences. “Experience in this definition then becomes not the origin of our explanation, not the authoritative (because seen or felt) evidence that grounds what is known, but rather that which we seek to explain, that about which knowledge is produced” (Scott 1992: 26). In this way, we can understand the ways in which Haitian pregnant women’s experiences of risk and responsibility reflect their local moral worlds, worlds that are negotiated through specific cultural, historical, and political processes.

Within an examination of the biopolitics of risk, it is also imperative to be mindful of Foucauldian discourses on “power,” and the various scholarly responses to these notions of disciplinary techniques and practices (Lock and Kaufert 1998; McNay 1992; Sawicki 1991). Whereas Kleinman’s analysis of moral worlds is illuminated by notions of resistance, I wish to

avoid any “romantic” portrayals of resistance (Abu-Lughod 1990; Lock and Kaufert 1998). While analyses of resistance are often strategies to demonstrate the ways in which subordinated people are not passive subjects, or unreflecting automatons, such analyses can foreclose certain questions about the workings of power. Inverting Foucault’s statement, Lila Abu-Lughod (1990: 42) famously asserts “where there is resistance, there is power,” and argues that such analysis allows us to “continue to look for and consider nontrivial all sorts of resistance, but instead of taking these as signs of human freedom we will use them strategically to tell us more about forms of power and how people are caught up in them.” To this end, I will use Haitian pregnant women’s narratives to illustrate the ways which these women constitute different local moral worlds for themselves, a location from which they can reflect on the ironies of their situation, both locally and globally (Lock and Kaufert 1998).

My analysis of the narratives of risk within this dissertation builds on the work of Patricia Kaufert and John O’Neill (1993) on risk in childbirth. They explore “three languages of risk”: clinical, epidemiological, and “lay” within discussions about childbirth among the Inuit in the Canadian Arctic. For Kaufert and O’Neill, “questions of risk are central to a discourse that both is a reflection on the realities of childbirth in the North and is itself constitutive of these realities” (33). My work examines epidemiological narratives as constructed through vital statistics and the biomedicalization of prenatal care, clinical narratives as constructed within an urban prenatal clinic in South Florida, and “local” narratives of risk as constructed through pregnant Haitian women’s stories of their own lived experiences. Following Faye Ginsburg and Rayna Rapp (1995: 8), I utilize “local” to describe the “small-scale arena in which social meanings are informed and adjusted through negotiated, face-to-face interaction.” Research which focuses on the lived experiences and pragmatics of behavior by those assumed powerless is one of the keys

to unlocking the subtleties of compliance and resistance (Lock and Kaufert 1998). And an analysis of reproduction becomes a powerful lens to examine the contemporary biopolitics of risk.

In particular, Haitian women provide an important case study in the biopolitics of risk and responsibility. Paul Rabinow (1996) and Nikolas Rose (2007) have looked at “biosocial” communities as a contemporary form of collectivities based on biology (see also Rabinow and Rose 2006). While their work focuses on biosocial communities comprised of active biological citizens, based on experiences of shared suffering or self-defined activist communities, their work argues that contemporary “biosocialities” are also formed around beliefs in a common disease heritage (Rose 2007: 174). The biopolitical legacy of HIV/AIDS has constructed Haitians in the United States as a biosocial collective, no longer simply defined by nation, race, or history, but one shaped by the shared experience of stigma, political violence, diaspora, and notions of risk.

The Biopolitics of Being “Haitian” in the United States

The Haitian community in the United States has long been bounded by margins beyond the common markers of race, nation, language, or class. Since the early 1980s, what encompasses “Haitian-ness” in the United States remains synonymous with HIV/AIDS. Nowhere is this more discernible than in South Florida, where the discovery of heterosexually transmitted HIV collided with a radical shift in the political and social landscape of Miami, as the “Third World” laid siege to South Florida through the arrival of Haitian “boat people” and the Mariel boatlift from Cuba. Between 1977 and 1981, it is estimated that close to 60,000 Haitians arrived by boat in South Florida.² While this was barely one-fifth of the population of Haitians residing in New

² Haitian migration to South Florida began to taper off after the initial frenzy of 1980 and 1981, particularly after Ronald Reagan took office and designed a new approach to keep Haitian refugees out. The INS began jailing all

York at that time, the method of their arrival as well as the timing stirred great attention both locally and nationally. As noted by Portes and Stepick (1992: 51): “Photographs of shirtless black refugees huddled aboard barely seaworthy crafts evoked images buried deep in the American collective mind. Like the slave ships of yore, these boats also brought a cargo of black laborers, except that this time they came on their own initiative, and this time nobody wanted them.” Concurrent with the arrival of the Haitian “boat people” was the Mariel boatlift from Cuba; over 125,000 Cubans arrived in Florida during 1980, yet their reception was very different. The Cubans were in effect “sponsored” by Miami, in that anti-Castro Cuban families encouraged this migration and assisted migrants in settling within their community. In a policy that remains in effect to this day, Cubans were declared “political” refugees and granted asylum, whereas Haitians were designated “economic” refugees and denied asylum, even though many of them came with stories of torture and genuine persecution. Portes and Stepick (1992: 53) argue that “the difference between the Cubans and the Haitians streaming into Miami had less to do with individual motivations than with the country they left behind, the community that received them, and their color.”

The reputation of Haitians in the United States went from bad to dramatically worse in the early 1980s with the advent of the AIDS epidemic. Early work in AIDS research hypothesized that this disease was associated with homosexuality (Treichler 1999). Yet in late 1981, Haitian migrants in Miami were found to be suffering from the same disease, and none of them fit the acknowledge risk factors. In July 1982, the Center for Disease Control and Prevention (CDC) reported 32 Haitians suffering from opportunistic infections, stating that it “is not clear whether

new Haitian arrivals and the Coast Guard was instructed to interdict all boats suspected of carrying Haitians. The number of Haitians detected by the Coast Guard and the INS heading for the United States dropped from over 8,000 in 1981 to only 134 in 1982 (Stepick 1998: 103). This rate remained low for the following years until civil unrest once again prompted high numbers of Haitians to escape to the seas towards the end of the decade.

this outbreak is similar to outbreaks among homosexual males, IV-drug abusers, and others, but the clinical and immunological pictures appear quite similar” (CDC 1982a: 361). This report was followed by an update on September 24, 1982, when the CDC made this announcement:

Reported AIDS cases may be separated into groups based on these risk factors: homosexual or bisexual males, intravenous drug abusers with no history of male homosexual activity, Haitians with neither a history of homosexuality nor a history of intravenous drug abuse, persons with hemophilia A who are not Haitians, homosexuals, or intravenous drug abusers (CDC 1982b: 508).

The CDC had introduced what came to be known as the “4-H Club”: Homosexuals, Heroin users, Hemophiliacs, and Haitians.

Haitians suffering from these infections in the United States declined any association with homosexual activities or drug use and therefore did not fit any previously defined risk groups. Because this disease remained marginalized in the minds of the medical community, Haitians as an entity became a “risk group”: “In the annals of medicine, this categorization of a nationality as a ‘risk group’ is unique” (Auguste 1983, quoted in Farmer 1990: 88). Further speculation and “research” led scientists to declare that AIDS had in fact come to the United States from Haiti, and this led to a series of articles published in various medical journals investigating this link between Haiti and the advent of AIDS. Much of this “scientific” literature drew on preconceived notions of Haiti and Haitians, often evoking vodou and human sacrifice (Farmer 1992).³ With the introduction of blood tests to confirm seropositivity, antibody testing could differentiate within risk groups between those who were infective and those who were not. The focus on high-risk groups should have been replaced by attention to high-risk “activities,” but this shift did not occur until “mainstream” heterosexuals were also targeted as a high-risk group in the United States (Oppenheimer 1988).

³ See also Farmer 1992 and Lawless 1992 for an extensive review of the discussions of Haiti as the origin of HIV/AIDS.

Haitians remained on the CDC's high-risk list for AIDS infection until April 1985, yet the organization refused to admit that they had made an error. The CDC commented that it had not intended to "imply" that persons were at risk of AIDS through mere casual contact with members of a risk group (Farmer 1992). The designation of Haitians as a risk group had intense, long-term repercussions, both for Haitians in Haiti and in the United States. Haiti was spiraling towards extreme debt in the late 1970s, and tourism remained one of the country's largest sources of foreign currency, generating employment for over 10,000 people in and around Port-au-Prince. By 1983, tourism had become non-existent in Haiti. In the United States, graffiti appeared in Brooklyn stating "Haitians = Niggers with AIDS" and Haitian children were beaten in school while their parents lost their businesses. In South Florida, immigrant service organizations could not place Haitians in jobs, and began to receive mail with messages such as "Hire a Haitian – Help Spread AIDS" or "There were [sic] no AIDS in the USA until the illegal criminal Haitian dogs came" (quoted in Farmer 1992: 214).

This legacy of the link between Haitians and HIV/AIDS remains vital even today. In October 2007, a study published by Gilbert et al (2007) utilized genetic data in an attempt to reconstruct the history of HIV in the Western hemisphere. In response to a press release sent out by the study coordinators, news agencies around the world announced, "HIV's path out of Africa: Haiti, the US, then the world" and "Analysis clarifies route of AIDS: The virus from Africa reached the U.S. by way of Haiti, a genetic study shows" (Chong 2007; Jensen 2007).⁴ While an *L.A. Times* article (Chong 2007) warned against "blaming Haitians," the Haitian-American community reacted with outrage at being targeted as the "source" for AIDS once

⁴ A recent study by Gilbert et al (2007) uses phylogenetic, molecular evolutionary, historical, and epidemiological perspectives in an attempt to reconstruct the history of the HIV subtype found primarily outside of sub-Saharan Africa. Using HIV-1 gene sequences recovered from some of the earliest known Haitian AIDS patients in the United States. (extracted from samples frozen in storage at the CDC), they argue that this subtype moved from Africa in or around 1966 to Haiti, where it spread for a number of years before entering the United States.

again. Paul Farmer, commenting in the *Miami Herald*, argued: “This does a disservice to the Haitian community, who feel like they already went through this twenty years ago. This is very slender evidence on which to base such a grand claim” (quoted in Tasker and Charles 2007).

For many Haitians in the United States, this media attention on “scientific” links between Haiti and HIV/AIDS recalled previous struggles against the stigma of being “AIDS carriers” in previous decades. Even after Haitians were removed from the CDC’s “risk groups” for HIV/AIDS in 1985, the Food and Drug Administration (FDA) continued to exclude natives of Haiti from donating blood. The FDA explained that the purpose of this policy was to protect the blood supplies from contamination with HIV (Antoine et al 1990). This policy persisted until December of 1990, when a rally held in New York City with an estimated 100,000 participants finally forced the FDA to overturn its policy (Farmer 1992).

In the aftermath of the media attention regarding the Gilbert et al (2007) study, Haitians began posting reactions on the “Corbett’s List,”⁵ a listserv for people interested in Haiti. Close to twenty or thirty posts a day appeared in the first week or two after the publication of the study. A number of these posts expressed outrage at being targeted as the “source” for HIV again and many others recall participating in the FDA protest in 1990.

As proud, hard-working people, we cannot accept to keep being attacked like this. This is the time that we, Haitians, stand up, just like in the late 80's to make our voices heard. (Laurence-Chounoune 10-30-07).

My fellow citizens, today you see the real reason for us to get together and stay together. The holocaust had brought the Jews together and they stay together. In the 1980's we joined hands together to force the FDA to remove our name from that list. Together, we are powerful and we are not learning this from anyone but from our ancestors who joined hands together on May 18, 1803 and 6 months later we became the first black independent country in the world and the second in this continent (Senou 11-1-07).

⁵ See <http://www.webster.edu/~corbetre/haiti/haiti.html>.

My blood pressure went up with floods of flashbacks. I remember being denied to participate in blood drive at school even though I was in perfect health condition. My wife suffered taunts ("4H" & "HBO") from her high school peers in Brooklyn. I was then a student at Baruch College, NY. The Haitian student associations of CUNY and other NY, NJ & MA schools organized a coordinated response with protest letters, Op Eds and demonstrations, the largest one being in front of the FDA office in lower Manhattan where ten of thousands demonstrated. We started in Brooklyn, shut down the Brooklyn Bridge for the entire morning and lower Manhattan for the entire day. We benefited from the help and support of our professors and fellow students of all races. Other Caribbeans/Africans participated in force. Like then, we are going to do something about it (Alexandre 11-1-07).

These comments illustrate the ways in which “Haitian-ness” in the United States has come to be shaped by the biopolitics of HIV/AIDS. While these posts demonstrate the shared notions of nation and historical struggle, they also hint at the legacy of this designation as “at risk,” one that remains a fundamental part of the everyday lived experiences of Haitians in South Florida and around the world.

A (Bio)Politics of Risk and Reproduction

Since 1995, and Ginsburg and Rapp’s groundbreaking collection, *Conceiving the New World Order*, the anthropology of reproduction has increasingly focused on the intersection of both the local and global politics of reproduction. To understand the transnational inequalities on which reproductive practices, policies, and politics increasingly depend, they argue for an analysis of “stratified reproduction” as a means to describe the power relations by which some are empowered to nurture and reproduce, while others are disempowered (3). Nowhere is this stratification more evident than in the contemporary United States, where differential access to healthcare based on insurance coverage, income, and citizenship status affect the everyday experiences of women seeking prenatal care. For pregnant Haitian women living in South Florida, accessing prenatal care has often involved previous experiences in Haiti and the United States; recommendations for physicians from friends and family; navigating between private and

public clinics; advocating for Medicaid coverage or local health care subsidies; and strategizing to access expensive diagnostic procedures.

All the Haitian women I interviewed were using prenatal care, and the specter of the “non-compliant” pregnant woman remained out of my ethnographic reach. While the importance of utilizing prenatal care was never questioned by these women, narratives of risk and responsibility remained a strong undercurrent in their stories. Yet these dominant narratives of risk became fractured in discussions about prenatal diagnosis or technologies of self. Situated within the larger politics of fetal rights in the contemporary United States, Haitian pregnant women’s narratives sharpen the focus on an examination of maternal and fetal subjectivities, contextualized within the biopolitics of risk.

Gender biases inherent in liberalism make it easier to implement strategies of regulation over women than over men, but Lealle Ruhl (1999: 96) argues that risk discourses regarding pregnancy are not particularly sexist. It is problematic to reduce contemporary strategies to regulate pregnant women’s behavior as simple misogyny, given that most women participate in and adopt the “risk model” of pregnancy. This cannot be seen as a result of “false consciousness,” which ignores the agency of women concerned about the health of themselves or their fetus. Situating pregnant women as agents in their own pregnancies was a logical outcome of the feminist movement and critique of biomedicine, which aimed to allow women as active participants within their own reproductive lives. Yet the risk model makes assumptions that are inappropriate in relation to pregnancy; women do not “control” their pregnancies in the way this model suggests. Pregnant women are simultaneously cast as an authority and agent in the care of themselves and their fetus, yet implied in this is the specter of the “irresponsible pregnant woman” who threatens the health and well-being of her “unborn child.” In projecting all

responsibility for the health and control of “risk factors” on pregnant women, the risk model is based on inaccurate assumptions about the realities of pregnancy (Ruhl 1999).

In the mid-1980s, anthropologist Brigitte Jordan began to document the practice of court-ordered cesarean sections in the United States (Irwin and Jordan 1987; Jordan 1993). Writing within an analysis of the “authoritative knowledge” of physicians over pregnant women, these articles detail strategies by medical authorities to safeguard fetal health irrespective of a woman’s wishes. As Anna Tsing (1990: 282) observes: “Pregnancy, childbirth, and child rearing are no longer seen as easy and ‘natural’ routes to motherhood, but as fraught with sacrifices, perils, and challenges that women must surmount.” In many cases, this maternal responsibility for fetal health entails remaining vigilant during pregnancy – eating well, having regular prenatal visits, counting fetal movement (fetal “kick counts”) and self-educating about strategies for optimizing birth outcomes. Dominant social narratives, or “monster stories,” about mothers who dump their infants in trash bags or otherwise endanger their newborns, shape these experiences, and inform women of a new public agenda in which fetuses, and children, must be protected from their own mothers (Tsing 1990).

One of the most recognizable forms of monster stories, and one which became most implicated in the precedent to establish fetal legal rights, were cases focusing on the use of illegal drugs by pregnant women (Balsamo 1996; Daniels 1993; Hartouni 1997; Schroedel 2000). A number of states have grappled with cases in which pregnant women were charged with “fetal endangerment,” or manslaughter in the case of fetal or infant deaths resulting from prenatal drug use. Various states have also proposed legislation which would require mandatory drug screens for all women during prenatal care or upon entry in the hospital for delivery (Balsamo 1996). During my observations of the Miami-Dade Fetal and Infant Mortality Case

Review Team, issues of prenatal drug abuse came up a number of times in response to the review of a fetal death. As one CRT member commented in the case of a suspected cocaine user: “If this woman was shot and the fetus died than someone would be prosecuted—but this woman uses drugs and her baby dies and she goes free” (fieldnotes 10-4-05). Public health specialists have long pointed out that routine drug testing of pregnant women discourages them from seeking prenatal care, further putting their pregnancy at risk. While some fetal rights advocates have argued for the detainment of pregnant drug-addicted women, maternal health advocates have pointed out that many jails are unable to provide prenatal care or drug treatment, ultimately contributing to a poor pregnancy outcome (Paltrow 1998; Roberts 1998).

Fetuses are situated as subjects at “risk” from their mothers. Pregnant women’s behavior is publicly scrutinized, as woman are informed by providers, family, friends, and even strangers about responsible behavior – what is appropriate for them to eat or drink, to wear, or even where they should (or should not) go.⁶ Many of these discourses are situated within the contemporary “culture of life,” in which current state and federal legislation dictates policy around fetal rights. For instance, in April 2004, when President George W. Bush signed the Unborn Victims of Violence Act into law, federal legislation defined the “unborn child” as “a member of the species homo sapiens, at any stage of development, who is carried in the womb” (HR 1997, 2004). Following other federal and state legislation such as the Partial Birth Abortion Ban and Florida’s Homicide of an Unborn Quick Child, these bills mark a radical transition in national policy

⁶ For instance, a recent tabloid featured a cover photograph of Angelina Jolie touring Iraq in a bullet-proof vest, accompanied by a headline that stated: “This is Crazy! – She prides herself on being a great mom but Angelina puts her unborn babies in danger in Iraq for publicity” (*Life & Style Magazine*, February 25, 2008). In March 2006, tabloids featured photos of another pregnant celebrity, Gwyneth Paltrow, and comments about her ingesting a beer and sushi at a New York restaurant even though she was five months pregnant (<http://www.usmagazine.com/node/880>).

which compels our nation to protect “our unborn” through the recognition of individual rights for the fetus.

In Florida, recent anti-abortion bus ads and billboards pictured a smiling (white) baby positioned in front of an American flag accompanied by the text “Life and Liberty Begins at Conception.” It is these sorts of nationalistic ideals which encompass the basis of Bush’s “culture of life.” When President Bush signed the Partial Birth Abortion Ban Act into law in November 2003 he drew on these notions when he commented: “American stands for liberty, for the pursuit of happiness and for the unalienable right of life. And the most basic duty of government is to defend the life of the innocent. ...In the debate about the rights of the unborn, we are asked to broaden the circle of our moral concern” (Office of the Press Secretary 2003). In the contemporary United States, this circle of moral concern encompasses a discourse of fetal rights, which is predicated on narratives of risk and responsibility. As noted by Ruhl (1999:97), “the simultaneity of the characterization of the pregnant woman as her fetus’ most ardent protector or its most dangerous threat makes a simple feminist response to this mode of governance of pregnancy impossible.” To this end, I will examine these narrative as means to get analytical and theoretical clarity on the conceptual categories, such as “mother” or “fetus,” and their implications for changing subjectivities. Using Haitian pregnant women’s narratives of their own local moral worlds, we can formulate a feminist analysis which illuminates both the collective and individual nature of pregnancy experiences.

A Multi-Sited Methodology

In 1995, George Marcus surveyed an “emergent” trend in anthropological methods, whereby ethnography moved from single-site locations to multiple sites of observation and participation, cross-cutting dichotomies such as “local” and “global.” Concurrently (and in the same issue of the *Annual Review of Anthropology*) Sarah Franklin (1995) highlighted new

directions within anthropology concerning the culture of science, and science as culture. The anthropology of science is an example of a strategy to address multiple points of view, movement across local and transnational sites, including the historical conditions in which capitalism is reshaping global power, and life in the new world order. Franklin points specifically to the study of gender and kinship as one of the early links to a contemporary anthropology of science, as feminist anthropology was a critical testing ground for biologisms in the mid-1970s onward, and many of these same scholars are now particularly interested in issues of biogenetics (see Haraway 1997; Strathern 1992).

Moving from ethnographies of the laboratory, anthropologists have developed multi-sited approaches which investigate the “multiple contexts in which technoscientific artifacts make sense in a kind of cultural hyperstack” (Franklin 1995: 174). Work in the anthropology of science has also been influenced by the actor-network theory (ANT) of Latour (1987) and Callon (1999) which emphasizes “practice” or “science in the making” by investigating scientific knowledge practices which enroll instruments, measurement techniques, scientists, and “facts” as networks of interconnected observers and devices that ground scientific authority across space and time (see also Law 1986; Pickering 1995). As argued by Thompson (2005: 48), the “hybridity of social and natural things is the condition of producing objective facts about the natural world” within these networks of actors. Clarke and Montini (1993: 45) build on these notions of actor-network theory, but instead of simply “follow[ing] the techoscientist” they attempt to view the constructed world within the actors’ own terms. In particular, their approach specifies all the key individuals and social groups “active” around a technology, or its related social issues as a means to visualize and hear the all too often invisible and silenced implicated actors (see also Clarke 1998).

My research builds on this legacy of the anthropology of science, science and technology studies, and feminist science studies. For an anthropologist interested in the biopolitics of risk, this involved situating myself within clinical spaces, but also following these narratives of risk as they played outside of the clinic. One of the first steps in this process was to locate myself within that Haitian community in South Florida. Although initially settled in Fort Lauderdale in Broward County, I quickly found that the Haitian community was more cohesive and therefore more organized in Miami-Dade, where I lived the remainder of my time in South Florida. After a number of contacts with various community-based organizations, I was invited to join Sant La, the Haitian Neighborhood Center based in Little Haiti (Miami) as a part-time employee. At Sant La, I compiled research reports, wrote grants, assisted in the day-to-day activities of the center, attended health advocacy meetings throughout the county, and ultimately dabbled in health outreach project management. While this participant observation is not written about explicitly within this dissertation, these experiences informed much of my writing about the Haitian community in South Florida, and remain implicit throughout this text.

In addition, because of my difficulties in recruiting women who were willing to be interviewed, Sant La assisted me in accessing pregnant women. Oftentimes women were more open to speaking with me after being asked by another Haitian, who would explain the project and my interest in their knowledge about these issues. Women's hesitancy at speaking with me reflects these issues of risk and power, which remain dominant throughout this dissertation. M. Catherine Maternowska, an anthropologist who has long worked in Haiti on issues of reproductive health, pointed out the irony of this situation: "If you were in Haiti, women would be very interested in talking to you about these issues, because they would want to 'teach' about these things in Haiti. But in the U.S., there are more issues of fear involved. The power dynamic

is different – they don't know who you are or why you want to talk with them” (personal communication 12-15-05). I was able to experience this difference first-hand when in the summer of 2004, I traveled to the Central Plateau in rural Haiti to observe a group of medical students from George Washington University providing health care through mobile clinics. I found Haitian women to be very curious about my interest in Haiti, and very proud to share their stories and knowledge of their island home.

Another location which became instrumental in tracking the biopolitics of risk in South Florida was through my association with the Healthy Start Coalition of Miami-Dade. While my role at this agency is discussed in more detail in Chapter Two, my work with the coalition became key in tracing out the intertwining narratives of epidemiological and clinical risk. My association with this agency also allowed me to access more locations where advocacy for maternal and child health occurred, although this was not enough to get me access to clinics in Miami-Dade County. Although a number of providers, public health researchers, and clinic directors advocated for me to observe at prenatal clinics which served Haitian women in the county, none of the hospital boards with which I interviewed could reconcile the “risks” to patient privacy with my research protocol. Therefore, I considered observing at clinics in Broward County, where I had made a useful contact at a small prenatal clinic on the east side of the county. This clinic was situated within a neighborhood with a large number of Haitian families, and over two years, I spent almost every Tuesday morning following the nurse-practitioner as she administered prenatal care to a diversity of clients, including a number of pregnant Haitian women. I call this clinic the “Prenatal Clinic” and it provides the foundation for the data described in Chapter Three.

As mentioned briefly above, recruiting pregnant women who were interested in speaking with me was difficult. Although the Prenatal Clinic provided me with weekly access to pregnant Haitian women, I found that to be my least successful source of recruitment. In many cases, women would give me their phone number but never take my calls or have given me the wrong number. While this is not unusual for qualitative research, it became clear that this was not the best method to locate women willing to speak with me, which led me to rely more on intermediaries to recruit for me. Ultimately, I interviewed twenty-seven women, nine of whom lived in Broward County and eighteen lived in Miami-Dade. Interviews were done in English or Haitian Creole, in some cases with an interpreter. All interviews were with the woman alone, with the exception of her children, except for one case in which the husband was present. The majority of interviews were done in the woman's or relative's home, although a few occurred in a church, at Sant La, or in a homeless shelter (where two of my informants were living at the time). These narratives inform much of my dissertation, but their stories become central to Chapter Four, as a means to situate the epidemiological and clinical narratives of risk within local narratives of risk.

When I initially designed this dissertation project and research methodology, issues of fetal imaging through ultrasound remained a central means to investigating issues of fetal personhood and subjectivity. Yet when this protocol was introduced to the hospital district in Broward County, where I did the clinical observation, it was deemed an unnecessary part of my research and potentially problematic ethically.⁷ I assumed that I would complete my research without actually witnessing a prenatal ultrasound first-hand, but in the last month of my research,

⁷ The Human Subjects Review Board felt that by observing ultrasound examinations I would "overhear" patient diagnoses which could potentially be in violation of the Health Insurance Portability and Accountability Act (HIPAA).

the nurse practitioner I was working with passed me the information for a private obstetrician who wanted to speak with me about her experiences with her Haitian patients. I interviewed her and was invited to spend a few days observing various prenatal ultrasound procedures at her clinic. These observations contribute to Chapter Five.

While my dissertation focuses on pregnancy and prenatal care, the underlying motivation behind my research and writing is to contribute towards reproductive justice, both locally and globally. Ultimately, I am interested in situating these narratives of the biopolitics of risk within changing policies around abortion and fetal rights in the United States. To this end, I was active in the reproductive justice movement in South Florida, as a means to track some of the dominant narratives of choice and morality, and their implications for subjectivities. I worked closely with Planned Parenthood of Greater Miami, Palm Beach, and the Treasure Coast (the local affiliate for Miami-Dade County), volunteering on their outreach and policy committee. I also accompanied a number of local advocates to Tallahassee for “Lobby Days” in March 2006, when various activists for Planned Parenthood lobby state leaders on issues relating to reproductive health policy in Florida. My work with this organization led to a number of interviews with key activists throughout South Florida, contributing a more cohesive picture of the history, politics, and priorities of reproductive justice advocacy in this area. These stories provide the context for Chapter Six, as means of situating larger media discussions on abortion and family planning both locally and nationally.

Finally, this ethnography is situated within my own experience of living in the Haitian community in South Florida: driving to Sant La through Little Haiti and along the streets of North Miami, lined with Haitian businesses and trailing behind the “jitney” or local bus service; chatting with my Haitian neighbors, as we shared frustration over the electricity going out again,

after yet another hurricane; discussing Haitian politics with my co-workers as they anticipated the first election since the coup of 2004; and finally, the collage of images, smells, and sounds as I wandered through Haitian homes, businesses, and celebrations through my two years living in this community in South Florida. While narratives of risk remained dominant throughout my research in this community, these technologies will always remain tempered through the local moral worlds of those Haitian women who struggle every day to create a better life for themselves and their families.

It is through notions of “risk” that this dissertation will critically examine the biopolitical constructions of Haitian subjectivity in the contemporary United States. A number of scholars have argued that contemporary discussions of biopower and governmentality are situated within notions of a “risk society,” one predicated on ideas of the identification of and preventative intervention for risky individuals, through self-regulation and responsibility (Lupton 1999a; Rabinow and Rose 2006; Rose 2007). In particular, I am interested in employing this analytical lens as a means to track changes in maternal subjectivities – as reproductive policies increasingly turn away from earlier biopolitical interests in “population” towards individuals and “technologies of self.”

I begin by considering the ways in which categories of people become constructed as risk groups. Although Haitians have been understood as a biosocial collective through their “risk” status for HIV/AIDS, additional epidemiological narratives of risk can be constructed through vital statistics. In Chapter Two, I examine how local community-based organizations, such as the Healthy Start Coalition of Miami-Dade, contribute to epidemiological narratives of risk about Haitian women and prenatal care. In addition, I situate Haitian pregnant women’s lived experiences as a means to complicate these dominant narratives. This is followed by an analysis

of the translation of these epidemiological narratives of risk into clinical practice. In Chapter Three, I explore how clinical narratives of risk within the prenatal clinic shape maternal subjectivities. Haitian pregnant women's "technologies of self" are situated within particular narratives of risk, and in this chapter I argue that this self-care both promotes and differs from the dominant clinical narratives. In Chapter Four, I situate epidemiological and clinical narratives of risk within local narratives of risk. In particular, I demonstrate how the transnational experiences of Haitian women, with their attending politics, violence, nationalism, and kin obligations, shape the landscape of risks accompanying pregnancy for these women in the United States.

The second half of this dissertation will take a closer look at these issues of "choice" and "responsibility" which become inherent within dialogues about risk. In the contemporary United States, issues of reproductive choice have become intricately linked to ideas about responsibility, particularly with changing notions of fetal subjectivity. For example, ultrasonography, utilized within the clinic for prenatal diagnosis, is tied to specific narratives of choice and responsibility endemic in risk for congenital abnormality and fetal health. In Chapter Five, I argue that ultrasound imaging has come to be understood as both a diagnostic tool and a pleasurable experience. It is in this intersection of prenatal diagnosis and pleasure that narratives of risk and responsibility become particularly powerful and interesting. Using ethnographic evidence from my observation at an ultrasound clinic in South Florida and interviews with pregnant Haitian women, I critically examine the conceptual categories and discourses which shape the debate on fetal life and maternal responsibility in the United States.

As ideas about fetal subjectivities change in the United States, the politics of abortion has led to a reevaluation of contemporary perspectives on maternal responsibility and choice. This

“reality” of the fetal subject has encouraged abortion-rights activists to argue for a “common ground” within the debate, one that promotes decreased abortion through the prevention of unintended pregnancy. In Chapter Six, I situate contemporary debates about abortion which focus on “morality” and “unintended pregnancy,” and the ways in which these terms assume particular liberal, responsible maternal subjects. Using media material, congressional legislation, public health policy, and ethnographic data from South Florida, I trace how these discourses assume that women will behave in rational, responsible ways to plan their reproductive futures, and how these assumptions intersect with Haitian migrants’ lived experiences in South Florida.

Finally, while the majority of this dissertation focuses on pregnancy and prenatal care, the underlying motivation behind my research and writing remains an advocacy for reproductive justice, both locally and globally. Ultimately, I am interested in situating these narratives of the biopolitics of risk within changing policies around abortion and fetal rights in the United States. In Chapter Seven, I conclude the dissertation by examining the biopolitical implications of the technologies of risk and responsibility which have become implicit within these debates. And by interrogating technologies and narratives of risk in juxtaposition with pregnant women’s local moral worlds, I demonstrate that these notions of risk are not hegemonic. Haitian women narrate a transnational landscape of risk and responsibility which informs their experiences in pregnancy and prenatal care. Their experiences and narratives contribute to a critical examination of the politics of risk and responsibility in reproductive policy in the contemporary United States.

CHAPTER 2
ACCOUNTING FOR RISK: VITAL STATISTICS
AND THE BIOMEDICALIZATION OF PRENATAL CARE

Provided that we remember that we are merely at the forefront of human knowledge, it is possible that the World Health Organization dream of ‘health for all by the year 2000’ will include the unborn. Some day, for a wider range of fetal illness, we may be able to offer a brighter prospect than the present dismal alternatives of neonatal death, abnormality, or abortion.

-- Sir William Lilley, Preface to *The Unborn Patient* (1984: xvii)

Until recently, the fetus did not need a healer, only an advocate or protector. The fetus has always had advocates—but the grounds for such advocacy were religious, emotional, and philosophical, rather than diagnostic and therapeutic. ... Now the possibility of treating certain fetal disorders before birth gives an entirely new meaning to prenatal diagnosis.

-- Michael R. Harrison, *The Unborn Patient* (1984: 9)

When a pregnant woman begins prenatal care, she is profiled by her provider as “high risk” or “low risk” based on a number of biomedical and social variables. This identification of risk status governs the expected treatment and behavior of a woman during her pregnancy, and there is no such designation as a “no risk” pregnancy (Lupton 1999b; Weir 1996). This form of profiling pregnancy into categories of high risk and low risk reflects a contemporary convergence of epidemiological and clinical narratives of risk. Epidemiological risk involves tracking illness and disease in specific populations using statistical and screening techniques to link illness and disease with their assumed causal variables. Clinical risk, also known as case-management risk, involves the qualitative assessment of individuals considered to be “at risk,” relying on interactions, observations, and interviews (Lupton 1999a). This chapter will take a closer look at the intertwining histories of vital statistics and the biomedicalization of prenatal care, as a means to illustrate this convergence of epidemiological and clinical risk.

Central to this discussion is a Foucauldian notion of biopolitics: “We should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts, etc.” (Foucault 1980:

97). State innovations in the collection of vital statistics have become a means of “making up” categories of people from above; as government interest in creating and controlling populations and the social body has grown, comprehensive statistical measures and interventions have become central tools in the process of naming and medicalizing particular groups of people. This chapter is particularly concerned with one group, namely “pregnant women,” and subsequently their division into “high risk” and “low risk” populations. I argue that this intersection of risk and vital statistics became very powerful with the advent of the fetal patient, leading to increasing attention to maternal behavior and health as directly related to fetal outcomes.

I begin with a brief discussion of Ian Hacking’s (1999) analysis of statistics and their role in “making up people,” and the means by which statistics contributes to state biopolitical objectives. Following this discussion, I will describe the intertwining history of the collection and development of vital statistics in the United States with the biomedicalization of prenatal care. Central to this discussion are the ways in which notions of “risk” – both epidemiological and clinical – begin to structure the practice of prenatal care, and the sorts of subjectivities that result from this convergence. For a project interested in the technologies of risk, a closer examination of the collection and deployment of vital statistics is key in understanding the sorts of assumptions that inform these processes and the sorts of subjectivities shaped by them. In the remainder of this chapter, using the Florida Linked Vital Statistics Database, I will “follow the numbers,” asking how these numbers have been collected, and how they have been deployed, in what contexts, for what aims, and by what techniques. I will follow these statistics through their use by the Healthy Start Coalition of Miami-Dade to create their Needs Assessment and Service Delivery Plan. In order to situate these numbers ethnographically, I will examine one variable or “risk factor,” the utilization of prenatal care, to explore subjective experiences in accessing

prenatal care among Haitian women. These narratives illustrate ways in which Haitian women's local moral worlds intersect with decisions about accessing biomedical prenatal care.

“Making Up People”

Innovations in England during the middle and late nineteenth century intimately linked the growing discipline of vital statistics with the administration of public health. The growth of this discipline was grounded in a notion of “population” as something which could be enumerated, measured, and controlled through interventions in public health. As the state became concerned with a productive labor force, it began to focus on how to raise the level of the social body as a whole. Using demographic estimates, marriage and fertility statistics, life expectancy tables, and mortality tables became an important technology of population control. Individual bodies and populations (as social bodies) became associated with recognizable and measurable variables (Brotherton 2003; Foucault 1980; Lupton 1995).

Ian Hacking (1999, 2006) argues that the act of classifying people in turn constructs them as particular objects of scientific knowledge. In some cases, in the act of creating categories of people, science creates kinds of people who did not necessarily exist before, in other words, “our classifications and our classes conspire to emerge hand in hand, egging the other on” (Hacking 1999:165). This concept builds on a Foucauldian notion of biopower, which becomes developed through the creation of objects of knowledge. In creating domains of expertise, these biopolitical processes construct their own objects of analysis to which it then responds (Lock and Kaufert 1998). Hacking refers to this process as “making up people,” and contends that each category has its own history, both constructed from “above” and from “below.” He describes these two processes as vectors – “One is the vector of labeling from above, from a community of experts who create a ‘reality’ that some people make their own. Different from this is the vector of the autonomous behavior of the person so labeled, which presses from below, creating a reality

every expert must face” (1999: 168) This chapter is primarily concerned with this process “from above;” this drive by statisticians and epidemiologists to discover the facts about maternal and child (and later fetal) health, and who subsequently construct certain categories of maternal and fetal subjects. Yet by situating this process from “above” with that from “below,” using Haitian women’s lived experiences, we can examine the processes by which individuals come to accept, embody, resist or reject this ideological knowledge (see Lock 1993).

A history of statistics is ultimately about shifting notions of risk, and increasing strategies to measure and intervene on behalf of individuals and populations. A number of theorists have noted that historically, the move from notions of “dangerousness” to “risk,” is important to an understanding of intersections between epidemiological and clinical ideas of risk (Castel 1991; Lupton 1999a). In the nineteenth century, as the state became more concerned with the management of and interventions into particular populations, “dangerousness” became a means to identify those individuals who possessed the inherent qualities that would present a danger to themselves or society. These dangerous individuals were then grouped and labeled – for instance “the insane” – whereby experts could create interventions based on these groupings (Lupton 1999a). If dangerousness was assumed to be an inherent quality in an individual, this still did not forecast who would actually act out on these impulses. Therefore, in the mid-nineteenth century, experts began to advocate for assessments of the frequency of dangerousness, and then relate the frequency to the living conditions of the lower class (those assumed most likely to be dangerous). As statistics became increasingly more sophisticated, notions of dangerousness shifted as experts were able to forecast a potentiality for dangerousness based on various external conditions (Castel 1991).

Ultimately, this was the transition to “risk,” which also acknowledges potentiality, but is calculated through statistical correlations and correlations from population-based data versus the routine observation of individuals (Lupton 1999a). This movement from dangerousness to risk has multiple implications in the management of individuals, given that interventions are no longer based on individual behavior. Instead they are based on techniques of surveillance and measurement of populations, leading to statistical calculations which subsequently categorize or “make up” individuals into specific “risk groups” (Lupton 1999a). Castel (1991: 282) argues:

The resulting situation might, if one chooses, be called a crisis of clinical medicine, a crisis affecting the personalized relation between professional and client; or it might be called a transition from a clinic of the subject to an ‘epidemiological’ clinic, a system of multifarious but exactly localized expertise... This certainly does not mean the end of the doctor, but it does definitely mark a profound transformation in medical practice.

As noted by Rose (2007: 70), “Risk here denotes a family of ways of thinking and acting that involve calculations about probable futures in the present followed by interventions into the present in order to control that potential future.” Not only have notions of risk gained ascendance in the management and interventions by states on populations, but the demands for collective measures of biopolitical risk management are globalizing. Yet throughout historical transitions in risk management, mortality and morbidity have remained key sites for the development of conceptions of a future that is calculable and predictable (Rose 2007).

Vital Statistics and the Governance of Pregnancy

Vital statistics truly came of age in the nineteenth century, as the growth of mathematical methods for measuring probability became increasingly more sophisticated. The appointment of William Farr as compiler of abstracts in England’s General Registrar’s Office allowed him to promote the use of mortality statistics to govern health policy. His work was supported by the appointment of Sir John Simon as head of the newly created medical department of the central government. For Simon, his work depended on the cooperation of General Registrar’s Office and

its weekly release of mortality reports. These reports were transformed into a working tool of inquiry and propaganda aimed at medical research and the promotion of public health legislation (Schweber 2006).

Across the Atlantic, the collection of vital statistics in the United States was not as formalized as the work in Europe. During much of the nineteenth century, much of the United States remained too rural to effectively collect and maintain vital statistics, but during this time local health officers observed remains and tabulated causes of death in a crude form of statistics as a means to communicate larger health threats to the local community. Inspired by the work in England, many states recognized the benefit of vital statistics in governing public health, and began to create public health boards, charged with both disease control and registration of vital statistics. By the late nineteenth and early twentieth century, vital statistics came to be increasingly standardized in the United States. At this time, registration of birth, marriages, and deaths still occurred through the U.S. Bureau of Census, which became a full-time federal agency in 1902. In addition, the American Public Health Association designated a Vital Statistics Section charged with working with registration officials to promote uniform state registration and model laws (Hertzler 1997).

Concurrent with the standardization of vital statistics, the creation of the U.S. Children's Bureau in 1912 had important implications for both the future biomedical management of pregnancy care and the collection of vital statistics. The creation of a federal agency for children was spearheaded by a group of progressive maternalists, unified in their concern for child welfare—particularly advocating against child labor and investigating increasing rates of infant mortality. These women promoted the idea that motherhood should have the “status of a profession” and be governed by the insights of science and experts. The initial work of the

agency focused on infant health, as a means to build support for the Children's Bureau in a non-controversial way (Ladd-Taylor 1994).

Julia Lathrop, the chief of the newly formed Children's Bureau, quickly set about promoting birth registration as a means of understanding infant mortality. The birth registration drive relied on progressive maternalist strategies of coalition building and scientific research. In order to encourage registration, Lathrop enlisted experts from the American Medical Association, the American Public Health Association and the Bureau of Census to draft a model birth registration statute, using the General Federation of Women's Clubs to launch a nationwide campaign. The 1915 campaign, which evolved into a "National Baby Week," involved the participation of over 3,000 women who conducted house-to-house surveys of infants in a given neighborhood and then compared the count to official records of registered births. In areas where the public records were particularly deficient, activists successfully lobbied state legislatures for better laws. By 1919, twenty-three states had passed model registration laws, and in 1929, there were forty-six states included in the registration area (Ladd-Taylor 1994; Wertz and Wertz 1977).

In accord with its work in promoting birth registration, the Children's Bureau argued that child health would be improved if women were taught to care for themselves more effectively during pregnancy (Wertz and Wertz 1977). There is little information on rates of the utilization of biomedical prenatal care in the early part of the twentieth century, but by piecing together state, regional, and local data, Barker (1993, 1998) estimates that less than five percent of pregnant women in the United States had any contact with a physician prior to delivery during the first two decades of the twentieth century. Yet many histories of prenatal care recognize the education campaign by the Children's Bureau as the first nationwide attempt to introduce

pregnant women to a biomedical conceptualization of pregnancy (Barker 1993, 1998; Ladd-Taylor 1994; Wertz and Wertz 1977).

Publication and distribution of childrearing literature became one of the Children's Bureau's first priorities; *Prenatal Care* was published in 1913, and *Infant Care* was published in 1914. *Prenatal Care* was intended to become a handbook for pregnant women, with an outline of decisions they would need to make concerning their confinement, guidelines for pregnancy hygiene, and warnings about potential complications and disorders of pregnancy. Initially written by a policy researcher and widowed mother, the guide was reissued each year with an introduction written by the Children's Bureau Chief until 1930, when the guide was revised by a physician. In an analysis of the original version (published in 1924) and the later version (published in 1935), Barker (1998: 1069) argues that both versions reveal the "implicit power embedded in biomedical discourse as a mechanism facilitating the medicalization of pregnancy." She also notes that differences in the two versions reflect the transformation in notions of the biomedical management of pregnancy, and biomedical roles for intervention, that were occurring during this period.

Notably, there was a growing argument that biomedical monitoring during pregnancy was important in order to avert disaster or danger. For instance, in the 1924 edition of *Prenatal Care*, women are warned: "Many a case of life-long invalidism has resulted from the lack of suitable and sufficient attention from the doctor... the extra dollars spent then may save a greater and possibly futile expenditure later" (quoted in Barker 1998: 1070). Obviously the realities of danger were influenced by the high rates of maternal and infant mortality which characterized pregnancy and childbirth at this time. *Prenatal Care* quickly became one of the government's best-sellers; a year after its publication demand exceeded all expectations (Ladd-Taylor 1994).

During its twenty years of existence, the document was distributed to over twenty-two million pregnant women in the United States (Barker 1998).

The next important moment for mainstream biomedical pregnancy care in the United States occurred with the passing of the Sheppard-Towner Act in 1921, also known as the Act for the Promotion of Hygiene of Maternity and Infancy. Using maternal and infant mortality statistics, the Children's Bureau, assisted by a large component of maternalist-oriented women's groups, lobbied the Federal Government to create a public health service for women and children. Initially introduced to Congress in 1918, several years and versions of the bill led to its support in 1921. Posters appeared throughout the country promoting the legislation, proclaiming: "A Baby Saved is a Citizen Gained," and "The Nation that Has Babies Has the Future" (quoted in Wertz and Wertz 1977: 209). The Children's Bureau argued that the new federal funds would serve two purposes: (1) improve women's understandings of what constitutes "good" prenatal and obstetrical care; and (2) make available adequate community resources for such care (Wertz and Wertz 1977). Although many of the medical associations lobbied against the bill, the Children's Bureau maintained that "Your private practice should immediately reflect [the Act's] work, which is to discover remediable conditions and stir up parents to visit their doctors for necessary treatment and supervision" (quoted in Ladd-Taylor 1994: 175). Most states used the funds from Sheppard-Towner to hold health conferences, make home visits, promote birth registration, and distribute literature, particularly *Prenatal Care* and *Infant Care*.

Federal support of maternal and child health was discontinued until 1935, with the passing of Title V of the Social Security Act. Yet unlike the Sheppard-Towner Act, Title V was needs-based, not a form of universal coverage for all women and children. In addition, much of the work of the Children's Bureau relating to maternal and child health was transferred to the Social

Security Board (Barker 1993). Although the Children's Bureau still distributed the money, much of its use was determined by state and local authorities. In addition, the American Medical Association (AMA) rejected the Children's Bureau's assertion that the Shepard-Towner Act had decreased infant mortality (supported by infant mortality vital statistics), arguing instead that maternity care would only improve with increased cooperation between women and their physicians (Wertz and Wertz 1977). Much of this history, which I do not have the space to address, is a narrative of professionalization: the professionalization of women as social workers and maternal health advocates; the professionalization of physicians and the ascendance of the AMA; and finally, the professionalization of statisticians, and their advocacy for the science and importance of vital statistics. However, a number of concurrent scientific "advances" supported the increasing biomedicalization of pregnancy care, as well as a number of key pieces of legislation supporting physician-governed prenatal care with federal funding.

The Biomedicalization of Pregnancy Care

While histories of maternal and child health services exist for the early part of the twentieth century, the record is thinner for the later decades. A number of key pieces of legislation point to important moments in federal policy, including the Title V of the Social Security Act (1935), the Emergency Maternity and Infant Care Act (EMIC 1943 – 1948), and the institution of Medicaid and Medicare (1963). The Social Security Act of 1935 contained the first attempts at a federal infrastructure for maternal and child health care. This policy was designed to address many of the extensive cutbacks in public health occurring during the Great Depression. Title V of Medicaid continues to provide the bulk of funding for maternal and child health services in the United States today. During World War II, military hospitals were overburdened with care, and the EMIC Act was designed to assist military wives with maternity and infant care (Speert 1980). A 1943 article in the *New York Times* informs newly pregnant

military wives that “Uncle Sam Looks after Babies” and would foot the bill for all their maternity care. After signing up for the EMIC plan, women were referred to a participating hospital where physicians cared for them during their pregnancy. As noted by the article, “prompt medical attention has prevented prenatal complications for many mothers” (Oppenheim 1943). In 1963, Congress passed the Social Security Act of 1963, and recognizing the importance of biomedical prenatal care in preventing infant mortality and “mental retardation,” extended the availability of maternal health services and provided a broad spectrum of diagnostic services, hospitalization for high-risk patients, social, dental and nutritional services to rural areas with high infant mortality rates and “needy” cities (Speert 1980).

In accord with federal policies promoting the institution and funding of biomedical prenatal care, a number of technological developments supported the notion that “scientific care” was needed to assist pregnant women. Eclampsia and toxemia were common causes of maternal death (as they are today) and in the late nineteenth century, physicians recognized that testing a pregnant woman’s urine for albumin, a protein synthesized by the liver, could indicate her risk of kidney problems (Oakley 1984). At the turn of the twentieth century, a Scottish physician named John Ballantyne began advocating for routine prenatal care; through his work he had observed that maternal exposure to alcohol, nicotine, lead, and infectious diseases such as syphilis and tuberculosis could be hazardous to the fetus (Moos 2006). In 1923, Allen and Doisy “discovered” the estrogenic hormone, leading researchers to develop hormonal pregnancy tests. While these tests were not regularly used at this time, this test launched the era in which physicians could claim to trump bodily experience with scientific knowledge (Oakley 1984). Another means of diagnosing pregnancy at this time was to use x-ray, as it allowed physicians to differentiate between abdominal tumors or pregnancy. Later, the use of x-ray for diagnosis of

pregnancy was replaced by hormonal techniques, as increasing evidence associated x-rays with long-term effects on children, including cancer. Finally, in the 1930s, advances in knowledge about anemia in pregnancy and the use of blood transfusions, as well as increased understanding about infections, such as puerperal sepsis, led to decreased rates of maternal morbidity and mortality (Oakley 1984).

In 1929, the White House convened a conference on Infant Welfare and Protection which, as described above, symbolized a growing specialization among physicians in the care of pregnancy. Four years later, Dr. Palmer Findley⁸ reflected on the abysmal state of maternal mortality in the United States, particularly in comparison with other “civilized” countries such as England and France: “It is not enough to provide adequate care for the mother at the time of delivery and for the few days of the lying-in period. ...Well-directed prenatal care will reduce the hazards of childbearing to less than half” (1933: 222). Findley’s text, *The Story of Childbirth*, demonstrates the discursive shift in discussions around pregnancy from a “natural” process to one that is fraught with danger. Of course, high rates of maternal and infant mortality reinforced such notions for many women at this time, yet this shift symbolized the ways in which pregnancy came to be represented as a “disease” that should be “treated” by physicians.

At the 1929 White House Conference for Infant Welfare and Protection, physicians and maternal and child health advocates released a framework for routine prenatal care, and this framework remains very similar to the recommendations advised today. In 1929, the recommendations were: first obstetric visit by 16 weeks, with subsequent visit at 24 weeks, every 2 weeks starting at 28 weeks, and then weekly beginning at 36 weeks. At each visit, uterine size,

⁸ Dr. Findley was Professor of Obstetrics and Gynecology at the University of Nebraska's College of Medicine, councilor of the American College of Surgeons, and onetime president of the American Association of Obstetricians, Gynecologists and Abdominal Surgeons.

fetal heart rate, urine, blood pressure, and weight were to be assessed (Moos 2006). As an increasing number of women began to seek biomedical care, rates in maternal and infant death began to decrease. Yet a number of researchers today argue that it is impossible to link increased use of prenatal care with decreased rates in mortality. Instead, improved sanitation, birth spacing, antibiotics, transfusion therapies, and neonatal intensive care are responsible for much of the decrease (Alexander and Kotelchuck 2001; Moos 2006; Strong 2000).

Most histories of the growth of biomedical management of pregnancy in the United States through regular prenatal care focus on the early part of the twentieth century. Oakley (1984) explores these issues in the United Kingdom, through the post-World War II institution of the National Health Service and the rise of hospital obstetrics. National data from the UK demonstrate an increase in the number of visits, early initiation of care, and standardization of biomedical diagnostic procedures, such as blood tests, urine tests, and blood pressure measurements from 1946 through 1957 (Oakley 1984). In the United States, rates of prenatal care were first tracked in 1968 through vital statistics, particularly as a means to examine the relationship between access to biomedical prenatal care and pregnancy outcome. In 1969, 98.1% of all women received at least some prenatal care during their pregnancies (DHEW 1978).

The first federal publication using vital statistics to track usage of prenatal care, *Prenatal Care: United States, 1969-1975*, was aimed at identifying the “groups” of women who received little or no prenatal care (DHEW 1978: 1).⁹ This report also demonstrated that biomedical prenatal care had become a standard aspect of pregnancy experience by the late 1960s in the United States; in 1969, only 1.9% of women received no prenatal care, and over 68% initiated care within the first trimester of their pregnancy. In 1975, these numbers had increased slightly,

⁹ Although this report does not explain how these deficiencies will be addressed.

with only 1.3% of women receiving no prenatal care, and 72.3% of women initiating care within the first trimester. Yet these numbers differed by race,¹⁰ for instance, in 1969, 94.9% of black women received at least one prenatal care visit in contrast to 98.7% of white women.

The next report tracking the utilization of prenatal care in the United States was released by the CDC and the NCHS in 1996, and tracked data for 1980 through 1994. *Prenatal Care in the United States, 1980 – 1994*, demonstrates the increasing routinization of biomedical care during pregnancy for women in the United States (DHHS 1996). In 1980, 76.3% of all women initiated prenatal care during the first trimester, and 80.2% did so in 1994. Rates of “no prenatal care” were a little more variable; while the rate was 1.3% in 1980, the rate steadily increased over the fourteen year period, peaking at 2.2% in 1989 and then declining to 1.4% in 1994. This variability was particularly clear among different racial groups: while the rates for “no prenatal care” varied slightly for whites (1.0% in 1980; 1.6% in 1989; 1.0% in 1994), the rates among blacks exhibited much greater variability (2.8% in 1980; 5.1% in 1989; 2.3% in 1994) (DHHS 1996: 9).

Intertwining Histories of Collection and Care

The histories of the biomedicalization of pregnancy care and the specialization of vital statistics are intimately intertwined. As noted above, the primary focus of the Bureau of Census in the early part of the twentieth century was to extend the registration area for births and deaths. Aided by the Children’s Bureau, as described above, this goal was completed in 1933 with the addition of Texas. The following years were a time of appraisal and evaluation for the Bureau of Census, with a focus on improving reports for completed registration areas and conducting research into the new fields which had been opened through vital statistics. In 1935, the Division

¹⁰ This report only differentiated between “black” and “white.”

of Vital Statistics, within the Bureau of Census, was drastically reorganized and charged with a number of important tasks, including the development of the data from the birth and death certificate and the means by which these data could be made available for special public health and scientific needs, and the stimulation of research into the analysis and solution of important vital statistics problems. In 1946, the National Office of Vital Statistics was created within the Public Health Service as a means to finally formalize the relationship between public health administration and epidemiological research. A measure of progress was made in 1950, with the second nation-wide test of birth registration completeness. This test indicated that 97.9% of infants born in that year had birth certificates on file. This was a great increase over the first test completed in 1940, when only 92.5% of infants had birth certificates on file. In 1960, the National Office of Vital Statistics was merged with the National Health Survey to create the National Center for Health Statistics, of which the Division of Vital Statistics was but one of five operating divisions (Hertzler 1997).

To track the ways in which these histories are linked, I analyzed the changes made to birth certificates over the past hundred years [See Table 1]. Up until 1930, birth certificates contained basic information such as place of birth, child's name, parents' names, and occupations of both the mother and father. Also included were the number of children previously born to this mother and, in the case of a stillbirth or fetal death both a birth certificate and a death certificate were required. In 1949, at the bottom of the form, a section was added, designating "For Medical and Health Uses Only" which allowed for health information to be omitted from certified copies of certificates.

Table 2–1: Birth certificate changes, 1900 to 2003¹¹

Year	Added to Birth Certificate	Removed
1900, 1910, 1915, 1918	Place of birth, child’s identification, mother’s and father’s age, mother’s and father’s occupation, mother’s and father’s race, number of children born to mother, birthweight, singleton/twin, child legitimate, type of attendant.	
1930	Information about stillbirth (incl. period of gestation, cause of stillbirth, and whether before labor or during labor), premature or full term.	
1939	Residence of mother (State, County, City, Address), name of hospital, mother married, mother’s “Usual occupation,” father’s “Usual occupation,” months of pregnancy.	Address of birthplace, legitimate, mother’s occupation, father’s residence, father’s occupation, information about stillbirth, premature or full term.
1949	Birthweight, legitimate, “For Medical and Health Use Only” added to bottom of certificate, born dead after 20 weeks pregnancy, length of pregnancy (weeks).	Mother married, mother’s usual occupation, Born dead, months of pregnancy.
1955	Certificate of Fetal Death created for stillbirths.	
1956	Born dead.	Born dead after 20 weeks.
1968	Mother’s education, father’s education, date of last live birth, date of last fetal death, date last normal menses began, month prenatal care began, number of prenatal visits, complications not related to pregnancy, complications of pregnancy, complications of labor, congenital malformations or abnormalities, birth injuries.	Length of pregnancy (weeks).
1978	Apgar score (1 min, 5 min), mother married, other terminations (spontaneous or induced), date of last termination, concurrent illnesses or complications affecting this pregnancy, complications of labor and/or delivery, name and title of attendant.	Legitimate, born dead, date of last fetal death, complications not related to pregnancy, complications related to pregnancy, birth injuries to child, type of attendant.
1989	Format changed and increased in size. Name of facility, type of place of birth [checkboxes], mother transferred prior to delivery, infant transferred, mother’s and father’s date of birth, mother’s and father’s Hispanic origin, clinical estimate of gestation, medical risk factors (incl. anemia, diabetes, herpes, etc...) [checkboxes], other risk factors for this pregnancy (incl. tobacco use, alcohol use, weight gain, etc...) [checkboxes], complications of labor and/or delivery (incl. placenta previa, cord prolapse, etc...) [checkboxes], method of delivery [checkboxes], obstetric procedures (incl. amnio, EFM, u/s, induction of labor, etc...) [checkboxes], abnormal conditions of newborn [checkboxes], congenital anomalies of child [checkboxes].	Name of hospital, mother’s and father’s age, concurrent illnesses for this pregnancy, complications of pregnancy, congenital malformations or abnormalities.
2003	Place of birth incl. home birth (planned to deliver at home?), mother’s and father’s race [checkboxes], mother’s and father’s education [checkboxes], date of first prenatal care visit, date of last prenatal care visit, Apgar 10 minutes, characteristics of labor and/or delivery [checkboxes], chronology of labor and/or delivery [checkboxes], onset of labor [checkboxes], WIC during pregnancy, principal source of payment for delivery [checkboxes], infections present and/or treated during pregnancy [checkboxes], maternal morbidity [checkboxes], breastfeeding, pregnancy resulting from infertility treatment.	Month prenatal care began, Apgar 1 minute, alcohol use during pregnancy, Amnio, EFM, ultrasound, complications of labor and/or delivery.

¹¹ Sources: NCHS 1991; 2003.

Beginning in 1955, a Certificate for Fetal Death has been required for still births, instead of a live birth and death certificate, and in subsequent revisions, this certificate came to be modeled on the sorts of information collected on a Live Birth Certificate (Hertzell 1997).

Birth certificates remained relatively unchanged throughout most of the first half of the twentieth century. The largest change to birth certificates came in 1968, when a number of items relating to maternal and child health were added. For the first time, such variables as mother's and father's education, complications not related to pregnancy, congenital malformations, and birth injuries could be tracked. In addition, contemporary concerns about "reproductive wastage" and congenital abnormalities encouraged maternal and child health advocates to explore the role of prenatal care in the prevention of low birth weight, preterm birth, and infant mortality. This led researchers to advocate for the inclusion of two items to the 1968 revision, "month of pregnancy prenatal care began" in order to indicate the duration of prenatal care and "total number of prenatal visits" as an indication of the amount of care received (DHEW 1978).

The continued interest in investigating infant mortality led to one of the next innovations in the use of vital statistics. Public health officials and researchers are often looking for means in which to better understand the causes and factors associated with infant deaths. One of the techniques used by vital statisticians is the linking of live birth with (infant) death certificates. The first national linked file of birth and infant death certificates was created for the 1960 birth cohort. At this time, the cohort was created by collecting paper copies of linked birth and death certificates and creating punch cards for each pair of certificates. Using the linked files, researchers could begin to see larger trends in infant mortality by focusing on such variables as birthweight, gestational age, and maternal health, which are not evident from death certificates alone (Buehler, Prager, and Hogue 2000).

In 1980, the CDC's Department of Reproductive Medicine undertook the National Infant Mortality Surveillance (NIMS) project, in partnership with state health departments and the NCHS. This project involved creating a national database of linked death and birth certificates as well as a forum to discuss the findings. For many states, the request to participate in this project was their first experience with linking certificates. A number of studies resulted from these collaborations, and for the first time since 1960, large-scale conclusions about infant mortality and its link to such variables as birthweight, race/ethnicity, gestational age, and maternal characteristics could be made based on this database (Buehler et al 1987; Friede et al 1987; Strauss et al 1987; Zahniser et al 1987).

Beginning with the 1983 birth cohort, NCHS began collecting linked files on a routine annual basis. These data have been available for state and researcher use since this time. In 1995, the CDC changed the ways in which states provided linked data; instead of providing the data as a birth cohort, they were provided on a period basis, based on the year of the infant death (Hertzel 1997). When data are released as a birth cohort, all deliveries from a given year are linked to infant deaths from that year, i.e. all live birth certificates from 2001 are linked to infant death certificates in 2001. However, because infant deaths are defined as any time within a year after a live birth, some infant deaths may occur in the next calendar year, i.e. 2002. Therefore, data based on birth cohort often include a lag time of a few years as files are linked and adjusted (University of Florida and FDOH 2004). With the move to a death cohort-based linking system, (i.e. infant deaths in 2001 are linked to their specific birth certificates) data can be released in a more timely manner (Buehler, Prager, and Hogue 2000; Hertzel 1997).

While minor changes were made to the live birth certificate in 1978, including a designation of Apgar scores at 1 minute and 5 minutes, the next major overhaul to the vital

statistics certificates came in 1989. Not only was the format changed and the certificate increased in size, checkboxes were included in order to greatly increase the recording of various kinds of occurrences during pregnancy, labor, and delivery. Rates of infant mortality decreased by 90% over the twentieth century, from around 100 per 1,000 live births in 1900 to 7.2 per 1,000 live births in 1997 (CDC 1999: 849). Most of the recent reductions in infant mortality are related to decreases in birthweight-specific mortality, which is the result of saving more tiny infants with high-tech neonatal intensive care units (Alexander and Kotelchuck 2001; Moos 2006). The rates of infant mortality remained steady throughout the last decade of the twentieth century, but, surprisingly, showed a slight increase in the 2000 – 2001 cohort. Researchers argue that the stability and subsequent small increase are most likely related to a larger number of low birth weight infants; this in turn was hypothesized to be due to improvements in perinatal medicine, which could have shifted the results of death before delivery to death after delivery (MacDorman et al 2005). The biomedicalization of pregnancy is particularly reflected in the growth of perinatology, and the recognition of the fetus as a patient separate from its mother. I argue that this massive overhaul of the certificate in 1989 reflects changing attitudes towards pregnancy care, in particular a growing interest in and knowledge about the “unborn patient.”

The Move towards Maternal – Fetal Medicine

According to an early textbook on fetal physiology, “[T]he practice of perinatal medicine started when obstetricians, having resolved most of the problems of the mother, turned their attention to the fetus” (Beard and Nathanielsz 1976: v). Some of the earliest work in fetal therapy resulted from an Australian physician, Sir William Lilley, and his attempts to transfuse fetuses suffering from Rh disease in utero in the early 1960s. While fetal surgery was first attempted in New York and Puerto Rico in the 1960s, the first successful open fetal surgery did not occur until 1981 in California (see Casper 1998). Ultrasound imaging and fetal surgery provide drastic

bookends to describe the growth of fetal medicine, yet the prevalence of both of these practices today attests to their significance in contemporary reproductive experiences. Although women who experience fetal surgery during a pregnancy are a small fraction of those who have an ultrasound, both of these practices contributed to notions of the fetal patient.

The mid-1970s saw the publication of one of the first textbooks on fetal medicine, *Fetal Physiology and Medicine* (Beard and Nathanielsz 1976) and was followed by a number of other texts, particularly in the early 1980s, including *The Unborn Patient* (Harrison, Golbus, and Filly 1984). The move towards the recognition of the fetus as a separate patient is also evident through various editions of the textbook *Williams Obstetrics*. For the first time, the seventeenth edition notes that the fetus deserves the same meticulous care by “the physician that we have long given the pregnant woman” (1985: 139) and that the fetus is to be recognized with “the status of the second patient” (267). Previously, notions of fetal development and life were restricted to cadaver studies of anatomy, or observations by midwives and physicians during delivery. As noted by Sir William Lilley, “The legacy of this era is well known—particularly the attitude that, apart from some aimless kicking which began in the fifth month, the foetus [sic] was a placid, dependent, fragile vegetable who developed quietly in preparation for a life which started at birth” (1986: 9). Yet with developments in imaging technology and fetal therapy, physicians were able to observe fetal life, including movement, ingestion, sleeping, growth, and development. These observations led fetal therapists and perinatologists to amend their previous notions of fetal life: “The sonographic voyeur, spying on the unwary fetus, find him or her surprisingly active, not at all the passive parasite that was previously imagined” (Harrison 1984: 7). In addition, the ascendancy of fetal “agency” altered philosophies around maternal-fetal relations in utero: “Far from being an inert passenger in a pregnant mother, the foetus [sic] is

very much in command of the pregnancy” (Lilley 1986: 9). Fetal therapists began to argue that the fetus induces changes within a pregnant woman’s physiology, including ensuring the endocrine success of her pregnancy, solving immunological problems raised by its intimate contact with the pregnant woman, and determining the duration of the pregnancy (Lilley 1986). These ideological shifts in scientific notions of fetal life were also accompanied on a larger cultural scale, as fetal images began to erase graphic representations of the connection between woman and fetus [see also Chapter Five].

For many physicians, the care of the fetus became the priority of obstetrical care. A 1979 textbook was written arguing that all clinical solutions should be

considered from the in utero patient’s viewpoint, since it may be that only with this approach will a break with the dogma of the past occur, and perhaps better fetal health and development will be achieved. This is not to deny that maternal welfare is of concern to every obstetrician, but rather to suggest that we should consider and evaluate the fetus with every possible technique, and at every opportunity (Goodlin 1979: vii).

Fetal therapy and diagnostics began to pay increasing attention to pregnant women’s behavior and its effect on the fetus and, particularly, behavior that could have a negative affect on the fetus, such as alcohol use, tobacco, cocaine, or other illegal drugs. As noted above, these behaviors began to be tracked in the 1989 revisions to the U.S. Live Birth and Fetal Death certificates. Reproductive health experts increasingly depict a model of pregnancy which posits pregnant women and their fetuses as potentially antagonistic actors (Oaks 2001), often described as “maternal – fetal conflict.” Particular maternal behaviors, and increasingly, genetics and biology, present *risks* for a pregnant woman’s fetus. This notion of risk has become one of the dominant foundations of pregnancy care today. And to return to the underlying theme of this chapter, the intertwining narrative of statistics and prenatal care, it is crucial to explore how statistical theory is fundamental to ideas of risk, as subsequent statistical measurements of risk have contributed to a biomedicalization of prenatal care and the construction of particular kinds

of maternal and fetal subjectivities. A useful technique for examining these issues is through “following the numbers,” and the remainder of this chapter will use the Florida Linked Database of vital statistics to explore how contemporary use of vital statistics inform profiles of risk as utilized by Healthy Start.

Following the Numbers

Susan Greenhalgh (2005), in her study of population governance in China, describes three phases of governmental projects for population control: 1) constituting the object of governance (i.e. population); 2) establishing the problematization (including defining the problem with its solution); and 3) implanting a solution among the selected target population (356). She argues that most feasible and productive strategy to examine the political techniques involved in regulating such projects would be to “follow the numbers.” As her work in China demonstrates, and this chapter has argued, numbers have particular forms of power within the modern technologies of government, based on the assumption of their relation to scientific truth.

Numbers have particular force in the science and governance of populations. Because population is seen as a biological object, an aggregation of bodies that exists unproblematically in nature, counting, or estimating the ‘vital’ attributes of populations such as fertility and mortality, and then manipulating the numbers so as to chart their variations and distributions, are seen as the fundamental activities of the science of population (Greenhalgh 2005: 356 – 7).

Central to an inquiry into the sorts of subjectivities shaped by vital statistics, would be to “follow the numbers” – asking how these numbers have been collected, and how they have been deployed, in what contexts, for what aims, and by what techniques.

For a project interested in the technologies of risk, a closer examination of the collection and deployment of vital statistics is key in understanding the sorts of assumptions that inform these processes and the sorts of subjectivities shaped by them. To this end, the remainder of this chapter will take a closer look at the Florida Linked Database of vital statistics, and the ways in

which this data is utilized and deployed by Florida Healthy Start Coalitions, to create their Needs Assessment and Service Delivery Plan. In order to situate these numbers ethnographically, I will examine one variable or “risk factor,” the utilization of prenatal care, to explore subjective experiences in accessing prenatal care among Haitian women.

Healthy Start is a nation-wide program that is administered at the state-level, aimed at reducing infant mortality, reducing the number of low birth weight infants, and improving health and developmental outcomes. The Healthy Start Program (HS) was enacted in Florida in 1991, and includes the following key components: universal prenatal and infant risk screening; Healthy Start care and coordination services; community based prenatal and infant health care coalitions; children’s medical services expansions; and increases in Medicaid funding (Florida Department of Health 2003: 1 – 2). The Healthy Start system organizes the activities and services within a particular community, with the ultimate goal of supporting and enhancing its ability to promote optimal health outcomes for all pregnant women and infants born in Florida. There are thirty-two Healthy Start Coalitions within the state, often organized based on the county. Large counties typically have a singular coalition – such as the Healthy Start Coalition of Miami-Dade (HSCMD) or the Broward Healthy Start Coalition. Smaller (population-wise) counties are grouped together, for instance twelve counties make up the Healthy Start Coalition of North Central Florida.

The main focus of the Healthy Start system is to assure that all pregnant women in Florida have access to the prenatal and child health care services necessary to “reduce risk for poor outcome” (Florida Department of Health 2003: 5). This is mainly done through the coordination of assistance for women deemed “at risk” by Healthy Start for a poor birth outcome. Risk screening is required by law to be completed for each women receiving prenatal care in the state

of Florida, regardless of her income level or whether she is utilizing private or public obstetrical care. The Prenatal Risk Screen is a one-page form that asks a series of yes or no questions regarding tobacco use, alcohol use, stress during this pregnancy, timing of pregnancy, domestic violence, depression, and previous birth outcomes. The Prenatal Risk Screen is then scored, and patients are referred to the Healthy Start program based on the score.

The Healthy Start Coalition of Miami-Dade (HSCMD) is housed in a tall building in Little Havana, next to the InterAmerican Campus of Miami-Dade College. HSCMD has grown rapidly since its incorporation in 2001, from when it was a small office administered through the Miami-Dade County Health Department to a now independent agency with over forty employees. The Healthy Start system is structured such that Coalition offices are typically responsible for the coordination of care; that is, after Prenatal Risk Screens are filled out, scored, and returned to the Coalition office, care is initiated by providers within various partner agencies, typically public health clinics or other outreach agencies. For instance, if a woman scores “at risk” on her Prenatal Risk Screen, the Coalition office will contact her prenatal care provider, who will refer her to a local Healthy Start provider for on-going services. In addition to coordinating the care among Healthy Start clients, the Coalition office also provides childbirth classes, offers continuing education classes for various maternal and child health professionals within their network, provides grant writing and project management for a number of locally-based outreach projects, coordinates the federally-funded MomCare¹² program, and oversees the local Fetal and Infant Mortality Review project.

¹² MomCare is a Medicaid-funded program developed through a partnership of the Florida Healthy Start Coalitions, the Florida Department of Health, the Florida Agency for Health Care Administration, and the U.S. Centers for Medicare and Medicaid Services. MomCare seeks to improve birth outcomes and infant health by providing services to Medicaid eligible pregnant women, including simplified Medicaid enrollment; choice counseling for selection of maternity care providers; care management to assist with initiation and use of prenatal care; and Healthy Start services for at-risk women (HSCMD SDP FY2006 – 2010: 66).

At the Prenatal Clinic, Healthy Start providers were given space about a year after I had begun observing there. One of the providers, Kathia, is a twenty-nine year old Haitian-American woman who had taken a job with Healthy Start, after her cousin, a provider at another clinic, referred her for the position. Kathia moved to New York City from Port-au-Prince when she was six years old, and relocated to Florida with her family for college, speaks fluent Creole and self-identifies as a “Haitian woman.” I asked her to describe how Healthy Start works for the women who come to the Prenatal Clinic, and what kinds of services they offer:

K: If we see new patients, it’s mandatory for them to do the screen. Once they do the screen, depending on how they answer their questions, if they score in [to the program], we tell them about the program, basically that it’s a referral service. If you need to be referred to substance abuse, we provide that. That’s the first half of Healthy Start. The second half is education where we do breastfeeding, parenting, childbirth, smoke cessation, interconceptual counseling. And if they’re interested they sign up for the course and then its just more paper work. Once they’re involved in Healthy Start, every time they come into the clinic either myself or Maricel will go over some kind of education with them. If they’re not being referred elsewhere.

L: Do you find that Haitian women are receptive to Healthy Start?

K: Some, a lot of the younger ones, a lot of the younger ones are. Um, because they feel, you know, especially if this is their first baby. And they’re like, “Ok, there’s nothing illegal, right?” And you say, “No one’s gonna track you down.” So they’re pretty receptive to it. They’ll come and they listen. They’ll be shy for the first two or three classes. But then after they understand and ask questions, then they’re a little bit more comfortable with the whole program. But a lot of the older women are kind of stubborn. They need it, especially for the ones who it’s their first baby here in the States. They need to know that they need to clean the umbilical cord and stuff like that. In Haiti it just falls off, they put some stuff on it right away. So it’s very different from there to here. So they’re not very receptive to the program at all. They’ll sign up for it, and they’re like, “Alright I’ll just do it” and then after two or three classes you can tell that they’re really, really not interested.

L: Is this the childbirth classes or other kind of classes?

K: Childbirth, parenting, the breast-feeding. A lot of times they’re, “yeah, yeah, yeah.” I try to make it interesting. Maricel [another Healthy Start provider] will do the childbirth classes and I would end up having to translate for her. So I’ll try to translate it in a way where they’re forced to ask questions, you know what I mean? So they’ll have some kind of feedback. Otherwise they’ll just sit there and listen and then it’s, “Oh, so I go to see the doctor.”

L: Do you do the classes here or do you go somewhere else?

K: No, we do it here while they're here, at their clinic appointments, it's easier for them. A lot of them don't have transportation, so their husbands have to drop them off. So we try to fit everything into one doctor's visit while they're waiting. A lot of times, when they have in-house services like nutrition, our nutritionist will try to come out, and speak to them about their nutritional needs then too. So it's not like we're taking them away from their lives, or making it hard for them (Interview 3-22-06).

Both in Broward County and in Miami-Dade County, Healthy Start is aware of the challenges and issues in targeting and providing outreach to a diverse patient population. Beyond basic care and coordination, such as the services described by Kathia above, specific health outreach projects are targeted towards women and children who are considered most "at risk" for poor birth outcomes. As mandated by Florida's Healthy Start Initiative, these strategies are outlined within a four-year Service Delivery Plan, which is a comprehensive document outlining the initiatives to be undertaken by the Coalition, funding allocation, data on the population segmented to receive benefits, and gaps in service provision. Prior to compiling the Service Delivery Plan (SDP), each Coalition is expected to carry out a community-wide Needs Assessment in order to provide the context and foundation for the SDP (HSCMD SDP FY2006 – 2010).

The most recent HSCMD Needs Assessment was completed in June 2007, although preliminary versions assisted in the compilation of the SDP FY2006 – 2010. The Needs Assessment is a data-driven document organized to review maternal, infant, and child indicators throughout Miami-Dade County to assist in promoting HSCMD's primary goals: reducing infant mortality and the number of low birth weight and preterm births, while ultimately improving the health and developmental outcomes of newborns in the county and state (HSCMD NA 2007). The HSCMD convened a Data Committee to serve in an advisory capacity and provide recommendations and oversight of the Needs Assessment. The Committee met over twelve times

during 2004 to 2006, and was made up of various maternal and child health specialists and stakeholders from Miami-Dade County. While various data were compiled to complete the NA, the majority of data on key health indicators was computed using Florida's vital statistics linked datasets. The linked database project was developed as a service to Healthy Start Coalitions throughout the State of Florida, in order to inform planning and evaluating its program.

A collaborative partnership between the Florida Department of Health, the Agency for Health Care Administration, the Lawton and Rhea Chiles Center for Healthy Mothers and Healthy Babies, and the University of Florida Perinatal Data Research Center has resulted in this linking project. This dataset is based on delivery cohorts, which links live births and fetal deaths to Healthy Start prenatal and infant screens, infant deaths, Healthy Start prenatal services, Medicaid Eligibility, and WIC Services.¹³ In addition, the birth, fetal death, and infant death records have been geo-coded in order to provide census tract information. The files have been de-identified in the linking process, all personal identifiers were removed from the final linked file and unique fake identifying numbers were generated as record numbers.¹⁴

A certificate of live birth¹⁵ must be completed within five calendar days of the date the birth occurred. The birth record is filled out by the hospital administrator or designated representative of the facility where the birth occurred, and the attendant at birth, either a midwife, physician, or other person who attended the birth. In addition, the institution is

¹³ As noted above, a delivery cohort is a combination of Florida's recorded live births and recorded fetal deaths for the calendar year. For this project, I had access to data from the 2002 and 2003 delivery cohort.

¹⁴ Because these data are de-identified, this project was deemed "Exempt" by the State of Florida's Review Council for Human Subjects (Project RCHS 1362) and the University of Florida Institutional Review Board (IRB Protocol 2004-U-24).

¹⁵ According to the State of Florida, a "live birth" is defined as: "the complete expulsion or extraction from its mother of a product of conception, irrespective of the duration of pregnancy, which after such separation, breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached; each product of such a birth is considered live born" (Florida Department of Health 2005: 10).

responsible for tracking down the medical details of the birth and previous care (Florida Department of Health 2005). Often, the mother will be asked for medical information while she is recovering from the birth. Certificates are then sent to the local registrar, of which there are 67 (correlated to counties) in the state. Local registrars are responsible for data entry and clarification of indecipherable fields by calling the hospital or birthing institution. Although there are regular training sessions and specific directions for completing the forms, in many cases certificates are not completed accurately, requiring a lot of problem management by local registrar offices (Schmitt 1999).¹⁶

Similarly to live birth certificates, fetal death¹⁷ certificates must be completed and filed within five calendar days of fetal death. If the fetus breathed or showed any sign of life, regardless of gestational age, this cannot be classified as a fetal death, and instead, a live birth and death certificate must be filled out. As noted above, fetal death certificates contain most of the same information as live birth certificates. For infant deaths, death certificates are filled out for children who were 364 days or younger at their time of death. In maternal and child health, infant deaths are often designated as “neonatal” or “post-neonatal.” Neonatal deaths occur in the first 28 days, and post-neonatal deaths from 29 days through 364 days (Florida Department of Health 2005). As described above in a description of linking projects, infant death certificates are then linked to the infant’s birth certificates, which leads to a lag time in the release of data, as delivery cohorts cannot be released until a full year has passed to be sure that all infants deaths

¹⁶ It is important to note that this process results in a relatively complete linked datasets. This is not the case for many States or municipalities. In conversations with anthropologist Sarah Orndorff, who is currently at George Washington University and doing similar analysis with vital statistics, claimed that the local datasets in Washington, D.C. are missing a lot of data (personal communication 11-29-07)

¹⁷ A “fetal death” is defined as: “a death prior to the complete expulsion or extraction of a product of human conception from its mother if the 20th week of gestation has been reached and the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles” (Florida Department of Health 2005: 83).

can be linked to the appropriate cohort. Data for the HSMCD NA 2007 utilized vital statistics from 2000 – 2003.

In a note about positionality, it is important for me to reveal my roles throughout the HSCMD Needs Assessment process. Through my connections at Sant La, the Haitian Neighborhood Center, I found myself one day at the United Way of Miami-Dade talking to the Associate Director for Community Outreach about their health outreach projects among Haitians in the county. She referred me to Healthy Start (which at that time was housed upstairs from the United Way) as a place to learn more about maternal and child health projects throughout the county. I quickly found myself upstairs and meeting with Manuel Fermin, the Executive Director of the Healthy Start Coalition of Miami-Dade, who seemed intrigued with my qualitative research skills, and passed me on to Diana Sierra, their Research and Planning Manager. Diana informed me about their upcoming Needs Assessment, and that one important aspect of this process would be a qualitative component involving a number focus groups with different stakeholders in “at risk” neighborhoods throughout the county. Within a few weeks, I found myself hired as a consultant for the Needs Assessment, and as a fully ensconced member of the HSCMD Data Committee.

I had long been intrigued by the use of vital statistics as a means to create health portraits of populations, and I imagined that participating in the Data Committee would be an interesting way to “follow the numbers,” observing as statistical data becomes compiled and manipulated to determine areas and communities of need, and subsequently, the sorts of subjectivities that are shaped by this process. My own identity at these meetings became multi-faceted and shifting; initially I was referred to as “the student” who would be assisting in the qualitative phase of the process. As the Needs Assessment work wore on, I became accepted as “staff” of the Coalition,

and was often introduced this way during meetings. But to complicate things, I continued to spend most of time at Sant La, and was slowly being given more responsibility and more public visibility as the Health Policy Specialist at this agency. This involved representing Sant La at public health or health policy meetings that neither Gepsie Metellus (Executive Director) nor Leonie Hermatin (Director of Research and Planning) could attend. As many of these meetings involved the same groups of people, I quickly became recognized as a representative for the “Haitian Community,” and it was expected that I could (and would) represent their interests and needs in these various spaces.

My own interest in the linked data files developed as I realized that vital statistics are one of the few ways to make Haitians “visible” statistically in the state of Florida. While census data allow people to self-identify by writing in their “race/ethnicity” or by language used in the home, Haitians have been historically undercounted by U.S. Censuses (see Stepick and Stepick 1992, 1995). Florida Live Birth, Fetal Death, and Death Certificates contain a variable for race and “Of Hispanic or Haitian origin” for both the mother and father (on the birth and fetal death certificate) and for the deceased on the death certificate. Those who fill out the form can check “yes” or “no” and then subsequently check “Mexican,” “Puerto Rican,” “Cuban,” “Central/South American,” “Other Hispanic,” or “Haitian.” Maternal and child health indicators can then be computed based on these variables, leading to specific indicators for the Haitian community.

As noted in the introduction, the experiences of Haitians in the United States have long been shaped by the biopolitics of the AIDS epidemic. Therefore, what does it mean to use statistics to create specific quantitative representations of a community – as if this community is bounded through biology or ethnicity? How would using these statistical portraits be any different than reifying Haitian-ness along the lines of the “4-H” club or previous designations of

Haitians as an HIV-risk group? I found myself in a “double bind,” as described by Kim Fortun (2001:11) in her work with various stakeholders in the aftermath of the Union Carbide chemical plant explosion in Bhopal, India. As advocates, often times we must reify bounded identities, in ways that are strategically configured: “collectivity is not a matter of shared values, interests, or even culture, but a response to a temporally specific paradox” (11). In the process of grant writing, and bringing to light the issues that face the Haitian community, I found myself, along with my co-workers at Sant La, drawing on very simplistic portraits of Haitians as “at risk” or “in need.” Fortun (2001: 53) describes this in reference to her work in Bhopal:

Ready, or not, I would have to see what it means to play a double game, strategizing the ways to represent the Bhopal disaster, aware of the inadequacy of the available idioms. Competing demands would structure the work: Demands to acknowledge the unfigurability of disaster alongside demands for categorization – thrown into high relief in all attempts to render the disaster into the chronologies and comparisons needed to demonstrate responsibility. Demands to acknowledge both contingent particularity of example and the universally valid – visible wherever stories of the disaster were turned into lessons for other places and times, rendering the experience of victims significant by emptying it of specificity.

Obviously portraits of Haitians in need are also grounded within a reality – there are a number of Haitian families throughout South Florida who struggle below the poverty line, often times children with parents who are working multiple low-wage jobs because of their illiteracy and poor English. Living in the United States as an undocumented migrant has severe impacts on strategies to seek health care or assistance through state agencies. As one of many communities struggling in one of the “poorest big cities”¹⁸ in the United States, Haitian community based organizations and social service agencies must project a community in great need or at great risk in order to appeal to rapidly shrinking sources of funding.

¹⁸ According to the 2000 U.S. Census, Miami was rated as the “poorest big city” in the United States (Miami New Times 2002). In the years since the 2000 Census, Miami has remained in the top five.

Yet postcolonial and “Third World” critiques of feminist theory have demonstrated the problematic assumptions that underlie writings assuming collective identities and sameness across groups (Haraway 1991; Lock and Kaufert 1998; Mohanty 1991). Instead, I turn again to Fortun (2001), who argues that being mindful of these double binds can become valuable – by organizing the analysis around these categories, we can begin to better understand the efficacy and problems inherent within these categories. Furthermore, tracking these double binds allows us to glimpse the new kinds of subject positions which emerge through these processes. While the majority of this chapter has focused on what Ian Hacking imagines as the process of “making up people from above,” I would like to now turn to this process from “below.” That is, how are subject positions imagined through epidemiological risk profiles embodied by those they assume to represent? Are Haitian pregnant women simply the “docile bodies” that animate statistical forecasts of poor birth outcomes (Foucault 1995)? Or can their narratives assist us in examining how individuals are active subjects operating in specific socio-political and historical contexts (Brotherton 2005; Lock and Kaufert 1998)?

“Utilization of Prenatal Care”

Based on extensive literature review searches and conversations within the Data Committee meetings, members chose seven health indicators as critical for determining geographic areas of need. Healthy Start program services are based on a zip code analysis, although throughout the Needs Assessment process, zip codes were discussed in conjunction with the community that inhabited that area. In order to determine the areas of “risk,” the Data Committee conducted a zip code analysis of the seven critical indicators that became the standard measure in identifying geographic priority areas of need. These critical health indicators were utilization of prenatal care, birth to teens, births to unwed mothers, preterm births, low birthweight births, fetal mortality, and infant mortality. The ten leading zip codes for each

indicator were then compiled within a matrix which clearly highlighted zip codes that are disproportionately affected by these areas of need. These zip codes were then grouped by their “common” neighborhood (HSCMD NA 2007). So for instance, when the Data Committee choose 33162 and 33168 as a particular area of “risk,” Committee members referred to this area as North Miami, North Miami Beach, Miami Shores, and Little Haiti, understood to be the center of the Haitian community in Miami-Dade County.

In addition, throughout the HSCMD Needs Assessment, data was often classified by “maternal race/ethnicity”¹⁹ into the following categories: “Non-Hispanic White,” “Non-Hispanic Black,” “Hispanic,”²⁰ “Haitian,” “Non-Hispanic Others,” and “Unknown.” The Needs Assessment concludes a presentation of the quantitative data with the comment: “Overall, it is evident from the data that Non-Hispanic Black and Haitian women have a higher rate of almost all of the risk factors designated as critical for evaluating risk among a given population. These two groups also have disproportionately higher rates of births to teens, low birth weight, preterm birth, fetal mortality and infant mortality” (HSCMD NA 2007: 179). While each of these risk factors could lead to an elucidating exercise in situating quantitative notions of risk within Haitian women’s lived experiences, I will concentrate on the “utilization of prenatal care,” which is often designated as a “direct contributing factor” to poor birth outcomes, such as low birth weight, preterm birth, and fetal and infant deaths (HSCMD SDP FY2006 – 2010: 43).

¹⁹ When using vital statistics the importance of using linked datasets and compiling infant health outcomes based on maternal race/ethnicity becomes abundantly clear. Initial comparisons between earlier Needs Assessment and the HSCMD NA 2007 demonstrated a marked difference in infant mortality among Haitians. This difference resulted from the previous NA relying on decedent race/ethnicity of the infant as the way to “classify” Haitian infant deaths. For more details about how this misclassification comes about, see Fordyce, Sierra, and Brown n.d..

²⁰ In some HSCMD NA 2007 tables, Hispanic was broken down further to include: Cuban, Puerto Rican, Central/South American, Mexican/Other Hispanic. This classification scheme is reflected on the birth certificate, as described above.

I was also interested in the quantification of the utilization of prenatal care because throughout my fieldwork, whenever I explained my interest in researching Haitian and reproductive health, most health policy and community advocates automatically commented – “because they aren’t getting prenatal care, right?” The other assumption is that Haitian women begin prenatal care late in their pregnancy, with the implied belief that they are jeopardizing their future child by not beginning biomedical prenatal care early in their pregnancy (i.e. during the first trimester). Therefore, the larger discourse surrounding Haitian women and prenatal care is that 1) they are not interested in prenatal care, and 2) that when they do seek care, they begin care later in their pregnancy. Oftentimes, this was presented to me as the assumption that pregnant Haitian women do not believe that they need prenatal care – that they did not get care in Haiti so why would they go to the doctor in the United States? Using data from the Florida Linked Vital Statistics datasets, the HSCMD Needs Assessment, and my own interviews with pregnant Haitian women and their providers, the remainder of this chapter will take a closer look at the socio-political dimensions of accessing prenatal care for Haitian women in South Florida.

The Healthy People 2010 target for percentage of live births in which the woman initiated prenatal care in the first trimester (1 – 3 months) is 90%, and the 1998 baseline measurement found that 83% of women in the United States reach this target (Healthy People 2010). Haitian women living in Miami-Dade County met this baseline, with 85% in 2002 and 84% in 2003 beginning prenatal care in the first trimester. Numbers for Broward County are significantly lower, with 75% of Haitian women in 2002 and 77% in 2003 initiating prenatal care in the first trimester (Table 2). This could reflect a number of things – the community in Broward County is less organized and not as established, with fewer community-based organizations in that area targeting the Haitian community and assisting them in accessing the health care system. Haitians

living in Miami-Dade County have access to Jackson Memorial Hospital, the large public hospital system and teaching institution that is affiliated with University of Miami and serves the majority of the uninsured and undocumented population within the County. The Jackson Hospital System has a number of clinics throughout Miami-Dade County, a number of them situated in Haitian neighborhoods. In Broward County, the hospital and clinical system is a bit more fragmented; while the North Broward Hospital District serves the uninsured and undocumented within Broward County, the majority of their clinics are located around Ft. Lauderdale and do not serve the entire County.

Table 2–2: Initiation of prenatal care among Haitian women in Miami-Dade and Broward Counties, 2002 to 2003.²¹

	Dade 2002		Dade 2003		Broward 2002		Broward 2003	
1-3 months	1580	85%	1667	84%	1406	75%	1465	77%
4-6 months	243	13%	270	13%	366	20%	340	18%
7-9 months	31	1.5%	38	2%	75	4%	76	4%
None	13	0.5%	17	1%	29	1%	20	1%
Total Live Births	1867		1992		1876		1901	

When I asked Kathia, the Healthy Start Provider at the Prenatal Clinic about her experiences with the educational component of Healthy Start services, she explained that at times it could be frustrating because Haitian women could be “stubborn” about some things:

K: Haitian women are stubborn. They are, sad to say [laughs] because I am Haitian. Haitian women are really stubborn and a lot of the younger ones will kinda conform to the American way. But a lot of the older ones, it’s really hard to get them to do things the American way especially when they’re just getting here. Two years, three years, they’ve only been here for six months and they’re pregnant. So they’re still in that Haitian mentality whether they are here or not, they’re still in Haiti. So a lot of things, they’re kind like, ‘Ok, well I am used to doing it this way,’ and we’re like, well you can’t do it that way here.

L: What kinds of things do they have a hard time conforming to?

²¹ These numbers were computed using the Florida Linked Vital Statistics datasets for Miami-Dade County (2002 – 2003) and Broward County (2002 – 2003).

K: Just coming to the doctor, period, just prenatal care in general. A lot of them will come in towards the end of their second trimester; and it's like why didn't you come to the doctor when you found out you were pregnant. And they're like, 'because I was fine.' Did you have morning sickness? 'Yeah, I threw up.' But you didn't come to the doctor? Yeah, what if you had lost the baby? 'Uh! That won't happen. In Haiti, when we're in Haiti, we don't go to the doctor until we give birth!' And it's like, here you can't do that, you have to come. Here, they file for Medicaid and I stress to them to get the hospital's plan, the financial assistance from the hospital from their very first visit whether they enter Healthy Start or not. I *stress* that they seek other kind of financial assistance for their prenatal care. Of course they don't take it seriously so their Medicaid cuts off and then when they come to the doctor they have to pay their \$50 plus that \$40 for labs, or whatever it is and then they don't want to pay it. So then they're no-shows from that point on. Then they hear from other people that when you don't have to go to the doctor, when it's time for you to deliver they'll give you emergency Medicaid. So they stay home throughout the rest of their pregnancy. The younger ones, we can kinda scare, not even scare but kinda intimidate them into coming for prenatal care. But the older ones, especially since they've had kids before, they're like, man, I've been through this four times already, I don't need a doctor to tell me that the baby is fine. I'll just wait, and they'll give me the emergency Medicaid and then they don't have to pay for anything, and I'll be good. They know when they're in labor.

To contextualize Kathia's comments about beginning prenatal care during the second trimester, in the majority of my observations at the Prenatal Clinic (the same clinic where Kathia is based), Portia, the main provider and nurse practitioner, oftentimes explicitly discouraged women from beginning their prenatal care during the first trimester. For Portia, this strategy reflected two things: First, it ensured that the pregnancy was viable. Given that the majority of miscarriages occur during the first trimester, and in most cases a spontaneous abortion during this time is not preventable or treatable, there is little a provider can do in this period beyond basic education. The fetal hearttone monitor (discussed in detail in the next chapter), one of the key technologies utilized in the prenatal visit, cannot detect fetal hearttones until the latter part of the first trimester. Second, it is also an issue of resources. For those women who are relying on Emergency Medicaid, with only forty-five days of coverage, initiating care early in the pregnancy precludes Medicaid coverage of the more expensive diagnostic tests that would be administered later in the pregnancy.

Danise, a thirty-one year old woman who was pregnant with her second child, described in her interview how she ended up at the Prenatal Clinic after initiating care at a private clinic near her home. She has lived in Broward County for six years, and although she is undocumented, she is a single mom who works as a security officer full-time to support her son.

D: I went to the doctor, so. I didn't know I was pregnant, since I didn't have my period for like two months, I was like, ok, let me go check the doctor. But I bought a pregnancy test, and it said that I was pregnant, but I still couldn't believe it, because I didn't feel anything. [laughs] And then I went to the doctor and they told me I was pregnant, and I was ten months, ten weeks pregnant. And I was so surprised! I thought that I was not going to have another baby. Cause, I have been with my boyfriend since... I never got pregnant, I never used anything, [laughs]. So it surprised me that I got pregnant.

L: How did you pick out the doctor you originally went to?

D: The nurse that was helping me fill out the Medicaid, she asked me if I have a doctor, and I said no, and she said, 'Ok, let me pick one for you.' She gave me one which is not very far from my house. I went, ok. ...The thing is, I had Medicaid before. Now suddenly they tell me that I don't have anymore Medicaid, but I went to the doctor, the first visit was \$250. And I was like, oh! [laughs] It's a private doctor, and every visit I have to pay \$250, \$150, I don't know what. Let me go to [Prenatal Clinic], and have an appointment. And then after two weeks, I receive a letter that says they review my case, and I have Medicaid until the 31st. Now after the 31st, I am going to have to pay the clinic.

L: And you started going to the Prenatal Clinic because it was close by?

D: Yeah. It's close, and it's cheaper! [laughs] That's why! Yeah, tomorrow is the last day, the last day [of her Medicaid]. So my next visit I am going to have to pay (Interview 1-30-06).

My conversation with Danise reflected many of the issues brought up by Kathia—that many of these women are encouraged to sign up for Medicaid in the beginning in order to get them into prenatal care. Oftentimes, this temporary coverage will be used up seeking care a private clinic, and once the coverage runs out, there will be a period of time where women may be without care while they locate more affordable coverage.

For some women, accessing prenatal care can become difficult as they negotiate family obligations as well. Valerie, who was seven months into her first pregnancy in the United States,

explained how caring for her father sometimes took precedence over accessing regular prenatal care in Florida.

L: When did you start going to the doctor for your pregnancy?

V: At three weeks, but my father was sick. You know when you have uh, old people they want to do things so I don't have a choice. Because I am the first uh, kid, child in my family. I have to travel with him, go to Haiti, go back here, so sometimes I just go when I can go to the doctor, he give me some medicine and go back to Haiti, so.

L: Did you see a doctor when you were in Haiti at all?

V: Yeah just to see if everything is ok for the baby, so he told me everything was ok, and I said all right, I come here [to Florida]. So, I tried to see the doctor often (Interview 7-5-06).

This practice of seeking prenatal care during travel was not uncommon among Haitian women. When patients missed a series of visits at the Prenatal Clinic in Broward, Portia would often ask them why they had missed their appointments. In a number of cases, women had traveled to Haiti and would bring notes or ultrasound images from visits with doctors there.

Another aspect of investigating the utilization of prenatal care is to examine the number of visits of prenatal care accessed per pregnancy. As discussed above, the American College of Obstetrics and Gynecology (ACOG) has recommended that prenatal care be initiated as early as possible and continued throughout the pregnancy. Since 1965, ACOG has recommended that all pregnant women received at least thirteen prenatal visits during a full-term pregnancy (ACOG 1965).²² In 1989, a report by the Public Health Service Expert Panel on the Content of Prenatal Care recommended at least 10 prenatal examinations as an adequate number for women in good health. According to data from the HSCMD Needs Assessment 2007, the number of women who received 10 or more prenatal care visits declined among all race/ethnic groups from the years 2000 to 2003. Yet according to data available in this document, it is evident that Haitian women

²² American College of Obstetricians and Gynecologists (ACOG). Manual of Standards in Obstetric-Gynecologic Practice. 2nd ed. Chicago, IL: ACOG, 1965.

in Miami-Dade County accounted for the highest percentage of pregnant women receiving ten or more prenatal visits during their pregnancy in 2003 [See Chart 2 – 1].

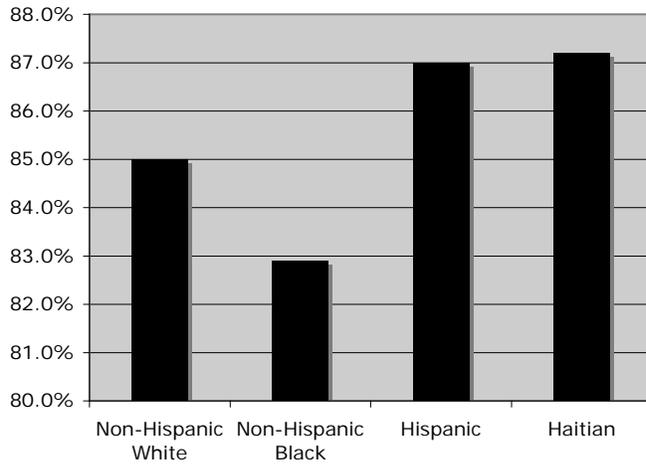


Figure 2–1: Percent of women who received 10 or more PNC visits in Miami-Dade County, 2003²³

Yet using data from the Florida Vital Statistics Linked Datasets, there is a significant difference between Haitians in Miami-Dade and Broward County [See Table 3].

Table 2–3: Number of prenatal care visits among Haitian women in Miami-Dade and Broward Counties, 2002 to 2003²⁴

No. of Visits	Dade 2002		Dade 2003		Broward 2002		Broward 2003	
0 - 4	37	2.0%	52	2.6%	132	7.0%	148	7.9%
5 - 9	150	8.0%	203	10.2%	477	25.6%	429	22.8%
10 - 15	1548	83.0%	1638	82.3%	1173	63.0%	1204	63.8%
16 +	131	7.0%	97	4.9%	82	4.4%	105	5.5%
10 +	1679	90.0%	1735	87.2%	1255	67.3%	1309	69.4%
Total Live Births	1866		1990		1864		1886	

These differences could contribute to the frustrations experienced by Kathia in trying to encourage Haitian women living in Broward County to utilize prenatal care. However, it is important to caution against assumptions that “culture” is the key variable that prohibits Haitian women from seeking prenatal care. An excerpt from an interview with Dr. Jean, a family

²³ The data for this chart was adapted from the HSCMD Needs Assessment 2007: 36.

²⁴ These numbers were computed using the Florida Linked Vital Statistics datasets for Miami-Dade County (2002 – 2003) and Broward County (2002 – 2003).

practitioner who had worked for a number of years within the Jackson Health System before moving to practice in South Dade, elucidates some of the myriad issues which face the access of prenatal care by Haitian women in Miami-Dade County.

L: What do you think are some of the challenges that Haitian women have seeking health care in the U.S.? Do you see differences in south Dade [County] versus women in Jackson [Health System]?

J: I don't think there is a difference. If you look at socio-economics for the more educated and more middle class Haitian women, I think they do well in having access to any care provided that they have health insurance or they have the money to have access. But for the lower level, like the ones that don't read that have to survive, it's difficult because of language barriers. The other thing is the culture that they can wait because they're not gonna give up their work to go to the doctor because this is a priority. Access to care, not knowing where to go, lack of education, lack of information. If they are lucky they deliver where other Haitian women went or by word of mouth they will go there. But if you are isolated and you don't know where to go this is where they get lost in the system until they end up in the hospital to deliver.

L: Do you think the majority of women are getting prenatal care or not?

J: I don't know. The advantage I think is more and more with education and the radio and all that. Because now with the Healthy Start program you have women knowing that if you are pregnant they can get Medicaid and they can get some coverage. And I think that increases the number. But in terms of overall prenatal care, I don't think so. Before I left Jackson [Health System] I had one that came in, she was already seven months with high blood pressure and high risk. We had to refer her to Jackson because her blood pressure was high. She never had any care and she in Miami in Little Haiti.

L: Do you think it's because of lack of resources, or do you think it's that they don't think they need to go?

J: I don't think so. Because even in Haiti where they didn't have anything, they would go. When I was at Albert Schweitzer hospital [in Haiti] and they had good coverage and the midwife, we knew about all pregnant women in the district. They knew who was pregnant, who was not pregnant and who was seeking care. And they required them to have three contacts with the health system. If you made three contacts that was great because it was indicated that they were looked at. I think they know it's important because they know the doctor is gonna give them vitamins. It's not because of lack of resources. It's because of not knowing what to do. You will find some of them not coming because they are afraid if INS catching them because some of them are illegal, or depending on a man to take them because they don't know their way around (Interview 9-22-06).

The differences between the utilization of prenatal care in Broward County and Miami-Dade County could reflect a number of things – the Haitian community in Broward is less established and less organized, with fewer community-based organizations in that area targeting this community and assisting them in accessing the health care system. Haitians living in Miami-Dade County have access to Jackson Memorial Hospital, the large public hospital system and teaching institution that is affiliated with University of Miami and serves the majority of the uninsured and undocumented population within the County. Jackson is but one of several federally-subsidized hospital systems in the County which serve undocumented and low-income families. In Broward County, the hospital and clinical system is a bit more fragmented; while the North Broward Hospital District serves the uninsured and undocumented within Broward County, the majority of their clinics are located around Ft. Lauderdale and do not serve the entire County. Also, Dr. Jean’s comment on Healthy Start is instructional; the HSCMD has been extremely proactive in marketing their “product,” the importance of prenatal care and completing the Prenatal Risk Screen for the past few years throughout Miami-Dade County. Broward’s Healthy Start is smaller and their Coalition has been more recently reorganized, therefore, their presence is not as widespread within that county.

To return to the process of “following the numbers,” based on the data culled from the HSCMD Needs Assessment 2007, the HSCMD Service Delivery Plan FY2006 – 2010 targets Non-Hispanic Blacks and Haitians as the key “at risk” communities. The three health problems targeted for intervention and outreach are infant mortality, low birth weight, and preterm birth. Within each of these health problems, “inadequate or late prenatal care” is designated as a contributing factor, and strategies to target these problems focus on “Outreach to women of childbearing age, especially non-Hispanic Blacks and Haitians regarding early and ongoing

prenatal care” (HSCMD SPD FY2006 – 2010: 43). My intention is not to demonize the Healthy Start’s strategies nor to disagree that outreach is ineffective. Instead, I used qualitative data from my conversations with pregnant Haitian women and their providers to describe some of the socio-political context to the issues of accessing prenatal care in South Florida.

Using vital statistics to demonstrate the heterogeneity of birth outcomes among women of African descent (i.e. “Haitian” versus “African-American”) can assist researchers in problematizing genetic and biological assumptions about race. In addition, they can help providers and social service agencies to create powerful portraits of need. Yet, as argued by Haraway (1997: 218), “the categories of biology often become universal donors in the circulatory systems of meanings and practices that link the family, state, commerce, nature, entertainment, education, and industry.” For Haitians living in South Florida, already understood as a “risk” group as a result of their historical legacy related to the biopolitics of HIV/AIDS, the use of vital statistics as evidence can be both emancipatory and problematic.

Haraway argues that the “statistics of freedom projects,” statistical analysis situated within justice-oriented policy formation, can be a vital component of moral and political reflection and action. “Credible statistical representation is one aspect of building connection and coalition that has nothing to do with moralistic ‘standing in the place of the oppressed’ by some act of imperialistic fantasy or with other caricatures of feminist intersubjectivity and feminist standpoint” (Haraway 1997: 198). In situating quantitative methods and evidence within a larger qualitative work, statistical freedom projects can expose the contradictions between subjective experience and ideology. We can begin to understand how individuals come to embody ideological knowledge as natural, even in cases where this knowledge may conflict with their own subjective experiences, by juxtaposing the institutional narratives with expectations about

pregnancy and risk (Lock 1993). As Lock (1993: xli – xlii) notes, “Ideology infuses subjectivity: many ideological practices shape ordinary everyday events based on tacit knowledge or unexamined assumptions that pervade our speech and behavior in social groups.”

Fundamental to discussions of the use of vital statistics as evidence are the ways in which they have become intimately tied to constructions of risk in maternal and child health. As demonstrated in this chapter, the intertwining histories of vital statistics and the biomedicalization of prenatal care has led to the categories of “low risk” and “high risk” as foundational within contemporary obstetrical practices. In the next chapter, I will examine this “clinical” notion of risk by demonstrating the ways in which these risk categories structure the everyday practices of Portia, a nurse practitioner, as she administers routine prenatal care in Broward County, Florida. In addition, building on Hacking’s “vectors” for “making up people,” the following chapter will explore these processes from “below,” situating Haitian pregnant women’s narratives of “lay” risk within these larger discourses of “clinical” risk.

CHAPTER 3
DOCUMENTING RISK:
EVERYDAY PRACTICES OF PRENATAL CARE

Everyday practices within the prenatal clinic evoke mounting narratives of risk. In the previous chapter, I described the intersections of epidemiological and clinical notions of risk, and demonstrated their implications for both fetal and maternal subjectivity. In this chapter, I take a closer look at clinical narratives of risk and the ways in which they contribute to shifting notions of subjectivity by examining the everyday practices within the prenatal clinic. Illustrating the daily tasks of documenting clinical encounters, listening to the fetal heart tones, and encouraging the use of biomedical prenatal diagnosis technologies, I argue that these everyday practices enact particular assumptions about maternal (and fetal) subjectivities.

In an examination of clinical practices, it is important to acknowledge the biopolitics of policies governing prenatal risk in the United States. Current biopolitical policies are informed by the politics of fetal rights, which have specific implications for providers and the practice of reproductive health care. In order to contextualize this discussion, I briefly turn to the practice of prenatal care in rural Haiti. I describe the “technologies of self” employed by Haitian women in Haiti and South Florida as a means to illustrate the narratives of maternal and fetal health implicit within these practices. I then turn to an ethnographic description of an urban public prenatal clinic in Ft. Lauderdale, Florida, where technologies of risk are implicated in a different sociopolitical world. I examine Haitian women’s decisions to engage with biomedical technologies of prenatal diagnosis, and how these decisions intersect with dominant narratives of maternal and fetal risk. Finally, this chapter describes how patient-provider interactions within the prenatal clinic are shaped by these multiple discourses on risk.

Haitian Technologies of Self

In striking contrast to my experiences in securing permission to do clinical observation in South Florida, observing medical care in rural Haiti was a very different matter. Notions of patient privacy become radically reworked during patient-provider interactions outside of a traditional American clinical setting. In Haiti, mobile clinics typically travel deep into the countryside, to areas where most people would have little or no access to medical services. Clinics are generally set up inside a small concrete building that serves as the village church or school, with patients triaged outside, and medical students working in groups of two or three, interviewing patients with the help of an interpreter. Diagnoses were made while we were all squeezed into this hot, stuffy church, stepping over chickens, trying to discourage whoever was peeking in the doorways seeking to “overhear” what the *dokté blan* prescribed.

Pregnant women were triaged first, and they are the first people you see, sitting and fanning themselves with their intake cards, waiting their turn. [Figure 3 – 1].



Figure 3–1: Pregnant women waiting for prenatal care in mobile clinic in rural Haiti, 2004.²⁵

²⁵ Photo by Lauren Fordyce.

Prenatal care in this setting is predominantly tactile: the stethoscope is used to determine the fetal heartbeat; the woman's blood pressure is checked; and her abdomen is palpated to determine fundal height and fetal position. Often she is asked only two questions – whether she has any pain or if there has been any fluid or blood discharge from her vagina. In Haiti, with one of the highest rates of maternal mortality²⁶ in the Western hemisphere, prenatal assessment remains focused on maternal risk. This is not to say that women and providers are not interested in fetal and infant health, but within the technologies of risk that exist in rural Haiti, maternal health is prioritized.

Haitian women living in both rural and urban areas describe a number of self-care techniques, or “technologies of self” which they utilize during pregnancy. In most cases, these remedies and techniques focus on maternal care – and these practices traveled with Haitians to South Florida, where many of the women I interviewed could describe these practices. Past research has noted very little in the way of “traditional beliefs” during pregnancy among Haitian women living in the United States. Harris (1987), interviewing eleven Haitian women living in the northeastern United States, commented that most advice during pregnancy has tended to focus on the post-partum period rather than on the prenatal period. While women were advised to follow any cravings during pregnancy, in the post-partum period, there were particular food prohibitions such as women avoiding food that is white because it can increase vaginal discharge. Seidman (1990), modeling her research on the study by Harris (1987), interviewed five Haitian-American women in the Boston area. Her research reached the same conclusion that the “traditional beliefs” focus on the post-partum rituals of herbal baths and abdominal binders, to help women gain their pre-pregnancy figures.

²⁶ The most recent available (2001) estimate for maternal mortality in Haiti was 523 per 100,000 live births (www.paho.org/english/sha/prflhai.htm).

One of the most common health practices among Haitians living in Haiti and in South Florida is the use of medicinal teas or *fèy*. The herbs for these teas can be collected around South Florida (many families grow the plants in their back yard) or purchased at “botanicas” or local shops which specialize in vodou supplies and “folk remedies.” According to a survey by a local community-based organization in 2004, there were twelve botanicas in the Little Haiti and North Miami area at that time (Little Haiti Community Collaborative 2004). The most common tea recommended during pregnancy is “*asorosi*,”²⁷ which is believed to clean and strengthen the blood during pregnancy. One of the women I interviewed, Rose, has a grandmother who is a *famn saj* (midwife) in Haiti and gave her very specific diet advice:

She always tell me you have to drink some tea. Like outside, I don't see it, I don't know how they call it here, but it's like something you take. [What's it called in Kreyol?] *Asorosi*. She tried to tell me also, you have to drink a lot, a lot of, I don't remember how you call it, it's like a carrot, that's Haitian, carrot. You put it in the blender, and she said you have to eat leafs, maize. I don't eat the leafs. She said that it is going to clean your stomach. Because you know when you are first pregnant, sometimes your face not feel right. Then try to drink it, it will make your stomach all clean (Interview 6-9-05).

A Haitian friend later pointed out to me that *asorosi* is supposed to lighten the baby's skin if you drink it while you are pregnant (Ariel Dominique, personal communication 7-28-05).

Marie, who had recently given birth to her first child in the United States, explained that she tried to take care of herself during pregnancy the way that her mom had taken care of her during her two previous pregnancies in Haiti. This included using herbal formulas that she bought at the local botanica.

When I was in Haiti, it's different. 'Cause when my mom was there, my mom's family was there, too, to help me, to help me out and give me some tea. To keep inside, inside me warm, to be strong. That's why I know, and I always help myself the way I used to be in Haiti. I do the best I can. Everything I can remember, my mom can do it for me, I was doing for myself. [Did you get those teas around here?] There was some tea around here-like some leaves, they call that, um, um, I buy it at the store, the Haitian store. *Aso [rossi]*

²⁷ In English, this is also known as Bitter Melon or *Momordica charantia* (LHHC 2004: 22).

see it's for that. It's for pain when you get pain at your stomach. But you drink *asorosi* for when you're pregnant, it give your baby good color. Like to be more light (Interview 10-15-05).

Many of the women I spoke with noted that carrot juice was also highly recommended during pregnancy, playing similar roles to *asorosi*.

Yeah, they say, you have to drink *asorosi*! That clean your blood. It says it cleans your blood. My mom says "you have to drink carrot juice" and then, also, *asorosi*. It clean cleans the skin and makes it look light (Danise 1-30-06).

My mom's friend gave me this tea and she said I would have a light skinned baby. I'm like, I'm black, the baby is gonna be black" (Eugenie 1-18-06)

They told me I have to drink a lot of milk, a lot of carrot juice. They told me the carrot juice is so your baby could have a nice complexion and milk to keep the baby healthy (Lise 3-30-06).

My mom gives me breakfast and feeds me vegetables, carrot juice, water. I think if God wants him to be black he'll come out black (Ketly 6-19-06).

Rosemarie, who is pregnant with her first child, found that the women at her church were very anxious to give her advice. For the most part, she found this advice helpful, explaining that Haitian women have been following these guidelines for many years, so it must work:

Every culture has like different things. So they told me to eat a whole lot of *akra* [fried dumplings or fritters], it's supposed to make the labor way easier. Now is the time for me to eat well, so, I guess I am trying, you know, you never know. Cause everywhere I go, all the Haitians tell me the same thing. I say it must have worked for them, so, I am going to try it (Interview 12-30-05).

For Roseline, because this is her second pregnancy, she did not ask or receive much advice from women in her family. Although, she did ask her mother about how to prepare and cleanse her system for her upcoming "sugar test."

The second time around I think they think I'm an expert, they don't tell me much and they just like to know how I'm doing. Like I was going to go take my sugar test now, and I was asking my mother, I think I ate a lot of junk that has a lot of sugar, what should I do? And I asked her, and she says to take aloe, take out the skin, take the slimy stuff off, let it soak, you know, and drink the water. She was telling me, you know, that should, and it's kind of like a cleanser, to make everything normal. (Interview 5-31-06).

Through these narratives it is clear that most herbal medicines and notions of self-care during pregnancy focus on strengthening maternal health during the prenatal period. While *asorossi* can help to make a “lighter” baby, most of these remedies contribute to optimal maternal outcomes.

A number of the women I spoke with wanted to differentiate between what was recommended in Haiti and what is done in the United States. It is within these intersections of Haitian “traditional beliefs” and American “modern practices” that we begin to see technologies of risk encompassing both maternal and fetal subjects. In some cases, women felt it was important to clarify these recommendations with their physician or biomedical provider, in order to gauge how these practices could impact fetal health.

Yes, I did nursing in Haiti. I always discourage people to drink herbs when they are pregnant because they not sure whether it was safe for the baby or not (Marie-Lucie 3-18-06).

When they tell me something I’m not certain of I ask my doctor. In the beginning they told me don’t eat eggs and fish. And I asked my doctor and he said but there’s a limit. But the way they explained it was no eggs, no fish. ... My mom won’t give me tea remedies because she tells me to ask my doctor first (Eugenie 1-18-06).

When you get pregnant people will tell you all kinds of things you don’t want to hear so you have to get keep a shut ear sometimes. I mostly listen to my aunt and my OB, other people outside of that, no (Nadine 7-11-06).

Maternal emotions could affect fetal health, reflecting other humoral-based notions of illness in Haiti (Brodwin 1996; Farmer 1988). For instance, in Brodwin’s (1996) work in Jeanty, he describes the case of Jeanine, whose *eklampsi* (or eclampsia, pregnancy-induced toxemia and one of the most common causes of maternal death) was the result of anger which caused the blood to rise in her head. Strong emotions, such as anger or shock, can cause a woman’s blood to heat, thicken or rise in the body. Such etiologies are also described in Paul Farmer’s well-known case study, “Bad Blood, Spoiled Milk” (1988) in which women’s emotions are related to *move san*, or bad blood, and can endanger their newborns through breastfeeding. Daphnee had lived in

the United States for about a year and a half when I spoke with her, after escaping on a boat after Tropical Storm Jeanne flooded Gonnaïves in the fall of 2004. She was living with her sister and nephew, and explained how her sister gave her specific advice during her pregnancy: “[Be]cause sometimes I walk fast and she told me, ‘You know what? You have a baby now. You can’t walk fast’ and she told me, I want to [be] happy, like if I’m angry, the baby, like, angry, too” (Interview 5-23-06).

Valerie had been living in Miami for two years, and was pregnant with her first child in the United States. She told me about her first pregnancy in Haiti, which happened when she was eighteen, which for her was “too early” because she thought of herself as too young. Valerie explained that her anger over her first pregnancy had negative implications for her daughter.

V: Because when you are excited, the baby is excited, too. And, it’s no good for the baby. When I was pregnant with my daughter, I was very angry for my, uh my boyfriend. He say, no it’s not the time yet [to be pregnant]. You, uh I was very angry. When my, my, my uh, when she birthed, at uh, before one year, she have a taint [birthmark] of the body. I go to see the doctor, what uh, what happened? He say the baby sick, my auntie say no, when you was pregnant, you talked too much, you was angry.

L: Angry?

V: Angry, yes mad. Yes, ok, I was very, very mad, that’s what happened. I say ah!

L: Were you mad about the pregnancy or...

V: Yes, because it’s...

L: Oh, because you were so young.

V: Yes, so that’s what happened to her, and she still have the little taint in her body, I think it’s my fault, you know? Because, you know, she was innocent. You know? So, when I was pregnant with my son, everything’s going well. For this baby, I think it’s gonna be better, too, because I think I give this baby more time because I know, I know more things (Interview 7-5-06).

Rose, who had been living in the United States for two years, also made references to advice that her family had given her, often designating this advice as “in my country” versus the advice she received in the United States.

In Haiti ... if you are sleepy, they don't wake you up, they don't call you, they aren't going to slam the door or sneak up on you, if you are pregnant. In my country, they said that if they wake up maybe your baby try to do something. [laughs] And it is going to be damage for the baby. They are always scared about that. They got some different also. When I pregnant now, my family are Haitian who believe, who in my family believe they don't let you do anything on their hair, or you take my hair for the baby, don't touch my hair. That is the way it is in my country (Interview 6-9-05).

In Haiti, and for many Haitians who are living in the United States, hair remains a taboo object—because hair can be used to do black magic through vodou.

As noted above in the review of Harris (1987) and Seidman (1990), most Haitian prescriptions and rituals around pregnancy and birth occur in the post-partum period. For many women, this includes using an herbal formula in a bath to cleanse themselves after giving birth.

A lot of old school Haitians have this mentality that after the baby is born, boil water and sit in front of it, and it will heal you. It's not true. And they will tell you this little thing about if you go outside immediately after the baby is born, you are going to get a labor set back and be back in the hospital (Nadine 7-11-06)

And uh, the leaf I was buy to drink some tea. It called *ti bòm*²⁸. I drank that, I wash my body with that. And also, I take a bath with uh, that leaf, and the kind of leaf mixed, uh mango leaf? Um, pineapple leaf. All those kind of leaf, I know, we used to take and ball together. And put it in the water and put, at your head, go down on you. To make you strong. To help you after your baby. [Oh, so you do it after your baby?] Yeah, after the baby born, you got to do it that, like um fifteen days or a month. It make you tight, especially your body. So, that's um, that's um, (pause) that's for specially Haitian people (Marie 10-15-05).

And I know like traditionally, after the woman give birth, Haitian women, oh my God, they have to take these leaves and bathe you with it, and do all this. The first time around I didn't want it, the second time I don't want it either. But the tea, I will drink the tea. My son, since birth he has been drinking tea. And he still wants tea now. The other day he went to my mom's house, he picked out the leaves (Roseline 5-31-06).

²⁸ In English, this is known as wild mint or *Mentha arvensis* (LHHC 2004:23).

After the baby they do that. But when you are pregnant, no. They give you tea, you know, to help you clean your system. [And do you do all that stuff?] My mom, yes she makes sure. (laughter) Mmmhmm, you cannot drink cold stuff too much you know. (Islande 6-20-06)

Some women who do not have a lot of family living with them in the United States rely on local women to help them with the post-partum bathing rituals. I met Gloria living in a homeless shelter in downtown Miami; she was twenty-three and six months pregnant with her fourth child. For her, the post-partum bath was an important means of reaffirming her Haitian identity, similarly to eating Haitian food or going to church. And as one of my most candid interviews, she also explained the main purpose of the postpartum ritual.

I love my culture, I love *diri ak sòs pwa* (rice with bean sauce). I love going to church, *chante* (sing) hallelujah! I like my Haitian culture, when you finish have a baby, see they give you stuff to wash your body. See your body come tight, looking like a virgin again. I love that. That's my culture, I love it! After each of my kids I do it. [And who told you about this?] Some Haitian old lady I used to talk to, used to be my neighbor. ... The lady that was sixty years old, she was living right next to me. I was living right in Little Haiti, I was pregnant with Ashante, she said, "Maman, do you have anyone to give you *benyen cho* (hot bath)?" I said no, she said, "I could do up for you." When I push out Ashante, she give me *benyen cho*. That was the worst experience in my life, it burned me up! [laughs] After a little while, after I finish the *benyen cho*, you got the tea, and then you get the *diri ak sòs pwa*, and the *legumes* (vegetables), and the *bouillon* (vegetable and meat soup). You become different, your body come right back tight. After three months, you get in contact with your whoever you have, he be like, "Wow!" [Are you going to do it after this pregnancy?] That baby is a C-section so I don't have to do it, because my body don't use it [the vagina]. (Interview 6-26-06).

For Haitian physicians, while it is important for them to support cultural practices, they also want to protect their patients from rituals that they feel could be harmful.

But the pregnant women... no, they talk to me more about what's gonna happen once the baby comes. There's a ritual about some massage and some *feuilles*²⁹ (leaves) that they are going to *benyen* (bathe). You know, I try to get into that with them, you know. Make sure

²⁹ In listening to the transcription of this interview, it was clear that Dr. Daniel used the French pronunciation of leaves, saying "feuilles" instead of the Creole term "fey." Yet when using the term "benyen," she used the Creole instead of the French. For people who were raised in upper-class families in Haiti, and educated in Canada (like Dr. Daniel) you often hear this switching between English, French, and Creole.

that it's nothing harmful because I didn't grow up in that kind of cultural environment, so I'm not savvy to it. So I know there's this ritual about *benyen*, I don't know what they put in there to tighten her up or something. So we talk a lot about that, about these issues. But I don't know that they ever mention to me a lot of rituals pertinent to the pregnancy itself. It's more the post-partum time and the baby comes and the breastfeeding and these things (Dr. Daniel 5-19-06).

A lot of things that they still talk about in Haiti, they talk about here. Like they bring ...the way they clean themselves. ... After birth there's some things they can and cannot do. A whole bunch of traditions, beliefs that they bring from Haiti. And we [doctors] have to say "No, don't do that." ... I have seen people burn with this. Or if they get the repair, the episiotomy repair, how it would destroy all the sutures and they would come back wide open. [Do you know the bath's purpose?] Cleansing and then tightening the muscles and the vagina (Dr. Jean 9-22-06).

As these comments indicate, Haitian providers often straddle the line between supporting cultural knowledge of reproduction and assessing the "risk" of these practices to maternal health.

As I illustrated in the previous chapter, technologies of risk have drastically changed in the second half of the twentieth century, as advancement in imaging technology have allowed us to "see" the fetus. Coupled with increased knowledge about fetal "life," quantifiable measures of fetal health have contributed to an increased focus on the technologies of fetal risk. The remainder of this chapter will examine the ways in which fetal health is documented and performed within an urban prenatal clinic in Broward County, South Florida. How does prenatal risk assessment contribute to the creation of fetal subjectivities? How are maternal subjectivities shaped by clinical narratives of risk within the prenatal clinic?

Documenting the Fetal Subject

The Prenatal Clinic is housed within a non-descript building located at the intersection of a major east-west Broward road and Interstate 95. As you drive along the exit ramp, you can just begin to see the three-story building situated across from a gas station. Parking is always an adventure because the lot is located between the general Health Department office and the building containing the Prenatal Care clinic, the Pediatric Clinic, and the Dental office, leading

to lots of patient traffic. The Prenatal Clinic is located on the second floor, you take the elevator up after passing by the WIC office downstairs, navigating around all the women with strollers waiting outside. The Prenatal Clinic shares the floor with the Pediatric Clinic, and even while in the examination rooms you can still hear the muted cries of kids and babies.

When I began observing there, the Prenatal Clinic had only been open a few years, and was configured as a satellite office to the main Health Department clinic in downtown Ft. Lauderdale, which I call the “Downtown Clinic.” The Prenatal Clinic is designated a “low risk” clinic, the main provider is a nurse practitioner, and she provides care three days a week, on Monday, Tuesday, and Thursday. On Friday mornings, two supervising physicians (M.D.s) rotate through and see patients. These M.D.s will be responsible for delivering the women at the hospital, so they typically try to see each woman at least once during her pregnancy. Portia, the nurse practitioner, was born in Jamaica and completed her basic nurse training there. She continued on to become a nurse practitioner while training in Miami, sharing with me some fascinating stories of doing deliveries at the public hospital there, Jackson Memorial. Portia speaks relatively strong Spanish and fair Haitian Creole, her husband is Haitian and her in-laws live with her and speak little English.

The women who use the Prenatal Clinic are a relatively diverse group, but predominantly Hispanic, including women from Mexico, Guatemala, Honduras, Peru, Venezuela, Colombia, and Ecuador.³⁰ The second largest group of women who utilize the Prenatal Clinic is Haitians, who are scattered throughout the neighborhoods around the clinic. This was followed by

³⁰ There were very few Cubans using this clinic, I do not have notes about a single one that I observed during my time there. I think there is a Cuban population in Broward County, but the majority of Cubans remain in Miami-Dade County.

Brazilians (which had forced Portia to start picking up some Portuguese), other English-speaking Caribbeans (Jamaicans, Bahamians), African-Americans and Anglo-Americans.

The Prenatal Clinic is relegated to about one-third of the second floor. It is essentially a small hallway with three examining rooms, a small waiting area, a tiny lab space, an office for the provider, an office for the Healthy Start providers, and a small office where the nurse does intake interviews. I rarely saw people sitting in the waiting room, usually there were kids running around in there, pulling out brochures or watching the little TV. Most of the women waited in the hallways, clustered around the examination rooms. There were a few chairs scattered around and oftentimes women kept busy chatting with others waiting or watching their children. Occasionally a husband would be waiting quietly with his wife, often looking uncomfortable in this powerfully feminized space.

The walls are decorated with the typical generic prints found in clinics and offices, but one item appeared during my observations there that is noteworthy of mention. About four months after I began observing at the Prenatal Clinic, a series of four posters appeared on the wall behind the chairs where most women wait for their appointments. The posters depicted fetal development, beginning with the cell splitting and culminating on the final poster with an image of a woman and baby accompanied with the text “Judith and Joseph at 3 weeks” (fieldnotes 12-7-04). Each of the posters lists pregnancy gestational week with its accompanying fetal development marker, for instance, “Week Eight – Your fetus is developing teeth!” I rarely saw women looking at these posters and I never heard Portia make any reference to them in her clinical visits with the patients. As a feminist anthropologist familiar with the legacy of fetal images and their association with changing notions of fetal subjectivity (see Chapter Five), I was particularly aware of the power of narratives of fetal development. In her work exploring the

governance of pregnancy in Canada, Weir (1996) argues that feminists need to look beyond imaging technologies and the proliferation of fetal imagery as the sole formative processes contributing to the creation of the fetus as a biomedical work object. To this end, I will examine the multiple other ways through which the fetal subject was being created in the Prenatal Clinic, beyond the posters documenting fetal development and the ultrasound images carried around by pregnant women. We need to look at these visual representations in coordination with the lingual ones: “the gaze operates as a co-patterned organization of language and vision, an alignment of saying and seeing” (376). Beyond ultrasound imaging and cutting-edge fetal surgery, the fetal body has also become constituted through various textual forms that govern the everyday practice of prenatal care. In particular, these texts include prenatal charts and the print-outs that accompany diagnostic testing such as ultrasounds and laboratory tests.

The prenatal chart is a powerful textual document. In an ideal world, the completed prenatal chart can play multiple roles: it is the record of the initial health of the pregnant woman and an on-going documentation of her prenatal care; in the event of a transfer to another clinic or physician, the record provides the history of care; during labor and delivery, the chart informs the delivery team of any risks or problems that have developed during her pregnancy; in neonatal care, the chart will form the foundation of biomedical care of the infant; the chart will be abstracted for inclusion as certain variables on the Live Birth or Fetal Death certificate (see Chapter Two); in the event of a fetal or infant death, the chart may provide clues to analysis of “what went wrong” for the family, lawyers, or community activists such as the Fetal and Infant Mortality Review Case Review Team; and finally, prenatal charts remain a research tool for multiple biomedical studies utilizing chart abstraction or analysis to understand broader practice and health trends.

At the Prenatal Clinic, each woman receives a chart upon her first visit to the clinic. The chart is a manila folder with multiple internal divisions to organize the various documents that accompany the administration of prenatal care. When you open the chart, the right side contains the Prenatal Record, which allows the provider to document each visit on a simple two-sided form. The left side contains the various print-outs of laboratory and diagnostic tests, such as ultrasounds or amniocentesis. Lab and diagnostic results are also documented on the prenatal record. In addition, each woman is given an “Update Sheet,” a purple cardstock version of the prenatal record which allows women to have a mobile prenatal record. The folder also contains the myriad informed consent forms and personal documentation, including Medicaid and/or payment information, copies of photo identification (such as license or passport) and social security cards (when available), and Healthy Start Prenatal Risk Screens. Much of the first visit involves discussing and signing various consent forms, including those for HIV testing, Maternal Serum Alpha Fetal Protein (MSAFP), HIPPA, prenatal drug screens and sexually transmitted infection screens. Because the R.N. at the Prenatal Clinic only speaks English, and the majority of patients speak Spanish, Haitian Creole, or Portuguese, the initial prenatal interview most often involves others: a friend who has accompanied the woman to help translate, her husband, or another patient who has volunteered to help out.

In addition to the stack of informed consent forms, each Prenatal Record contains a “history,” both of previous obstetrical experiences, and of the current pregnancy. The history includes information on the year, sex, weight, type of delivery (vaginal, caesarean, vaginal birth after caesarean), and delivery location³¹ for each previous child. Also, each woman is asked whether anything noteworthy occurred during any of her of her previous births—a preterm baby,

³¹ In most cases, this refers to an institution, either hospital or birth center, but because many of the Prenatal Clinic’s patients are migrants, this also refers to the country of birth, such as “home, Haiti” or “hospital, Peru.”

an infant in the NICU, a low birthweight infant, and so on. Documenting a pregnant woman's obstetrical history is an important means of establishing her "risk" profile for the current pregnancy. For instance, given the particular climate around vaginal births after cesarean sections (VBACs), a woman with a previous cesarean section would be advised that she should have a cesarean with this pregnancy as well. This risk profile is based on the intersection between epidemiological risk and clinical risk, such that women who have previously given birth to a preterm or low birth weight infant, or previously experienced a fetal or infant death, are at much higher risk for a similar outcome in this pregnancy (ACOG 2002).

Finally, the prenatal record allows for the ongoing surveillance of the pregnant woman and her fetus during each prenatal visit. One page allows for the tracking of labs throughout the pregnancy, including urine analysis, STI screens, RH testing (see below), HIV tests, and tests for tuberculosis and rubella. The next page is a series of columns which allow the provider to track fetal health throughout the pregnancy. Each visit includes an estimation of the gestational age, fetal position, fetal heart rate, fundal height, and acknowledgement of fetal movement. Providers often use a series of symbols to complete each column, except where numbers are more appropriate. Often, symbols are "+" or "-" to designate yes or no for fetal movement or edema.

The filling out of these forms takes up the majority of time during a routine prenatal visit; in addition to filling out the form in the prenatal record, the provider must also create the duplicate on the "Update Sheet" which belongs to the woman. Patients are very active in making sure that this form is completed. If Portia accidentally leaves it in the file, patients will ask for the form or return upon realizing that it was not given to them after their appointment. Most women carry a special folder or notebook in which they have all of the forms associated with their pregnancy—the update sheet, ultrasound images, Medicaid information, referrals to WIC or

nutritional counseling, Broward County grant information, etc. In addition, Portia spends a lot of time tracking down reports—ultrasound or lab results—that have not been filed in the woman’s record. This may include finding the report in the computer, printing it out, and then documenting the information on the woman’s chart and update sheet.

This process of documenting the minutiae of prenatal care contributes to constructing the fetus as a biomedical work object. Much like tracking the growth of a tumor, this process creates a particular object of knowledge which necessitates evaluation and intervention. Yet where this process becomes very different from tracking a tumor is in the subtle transition from a fetal work object to a fetal subject. As I described in Chapter Two, the growth of perinatology as a specialty has led to contemporary conceptualizations of the fetus as an active participant in pregnancy, attributed agency and capable of independent behavior. While a growing amount of scholarly research has focused on fetal agency and personhood in reference to ultrasound,³² I wish to turn to one of the everyday practices within the Prenatal Clinic, listening to the fetal hearttones. The verbal interaction between provider and patient during routine prenatal care visits becomes a powerful moment in the creation of fetal subjects.

“Talking” the Fetal Subject

As noted in the review of Weir (1996) above, the medical gaze is co-constituted through both language and vision. With the exception of the first visit and the 36th week visit, women remain fully clothed and the physical examination is relatively short. Most women are asked if they have any questions or if they have experienced anything unusual since the last visit, and then they are asked to lie back on the table. Portia asks her to pull up her shirt, and begins to palpate the woman’s stomach, feeling the edges of the uterus and the outline of the fetus. If the

³² For instance, see Mitchell 2001; Petchesky 1987; Rapp 2000; Taylor 2002, 2004.

woman is over 16 weeks pregnant (and therefore really beginning to “show”), Portia then removes a thin strip of paper from the drawer next to the examining table, a disposable measuring tape, and measures the length of woman’s stomach from her pubic bone to the top of her uterus. She is measuring the “fundal height” of the fetus, which is a low-tech means of estimating gestational age and the size of the fetus. In a “textbook” pregnancy, the size of the fundus should match the number of weeks in the pregnancy; therefore, a woman who is twenty-two weeks pregnant would have a twenty-two centimeter fundal height.

Next, Portia squirts a small amount of transducer gel (similar to the kind used in ultrasound examinations) and applies the fetal heart tone Doppler to the woman’s stomach. All of us in the room stand silently and expectantly for the quick “bip, bip, bip” sound of the fetal heartbeat. Portia may provide a commentary—“Oh, he is feeling active today” or “Can she just sit still? She must like dancing. Do you like to dance?” When the heartbeat first becomes audible, Portia glances up at the woman to catch her reaction. If the woman is visibly moved, Portia will keep the hearttone Doppler on for awhile, increasing her commentary to describe the fetal “personality.” If the woman has brought her husband or others with her to the prenatal appointment, they are invited in to hear the heartbeat. In many cases, the woman has other children who are in the room during her visit, and Portia will invite them to listen: “Do you know what this is? This is your little sister!” Sometimes, the heartbeat is not immediately audible, which often accounts for a stressful wait of several minutes. If it is early in the pregnancy, before ten or eleven weeks, it is very difficult to hear a heartbeat, and Portia often warns the women that the “baby is just too small to hear right now” or that “the baby is swimming, and too hard to hear!”

When Portia first places the heart tone Doppler on the woman's stomach, there is often a "woosh, woosh, woosh" which is the sound of the placenta. Portia explains, "this is the placenta, this is what feeds the baby" while we anxiously await the "bip, bip, bip" of the fetal heart tones. Portia glances down at the monitor and notes the fetal heart rate, later recording it in the prenatal chart and on the "Update Sheet." As noted above, Portia closely observes the woman as she listens to the heartbeat. During most of my observations, women stared straight ahead, only permitting a small smile if Portia caught their eye. Often, she would point out, "the heartbeat!" or "do you hear the baby?" trying to elicit a response from the women. In my two years of observations, only Anglo-American women (and there were very few at this clinic) and Brazilian women ever really displayed any explicit emotions—sometimes crying or asking, "That's the baby? That's my baby?" Hispanic women and Haitian women generally remained quiet and displayed little engagement with the procedure.

Yet in my conversations with pregnant Haitian women, many of them brought up that this routine practice was their favorite part of the exam.

When you listen everything is worth it. It's a blessing. That's the only time I feel happy. It makes you feel it's all worth it (Ketly 6-19-06).

They start doing it last week, but before, they couldn't really hear the heartbeat. Yeah, they make sure it's healthy. I like, I like that. That's my favorite part! (Danise 1-30-06)

Every Tuesday I have a check-up, you know, listen to the heartbeat. See if everything is okay. That was my last one. My next one is on the 10th of January. I am supposed to go to listen to the heartbeat again, and see how much pounds she weighs. ... I love it. It just something, something growing inside of you. It's just, hmm, something (Rosemarie 12-30-05).

For many of these women, listening to the heartbeat assures them that their fetus is okay. In some cases, this audible practice comforts them more than their bodily experience of the pregnancy.

Sometimes, like last night, I was asleep, I was sleeping this morning at six o'clock, and she doesn't move. And I feel like, I go to the frig, I take some ice, I put it on my stomach, and she moved, and I was like, oh, ok. Thank God, thank you. That's how I usually feel, like when I hear her (Rose 6-9-05).

For the day I had to go for my December appointment, the baby wasn't moving. And he did the heartbeat and he said the baby was asleep and don't worry about. It was interesting because he showed me the monitor and I saw something flickering; and he said that was the baby's heartbeat. It was mind boggling. I was happy (Eugenie 1-18-06).

That helps because at the beginning when you don't really feel anything because the baby doesn't move or it's so small you can't really feel anything. I think it helps to feel more secure and less scary, because that tells me that everything is ok (Josette 2-16-06).

I like that because my daughter was born with a heart murmur. You know, VSD [ventricular septal defect] and when I was pregnant they never mentioned that she had anything. It after they day she was born they find out. So that's why I was so concerned about this one to find out if everything is ok (Yousline 6-8-06).

Even if I feel it moving, I like to listen to the heartbeat. Ok, he is still there (Marie-Lucie 3-18-06).

When I asked Valerie if the doctor "listens" to the baby when she goes to prenatal care she answered yes, and explained: "Yes, and, and the father, he buys something. So, sometimes the, my child, me, and him we listen to it" (Interview 7-5-06).

In cases when the fetal heart beat should be audible, and the anxiety slowly builds, Portia will often tell the woman that the baby's heart was most likely located anteriorly, and that maybe she should stop by the hospital for an ultrasound "just in case." Portia never likes to be responsible for bad news; if a patient appears with a problematic ultrasound report, Portia would tell her that she needs a Level II ultrasound³³ "in order to get a closer look at the baby." Much of this is the simple fear of having to be the "bearer of bad news," or her wish not to worry the woman unnecessarily without knowing more. But there is also something more important going

³³ A Level I ultrasound provides general assessment of fetal health, most women receive a Level I ultrasound during their pregnancy. A Level II ultrasound is more targeted, and is aimed at discovering fetal anomalies and observing organ development. This type of ultrasound is typically advised for women with particular risk factors or if something was noticed on a Level I scan that warrants further exploration.

on here. Portia's role as a nurse practitioner includes particular kinds of limits on her clinical skills; she is allowed to make routine judgments, but similarly to the way in which Cindy, the sonographer at Dr. Albert clinic relied on the physician to counsel patients about abnormal screens, Portia leaves those judgments to the hospital's perinatologist. Essentially, notions of risk govern Portia's every practice in her routine administration of prenatal care.

Negotiating Risk at the Prenatal Clinic

As discussed in the previous chapter, ideas about risk now structure the ways in which women receive prenatal care in the contemporary United States. During the first prenatal visit, the elicitation of a woman's medical history provides the first important step in designating her risk status. For Portia, this essential step quickly decides whether or not she can provide care for the woman. The Prenatal Clinic is but one community clinic within a network governed by a regional hospital district in Broward County. Although Portia provides most of the care, she is a nurse practitioner and her work is overseen by two physicians. The Prenatal Clinic is designated as a "low risk" clinic within this network of care; any patients who become classified as high risk have to be referred to the Downtown Clinic, which houses the perinatology clinic and provides genetic counseling, ultrasound, and nutritional counseling on-site. In addition, Prenatal Clinic patients may be referred to the Downtown Clinic for consultations, such as genetic counseling and an amniocentesis for women over 35 or for nutritional counseling if a woman is diagnosed with gestational diabetes, but Portia and the supervising physicians will continue to provide the routine prenatal care.

The actual designation of a pregnant woman as "high risk" is governed by the American College of Obstetrics and Gynecology (ACOG) and is published as their *Guidelines for Perinatal Care*. According to ACOG, some pre-existing medical problems may increase pregnancy risk and warrant "further evaluation, consultation, or referral" (1992: 55). These

include cardiovascular problems, metabolic or endocrine disorders, maternal infections, diabetes, substance abuse, and nutritional disorders. A number of problems that occur during pregnancy are also cause for the designation of a pregnancy as “high risk”: poor obstetric history, maternal age, previous congenital abnormalities, multiple gestation, prematurity, breech or transverse lie, pregnancy-induced hypertension, and third trimester bleeding. In many cases, Portia may feel confident in her skills to care for a patient, but she is governed by these guidelines of care, and if anything were to happen, she would be putting her license, the clinic, and the attending physician at risk.

In one case, a pregnant woman at the Prenatal Clinic was diagnosed with high blood pressure, and while Portia thought that it was chronic hypertension and not pregnancy induced hypertension, she still thought that she should refer her to the Downtown Clinic for a consultation with the high-risk obstetrician. Yet she hesitated, mainly because the head obstetrician at the Downtown Clinic had berated her on the phone the day before for “sending over so many patients” when “there is absolutely nothing they [the doctors] can do.” She explained that “my hands are tied, legally I have to make sure that I cover all my bases. If something were to happen, I want to make sure that it is not on my watch” (Fieldnotes 11-23-04) And so she finds herself again facing a referral for a pregnancy she feels that she can handle. Instead, she calls her attending physician, and he agrees that she should prescribe some medication and refer her to the Downtown Clinic.

Another case involved a 37-year-old Haitian woman who had a previous preterm birth, giving birth to twins, and also experienced a stillborn in Haiti. Portia acknowledged that ACOG and the American Medical Association (AMA) would consider this birth “high-risk.” Yet the woman was adamant about being seen at the Prenatal Clinic and expressed frustration at being

transferred to the Downtown Clinic. “You have to wait so long there,” she explained, “and you never see the same doctor.” In some cases, the patients can get caught in the bureaucracy of the administration of community health. For example, a Haitian woman was 26 weeks pregnant and had tested positive on her MSAFP, which could be an indication of Downs Syndrome. Portia referred her to the Downtown Clinic for genetic counseling, where they would offer her an amniocentesis. Because this woman spoke very little English, and mostly Creole, the nurse at the Prenatal Clinic made the appointment for her. During her next visit at the Prenatal Clinic, Portia asked “You had an appointment at the Downtown clinic, correct?” The woman agreed but said “they told me I didn’t have an appointment. The appointment was on Thursday, I called and they told me I didn’t have an appointment.” Portia decided to investigate by going to ask the nurse. It turned out that the patient was unsure of the location of the Downtown clinic, so she called the Prenatal Clinic to ask about her appointment. The Prenatal Clinic shares space with the Pediatric Clinic, and the phones and appointments are handled in that clinic. The nurse explained:

The patient called here and asked about her appointment on Thursday, but because she reached the peds clinic, they looked it up and said ‘No! You have an appointment on Tuesday’ [at the Prenatal Clinic]. The patient asked specifically about her appointment at the Downtown Clinic, but instead of interpreting that as meaning she was asking a question about it, they just told her that she had this appointment on Tuesday. So she didn’t go (Fieldnotes 1-11-05).

Situations such as this contribute to Portia’s reputation of referring patients to the Downtown Clinic who never show-up, exacerbating the problems already governing her referrals.

Finally, women can become designated “high-risk” through particular behaviors during their pregnancies. While the *Guidelines for Perinatal Care* point to tobacco, drug, and alcohol use during pregnancy as particular behaviors which lead to poor pregnancy outcomes, substance abuse is not a problem among the majority of Haitian I observed utilizing the Prenatal Clinic.

The area where I saw Portia express the most frustration was around women who missed

appointments or did not follow through on diagnostic tests, such as an ultrasound. For instance, in February 2006, Portia had a Haitian woman who was over 34 weeks pregnant. She had not been to the clinic since December 2 (although she did manage to make it to her ultrasound appointment on January 16). She had pretty severe edema and was in a lot of pain. She was also “RH negative”³⁴ and because she had missed the last two months of appointments, she missed her Rhogam shot (which is typically administered during the 28th week of pregnancy). For Portia, this patient was already skating the edge of her practice guidelines given that she was Rh- and by missing appointments and necessary injections. Portia thought she may have to refer her out. Yet she wondered if this was even worthwhile, because how could she be sure that she would adhere to her appointments at another clinic? Instead she chose to refer her to the hospital for the Rhogam shot and hope that she would return to the Prenatal Clinic for her remaining appointments (Fieldnotes 2-13-06).

Dr. Daniel, a family practitioner who practices at Jackson Memorial Hospital, the large public facility in Miami, and also at a small community clinic in Little Haiti, explained to me that for her, the cultural competency of the provider also plays a role in her decision to refer a high-risk patient.

I want to do what’s best for the mother. But I also know that sending them to Jackson is not necessarily the best thing for them. So therefore I would rather follow a high risk pregnancy with my cultural competency and a very close one-on-one relationship than have her sent to the big Jackson where she’s gonna be a number and not understand what’s going on. In the end I’m not sure who would have given her the best care. So therefore it is a balancing act, I am dancing all the time with my patients. So, you know, it depends what the resources are, whether she’s documented or not. So many things come into play before I make that decision (Interview 5-19-06).

³⁴ “Rh” refers to a woman’s “Rhesus” factor, a protein that most people have on their red blood cells. The majority of women are Rh+, but for the small minority of women are Rh-, there is a chance that their blood could be incompatible with the fetus’ blood, which is most like Rh+. There is a chance of contamination during the delivery, and to protect from this, a woman’s blood is sensitized through the injection of the drug “Rh immune globulin” or Rhogam.

Because she is an M.D., her risk for liability is lower than that of Portia, who is a nurse practitioner and limited by her scope of practice. Yet Dr. Daniel's comment illustrates that for many providers, notions of culture and language become important elements of risk assessment.

In another case at the Prenatal Clinic, a Hispanic woman called to discuss with Portia her trip to the emergency room over the past weekend. She had been diagnosed with "Bells Palsy," a condition in which all the nerves on one side of your face go slack, similar to a stroke. It can cause permanent damage if not treated quickly. After her visit to the ER, the physicians there reminded her to speak with her obstetrician, and so she called the Prenatal Clinic. Portia expressed frustration to me that she had not seen this patient in months, "she had missed her last five or six appointments and she should be in here every two weeks now because she is over thirty-six weeks. I almost wish I could dismiss this patient, because she is just negligent and has stopped coming!" (Fieldnotes 11-9-04)

Finally, this frustration with patients can also lead providers to have a fatalistic attitude towards patient assistance. In one instance, a 20 year-old Haitian woman was seeking care during her first pregnancy. She had maintained her visits, and she was close to giving birth. But she had never gone to get her ultrasound, even though Portia had provided a referral for her to go to the hospital to get one. Because she was so close to her due date, Portia asked the nurse to make a copy of her medical records to have with her to take to the hospital once she began labor. The nurse exclaimed, "It is not worth it, they all just lose the paperwork anyway!" (Fieldnotes 11-17-05).

Eliciting Risk at the Prenatal Clinic

During the first prenatal visit, risk factors based on a woman's medical history are used to classify a woman's pregnancy as "low risk" or "high risk." A large part of this medical history involves their family history, asking women to recall genetic "abnormalities" in their family,

such as Down's syndrome or other congenital anomalies, chronic diseases such as hypertension or heart disease, and mental illness. In addition to providing clues to previous obstetrical experiences, these questions also alert the provider to genetic medical conditions, ones that may warrant a referral for genetic counseling. At the Prenatal Clinic, most of the obstetrical history is recorded by the Nurse during the first visit, along with signing the informed consents and the gathering of personal data. But in some cases, particularly when there is no one available to translate or the clinic is understaffed, Portia would be responsible for this part of the visit. For many women, remembering dates and details of previous births can be tricky, particularly when they occurred a long time ago. For instance, one patient at the Prenatal Clinic was a 40-year-old Haitian woman, pregnant with her seventh child. She had given birth to the first four children at home in Haiti, and the last two children at a local hospital in Broward County. All of them had been vaginal births with no problems, but she had a difficult time remembering all of the birthdates (Fieldnotes 8-30-05).

These issues with memory can be exacerbated by the fact that families are separated, with parents in the United States and some children still in Haiti. One of the women I interviewed, Marie, had a difficult time telling me when she had her first child in Haiti. Her eldest daughter lives in Haiti, but Marie moved to the U.S. in 2001 to accompany her younger daughter, Nelly, who is receiving medical care in Miami for a heart problem.

It was um, on June 29th. Um (pause) she's fourteen, what year she was? Um, 1990? Yeah, she's fourteen. Exactly. Yeah, she was born in 1991, exactly. June, 1991, I remember, Nelly [her other daughter] was born in 1995. She was four years, when I get Nelly. I'm trying to remember, Nelly... Because I use Nelly's birthday more than her. That's what happens. Yeah, she's with me. I got to count, I still don't believe. You think it's right? (Marie 10-15-05)

While many of us would be hard-pressed to remember details such as birthdays for everyone in our family, these examples demonstrate the common values that structure how providers expect prenatal histories to be recounted.

For some providers, the fact that women neglect to give them pertinent clinical information from their medical history is frustrating. When I was called by Dr. Albert, the perinatologist, to discuss her experiences with Haitian patients, she expressed her concerns about her ability to adequately assess the risks for these women because they were not very detailed in recounting their medical histories.

And the other thing that I find that makes it very difficult to relate to Haitian patients is that they're not always very forthcoming with clinically very significant information. You know it took me seven antenatal visits to find out that [a patient] had hemorrhaged at a previous C-section, that she'd had a DVT [deep vein thrombosis] at her, after her first C-section. And, you know, when I recommended anti-coagulants and the risk of transfusion, and it's like she wanted nothing of that. And she didn't even think that it was relevant that um, you know, that she mentions these complications to me. She didn't understand why I was upset that, that she kept that information from me on the initial intake (Interview 8-18-06).

Rayna Rapp's (2000) work on amniocentesis in New York made similar observations. "From a [genetic] counselor's point of view recent immigrants, especially those from very poor countries, are likely to exhibit shallow knowledge of their own heredity" (74). A "no" answer or silence to questions about a woman's medical history may result in misinterpretations, either that there is no incidence of these health problems in their family or a lack of intelligence on behalf of the patient.

Rapp described how one of her Haitian informants commented: "I left home when I was real young, and my mother, then my father, they just got sick. Then they died. That's all I know" (2000: 74). One of the providers I interviewed, the Haitian physician Dr. Daniel, explained that many of her patients also differentiate between "natural" illness and "spiritual" illness, such as deaths resulting from vodou:

A lot of their family members died from whatever illness. But because they didn't know what illness it was, therefore it was something not natural. That's very common. 'What did your mother die of?' 'Somebody didn't like her. They did something to her.' Nobody in my culture seems to be dying of natural causes. So therefore I reinforce to them- because a lot of my patients are hypertensive or have diabetes- and I say to them 'Your blood pressure is 240/100, you don't have any problem or a headache or anything like that. If you drop dead, your parents are gonna say that somebody did something to you, but the fact is that it's your blood pressure that's so high it's gonna kill you.' So I try to put it in perspective for them (Interview 5-19-06).

For many Haitian women, family members who died in Haiti may never have received biomedical care and therefore never received a biomedical "diagnosis" for illnesses which may have led to their death. Throughout Haiti, not only is preventative and emergency biomedical care unaffordable for most people, for those in the rural areas, clinics are few and far between; and for those in Port-au-Prince or Cap Haitian, larger urban centers in Haiti, the last few years of civil unrest have disrupted much of the available care to this population.

One provider I interviewed pointed out the gendered aspect to presenting the medical history. As mentioned above, many women cannot speak English and rely on others, particularly their husbands, to translate their intake. Kathia, the Haitian-American Healthy Start Provider at the Prenatal Clinic, expressed her frustration at the ways in which many of her older patients defer to their husbands during the intake process.

... because husbands don't care. Especially Haitian husbands, they are, like, whatever, it's a woman thing. They know nothing, nothing about the whole pregnancy thing. They will come here with their wives. And during intake, [the nurse] has a series of questions that she asks them, where she says things, like, you know, "If you're dying can we give you blood?" and ninety percent of them will turn around and look at the husband, so the husband can answer it. And to me, that boggles my mind, and I look at her, like, he's not the one that's gonna be dying. If you are dying, are you going to say yes if they're going to give you blood, or should they just let you die. And she's like, "well I don't want to die," and I say "well don't look at him for the answer, answer the question." You know what I mean? It got so bad, to the point where these Haitian women didn't want to answer questions and the husbands don't come in the room with them anymore. ... You have some women who have had abortions in their past life and their husbands didn't know, or if they had miscarriages and their husbands don't know. On more than one occasion they'll tell me one thing when their husband is there on their first visit, and then on their next visit they'll say I told you last time I had two pregnancies but it was really three. And you gotta

go back, to the paperwork and put three instead of two. Because the husband is very strict, Haitian husbands are very strict (Interview 3-22-06).

This discussion is supported by research in Haiti as well, where a recent study by White et al (2006) on health seeking behavior among pregnant women found that 94% of women designated their husband or male partner as the primary decision maker in matters of health. No study has yet assessed this in the United States, so it is difficult to say whether this statistic would hold true. None of the women I interviewed mentioned their husband or partner impacting their decisions around seeking care, but I had not asked specific questions about this. White et al (2006) comment that some of this deference is a result of economic dependence on male partners in Haiti, and of the women I interviewed in Florida who were not single mothers, they all had some form of income beyond that of their partner.

Finally, what we see in these narratives is a certain expectation for how a patient is supposed to behave, what communication between partners is supposed to be, and what considered an autonomous decision. During one afternoon while I was observing Portia at the Prenatal Clinic, she had to leave the examining room to track down the ultrasound report for a patient. She called to me from her office and commented:

It is always like this with these women. They never really answer my questions, and I have to tell them things over and over. For them, prenatal care is the visit, and the questions you ask them. There is no personal responsibility that occurs outside of the visit (Fieldnotes 11-2-04).

In this case, Portia was frustrated that this patient had only made it to two prenatal visits during this pregnancy, and had missed the window³⁵ to be given the MSAFP test. Yet Portia is sensitive to the fact that “this is a cultural aspect of care in the United States. I don’t want to blame the women.”

³⁵ The Maternal serum alpha-fetoprotein (MSAFP) test can only be administered during the sixteenth to eighteenth weeks of pregnancy.

Feminist scholars of reproduction have pointed out that the social aspects of pregnancy, such as the economic factors which could influence use of prenatal care, or the social variables such as domestic abuse or physical violence that can endanger a pregnant woman and the fetus, are overshadowed in the dominant risk model of pregnancy (see Weir 1996; Ruhl 1999). As Lealle Ruhl (1999) suggests, this model emphasizes “the *individual* responsibility incumbent upon the pregnant woman to provide her foetus with the best possible gestational environment” (102, emphasis in original). The dominant clinical risk model within prenatal care in the United States posits individualized risk, whereby pregnant women are expected to be active participants in their self-care during pregnancy. While I discussed local “technologies of self” in the beginning of this chapter, I would now like to turn to another contemporary technology of risk which has become a pervasive part of prenatal care – biomedical prenatal diagnosis.

Biomedical Technologies of Risk and “Knowing”

To return to biomedical conceptualizations of risk, one element of prenatal care which has begun to receive the most attention in feminist anthropological analyses is the use of prenatal diagnosis technologies such as maternal serum alpha-feto protein (MSAFP) testing, amniocentesis, and ultrasound. The remainder of this chapter will focus on the first two (see Chapter Five for a discussion about ultrasound) as a means to explore how these technological conceptualizations of risk are enacted within routine prenatal care, and the ways in which Haitian women’s narratives of pregnancy embody or interact with these conceptualizations.

The MSAFP test was first developed in the early 1970s when routine prenatal blood tests revealed that higher levels of alpha-feto protein could be related to neural tube defects. Alpha-feto protein (AFP) is a protein that is typically produced by the fetal liver, and is usually present in the amniotic fluid, with a small amount crossing the placenta and into the pregnant women’s blood stream. The assumption is that high levels of fetal AFP in a pregnant woman’s

bloodstream may be the result of the fetus leaking fetal protein, most likely from an open neural tube. In addition, low levels of AFP can be associated with Down's syndrome (ACOG 2002). Early strategies to universalize screening were opposed by many physicians because of the high rate of false positives, the lack of recognizable risk groups for neural tube defects (NTD), and because diagnosis most often led to termination of the pregnancy. Yet by 1987, ACOG was recommending the test for all pregnant women who were receiving care in institutions with access to ultrasound or amniocentesis for follow up (Soto, Almario, and McCormick 1999).

Some states now subsidize all MSAFP testing, offering the test to all pregnant women in a non-directive way (see Browner and Press 1995; Soto, Almario, and McCormick 1999). As a blood screening device, it cannot provide a definitive diagnosis, but as a "simple" blood test, it has become a routine part of prenatal care in the United States for all women, irrespective of their "risk" for NTDs or Down's syndrome. The most common NTDs diagnosed by AFP are spina bifida, a lesion on an incompletely closed spinal column, and anencephaly, the lack of a brain. In the United States, it is estimated that 1 – 2 per 1,000 live births are diagnosed with a NTD. Yet for every 1,000 women who take the MSAFP, 50 to 100 will have abnormal readings (Browner and Press 1995: 309 – 310). Abnormal readings can be associated with gestational diabetes, multiple gestation, or the underestimation of gestational age. Often the AFP is measured with other pregnancy hormones, which are called the "triple screen" or the "quad screen," during the fifteenth to twentieth week of pregnancy. As discussed above in the descriptions of the Prenatal Clinic, the exact timing of this test is imperative, as there is a specific "window" to measure the AFP. Elevated or low AFPs will result in a woman being referred for genetic counseling and amniocentesis, as well as high level ultrasound.

Browner and Press (1995) discuss the administration and acceptance of this test among prenatal care users in California, where the test is subsidized by the state. In their study, each woman was counseled and asked to consent to the test, and was given an educational brochure to inform her about the procedure. During my observation at the Prenatal Clinic, the AFP was considered but one aspect of the battery of blood tests administered during routine prenatal care. On only one occasion did I observe Portia actually discussing the MSAFP with a client; in this case, the woman had received a positive diagnosis, and Portia explained that she would be referred on for genetic counseling and an amniocentesis, but there was a good chance that gestational diabetes could be the cause of the elevated AFP, given her obesity (Fieldnotes 3-25-05). In many cases, I heard Portia discussing AFPs with the nurse or the medical assistant, either searching for lab results or reminding them that it was time for the test to be administered, but that was the extent of the discussion. Although this was a routine test, I never heard Portia discussing the results with the women, except for the one time I witnessed the positive diagnosis.

During my interviews with pregnant Haitian women, I asked them about the kinds of tests that the doctor performed when they received prenatal care. Many of them talked about having their urine tested, listening to the fetal heartbeat, having their sugar tested, or getting their blood drawn, but only one actually specified the AFP. For instance, when I asked Nadine if her doctor recommended that she get any special tests such as amniocentesis because she is considered a “high-risk” pregnancy, she said, “No. They checked to see if the baby was retarded and she was perfectly fine.”

Very few of the women I interviewed had actually been offered amniocentesis, because the majority of the women were under 35. Amniocentesis is one of the most common forms of genetic testing during pregnancy, when a long syringe, guided by an ultrasound, is inserted into

the amniotic sac to extract a small amount of amniotic fluid. The sample is sent to the lab for analysis of the fetal chromosomes. Amniocentesis is accurate in detecting nearly all chromosomal abnormalities, as well as genetic disorders (such as Tay-Sachs or sickle cell) or neural tube defects. There is a slight risk of spontaneous abortion after an amniocentesis, the estimated risk that 1% of women experiencing this procedure after 15 weeks gestation will have a miscarriage (ACOG 2002). Amniocentesis is recommended for all women over 35 years of age, and for any woman who has received a positive MSAFP or a problematic ultrasound. The procedure is often done in conjunction with genetic counseling.

Throughout my research, amniocentesis often framed my conversations with providers; I was initially contacted by Dr. Albert, a Canadian-born (and non-Haitian) perinatologist, because of her frustrations with counseling for prenatal diagnosis among her Haitian patients. She explained, “I do amnios here [in her clinic] but they always decline. I’ve never had a Haitian patient, you know, consent to an amnio.” She feels that her Haitian patients, when faced with a troubling ultrasound image, are not interested in discussing further testing.

That their baby is going to be the way that it’s going to be, you know, with two heads and three legs, and, and that’s the way its going to be, and they’re not really interested in or they don’t seem to grasp the whole concept of antenatal diagnosis. So, it makes it very hard to, um, to do antenatal diagnoses and counseling. ‘As far as I see this on the ultrasound, I think there’s an increased risk that your baby might have Down’s Syndrome,’ or what Down’s Syndrome is, this is that, and implies this and that, and you know, we want to try and give you the option of knowing before the baby is born, if the baby has this or not. ... [t]hey just take what comes, and they don’t, you know, they’re on a different level of reality, you know? (Interview 8-18-06)

This chance for “knowing” has begun to inform our everyday notions of pregnancy in the United States, and the decision to “not know” becomes almost an immoral act. Dr. Albert expressed frustration because her Haitian patients were uninterested in even “knowing” whether or not their fetus was diagnosed with an abnormality, and therefore uninterested in “preparing” and “educating” themselves on living with disabled children.

Yeah, even if you're not thinking of terminating, there are advantages in knowing. First of all, most of the time you'll have good news and you can take that out of your mind for the rest of the pregnancy, and you know, God forbid there is something wrong with your child then you'll be able to prepare yourself. And to read up on it, and contact resources in your area, you know, to help you take care of a child with special needs (Interview 8-18-06).

Some scholars have referred to providers' assumption that parents want to "know" as the "gift of knowing" (Kenen 1996; Hunt and Voogd 2003). This is built on the assumption that knowledge is intrinsically good, and knowing the results of prenatal diagnosis would enable parents to make informed decisions. The possession of knowledge is equated with empowerment, as prenatal diagnosis is assumed to result in parents who are empowered to make rational, informed choices (Kenen 1996). Dr. Albert's frustration that Haitian women and their partners denied this "gift" of knowing illustrates the ethics of responsibility that underlie the contemporary biopolitics of risk management. It is a woman's responsibility to be informed of her fetus's proposed health status, and to plan for this future, regardless of the outcome. Narratives of prenatal risk diagnosis is based on broader development in contemporary subjectivity, one which imagines life and the self as a "planning project," requiring constant work and attention on the part of the individual (Lupton 1999b). Yet by situating Haitian women's narratives on prenatal diagnosis we can begin to fracture monolithic notions of subjectivity. Their stories illustrate the ways in which these moral decisions on life and illness are contextualized within local moral worlds, where women's knowledge, relationships, and lived experiences intersect with this "gift" of knowing.

For Haitian biomedical providers, their explanation of the lack of interest in prenatal testing and particularly amniocentesis, was that most likely Haitians would not "understand the concept." As Dr. Daniel commented, "That you have to put a needle in their belly to figure if the baby has a problem with the brain" is not something that makes sense to many of the Haitian women she sees in her practice. Haitian providers also pointed out that for many Haitian women, by the time it is recommended that they receive prenatal testing they have already committed to

the pregnancy and therefore would not be interested in terminating even if there were a problem.

Dr. Daniels evoked the common Haitian belief that because God gives children, you would not mess with his work:

Because God gives children, once they have accepted to carry the pregnancy, they will accept it no matter what the consequences. Another aspect also with amnio referral, I'm not sure that in the end even if the amnio revealed that there was something wrong with the baby, I'm not sure that they would be able to comprehend what it means and two, what to do with it (Interview 5-19-06).

This disinterest in late-term abortion is not evidence that Haitian culture is highly forgiving of disabled individuals. In fact, disabilities are often stigmatized and many families attribute them to interaction between the natural and supernatural world, rather than genetic or medical origins. For some families, a baby born with a physical or mental disability is paying the price for a family members' spiritual transgression or misdeed (Jacobson 2003). Therefore, this notion that you can "know" about a disability before birth is not one that is culturally acceptable for many families.

Haitian biomedical providers question whether telling a woman that she is going to have a disabled child actually "helps" her in any way:

So therefore, if I'm not helping her in any other way but just telling her that she's gonna have an abnormal child, then I haven't done anything for the patient. So let her have her baby and let her see for herself that as he grows or she grows this isn't a normal child (Dr. Daniel 5-19-06).

For Marie-Lucie, who was offered amniocentesis because of her advanced maternal age, this act of "knowing" would not change the way she felt about her pregnancy or her child-to-be:

I have to say, like, when they do the amniocentesis, they going to found the baby has a Trisomy 18 or Down's syndrome, or spina bifida, everything. I just ask them, what am I going to do after that? So after I get the results I have to either decide to keep it or not. But I already decide to keep it, so I just keep praying. Not that I am like, not pro-technology or stuff. I just don't see why I am going to do this. If it was something just draw my blood or something, but I don't like invasive procedures. All this for nothing. For some people they may want to terminate the pregnancy or the baby is not well, but I am not gonna do that (Interview 3-18-06).

Many women are concerned about the risk of miscarriage during the procedure; Dr. Jean shared her story of her own amniocentesis during her last pregnancy:

But when I was pregnant with Rafael I wasn't going to do an amnio. The doctor told me your ultrasound looks abnormal. The heart has some problems and I would advise you to do an amnio. I said I don't care but I didn't do it out of fear. So I came here and I talked to my husband and he said I think you should go and do it. And the baby was perfectly normal. It was an X-Y normal baby. I understood the risk I was taking (Interview 9-22-06).

And although she understood the "risk," she explained that hearing about the procedure can cause concern:

They tell you they're gonna put a needle in your stomach and you wonder what if you hurt the baby. Then they tell them the risk that you might hurt the baby. After the amnio I lost some fluid and I had to stay in bed for two days (Interview 9-22-06).

Notions of scientific literacy inform these ideas of prenatal diagnosis; that women comprehend the "risk" of miscarriage versus the "benefits" of knowing is understood to be clear for all women (Rapp 2000). Marie was the only other woman I interviewed who had been offered amniocentesis during her pregnancy, which she explained was because of her age.

M: My age was more than, more than thirty-five. When you are this age, they always care much about you. Because you're too old, that's what they mean.

L: Right. Did they make you do special tests?

M: Uh, they ask me, for a special test, to take some water- that's what I heard. And you, um, how you call that? I forgot-

L: Your amniotic-

M: Yeah, so, I told them I don't want the test.

L: And why did you not want to?

M: Because I heard the, some people say when you do that, you maybe lose the baby. That's why I told them no, I don't want to do it.

L: Did they have someone talk to you about the test? Someone special to talk to you about what this test was and what it did?

M: That test? No. They just asking me and I was refuse. I say no way, I don't want it. Forget about that (Interview 10-15-05).

Genetic counseling interviews presuppose a particular kind of patient, one that is informed of protocols, prepared to ask questions, and ready to filter through biogenetic information (Rapp 2000). Yet this does not take into account language, class, and educational barriers that may inform the patient-provider interaction. Dr. Daniel explained that physicians in the United States expect their patients to “be at a level that [they are] not.”

My very concern is that every time I see a patient that was referred to any specialty, generally, when they come back, and ...they are Haitian and I ask them, “Ok, what did the doctor tell you?” “Nothing.” “What do you mean, nothing?!” “Nothing.” So, I, and I am sure the doctor did say something, don’t get me wrong. Um, as much as you say, if the person in front of you does not get it, or you don’t make, you don’t go the extra mile to at least assess, whether the patient has understood anything, then what have we done for this patient? Nothing. (Interview 5-19-06)

Eugenie, who was pregnant with her first child when I interviewed her, provided an interesting case study. She also works for Healthy Start in Miami-Dade County, and although she works in the administrative offices, her Creole language skills often require her to “represent” her community at larger public health events or “translate” cultural practices for her fellow staff members. She explained that her family or friends would refer Haitian women to her with questions about pregnancy or prenatal care, because in many cases physicians did not take the time to explain procedures to women.

Last year I knew a Haitian lady who was pregnant. And she called me because her doctor suggested she do the amnio. She didn’t understand what the doctor was telling her and I explained to her what it was and then she got it. So I think that’s a problem too. If there’s no one in that office to explain to them they won’t do it. It’s lack of communication, that’s why they’re not doing it. If they knew it was something that was healthy for them and their child they would do it. But there’s no one sitting there explaining to them word for word what it’s about and why they should get it done. Once you explain it to them they’re ok. But if you just throw something at them... One of my friends, it was recommended that she have amnio, she’s 32. She asked what it is. And I said it’s something that you do to see if your baby is safe (Interview 1-18-06).

Beyond the socio-economic barriers affecting patient-provider interactions, conceptions of race and discrimination also inform whether women choose to participate in particular kinds of

prenatal diagnostics. Regine, a well-educated, upper class, Haitian woman who was working as an outreach worker for a Haitian community-based organization in Broward, expressed her concerns over the heightened risk for miscarriage among Haitian women accessing amniocentesis in Broward County. “I don’t want to be the whistle-blower or anything, but when we send Haitian women to get amniocentesis, they all lose the baby. The women think the doctor is wiggling the needle, and causing them to miscarry. The black [African-American] women don’t lose their babies, the Hispanic women don’t lose their babies, only the Haitian women. ...We can’t get any of our women to do an amnio now” (Interview 2-15-06). Given the specific historical narrative of Haitians as a biosocial risk group for HIV/AIDS, it is not surprising that many women would infuse decisions about an unfamiliar procedure with notions of racism and discrimination.

As these narratives suggest, Haitian women’s experiences with biomedical prenatal diagnosis fracture assumptions about liberal subjects, about pregnant women as docile bodies, and maternal and fetal subjectivities. Haitian women’s experiences with the technologies of pregnancy represent not only the interests of themselves as individuals, but also the wider sociopolitical fields of shared engagements and interests. It is also a reflection on local moral worlds, worlds which are negotiated through specific cultural, historical, and political processes. In the following chapter, using the stories of a few of the women I interviewed, I will move beyond epidemiological and clinical narratives of risk to interrogate these local moral worlds. In this way, we can examine how the transnational experiences of Haitian women, with their attending politics, violence, nationalism, and kin obligations, contribute to shaping the landscape of risks accompanying pregnancy in the United States.

CHAPTER 4 TRANSNATIONAL LANDSCAPES OF RISK

Feminist anthropology has long been interested in representations of women's experience. Historically, anthropological conventions of writing have encouraged feminists to create monolithic representations of women's experiences, leaving little room for transcultural experiences of local women (Tsing 1993). In this chapter, I build on Anna Tsing's (1993) discussion of "eccentric subjects," as a means for grounding women's individual stories within the limitations of dominant categories. As noted in the first chapter, my use of "experience" works against assumptions that experience is something that individuals simply "have," but instead asks how conceptions of subjects and their identities come to be produced through their experiences (Scott 1992). The stories of the women below are not imagined as "authentic" or unifying. As Tsing argues, "if personal stories are read as representing the 'authentic voice' of a particular category of people, they can become further exclusionary devices that marginalize all those who speak outside of an imagined authenticity" (1993:232),

The previous two chapters situated discussions of epidemiological and clinical notions of risk within truncated discussions of Haitian women's local moral worlds, and this chapter will take a closer look at the situations and life experiences which can influence local perceptions of risk. This chapter moves out of the clinic and into the everyday lives of pregnant Haitian women situated throughout South Florida. Rather than attempting to illustrate patterns, this chapter seeks to demonstrate the diversity of experiences among these women. The unifying characteristic among these women is their identity as Haitian women, yet even this is complex and variably experienced by those I interviewed.

Haitian women's narratives of pregnancies illuminate a transnational landscape of risks – as experiences of violence and danger stretch from turbulent political situations in Haiti,

problematic immigration policies in the United States, and finally to gendered power relations within the household. By examining these narratives, we can understand the ways in which Haitian pregnant women's experiences of risk and responsibility reflect their local moral worlds, worlds which are negotiated through specific cultural, historical, and political processes. Relying on a few "key" informants, I broaden Tsing's use of "eccentric subjects" as a means to critically examine Haitian women's experiences of risk in the United States. Tsing describes eccentric subjects as those "whose agency demonstrates the limits of dominant categories, both challenging and reaffirming their power. ...Eccentric subjects are multiply and complexly constructed according to their relationship to power and difference" (Tsing 1993: 232). While there are similarities in experiences among Haitian women in South Florida, their narratives serve to fracture dominant ideas about "culture" as a structural and constraining force in Haitian women's notions of risk and responsibility within prenatal care. I present their experiences as a means to contribute to feminist conversations about the construction of maternal subjects and the ways in which this process is negotiated in reference to power and difference.

"Why she pregnant so early?"

Rose

Rose was twenty-three years old and thirty-seven weeks pregnant when I interviewed her at her apartment in northwestern Broward County, where she lives with her aunt and cousins. With little family left in Haiti, she decided to come to stay with her aunt in Florida, and had been living here for the past two years:

L: Why did you come to the U.S.?

R: Well it's like, my mom, my mom don't live in Haiti, she live in Paris. All my family, when my dad was dead, I don't have no family who lives there anymore and even now, it's terrible over there. After high school, you can't do anything. You have to try do something. And I am so young, and I think to go through that would be scary.

Rose had quickly learned to speak English, by taking classes and having her cousins help her. She explained that she remained isolated from the Haitian community, because she wanted to learn English faster.

When I first, I go to ESAP first, for English, because in my country, we learn English, but we write English better than we speak. Because we are always shy to speak. [laughs] ... That is the only thing help me, when I come here. I got my cousin, they from here, and they born here. And my auntie, she live here more than twenty years. And they speak all English. And every time I try to speak Creole, they say no. That's why, they try to help me to speak. That's why I don't have any friends, any relationships with Haitians. If I see them, I can talk to them, and try help them with something, but we don't have relationship. Not like when you was in Haiti.

Throughout Rose's narrative, the differences between growing up in the United States and Haiti were brought up again and again. She was particularly intrigued with the freedom that her young female cousin has, freedom she never imagined growing up in St. Marc, a small town outside of Port-au-Prince, the capital city in Haiti.

I think, when I was in Haiti, also that was the same thing. All day, since I was little, to be younger, they never let me go out with friends. Yeah. I think that is the way I am not so surprised to be like that. I remember when the first day I go to the movies, I was like eighteen years old. And not with friends, with my uncle. The first day I go to the movie, that was a Haitian movie, and everyone keep talking in that movie. But me, I was shy to talk except to my family. I want to see that movie and I asked my uncle, and he say, ok and that was the first time. And I think when I was leaving, they got a gate, I never go out that gate, without my family. But my brother go. [laughs] When I come here nothing interest me and I always stay home. If I have to go out, even now, I have to call my family and let them know. Ok, I go somewhere. Where? I go, if I want to go to the movie, I say I go to the movie. Well, it's in Miami, I am supposed to give the address or something. But I have my cousin she lives here, she born here, she's not going to do that. If she wants to go out, she just opens up the door. [hand slapping] And take a car and go. When I see that, that is so strange for me. That is strange. If you are seventeen years old you go to the club, eighteen you go to the club. I like that. That is different. We don't know club like that in my country.

Some of these differences allude to tensions of class; Rose's father is dead and her mother lives in Paris, where she buys perfume and beauty supplies to sell in Haiti, Martinique and Guadeloupe. Rose's story narrates a life that would be described as "middle-class" in Haiti, where bourgeois notions of gender strictly dictate women's behavior. This is particularly clear

when Rose describes her status as a single parent. The father of her child was a family friend who visited the United States, but still lives in Haiti, and she has no on-going relationship with him.

I was so shy to tell people I was pregnant. They are going to keep talking to me bad. Why she pregnant so early? She don't have profession or nothing. That is how Haitian think, you know? [laughs] The only thing, when they are mad about Haitians pregnant, before you have a boyfriend. You should have that boyfriend six years or seven years. After that, they do something we call in my country, like, they get 'fiancée' or something. They should get married, two years later. After that, married, they should be pregnant. That's when they feel better. And if you just have your boyfriend, and be pregnant. No, Haitians are going to be talking, talking, talking, everyday on your back. That's not easy. In my country, when you have the kids, it should be around 26 or 27, something like that. The parents, they have to know if that man, if he is working or something, if he got a good job, if he can take care of himself, his wife. If he go to school, you have to know first if he has education or something. Or that pregnancy, that woman should stay home, with her husband. And they expect everything, that the husband should be available to do it, not the family. They let you go. Some family, in my country, they say you take your own place and you are able to take care of yourself, that's why you try to be pregnant. I think that different here.

In Haiti, the urban elite historically valued cultural practices associated with French ideals – including enacting a civil code that gave men control over family life, wealth, and property, modeled after the Napoleonic Code. This resulted in social practices which idealized legal marriage, patriarchal authority, and women who did not work outside the home. To live within these families was to uphold both family and national honor. As Glick-Schiller and Fouron (2001:135) conclude, “these gendered cultural practices, unattainable for the majority of the population, have been part of the national narrative that is intimately linked to most Haitians’ sense of self.” For those women who were raised in the Haitian middle-class, a mere sliver of the population sandwiched between a massive underclass and a minority of light-skinned, urban elite, they find themselves caught between the family and marital practices of the poor and the elite values which are thought to embody the nation (Fouron and Glick-Schiller 2001; Glick-Schiller and Fouron 2001).

This middle-class ideal of marriage and children was also discussed by Danise, who was pregnant with her second child when I interviewed her. Although she was still involved with the father of her children, he did not live with her, nor did she have any plans to get married. However, she did comment about the different expectations for women in Haiti and the United States.

It's like in Haiti, yeah, it's a big part, woman if you have a baby, you get married and stuff, but I am not married. Yeah, everyone is like, why you don't get married? Yeah, but being married and having kids, it is like very important for Haitian family. That's what happened too, it's like, it doesn't matter how old you are, in Haiti, sometimes if you get pregnant. They don't care if you don't have money, you have to get married. And then they force you to. It's like they feel ashamed. It's like, if I was in Haiti, I would never have [my son] and no, because you have to get married to have a child. Even though you are pregnant, and not married, before the child is born, you have to get married. (Interview 1-30-06)

For Rose, even though she was living with her aunt and cousins, who helped with expenses, the tensions of being a young, single mother made her pregnancy difficult.

I am working since my pregnancy, since eight months, eight months and a half. She called and said "stop working, I am going to take care of everything. Send you money, and if you need pay for your bills. Don't work anymore." And I said thank you. And I stopped working. And she sends me everything I need, and my family do also a baby shower. Each other and they try to give me everything. And I feel a little bit better. ... Only my mom, my mom at the beginning was not for it, 'How come? You are too young to take care of baby. Who's going to help you? I am not going to stay.' She says, 'I don't like it, I am not coming, I can't stay with you, who's going to take care of that baby with you?' She doesn't like it here. ... Now, she tries to make me feel better. She's coming, coming on the 28th of April, she go on the fifth of last month [May].

Rose still hoped to follow her dream of continuing her education. She was thinking about sending her daughter to live with her mom, particularly as her grandmother specifically asked her not to send her to Haiti, given the current political climate.

But now, after my baby, I want to go to some, I want to go to Medical Institute. I want to start in September. When I tell her [grandmother], after four months, I want to send my kid to my mom. I want to be able to go to school. She said 'Okay, but not Haiti. Don't send her in Haiti.' I said, 'What? Why Grandma?' She said, 'Oh, that's not Haiti you know anymore.' They all different now. Now they got new things, the kidnappings. You should be able to have 50,000 [dollars]. Not fun, I don't even have one thousand! [hand slap] Yeah, no, it's different. Every time, since I left, they say, oh, Haiti is bad, Haiti is bad. But

now! When people, try to call you, and they go, just open the door, take people, to kill those people in front of you. They don't even do nothing. Specially, young men. Young boy, fourteen, sixteen years, eighteen years old. That's terrible.

She worries that even if she had money to support children living in Haiti, it would be too dangerous for them. Although she has little family other than her grandmother still living in St. Marc, she talks to her friends often to be updated on the situation there.

Now if you are supposed to have money to send over there, and if your kids have something, like that country, and they can wake up and they can't even go to school. Fire everywhere. Like yesterday, I call, I got my friend in Haiti, because since I was six years to fourteen I lived with a priest in a catholic church, we all go to church together, we go in our church, we do everything, and I call them yesterday, and they say, we can't even open the church this morning. I say, ok, what happened? And they tried to explain to me what they do over there, it's fire on the street all day, no one can stay out. At twelve o'clock, everybody has to be inside. I cannot sleep. (Interview 6-9-05)

Many of the women I interviewed shared their fears about the recent violence in Haiti, the risks to their families, and their own futures in Haiti and as Haitians living in the United States.

Narratives of transnational migration among Haitians often include a desire to return, or for their children to experience, their island homeland (Glick-Schiller and Fouron 2001). Yet the escalating violence which gripped the nation since the 2004 political coup d'état had important implications for narratives of risk among pregnant Haitian women living in South Florida.

“Chaos and Crisis” in 2004

Jean-Bertrand Aristide, a popular former priest in Port-au-Prince, was elected to the presidency of Haiti in December 1990, when people turned out in huge numbers to vote in the first free and fair election in Haitian history. Coming from humble origins, and preaching “preferential options for the poor,” a basic tenet of liberation theology, his background played a major role in his popularity among the impoverished majority (Dupuy 1997, 2007; Farmer 1994). Aristide's initial period in government was unlike anything experienced in Haiti previously. His initiatives included literacy projects, improvements in workers' rights, anti-crime

activities, and anti-corruption campaigns. These left-leaning programs did not earn him many supporters among the bourgeois elite and Duvalierists³⁶, provoking outright confrontations in the legislature. In late September 1991, a group of Haitian soldiers attacked Aristide's residence, taking him in handcuffs to the National Palace. Interventions by the French ambassador and other diplomats prevented his death, and he was escorted out of Haiti to Venezuela. General Raoul Cédras, head of the Haitian army and member of a military junta, declared himself president³⁷ (Dupuy 1997).

Aristide lived in exile in Paris and Washington D.C. for the next three and half years, while various international leaders worked to negotiate with the Haitian junta for his return. President Clinton negotiated under the condition that any assistance in returning Aristide to the presidency would be contingent on particular concessions, including compromises with the opposition,³⁸ a consensus government, and neoliberal economic strategies. Aristide agreed to these concessions in the signing of the Governors Island Agreement in July 1993 (Dupuy 1997). After a failed attempt at reinstating Aristide in 1993, he was returned with the assistance of the United States military in October 1994, while Cédras and others associated with the military junta were escorted to exile in Latin America and the United States (Rey 1999).

Aristide served out the rest of his term, but was constrained by the Constitution from serving another consecutive term. In 1995, his ally and former Prime Minister, René Préval, ran

³⁶ Duvalierists refer to supporters of the former "President for Life" Jean-Claude "Baby Doc" Duvalier who fled Haiti in 1986 after fear of an armed uprising against him. Baby Doc became president after the death of his father Francois "Papa Doc" Duvalier, and the family controlled Haiti from 1957 – 1986. The Duvalier rule was associated with violence and state repression towards the impoverished majority, and corruption among the elite supporters of the Duvaliers.

³⁷ In the years that followed, it is estimated that 4,000 Haitians were killed, 300,000 became internal refugees, and more than 60,000 took to the seas to seek asylum in the United States. Anyone suspected of having ties to *Lavalas* or supporting Aristide being raped, beaten, or killed. (Dupuy 1997: 139).

³⁸ As a result of these compromises, anyone associated with the coup (and therefore widespread human rights abuses) was granted amnesty and allowed to leave Haiti without persecution or retribution.

on the *Lavalas*³⁹ platform and easily won the presidency with eighty-eight percent of the popular vote, taking control in the first peaceful transition of power in the twentieth century (Dupuy 1997). Yet splits within his political party, *Lavalas*, foreshadowed the waning charismatic power of Aristide and his ability to maintain his massive appeal (Dupuy 2007).

In 1996, *Lavalas* splintered and some members became the Organization of People in Struggle (OPL in French), bitter rivals of Aristide's new party, *Fammi Lavalas* (Lavalas Family or FL). This struggle culminated in the 2000 legislative elections, where FL won seventy-two out of eighty-two seats in elections that outside observers ultimately called flawed. When the Provisional Electoral Counsel (CEP in French) refused a recount, the OAS and international monitors refused to observe the presidential elections in November 2000. In response, the United States, the European Union, the Inter-American Development Bank, and the World Bank suspended all economic aid and debt relief.⁴⁰ Aristide easily won his second term of the presidency during these elections in November, yet power struggles foreshadowed his downfall just four years later (Dupuy 2007).

Given that Aristide was distrusted and shunned by the middle class and elite in Haiti, who held the majority of connections to international support, he was forced to rely on his mass base

³⁹ Unhappy with the current choice of political parties in Haiti, Aristide christened his own organization *Opération Lavalas* (OL) meaning the “cleansing flood.” As stated by Aristide: “The idea of *Lavalas* – the torrent that cleans everything in its path – was growing in the [people’s] opinion: the unity, the unraveling, the cleansing of a shameful past, eradicating the roots of the Macoute system. To unravel. To uproot. To be born again” (1992: 142, quoted and translated in Dupuy 2007: 91). For Aristide, *Lavalas* was not to be confused with a political party, but was instead a movement open to all who were interested in bringing about change, regardless of their class location or institutional affiliation (Dupuy 1997, 2007; Farmer 1994).

⁴⁰ Although the 2000 presidential elections were not contested (and not monitored by international observers), the Bush administration refused to resume economic aid to Haiti. The Bush administration did not trust Aristide, and was unhappy that he did not implement all of the neoliberal reforms that were part of the United States assistance in returning Aristide to his presidency in 1994 (Dupuy 2007).

for support. An important element to this popular support was the *chimès*,⁴¹ or armed gangs, which were associated with violence against the opposition during the elections in 2000.⁴² His association with the *chimès* would ultimately cost him his presidency, as increasing numbers of Haitians were subjected to terror and violence. In addition, the multitude of factions that developed within the FL and throughout the legislature led to very little being accomplished within his goals for “preferential options for the poor” (Dupuy 2007) As Jocelyn, a Haitian-American nurse working in rural Haiti commented to me: “He provided this country with so much hope. [But] he preyed on the uneducated, the impoverished. When I would argue for him, I had friends who told me, ‘Look, I know that guy – you just wait.’ And sure enough, he was a lot of talk and no action” (Interview 7-31-04).

January 1, 2004 was celebrated with great festivity in Haiti and throughout its diaspora. Two hundred year earlier, Haiti became the first black republic as it declared its independence from France. President Jean-Bertrand Aristide celebrated on the lawn of the National Palace in Port-au-Prince, noting that if “1804 was the stinging bee, than 2004 was sure to be the honey!” (Dodds and Norton 2004). His supporters had waited all night to hear him speak and rushed the gates of the palace, toppling a fence and shouting “Aristide or Death!” Yet across town, thousands of demonstrators amassed to march to the statue of Jean-Jacques Dessalines⁴³ in opposition to Aristide and his management of the country (Polgreen 2004). Just a little over a

⁴¹ The origin of the word *chimès* is disputed, either associated with the Haitian Creole term meaning “I’m angry” or the French word, “*chimère*” for fanciful idea. I have heard it also used in association with “ghost.”

⁴² Aristide’s exact connections to the *chimès* are contested and complex. Some argue that he created and controlled the gangs, while others believe that he relied on their support. He continues to deny any connection to them, but never condemned them or persecuted them. In addition, the *chimès* were not associated with any particular political message or party. They were essentially hired thugs and could and did switch allegiances under various circumstances. For a longer discussion on the relationship between Aristide and the *chimès*, see Dupuy 2007.

⁴³ Dessalines was one of the leaders of the Haitian revolution and the first ruler of the independent Haiti in 1804. He is remembered as one of the “founding fathers” of Haiti.

month later, the cover of the *South Florida Sun-Sentinel* declared “Haiti in turmoil” and the *New York Times* confirmed: “Chaos Becomes a Way of Life in Rebel-Held Haitian City.” Only two months after his celebratory speech on the palace lawn, President Aristide left⁴⁴ Haiti for exile in the Central African Republic, after an armed insurgency⁴⁵ took over the city of Gonnaïves in early February 2004, and rebellion led by various armed gangs spread throughout the country. The rebel forces gained control of a large portion of the countryside and began an armed march towards Port-au-Prince. The situation became even more tenuous when pro-Aristide *chimès* went on a rampage throughout the capital, reaffirming fears that the situation would become a bloodbath unless Aristide left Haiti (Amnesty International 2004; Dupuy 2007). On February 28, the U.S. Ambassador informed Aristide that the Bush administration had “decided” that it was time for him to go. The United Nations authorized the deployment of a Multinational Interim Force immediately after Aristide’s departure, which remained in Haiti until June 2004, when it was replaced by the United Nations Stabilization Mission in Haiti (MINUSTAH in French). Meanwhile, the United States approved “Counsel of the Wise” appointed Gérard Latortue⁴⁶ to serve as Prime Minister of the interim government (Dupuy 2007).

Coincidentally, I arrived in South Florida to begin my research in early February 2004, and watched as Haiti graced the covers of the local papers, the *Sun-Sentinel* and the *Miami Herald*

⁴⁴ Aristide later argued that he was “kidnapped” by the United States and forced to resign as president. I think Dupuy (2007: 173) sums this issue up nicely when he states: “Whether or not Aristide’s allegations that he was kidnapped are true, it is clear that the administration of President George W. Bush forced him out.” See also Chomsky, Farmer, and Goodman 2004.

⁴⁵ This armed insurgency was made up of former members of the Haitian Army, FRAPH, and the Armée Canibal (Cannibal Army). The Cannibal Army originally supported Aristide but when their leader was killed the group blamed Aristide and turned against him (Amnesty International 2004).

⁴⁶ Latortue was a retired World Bank technocrat and business consultant who had been residing in Boca Raton, Florida. As noted by Laguerre (2005), this appointment represented a new chapter in Haitian diasporic politics: “Former President Aristide did not exit Haitian politics, but reconnected to it from a diasporic base, and Gerard Latortue did not exit diasporic politics, but reconnected to it from a homeland base” (206).

for weeks, finally making the front page of the *New York Times* and the *Washington Post*. Groups of Haitians protested outside the Courthouse in Ft. Lauderdale and in front of the Department of Homeland Security in Miami. Armed with signs proclaiming (in English) “Why are you doing this to Haiti?” and T-shirts picturing Aristide’s face, participants yelled “Aristide, Yes! Coup d’état, No!” (Fieldnotes 2-26-04). The diasporic communities in New York and South Florida were instantly polarized around the removal of Aristide and the placement of Latortue as Prime Minister. While many of them were fearful of the violence and unrest that had overrun the island in the weeks before Aristide’s departure, many were also uncomfortable with the fact that a democratically elected president was unable to complete his term. Support for Latortue versus Aristide fractured households, churches, and the community, as Haitian radio hurled accusations at rivals for being *Lavalas* or against *Lavalas* and Aristide.⁴⁷

Civil unrest and violence in Haiti did not immediately settle down, leading to continued attempts at migration to the United States.⁴⁸ In urban areas, pro-Aristide gangs of *chimès* continued to clash with the UN MINUSTAH and government forces, and kidnappings became a great concern in the period after Aristide left. While the use of kidnapping by armed gangs to extort money from the elite is a common practice throughout Latin America and the Caribbean, it was not as widely practiced in Haiti until the past five years. Both supporters and critics of the Interim government argued that it was far too weak to instill confidence and negotiate calm

⁴⁷ A Haitian colleague of mine in Miami was asked to appear on a Miami-Dade public radio station in a round table with Latortue; subsequently, her ex-husband publicly “outed” their recent divorce in a local Haitian paper. He denied any future relationship with her because of her involvement with Latortue and supposed turn against Aristide. She complained to me that she had supported Aristide, arranging rallies for him in California when she was living there, but the situation had changed and she wanted to have a voice in the future of Haiti (personal communication 5-25-04).

⁴⁸ President George W. Bush repeatedly stated that the United States “would turn back any refugee that attempts to reach our shore” from Haiti, angering human rights activists for this flagrant disregard for asylum policies. Immigration officials countered that Bush had “misspoken” and that the Coast Guard was in fact screening Haitian migrants but sending back those who qualified as “economic” refugees (Swarns 2004).

among the various factions ruling Haitian politics. The majority of kidnappings targeted middle and working class families, and in 2005, foreign diplomats and the interim government estimated that 6 to 12 kidnappings occurred in Port-au-Prince each day (Thompson 2005).⁴⁹

Even after René Préval was reelected as president in February 2006, kidnapping remain a scourge, inciting fear and frustration throughout the country. In December 2006, dozens of schools remained closed after students were kidnapped and a school bus was hijacked (Roig-Franzia 2007). In Miami, *teledjol* (rumor) stated that kidnappers were targeting people who were known to have family members in the United States, assuming they could pay high ransom amounts (fieldnotes 2-17-05). The diaspora became fearful of even traveling to Haiti, assuming they or their family would be targeted for kidnapping. This also resulted in on-going concern and fear for those family members remaining in Haiti, particularly for women who still had children remaining in Haiti.

Loudjina

Loudjina was twenty-six weeks pregnant with her third child, and also had a five-year-old girl who was born in Florida, and a twelve-year-old boy still living in Haiti. She has lived in the United States since 1999, moving here to make money to send home and support her family. Recently, she has not been working because her daughter is still too young for school, and she lives with her partner and child in a concrete-block duplex on a dusty street not far from the Prenatal Clinic. A number of Haitians live on this street, as evidenced by the smell of *griot* (fried pork) and the sound of *Kompa* music drifting out from the neighboring homes as we sat outside in the yard during the interview. Although Loudjina has dreams of returning to live in Haiti

⁴⁹ http://www.nytimes.com/2005/06/06/international/americas/06haiti.html?_r=1&scp=1&sq=new+scourge+afflicts+haiti&st=nyt&oref=slogin

someday, she spoke more about her dreams for her daughter to go to Haiti and spend time with her father's family.

Lo: Yeah, maybe this year, I think this year she will go to Haiti, with her Daddy. Maybe she go in the summertime next year.

L: Why do you think it important that she go to Haiti?

Lo: She has some family of her Daddy, [to her child] Daddy has more family there. She go to see my Mommy, Grandma, her brother, her uncle. Yeah, only my mom in my family, she stayed. I think she [child] would be different.

L: How do you think she'd be different?

Lo: Because she don't see all the family she wants, her dad family, her grandma, uncle, auntie. Not for me... maybe her brother be coming this year, thanks to God give it to me. You can find, see the country look different now. I am scared for us! I scared, I pray, pray, pray for my son. When he goes to school every single day, I am calling my country every night, to make sure he come in, go to school and coming back. They are kidnapping!

L: Is your son going to come here to stay with you, or do you think he will stay in Haiti?

Lo: I think he will come here with me, I don't know what time, or... only immigration know that (Interview 4-28-06).

For Loudjina, the risk of violence to her son and her family remained a strong fear during her pregnancy. Although she wished her daughter could see Haiti and meet her extended family, Loudjina was negotiating with immigration to bring her other child to the United States, so he could go to school and have a better chance at an education and a future than in Haiti.

Carline

Carline, whom I met at a Minority Development and Empowerment⁵⁰ baby shower in Ft. Lauderdale, was eight months pregnant and had recently moved to South Florida, although her husband had stayed behind in Haiti. Unlike many of the women I interviewed, who had little job

⁵⁰ Minority Development and Empowerment, Inc is a non-profit agency based in Broward County with a goal to provide programs and services to the Haitian and other minority communities. The baby shower was an activity of the Targeted Outreach for Pregnant Women Act which assists immigrant and low-income women with accessing and navigating prenatal care services in the county. <http://www.mdeinc.org/index.asp>

opportunities in Haiti and migrated to make a living and support their family there, Carline had been living a comfortable life in Port-au-Prince. She worked as an architect in an office, but threats to her family led her to migrate to Florida, even though she was two months pregnant at the time.

L: How long have you been in the United States?

C: Six months.

L: When did you become pregnant?

C: Eight months ago.

L: And why did you decide to come to the United States?

C: Well, there is a lot of problems in Haiti, like, our family was kidnapped and all that. There've been, how do you say that, blackmailing you. It is has gotten so there is too much stress. We hope it change.

L: So you were pregnant when you came here?

C: Well, there was a lot of things that make you want to come, like the situation, what happened to you, to your family. You just don't know. You don't know if you are next. You are trying to get another chance for your baby, because you don't like your country. A lot of things, but I didn't plan it, I didn't say, ok, I am pregnant. A lot of things happen, and we came here. ... I used to be nationalistic, 'I am not going to leave Haiti!' But now I am like, you can't know.

L: So you weren't planning on living in the U.S.

C: No. No.

L: Would you like to go back?

C: Everyone wants to go back. When it's good, it's the best country. Everybody wants to go back one day. (Interview 6-30-06)

For Carline, risks of violence to herself and her pregnancy became the impetus to migrate to the United States, even though economically she was better off in Haiti. She commented that life in Florida was not necessarily easy: "But it is very hard, the life, everything is expensive, the food,

the house is expensive.” But for her and her family, the risk of economic hardships and navigating immigration policies are worth it when faced with everyday violence and insecurity.

“It’s scary down there”

Sherley

The on-going threat of violence also had implications for couples who were negotiating long-distance kin obligations and the integration of their future children into these relations.

Sherley, who already has one son, was sixteen weeks pregnant when I interviewed her at their apartment where she lives with her husband in North Miami. She spoke about the differences between her husband and herself and their relationships to family still in Haiti.

L: How did you come to the US?

S: Um, well, when I came, I came by boat actually. And it was 1993, in January, I think.

L: And how old were you?

S: I was, I was fourteen. Fourteen or fifteen or something like that.

L: Did you come by yourself or...

S: Yeah. Actually, yeah. I came by, somebody else was coming but not, she was coming on her own. But she was a friend.

L: And why did you decide to come to the US?

S: It was hard down there. And, my mom was here, and I had nobody over there. So, there was no need to stay there.

L: Do you think that your children will have any sort of connections to Haiti, or do you want them to have connections to Haiti?

S: Well, I want them, but not like that.

L: Not like that? Why not?

S: It’s too bad back there.

L: It’s too bad?

S: (pause) I don't see how. I would not even want to go to Haiti, 'cause I'm scared. And they have these kidnapping things going on. I don't even want to go.

L: And what about your husband? Does he still have family in Haiti?

S: Yeah. He always sends stuff there. He went to Haiti and he's going in December. He wants me to go- 'cause I think his brother getting married. I'm not going to Haiti. They gonna, they might kidnap a pregnant woman. [laughter] They gonna kidnap me, just like that.

L: Does he want to take the kids to Haiti at all?

S: He's not taking my son. No, no. Or if I'm going, yeah, 'cause my husband is negligent. I wanna, you know, I pay more attention to him. But, I don't think I would take him.
(Interview 10-17-05)

Sherley, similarly to many of the women I interviewed, described a tenuous future in her relationship with Haiti. While her pride about being Haitian and Haiti as a nation was evident in her narrative, her fear at the risks to herself and her family in traveling there were also clear.

Lise

Some of the women I spoke with did not have personal experiences with the current violence, but were familiar with stories from friends or acquaintances. In some cases, these stories revived memories of their own reasons for leaving Haiti, reasons that were also driven by fear and insecurity. Again, these fears could lead to differing ideas among families about their children's future relationship with Haiti. I met Lise when I was working at a health fair at her church in North Miami. She initially seemed uncomfortable with speaking to me, but once I began asking questions she warmed up and hers became one of my most interesting interviews. Lise was twenty-three weeks pregnant with her first child, and has lived in the United States for twelve years. Her mother had traveled to buy and sell goods in Haiti, eventually moving to the United States and settling in Florida in 1987.⁵¹ As the political situation became more tenuous in

⁵¹ Many women in Haiti engage in marketing of items bought in the United States or other Caribbean islands, which they then sell in Haiti. This can include clothing, food, beauty supplies, etc. A large number of the women I

the early nineties, Lise and her two sisters joined their mother in Miami, leaving their father behind in Haiti. They came to the United States in 1994 following the first coup d'état of President Aristide, a period filled with risk for violence and civil unrest.

Yeah, so we had to go in hiding, I don't know if you have ever been to Jacmel? Ok, so that's where my parents from. We have to go hiding there, until things get – not better – but settled. That is one reason, this thing I will never forget it. Never, never. I remember one Sunday when I went to buy something, like in the market, and there were people from church. And some soldiers, they make those people with their clothes on, in a lake, in a lake where they used to have pigs. They make them go in the lake. They used to be FRAPH. Those people, it was sad. It was sad. My brother, he has to hide in a toilet! [exasperated laugh] Cause they [FRAPH] were like behind him, so. It was sad.

FRAPH is the common name for the *Front for the Advancement and Progress of Haiti*, a neo-Duvalierist death squad formed to spy on the *Lavalas* movement, or anyone assumed to have supported Aristide. FRAPH⁵² is associated with torture, rape,⁵³ murder, and anti-democratic demonstrations throughout the years of the post-coup period, 1991 – 1994 (Glick-Schiller and Fouron 2001).

While much of Lise's family had settled in the United States to escape targeted violence, her husband still has a lot of family remaining in Haiti, prompting him to urge a visit after the baby is born.

Li: Last time I went to Haiti was in 2004, after that I never go back. There has to be a major emergency for me to go there. It's scary down there. So scary. I don't want to make this kind of experience. I said if it's not an emergency, a major emergency, I will not go there. Like my husband, he said, 'Yeah, let's go to Haiti in July.' And I said, 'Hell, no!' [He said] 'I wanted to take you and the baby.' Because I don't know, I only know his mom

interviewed had mothers who had engaged in these economic strategies, and a few of the women themselves also did this before they settled permanently in the U.S.

⁵² For commentary on FRAPH connections with the CIA and U.S. funding, see Dupuy 1997; Glick-Schiller and Fouron 2001b; Rey 1999.

⁵³ In the last year of the military junta, there was a massive increase in the amount of sexual violence targeted towards women (ENFOFANM 1995; James 2003; Rey 1999). Rey (1999: 75), conducting surveys in 1995, found that forty-five of the ninety-eight respondents had been raped, and the vast majority (forty-one) had been perpetrated during the last year of the junta. For a sophisticated analysis of the role of gender and sexuality in the violence of the 1991 – 1994 coup period, see James 2003.

and his sister. Most of his family lives in Haiti. To see his family, to meet them. But I said, 'No, not yet.'

L: Are you planning on ever moving back to Haiti?

Li: Only to visit. Staying there? No. My mom says I should buy a house down there and I say no. Hopefully I will go to visit my dad. I may go to Haiti on a church mission. My church goes every year on a mission to different areas. This year, they will go to Cap Ayisyen. This year they'll go in July and I will have the baby so I won't go. Maybe a funeral, if one of my family, someone who is close to me, but it depends on the situation in Haiti. It's tough, it's very tough.

During her pregnancy, Lise was working as a security officer in a large condominium on South Beach, although she was planning on attending nursing school in the near future. She shared with me the story of a man who lived at the condominium where she worked, and his experience with the recent kidnapping of his parents.

There is a guy, some guy in my job was telling me. The guy was Haitian but he was born here. He lives in the place where I work. And they were kidnapping his mom and his dad. And they ask him to give like \$50,000. So they give them, even though the guy bring the money. But when first he was trying to decide to go to lower than that, they say 'oh, if you think I am playing here.' Then they kill his dad. They say, 'your mom will be next.' And he decide to bring the money. Even though he gave them the money, fifty thousand dollars. Then after he give them the money, he receive a phone call saying, 'hey, go to this place, and there you will find your mom.' And he go there, and then, guess what. They kill his momma. They cut, every part in her body, and then they put it in a black plastic bag. It was tough. It was hard. The guy was like, 'why me, why me?' What he was doing, just drinking. 'Maybe I could get over it. They kill my family, now I have no mom, no dad.' It was really sad. I don't know. I will never say I will never go to Haiti, but those kind of things, from hearing those things about Haiti, whoa. It's really terrible. Then there was a guy in my mom's church, and he went to funeral, and then they kidnap him and they kill him. He went to a funeral, his mom's funeral and then look what happened. I'm telling you. Those people they don't care, they just have to do what they have to do. And then, from what I heard, even though it was like the government was involved. Come on, what kind of life is that? (Interview 3-30-06)

Working in the Haitian community, I became familiar with these stories of kidnapping and violence. A Haitian friend of mine was paralyzed with grief when her cousin was killed in a kidnapping gone awry. Through another friend, I met a young woman who had recently settled in Broward County. Belonging to an elite family of light-skinned Haitians, she was kidnapped

three times in a two-year period, prompting her family to send her to Florida. Yet for some of the women I spoke with, moving to the United States did not insulate them from all risk of violence, especially the risks of unequal gendered power relations within the household.

“When you don’t have nobody it’s hard”

Nadine

Nadine was twenty-four weeks pregnant when I spoke with her at her apartment in Coral Springs, which is located in western Broward County. I also met her at the Minority Development and Empowerment baby shower; I think she felt sorry for me after I was continually asking women if they would allow me to interview them and they continually rejected me. Nadine is twenty-one years old, and lives in a small, but neat, one-bedroom apartment she shares with her partner. She has lived in the United States for fifteen years, but unlike the majority of the women I interviewed, she spent most of this time in California, where there are very few Haitians. She explains that when her family left Haiti, they settled on the West Coast to avoid the large Haitian communities in New York and Florida, which were assumed to be “low class.”

My grandmother and my aunt, what they were trying to do with us, they didn’t us want to go to Florida because there were too many Haitian people. They felt they wanted to get out of that environment. The reason is, like my grandmother, old school Haitians, they’re very racist against their own kind, to be honest with you. You have different segments of Haitian people- you have poor, the high class and all that. Even in that third world country you still have that. My family was very high class, and their whole thing was, I remember growing up in Haiti and if I spoke Kreyol or I had contact with the maid I would get hit because they didn’t want me to go below our class. So my grandmother, when she did our papers in 1991, we came in illegally because of the war, the chaos that was going on. She shipped us off to where my aunt had lived, which all my aunts resided in California. And I had a few aunts who lived in New York, and nobody who lived in Florida. So they sent us over there to California because they felt it would be better. And we would grow better because there were more opportunities in California. They didn’t want me to go to New York because they didn’t want me in the same environment and they thought the likelihood of me catching on English would not be that much. Because people in New York speak Haitian, speak Kreyol, people in Florida speak Kreyol. So they thought it would be easier if I went to a different environment, which made it a lot easier.

Nadine also talked about the incongruities between living in Haiti and imagining life in the United States and the reality of life here. She was familiar with California from American movies and television, but her experience was very different than the one she viewed on *Beverly Hills Cop*.

Most of the Haitians [in California] come from either New York or Florida. Most of them, no one is like my family who went directly there, which is rare. A lot of Haitian people, they have the dream of living in California. When I was a kid in Haiti you saw *Beverly Hills Cop* with Eddie Murphy and thought wow! But it doesn't show you that you have to work to get to that Beverly Hills. My aunts, when I first came to the United States, it was my cousin, my aunt and my other aunt, three of them in the same house. We lived in an apartment, to be honest with you, the first time. This was the worst apartment in the world. When I first got off the plane, I thought big city. When you first get out of LAX airport, you see all the big hotels and you're like wow! It had cockroaches all over that place, and for no reason, and we could clean and clean. And the six of us were cooped up in this two-bedroom apartment. We would sleep out in the living room, sleep out in the first bedroom, and sleep out in the second bedroom. And sharing this bathroom, with like all these women, it was horrible! If I had to be at school at 7:30, we had to get up 5:30, because my aunts go to work from 7 am to 7 pm. Cause they didn't want to work overnight shifts and then they would leave us by ourselves. So they would go to work, and we would come home from school around four o'clock and we would be by ourselves for three hours. But then in that three hours they would give us lots of stuff to do so we wouldn't be messing around, even though sometimes we did [laughs]. But it wasn't like the big dream that you see on TV.

Nadine moved to the United States in 1991, in the period after the first coup d'état against Aristide. Having firsthand experience of the violence herself and a family which was associated with the Duvalierist military, her grandmother thought it best to send the children to live in California.

That's why we left when I was little, because I remember when I was five going on six. [pause] The only image I remember from Haiti, we were coming home from school with my friend's dad. And I had a blue dress on, some ribbons in my hair, some black shoes and some lacy frizzled socks. And she had on a yellow dress with strawberries on the front part, with ribbons in her hair. Her and I, she was on her dad's right side and we got stopped by some soldiers. Don't know why, we took the same route every day. And he pushed us to the back. They pulled us from him, and they pulled him one way. I don't remember anything being said, I just remember her and I being scared to death. They shot her dad right in front of us, cold dead. And they left us on the street and walked away and went on to the next person. We both peed on ourselves, we were both freaked out. My grandmother didn't even notice we were missing until, well, we were always home at the same time, and

she noticed - three o'clock, I was not there. Three thirty, not there. She was, she was filthy rich. So she went in the car, had her driver drive her around, follow the same exact route. She saw us sitting there. People asking us stuff. Asking who's this, who's that. But we couldn't reply, once you see something like that. And she, after that day, she was like, this is getting bad out here, we need to send all the kids. It was getting really bad. So she decided to send as many of us as she can to the US. My grandfather, he had been in the military his entire life. And he wanted to find who had that man shot. And my grandmother thought that if he went into that process it was going to create more problems for our family. He was like Papa Doc military. But at that time, the military, the president was Cedras. It was bad. It was horrible. We used to have nightmares all the time, my grandfather who was in the military all his life. He would have nightmares that they would come and we would disappear the next day. You would see someone walking down the street and then their family would be like, 'Oh! They took him last night. He is gone.' Six weeks later, he's in a body dump with all these bodies. That was why we left. It was bad. That time was like really, really bad. There was like nothing. It was just like, uh – [shudders]. And I don't want my child to like ever see that.

Nadine has had a difficult life, and was one of the few women I interviewed who had been classified as a “high risk” pregnancy. She suffered from epilepsy, migraines, and panic attacks, and was surprised that she had even successfully gotten pregnant. After suffering two previous miscarriages, it was recommended that she have gynecological surgery that she was told would leave her infertile. This pregnancy was a complete surprise to her and her partner, and she explained that they were both hopeful and fearful about the upcoming birth of their daughter. They were both isolated from their families for various reasons, and were concerned about finances and her health. Narratives of risk ran throughout Nadine's story, often oscillating between biomedical notions of risk within a pregnancy and stories about difficult life experiences.

Throughout Nadine's narrative of her life as a Haitian migrant living in the United States, there are veiled references to discord and violence. Separated from her mother, who died in Haiti when she was twelve, and without knowing her father, a Haitian-American living in New York, she was dependent on extended family for support and care.

It was easier living with my aunts, I think, than living with my dad. My mom died in Haiti when I was about twelve years old, but I left when I was about six. I kept touch with her

when I first came to the United States, for the first three or four years. And I used to send her money and things like that. But when I got to like nine, like nine years old, I was put into like foster care cause our neighbors reported our aunts for leaving us alone too long. And Americans consider certain things child abuse, whereas in other cultures, like Hispanic, Haitian, Jamaican, it is not considered child abuse. Even though it should be, but it is not considered child abuse. They reported us for that, and I was in the system for like about three or four years. And then my family got me back, and we're back on track. Still got hit, but it was nothing biggy. We weren't spoiled brats or anything, it was just that if we did something wrong, we knew there were consequences. I was the kind of kid that would keep on, even knowing the consequences. Which was my hardheadedness.

Towards the end of the interview, she opened up about another diagnosis which complicated her pregnancy and plans for her future. In the midst of her early routine prenatal care, she was informed that she was HIV positive.

N: Pregnancy is hard, especially if you are a high-risk pregnancy. I also recommend that people get HIV tests before they find out they're pregnant, because when you find out when you are pregnant it's harder to take. It's a lot harder to take. When the doctor tells you, oh, by the way, you are HIV positive, that makes you a high-risk pregnancy. ... When I found out I was pregnant, I was happy, I had plans and what not, wanted to do the water birth. [pause] When I found out I had HIV, my old OB told me I should abort. He didn't give me any help, he just said no news is good news. I felt like I was a plague, like I had black tar poured all over me.

L: He told you to abort?⁵⁴

N: Yeah. Because I had my epilepsy, the HIV, all that. But don't let that disease consume you. Just live your life like normal, you would before. Find joy in everything you can. I get depressed, I am still in the denial phase, asking why did this happen to me? But, I find a reason to continue. I try my best to keep myself healthy, and I make sure to take my medicine every day on the dot, to make sure she doesn't get it. And I do plan on having a c-section even though they said the risk isn't that high, I could have a vaginal birth, I do plan on having a c-section because it is less risk. I don't want to have a seizure in the middle of the birth and then blood starts pouring out of my body and then she gets it.

⁵⁴ After I completed my fieldwork, I spent a few months in Miami volunteering for a abortion advocacy group called Women's Emergency Network (WEN), which was part of the National Network of Abortion Funds. WEN was completely volunteer run, and provided financial assistance for low-income women seeking abortions in Miami and Broward Counties. As a volunteer, I screened women over the phone and authorized funding. In one case, a young woman called who had just been diagnosed with HIV and the local health center encouraged her to get an abortion. I found this case to be extremely problematic and ethically troubling, and referred her to a case worker I knew who worked with HIV positive pregnant women. Nadine's story that she was also encouraged to abort has led me to wonder about whether this is a common practice, and how narratives of risk as related to maternal and fetal subjectivities are negotiated through the diagnosis of HIV.

Notions of biomedical risk dictated technologies of self-care during her pregnancy, but for Nadine, her strongest notions of risk focused on her daughter, and her risk for sexual abuse. As a survivor of sexual abuse, Nadine worries about her daughter's future, and the ways in which she can protect her from similarly devastating experiences.

My boyfriend does not have HIV. I do, because the reason why, is because up until a few months ago, the virus load was so low it was undetectable until I got pregnant. And he doesn't have it, we are still getting him tested. I do, I got it from a parent, my aunt had gotten remarried and I got it from her husband because I was sexually abused as a kid. And I figured, he's [her boyfriend] my first, so other than my dad, well my uncle-slash-dad, so why would I get HIV? I think women need to be more alert when it comes to their children. I think you should, as a woman, regardless of how your husband may seem, or you boyfriend may seem, just always keep that eye. [I am] Twenty-one years old, now starting to take these HIV pills every morning, it gets harder. I am not looking for a more fulfilled life as I was before. I had big goals and plans. It gets harder, my only focus is to live as long as I can for my child, to make sure everything is okay, so that way she won't have to grow up without a mother or father or just one parent. And she doesn't have to go through sexual abuse, or anything like that (Interview 7-11-06).

Catherine Maternowska (2006), in her work on family planning among Haitian women living in Port-au-Prince, cited a high incidence of domestic abuse among the women she interviewed. For these women, daily beatings are not defined as violence, given the possibility of being without any economic support. In a study by Smith-Fawzi et al (2005) in Haiti, researchers found that 54% of women accessing health services at a clinic in rural Haiti had experienced forced sex during their lifetime. Data from the Haiti Demographic and Health Survey in 2000 demonstrated that 15% of women surveyed had been physically hurt by family members since the age of 15. Women who had grown up witnessing their fathers beat their mothers or were subjected themselves to violence in their home were most likely to be involved in relationships that resulted in intimate violence as adults (Gage 2005).

Much of the research focusing on abuse in Haiti has analyzed its occurrence among women, but a study by Martsolf (2004) found that 60% of women and 80% of men reported a history of childhood abuse of at least one type at the moderate or severe level. Physical neglect

was the most common form of maltreatment reported, and childhood sexual abuse was reported by 52.4% of men and 20.6% of women. Kathia, the Healthy Start Provider at the Prenatal Clinic, also talked about the practice of domestic violence within the Haitian community. She expressed her frustration at her lack of action when she detected issues of abuse among women enrolled in Healthy Start.

You'd be surprised, Haitian women, they're pretty slick. It's not like... They're afraid, but some of them will actually take a risk. [Be]cause when they come here we ask them things like do they go to bed hungry or have they been hit or hurt. The majority of them would be honest and say, yeah, you know, my husband beats on me. I say we can offer you supportive counseling and they say no, what's the point. And that's the end of my conversation, cause I can't take action because they are denying the service. But I try to keep them [their file] open within Healthy Start, just so that whenever they come we monitor how they're doing. And you keep pushing that 1-800 number on them every once in a while. But other than that what can you do?

She contextualized Haitian women's lack of reporting domestic abuse on their dependency on their partners and their fear of the system. The day-to-day struggles of making life livable in the United States preclude many women from reporting abuse. In addition, language skills, fear of immigration and deportation, and traditional notions of gender all work to keep women in abusive relationships (Sant La Focus Group 1-31-06).

This is how Haitian people think. It's like, okay, imagine you come here from a different country. You come here from Haiti, you're Haitian and you already feel like you're at the bottom of the feeding pole. Everybody else gets all their papers, all other benefits and everything else before you do. Haitian women, well Haitians period are extremely prideful. Ok? They're very, very prideful. So a lot of them feel, like, I'm leaving my country which they feel is the most beautiful ever, but they're leaving it, to come to *here*, just to try to make money here and hope one day to support the family back there. Or to one day go back and open their own business with all the money they accumulate from here. They get here, they're here for six months and immigration hasn't sent them their work papers yet, they're stuck. Whoever they're staying with is annoyed that they're there, you have to get fed, you're using their electricity, I have to take you everywhere, you don't have a job yet, you're not contributing. And now they have to find other means to get around. So they do those cash paid kind of jobs, then they become migrant workers. Then they actually get their working papers. So now they can get a good job but they don't speak English so they're not qualified. So they have to get a job from a hook-up: dishwasher, maid service, home health aid, anything that requires them to do very little speaking because they can't do anything else. But these are not high paying jobs. You see what they live on. So now

there's bitterness. They're like, 'I left everything I own' and they can't go back because their papers have run out and if they go back they'll never get a chance to come back here. (Interview 3-22-06).

In a recent study by Latta and Goodman (2005) about domestic violence and use of services among Haitian women living in the northeastern United States, participants argued that violence was an "everyday occurrence" in Haiti, it was "just what happened" and was accepted as a part of everyday life (1447). Police are unwilling to intervene in domestic situations in Haiti, and Haitian migrant women assumed that the situation is the same here in the United States.

Immigration status also influences Haitian women's reluctance to seek assistance in the case of intimate partner violence; even for women who are "documented" there is a fear that utilizing social services could affect their status in the United States. As in many communities, long term violence and sexual abuse can lead to difficulties in navigating life in the United States, which are exacerbated by issues of immigration and documentation. In some cases, dependence on the system, for housing, food stamps, and medical care, are the only ways women can survive.

Gloria

When I met Gloria, she was living in a homeless shelter in downtown Miami with her three kids, and six months pregnant with her fourth child. She has lived in the United States since she was four years old, when she was brought to Florida with her aunt and cousin in 1987, not long after the overthrow of Baby Doc Duvalier. Twenty-three years old, she is currently separated from the father of her children, and has been in and out of shelters since she was twelve years old.

G: My first pregnancy was at twelve years old.

L: At twelve years old.

G: That's, that's not with Ashanti [her eldest child] because I lose that first kid.

L: That's rough at twelve, it's hard to carry a pregnancy at twelve.

G: Really it's easy. Just like you have people who care for you. It's easy. When you don't have nobody it's hard.

L: Were you living with your aunt?

G: No sweetie, my auntie kicked me when I was twelve. Mostly I live on Children's shelter for past years of my life. ... It [the pregnancy] wasn't choice.

L: Why do you say it wasn't your choice?

G: My virginity was taken. My uncle, my uncle take my virginity away when I was five. He raped me.

Gloria was living in the homeless shelter at this point because she had recently separated from the father of her children. She explained the difficulties in finding a job, especially with three small children, one on the way, and no "papers." She had come in the United States illegally as a child, and while she had a work permit for a short time, had a difficult time keeping up with the paperwork at immigration.

L: Have you been able to work at all since you've had the children?

G: I can't. Its um, its really hard to like have three small kids. And trying to look for a job, sometimes the money you working with, you're just trying to find the daycare stuff. And you can't even pay your rent, [be]cause each of the kids needs the money. Jeremiah in daycare, that's like seventy-five dollars- Ashanti is like sixty-five sometimes, per person its different you know. The kind of person you're putting them in, Sade is the same amount for her. It's like for the month, it could be three hundred or four hundred dollars a month, and sometimes when you, when you like Haitian, you're not American with a nice paper, you just, they have to offer you a work permit- and everybody that will hire you, not a work permit. The only thing I get is a little work permit. That's all that the state give me and that's all I'm working, with a work permit.

Sitting in the shelter, Gloria dreamed of returning to Georgia where she had lived for awhile before the birth of her third child. Many Haitians I had met while in Miami had talked about moving to Georgia, particularly the Atlanta area, given the state of the housing market in South Florida at the time. Gloria was among the few women I interviewed who had experienced prejudice in Florida because of being Haitian. She felt that Georgia was more open to immigrants, and wished she had not returned to Miami.

G: My plan for getting out of here is a lot. Right now, I got six hundred dollars incoming. I will find an apartment for at least four or three hundred dollars. While I'm staying overtime, I will try not to get in trouble with nobody. And Lord help my stuff in that house. If its still there when I get home from work. But after a couple a three or four months, I will go to Georgia. Take my kids and go to Georgia. While I'm in Georgia I can find a better job. And better place.

L: And why, what's in Georgia?

G: I used to go to Georgia. I used to work in Georgia, and I went to Cordell for like, two years, and it was real good. Nobody, they don't treat you different. They treat you just a number. You will feel comfortable with the people you working with. It's not matter about the color of your skin, or where you come from, or how much English you speak, or what degree you have, they just think you're somebody to work. And um, in the same with everybody. That's what was so good about it. In Georgia, not only Georgia but different places, its good.

L: So, why did you come back down here?

G: I got pregnant with Sade, her father tell me that he was going to help me with her, and Ashanti, he was telling- he was telling me how good he was going to do for us. He was, it would be better than staying in Georgia. I still came, I lived with him because I was in love- and I was being stupid, and then I found him. The first time I come down here, he rent a house in Liberty City. I do not like it. He said don't you like it? I said, yes [be]cause that's the best he could do. The second time, he rented another house in Liberty City. Every year, we have to keep moving, and that's become a little bit rough. Cause after you have, after preg-, after you have a baby, I couldn't find a job, my work permit, my work permit was expired for like a year or so, when I went back to Immigration, they sent me a deny paper. I have to wait for another hundred thirty-five days, and it's a lot. Let me go see if I can find a little under table job. So, I was working the house cleaning, sometimes she will pay me, sometimes she will say the bills are so high [so she can't pay me], either three hundred dollars or there will be nothing at all. I get tired of it. And I give Immigration another try and they give me my work permit. In March, my daughter just turn two. And that's ok, I'm going to try to have a job. I go and get a security license, I apply to security company. They give me temporary, they still don't send my license yet. Because of what? I don't have anything. I have a work permit. Whatever they want to do is whatever they want to do. You can't do it in the state.

Gloria's experience as an undocumented immigrant living in the United States is not unusual, particularly in finding a job. Throughout my work in South Florida, I met many Haitian men and women who were working in security or as home health aides because these jobs were often available without work permits. Yet negotiations with immigration authorities and the difficulties in find a decent paying job in South Florida without legal papers leads many women to become

dependent on their partners. While Gloria explains that she was committed to her partner because of love, she also comments that she has begun to see why many women take multiple partners.

L: Your babies' daddy was Haitian or American?

G: If their daddy was American, I would say that would be a blessing because I could get child support from him. He don't have papers. He's a Haitian. What I, my belief is like that, if you're Haitian, go with your own culture. Go with your own culture, go with a Haitian man and a Haitian woman. But I was wrong! I thought I'd be miserable woman with having two babies' daddies, I was wrong, too! Because having different babies' daddies usually one is there for you. If one not going to take care of you, I guess you go to a second or third one to take care of you. Having a baby, having three babies by one man and that dog does not take care of them, no, that's a problem. And now forever with his kids. He won me over with his heart. That's horrible. But, hey, that's life, you know. But now I learn. I been with their daddy for eight years. The first time when they in love with you, they will treat you like a princess. Second year, it'll be like ok. Third year they will say they don't have no money. When they find a girlfriend, they will treat you like dirt. If that girlfriend is cooking or cleaning, or if that girlfriend know more stuff than you do, they're gonna forget all about you and your kids, they will not care. For me, Haitian men is the worst men alive. I regret being with my babies' daddy. I wish I could, he could be an American boy who can gets benefits- they will pay you [be]cause he's an American, Haitian men won't pay you nothing, [be]cause he's Haitian (Interview 6-26-06).

The majority of the women I interviewed were in stable marriages with the father of their children, but a number of women I spoke with had children with multiple partners or were single mothers. While serial monogamy is not unique among other communities in the United States, a number of Haitian scholars have recognized a spectrum of sexual relationships with varying degrees of social approval, cohabitation permanence, and mutual obligations in Haiti (Allman 1987; de Zalduondo and Bernard 1995; Glick-Schiller and Fouron 2001; Herskovits 1937; Lowenthal 1984; Maternowska 2006; Maynard-Tucker 1996). As Maternowska (2006) demonstrated in her work on the use of contraception among Haitian women living in Port-au-Prince, there is an implicit understanding that a child must be produced if a union is expected to maintain itself: "When resources are dangerously low, men can easily enter into women's lives, providing tiny amounts of cash. ...Subsequently, men exercise their "right" to demand a child.

And how can women refuse? Bearing children is often the only way, women claim, they can *kole yon neg* (keep a man)” (60).

Valerie, who was pregnant with her third child, was excited about her current pregnancy because it was the first with this partner. She moved to the United States two years ago to join her parents, and brought along her eight-year-old and thirteen-year-old.

V: It’s the first one for the father, it’s not the same father. He is very happy, so I am happy too for him.

L: Are you happy for yourself?

V: Yes, I am happy for myself, too because when you have someone take of you and he like your child and he like you, too, so you try. Life is a try, you have to try and that’s it (Interview 7-5-06).

For Valerie, having a child with her new partner was gratifying, a means to fulfill his wish to have children and to satisfy her role as a partner. Yet I do not wish to simplify Haitian women’s desires for children as the result of pressure to keep male partners. Instead, these narratives illustrate the diversity of issues which govern women’s experiences in pregnancy, experiences which could influence perceptions of risk, both biomedically and socially.

“I would like for me to stay here”

While some perceptions of gender relationships remained unchanged in the United States, particularly among women living in more impoverished circumstances, a number of the women I spoke with saw many more opportunities for women living here than in Haiti. Even Gloria, who was living in the homeless shelter and who professed her love of Haiti as the country of her birth, explained that she would never want to move back there.

G: What I say it’s stupid is like that, people that come from Haiti, people from Haiti want to come to America, why would you say you wanna go back? I don’t think so. [laughter] I’ll stay. I love America. There’re no jobs. They will not give you no paper. But they will help you in different ways. They will give you food stamps. Even if the system is not a lot, at least they help you.

L: Right.

G: In Haiti, there's a lot of hungry people up there. They won't find nobody giving you nothing. They don't find no help. Look at me right now, I'm homeless. I'm in a shelter, at least I got a shelter to stay, I got a bed. Even if I got to sleep with three little kids in a little twin size bed, but I think that's a blessing.

L: Mmmhmm

G: Some people in Haiti, they don't have that. They are homeless, they just stay homeless. And so, that's the way it is. I don't imagine myself going back. I don't know Haiti, I would like for me to stay here. 'Till I die. I will keep telling people, this is my country, even if I'm not American, I don't have no paper, but my Lord Jesus help me, one day I'm gonna get it. I'm gonna get my papers. Soon as I find a good job.

L: Well, that doesn't change the fact that you're Haitian, right? It's not the paper that makes you American?

G: It doesn't matter, how much paper they give me, I'm still a Haitian. I love my culture (Interview 6-26-06).

For Haitian women who had predominantly grown up in the United States, life as a woman and mother in Haiti was often romanticized as more "simple." Eugenie, who was born in the Bahamas to Haitian parents but has spent most of her life in the United States, imagined how things could be "easier" in Haiti, especially given her more middle-class background.

I would say [it is easier to be a mother in] Haiti, depending on your lifestyle. If you can afford to get someone to watch your child it's easier because you're paying them to watch your kid while you do what you have to do. As opposed to here, thank God my mother is retired and she can watch the kid. But if she were working, as soon as I go back to work I would have to look for day care and tote the baby wherever I go. So that I give credit to Haiti (Interview 1-18-06).

Marie-Lucie, who is pregnant with her second child and currently working as a nurse in North Miami, began talking a bit more about raising children in the United States after her interview. I was accompanying her and her daughter to the little patch of grass that was situated across from her apartment complex Marie-Lucie explained that the nice thing about raising children in Haiti is that everyone keeps an eye on everyone else.

You know your neighbors and they look out for each other. Kids can run around on the street and everyone watches them. Here there are no fences in the park, so I have to come and keep a close eye on my daughter. I wanted to go back to Haiti, after the birth – here it is so hard by yourself. I had a really difficult time after my first daughter, my husband wasn't much help. Men in Haiti, they are taught to go out of the house and bring the money in, they are not taught to help around the house. Like with my first daughter, I wanted to breastfeed. But she was crying and crying, my husband went to buy milk and said to give it to the baby (Interview 3-18-06).

Kathia, a health outreach worker for Healthy Start in Broward, described how her husband romanticized their potential life in Haiti, and expressed frustration at the realities of actually raising children in such an environment.

My husband loves Haiti. He says he walks in the street barefoot and nobody says anything. He says he has money in his pocket, he buys what he wants, he eats when he wants, then he goes home. He says he doesn't feel threatened. And I say it's because you're not a woman. Can you imagine walking barefoot six months pregnant? My husband says, 'your life would be easy if you moved to Haiti. You speak English, Creole, French – you can get any job you want.' And I'm like there are no jobs. He says we can pay somebody \$20 a month to take care of the kids, they'll clean the house and do the laundry. 'You'll never have to do housework again.' And I'm like do you want to live like that knowing you can't get a good night sleep. You would have to buy generators from the States and pay for the high priced gas because they took the electricity. Or if we're the only ones with electricity we're powering the whole village. ... You have Haitians who speak Creole in the city which is different from the Creole they speak in the mountains. And it's not even proper French. It's the French that they think is proper but it's not because they're not educated enough to understand proper French. Then you have the other ones who left Haiti a long time ago who speak English who want everyone to know that they're Haitian and that they lived in the States. So they have a big house with the guard wall and the barbed wire all around their fortress. Can you imagine me raising my two children in a house that is surrounded by barbed wire? (Interview 3-22-06)

Women who had migrated to the United States more recently also problematized the simplicity of life in Haiti; they narrated its difficulties, and the frustrations of having to depend on family abroad for daily survival. Much like Gloria, they point out the opportunities for state benefits that exist in the United States, as well as the possible futures for their children.

In Haiti, even though I am paying daycare [in the U.S.], and it's very expensive, next year, I am not going to have to pay daycare, for school for Brian. But in Haiti, school is expensive. And you have to, the public school are no good, they are really no good. They are only for like, poor people, for their child there because they don't have any choice. But if you have an education, you would never send your child to public school in Haiti. You

have to work for the business, or selling stuff or whatever, something to. But here, here you have help. If you don't have food, you can go ask them for food stamps, you know what I mean? If you don't have money to go to the doctor, you can go for Medicaid, especially if you are low income. It's better (Danise 1-30-06).

You know, when you got somebody in the U.S., and you got money, you think about it. When you say, oh, I don't have no money, let me call my family in the U.S., send me the money tomorrow. And when the people don't have nobody, what you going to do? You don't have to do nothing. You know? Just like my, my mom. Sometimes she'll call me and she'll say I don't have no food. She make me sad. Because, you know, every day you have some food, you know, you don't have rice, you mix some other food. ...It's easier here. Yeah, because you go to work. You can get a job and you can get money easy. You have to work- for the money. Hard, very hard. And you have school, free school, you don't have to pay. In Haiti, woohoo. You have to pay for uniforms, and the books, everything! But here, you don't have to, to pay for the school, but you have to buy your clothes, it does not mean nothing, you know? (Gislene 5-10-06)

I don't think it is harder [in the U.S.], because you can take care of them. Which you cannot in get in Haiti, you have to pay for school and it costs a lot of money, and the kids just stay home, they don't go to school, they do nothing. It is very hard (Carline 6-30-06).

Yes, way easier. We have more opportunities here than in Haiti, way more. I mean, you can see a doctor in Haiti, but if I was pregnant in Haiti, and my mom wasn't giving me the money, how would I see a doctor? It's not free. It's way easier (Rosemarie 12-30-05).

Throughout the narratives in this chapter, these women reveal a tension between nationalistic pride in Haiti with the acknowledgement of a better future in the United States, for both them and their children. While they acknowledge the difficulties of living far from “home” – the expense, the obligations to family in Haiti, raising children who are more “American” than Haitian, and fear of deportation – the risks incurred in the violence of everyday life in Haiti make these difficulties manageable.

Haitian pregnant women's narratives provide a means for charting a transnational landscape of risks, as navigated and negotiated both inside and outside the clinic. Their impetus for migration often speaks to political and economic turbulence within Haiti, instability which remained constant throughout these stories, stretching from the mid-eighties to today. Their stories speak to elements of a nationalism, but one that is structured by notions of race, gender,

and class. By focusing on a few “key” subjects, I illustrated the diverse ways in which these subjects are multiply constructed by their relationship to power and difference. These stories are not assumed to represent “the Haitian pregnant woman” but instead illuminate the intersections between these women’s local moral worlds and notions of risk and responsibility.

CHAPTER 5 IMAG(IN)ING MATERNAL RESPONSIBILITY

It was not until the last half of the twentieth century that the prying eye of the ultrasonographer rendered the once opaque womb transparent, letting the light of scientific observation fall on the shy and secretive fetus.

--- Michael R. Harrison, M.D. (2001: 11)

Our notions of the fetus are long grounded within a particular history of fetal images.

While much of this chapter focuses on the making of fetal images within clinical spaces and the mobility of these images outside this realm, our ability to “see” the fetus in those original, grainy, black and white ultrasound exams is based within a long history of fetal “imaginings” (see Duden 1992, 1993; Haraway 1997; Hartouni 1997; Petchesky 1987; Stabile 1998; Taylor 1992). Intricately linked to changes in fetal images are the ways in which these imaginings shape maternal subjects. In Chapter Three, I described how the everyday practices in prenatal care are shaped by clinical and epidemiological narratives of risk. In Chapter Four, I illustrated how Haitian migrant women’s local moral worlds incur other narratives of risk and responsibility, narratives which infiltrate their experiences in pregnancy. In this chapter, I turn to the ultrasound imaging, a technology structured as both a diagnostic tool and a pleasurable experience. It is in this intersection of prenatal diagnosis and pleasure that narratives of risk and responsibility become particularly powerful and interesting.

Using ethnographic evidence from my observation at an ultrasound clinic in South Florida and interviews with pregnant Haitian women, this chapter seeks to contribute to larger feminist discussions about the power of fetal images and its implications for maternal subjects in the contemporary United States. In this chapter, I present Haitian pregnant women’s narratives on ultrasound to illustrate the plurality of experiences which exist at this intersection of fetal imaging and subjectivities. Through this investigation of Haitian women’s utilization of fetal

imaging technologies, I critically examine the conceptual categories and discourses which shape the debate on fetal life and maternal responsibility in the United States.

Tracing Fetal Inscriptions

Ultrasound involves the use of high-energy sound waves that bounce off internal structures and are converted into electrical signals that are displayed on a screen. This technique was first utilized by physicians in the 1960s, but played a small role in obstetrical care; physicians relied on other forms of knowledge, including the mother's embodied experience of pregnancy, to guide reproductive care. In the 1970s, the use of gray-scale standard film and scan converters allowed fetal images to be portrayed on a TV-screen instead of through a camera positioned above the pregnant woman's abdomen, although its use was considered rare and even experimental during the 1970s (Mitchell 2001; Oakley 1984). Early uses of this technique focused on high-risk pregnancies,⁵⁵ and in 1984, the United States established a list of twenty-eight indicators which warranted the use of ultrasound. [Figure 5- 1]

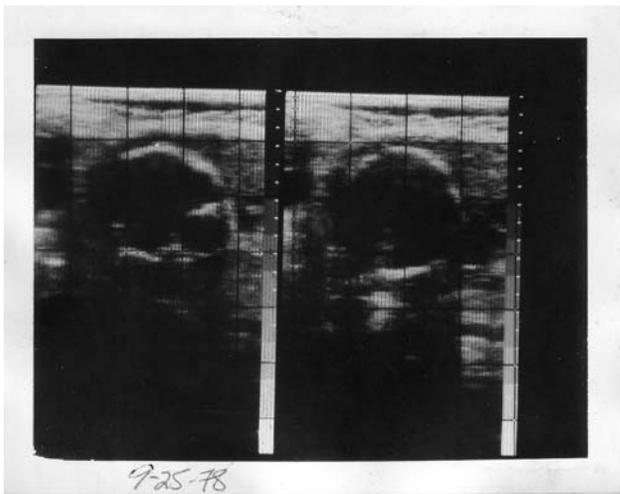


Figure 5–1: Ultrasound Image from 1978 (24 weeks)

⁵⁵ My mother had two ultrasounds during her pregnancy with my brother in 1978 [Figure 5 - 1]. She was considered “high-risk” because she had suffered a miscarriage the year before.

During the last twenty years, ultrasound has become a highly utilized component of prenatal care because it is conceived as a useful diagnostic technique. Initially used to detect fetal anomalies such as spina bifida or anencephaly, ultrasound is now used to verify viability, detect gestational age, check for multiples, detect the heartbeat and placenta location, and assist in other diagnostic techniques such as amniocentesis (Taylor 1997). Although very little data measure the pervasiveness of the procedure, a few studies exist. One of the first was the National Maternal and Infant Health Survey, which correlated birth outcomes with exposure to technology such as ultrasound or x-rays during pregnancy. This survey found that between 1980 and 1987, the percentage of pregnancies that were scanned with ultrasound increased from 33.5% to 78.8% (Moore et al 1990).

In 1989, the Centers for Disease Control and Prevention (CDC) and the National Center for Health Statistics (NCHS) completed their revision of the nation-wide Live Birth certificate. At this time, they added a section labeled “Obstetrical Procedures,” which included a space to designate the use of ultrasound (CDC/NCHS 1991).⁵⁶ According to data from the 2002 vital statistics, 68% of mothers with live births received ultrasound, a marked increase from 47.7% in 1989 (Martin et al 2003). Yet as discussed in Chapter Two, such data may be underreported on birth certificates, and it is likely that this number is even higher. The 2003 revision of the United States Live Birth certificate removed ultrasound from the “obstetrical procedures” section because it was no longer considered a “manipulative procedure that carr[ies] risk to the fetus” (CDC/NCHS 2001: 73).⁵⁷ Therefore, after 2002 data were no longer tracked for ultrasounds on a national level through vital statistics. Using claims and encounter data from a national HMO

⁵⁶ The form includes a series of “check-off” boxes, therefore it was not possible to know how many scans or when scans were performed during an individual pregnancy.

⁵⁷ Electronic fetal monitoring was also removed from the 2003 revision of the Live Birth Certificate.

database, one physician was able to track the number of scans performed through payments by a private insurance company. This study found 3.5 scans performed per woman, with 89% of women receiving at least one scan in 2002. According to the data, this is up from 67% in 2000 (Mulcahy 2004). Yet considering that the data only track women covered by private insurance, it is likely that this also underestimates the percentage of pregnancies subjected to ultrasound scans in the United States.

As these data attest, the majority of pregnant women in the United States receive ultrasound examinations during their pregnancy, and many receive multiple scans. To think through the intersections between technology and subjectivity, it is important to trace the means by which maternal and fetal subjects are co-constructed in both scientific and public domains. Latour's (1986; 1987) work on inscriptions can be valuable in tracing these "fetal movements." Visualizing instruments, such as ultrasound, produce inscriptions or visual displays that can be utilized to represent the objective world. Inscriptions graphically represent scientific knowledge—such as graphs, computer print-outs, maps, models, charts, photographs, etc. One of the more powerful aspects of these inscriptions is that they are "immutably mobile": the "photo" resulting from an ultrasound scan is carried out of the office, becomes mobile, and is considered to be an objective, incontrovertible representation of an inscription device/procedure.

While a number of ultrasound machines have made their way into private obstetrician offices, the majority of obstetricians rely on sonographers and radiologists to perform and read obstetrical ultrasounds. When an ultrasound scan is performed, still images or "photos" are produced for the parents and for review by the radiology director. In addition, a "report" is filled out which numerically represents the data that was attained in the scan. This report is what is given to the obstetrician or provider. In my observations at the Ultrasound Clinic, the report is a

word processing template with a series of spaces for the necessary measurements that is filled out by the ultrasound technician. After a final approval by the radiologist or managing physician, the technician reports any concerns or recommendations, such as “enlarged kidneys” or “single fetus in breech presentation.”

For providers like Portia at the Prenatal Clinic, the ultrasound *images* are of little interest. Many times, when Portia would ask patients about their recent ultrasound exam, the patient would dig in their purse or in their folder and pull out the strip of images. Portia would briefly admire the images and then go track down the report. Often she would turn to me and say, “I can’t read these things either!” For Portia, other than the assurance that the “baby looks okay,” she was most interested in the “estimated gestational age.” Considered more reliable than women’s reports of their “last menstrual period” (LMP), many providers point to the “accurate” estimate of gestational age as one of the primary uses of ultrasound, second to detecting fetal anomaly (Barr and Pecci 2004; Olsen and Thompson 2006).

I was introduced to the physician and sonographer at the Ultrasound Clinic through their association with the Prenatal Clinic. For women who have no insurance or Medicaid coverage, ultrasounds done at the hospital cost \$750. Dr. Albert, the supervising physician at the Ultrasound Clinic, worked out an arrangement with the Prenatal Clinic in which these patients received an ultrasound for \$175. I asked Dr. Albert about her connections to the Prenatal Clinic:

A: Through the district- I think there was a period of time where they were in transition as far as perinatology, and so I do a lot of what the perinatologists do as far as ultrasound and antenatal screening and amnio, so I started seeing patients from the district and then, I guess it’s just more geographically convenient for the Clinic patients to come here than to go all the way to the Downtown Clinic. And I think our rates, you know we try to, you know you try to give them favorable rates, I don’t know how much they get charged over there, but I think we charge less.

L: Well, I think at the hospital it’s close to seven hundred and fifty dollars.

A: Just for an ultrasound?

L: Yeah.

A: See, that's ridiculous.

I spent two days observing sonographic examinations at the Ultrasound Clinic, and shadowing the technician, Cindy. In my conversations with Cindy, she often differentiated between "our" patients and "Clinic" patients, "our" patients referring to those who are patients of Dr. Albert, and "Clinic" patients referring to those patients of the Prenatal Clinic. Cindy pointed out that it is very important for patients to have at least one scan, to at least "check their dates." "It seems that Clinic patients always have their dates off," she said, "their knowledge of their LMP [last menstrual period] never matches their actual gestation" (fieldnotes 9-5-06).

Kathia, who was introduced in Chapter Two as the Haitian-American Healthy Start Provider at the Prenatal Clinic, often spoke candidly about her frustrations with Haitian women's lack of knowledge about their bodies.

K: The younger ones are really naïve, you know what I mean? Especially when they're just, just getting here [to the United States]. They're clueless to a lot of things that go on. I had to relay to a doctor once, that a young lady was having some vaginal discharge and she didn't know what it was, and I told her she had to tell the doctor. Of course she didn't speak English, so I told the doctor for her. After the doctor checked her out she prescribed some things for her, you know, whatever. And after she got the prescription she came back to me and said 'I'm not sure if she diagnosed me properly because now that I think about it, I'm not sure if it's discharge because I'm pregnant,' this is gross, 'or if it's discharge from when me and my boyfriend does it, after he does whatever he does.' She said, 'Can you ask the doctor if that's what it is or if it's really something due the pregnancy?' And in my mind I'm like how can you not know which one it is? I mean, were you a virgin when he got you? I mean, seriously! [laughs] It was very awkward and I had to ask the doctor because she wants to know. So you have to put your feelings aside, and ask the doctor. So I asked the doctor and the doctor said, 'I diagnosed her, it's not what she thinks it is. Just tell her to take her medication.' [laughs]

L: Why do you think that is?

K: There's no sex ed in Haiti. That day, [from the above narrative] I found it absolutely, I was "wow." People can't be that naïve, people can't be. But then my cousin⁵⁸ was like,

⁵⁸ Kathia's cousin is also a Healthy Start Provider, at the Downtown Clinic.

‘Are you kidding? I see it all the time.’ All the time, they don’t know what’s going on with their bodies. It’s like four months later and they’re pregnant and you ask why did you wait so long [to start prenatal care], and she’ll tell you she’s pregnant because she saw the body growing and said ok, I must be pregnant. The majority of Haitian women have irregular periods, it’s like ninety percent. Apparently, because half of them are like, oh, yeah, I think I’m pregnant, cause I haven’t got my period. You ask them, ‘well when was your last period?’ ‘I don’t remember.’ And you’re like, how can you not remember when your last period was? The majority of them are like that, young or old, doesn’t matter. The majority of them are like, ‘When was your last period?’ ‘Umm... I don’t remember.’ And you’re like, ‘Try to remember. Was it September, October? What were you doing the last time you had it’ and they’re like, ‘I really don’t know.’ What can you do? Put nothing down on the paper and have to wait to get a sonogram, next time they come, and find out they’re like five and half months pregnant. Six months pregnant. And you’re like, oh (Interview 3-22-06).

These comments provide a telling example of notions of class and education which influence Haitian providers’ discussions about reproductive health among Haitian women. While physicians, such as Dr. Daniel and Dr. Jean, were more sensitive to these tensions, community health workers and “peer” providers like Kathia expose the ways in which these values contribute to experiences in health care among Haitian women. Kathia’s narrative evokes notions of contemporary maternal subjectivity, one that infers a responsibility for women to understand their bodies and to be aware of and manage their menstrual cycle. Such ideas also inform expectations about family planning, a responsibility for reproductive planning throughout the lifecycle (see Chapter Six). Yet beyond these expectations around embodied knowledge, maternal subjects are also assumed to be responsible for the potential life inside of them.

In Chapter Two, I discussed the growing specialization of fetal medicine and its links to the growing use of ultrasound and the visibility of the fetus. In Chapter Three, I described how the everyday practices of prenatal care are influenced by discourses on maternal and fetal risk, and how these practices situate a fetal subject as both dependent and separate from the pregnant woman. Yet discourses of risk often incur narratives of responsibility and an interesting space to track these are within the ultrasound exam. Structured as both a diagnostic tool and a pleasurable

experience, the ultrasound examination becomes an important space through which to examine maternal and fetal subjects in the making.

Staging an Ultrasound Exam

While the importance of the inscriptions or fetal images themselves can be overestimated, it is through the staging or setting the scene that this one set of dramatized inscriptions becomes central. As noted by Janelle Taylor (2002) in her work on ultrasound, “[N]othing about the physics of high-velocity sound waves, nor the medical imaging devices constructed to exploit them, *requires* that a diagnostic ultrasound procedure be performed in just the way that it has come to be in this country” (368, emphasis in original). Dr. Albert’s clinic has three examination rooms; two devoted to clinical visits, and one for the ultrasound exams. Appointments are scheduled to last half an hour, and are performed by a certified technician and reviewed by Dr. Albert. The room was large (particularly in comparison to my observations at the Prenatal Clinic), with the sonogram machine set next to an examining table. When I first arrived at the clinic, I was ushered into the room, where an ultrasound was in progress. I was a bit surprised—although the woman was reclining next to the machine (as the technician rubbed the transducer across her belly), she was not even facing the screen. Then I realized that there was a large flat screen TV on the opposite wall, directly in view of the woman and her husband, who had accompanied her. So while the technician narrated what we were “seeing,” the woman and her husband could look at the TV.

During the exam, the sonogram technician stands facing the machine; using her⁵⁹ left hand she adjusts the dials and knobs which assist in getting the various views. With her right hand, she is able to move the transducer over the woman’s belly, or position the trans-vaginal transducer

⁵⁹ Both of the ultrasound technicians I observed were women. See also Taylor (2002; 2004) for an analysis of the “feminization” of obstetric ultrasonography.

for a particular view. Narratives of responsibility seep out in this disjuncture of diagnostics and pleasure. While I spent only a few days at the Ultrasound Clinic, both Cindy's and Dr. Albert's comments to me highlighted their frustration that many women view this experience as only to "see the baby," and that they disregarded ultrasound's role as an important diagnostic tool. For instance, Cindy told me of a recent "Clinic" patient who had received her twenty-week scan, bringing her entire family, including her five kids. The woman did not speak English, so her daughter was translating into Spanish for her. As they were doing the scan, the daughter started getting excited about twins. Yet Cindy noticed that what the young girl thought was another fetus was actually the bowels and stomach floating outside of the fetus. She tried to move quickly through the exam, and pointed out the findings to Dr. Albert outside of the room. They suspected Trisomy 18, and a subsequent amniocentesis confirmed this. Cindy expressed frustration to me a number of times during my visits when patients seemed only interested in the sex of the fetus or in getting a good view.

Another case I observed was Becky, a 30-year-old Anglo-American woman, who was twenty-one weeks pregnant. As she prepared to have the external scan, she had to remove her belly-button ring. Cindy reminded her that she needed to remove that permanently – it was going to become harder to remove once her stomach began to stretch out. Cindy confided to me before the patient walked in that she had been scanned last week and was diagnosed with an elongated cervix⁶⁰, but Becky was only interested in finding out the sex, and completely unconcerned with the prescription for bed rest and weekly scans. Cindy asks if she has had any cramping or bleeding and Becky answers, "Yes some cramping, but it is just the muscles stretching." Cindy asks, "The muscles stretching? Are you sure?" and Becky replies, "Yes, yes, that is what it is."

⁶⁰ Elongated cervix can be a symptom of preterm labor.

Cindy looks incredulous at her self-diagnosis, and reminds her that the doctor will be in to examine her after the scan.

Cindy did both an external and vaginal exam, to check the presentation of the fetus and to view Becky's cervix. We started to view the scan, and the fetus was very active, turning again and again. Becky became visibly excited, giggling and exclaiming as the images moved across the screen. Cindy referred to the fetus as a boy, and then moved the transducer so that a very clear image of a penis and scrotum appeared. As we listened to the heartbeat, Becky commented that she had one of these machines at home, but it did not always work. Becky was wearing medical scrubs, and explained that she was in school for medical billing. Dr. Albert told her she needed to quit school and stay on bed rest, but Becky argued that she needed to finish this course in order to find a job that she could do at home. After a brief use of the vaginal ultrasound to check that there was no change in Becky's cervix, she was on her way out of the office with a stack of that day's images to take home (Fieldnotes 9-5-06).

Many who have been confronted with 2-D ultrasound images can attest to the difficulties in interpreting them without a radiologist or sonographer. [Figure 5 – 2]

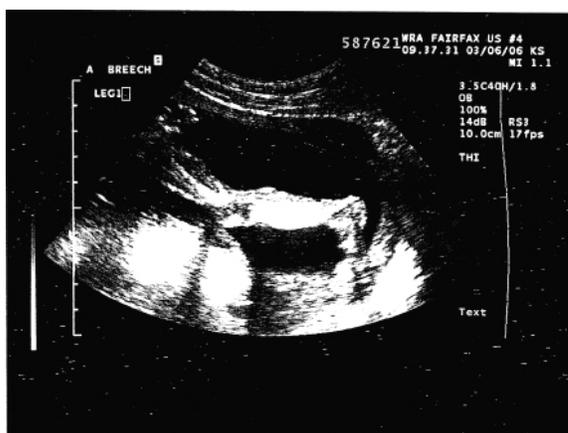


Figure 5–2: Ultrasound scan of leg at 19 weeks

We are not looking specifically at a photograph of a fetus, but instead a photograph of the scan—that is, the movement that produces the image is the movement of the scanner. These scans actually come from the ultrasound machine, the rendering of the insides of a woman’s body. As described by Marilyn Strathern (2002:100) “[T]he picture is composed, then, of a series of moments that interpret echoes as images, and that is what the picture is of. The whole sweep gives a configuration of sorts, but the movement is between these points of interpretation” (99 – 100). As a result, these “interpretations” require interpretation: “[T]hose who look at the ultrasound scan can do nothing but interpret it.” A requisite part of the ultrasound examination is the narration/interpretation by the sonographers, describing fetal “life” for the parents-to-be.

A number of the scans I observed were early, often six or seven weeks, to confirm the existence of the pregnancy. Other than a brief description of “what we are seeing,” these scans were not very oriented towards “pleasure.” This was quite a contrast in the case of the later scans; Elizabeth was in for her thirty-ninth week check-up and provided a running dialogue with the sonographers about the activities of her fetus. While Cindy was busy trying to get measurements, the fetus was quite active, provoking a quip from Cindy that this one was “dancing.” Elizabeth commented: “Oh, it takes after me, I love to dance.” Later, Elizabeth turned to her husband and said, “I hope it has your temperament, but it will probably be like me, very hyper!” Later, as we saw the image of a foot, Elizabeth pointed out, “Look at those big toes! It has your feet, Tom!” In this case, the tech tried to use gender neutral terms, because the parents asked specifically not to know the gender. While we were waiting in the hall for Dr. Albert to review the scans, I asked Cindy if she knew the sex of the baby: “Oh, it is so hard, I hate to call them ‘it’ so I always call them something, and this one I keep slipping and calling she. So then I

remember and will say he, but whenever I see anything, I try to move on quickly. But she is definitely having a girl!”

Countless still images are taken during the course of the exam, and the tech tries to pick the “best” ones to send home. In some cases, Cindy spent much of the exam trying to get the fetus to roll over or turn a certain way in order to get a “face” shot or another highly valued shot, such as the feet, or the hands (or the genitalia!). Particularly in early scans, the feet or the hands are considered most “human”-like, attesting to their popularity as well in the world of anti-abortion images (see also Ginsburg 1998: 105). The machines often allow the tech to tag a descriptive to the scan, such as “leg” or “arm.” It is not unusual to see scans with the tag line “It’s a boy” next to a blurry image of a penis or “Hi Mommy!” next to a “waving” hand.

Although the ultrasound report is considered a valuable inscription for its power to communicate fetal diagnosis, it is the ultrasound image, or photo, which has become one of the most powerful symbols of fetal subjectivity in the contemporary United States. For the Haitian pregnant women that I interviewed, the ultrasound examination was an expected part of their prenatal experiences. Many women talked about saving their ultrasound images in an album, along with the images from previous pregnancies. Danise, who had saved the images from her pregnancy with her son, already had an album prepared for this child.

L: Did they give you any pictures?

D: Uh-huh. Yeah, it’s in my bedroom. I looked, yeah, I did it yesterday. I was looking at this morning, last night, ‘Well, how are you?’

L: Are you going to save it?

D: Yeah, I already have an album, so I am going to put it in there (Interview 1-30-06).

In some cases, ultrasounds reaffirmed potential kin ties between partners. Valerie, whose current pregnancy was with a new partner, used her ultrasound image to announce this new

development in their relationship. Her first ultrasound was performed at three weeks for the provider to verify her pregnancy.

V: Yes, but at three weeks, there was nothing [laughter]. Just a little ambiance, yeah not a big thing.

L: Do you keep the pictures?

V: Yes, yes- because I keep the, the first one- when I was three weeks. I gotta have it home, cause the father, he don't know. I feel the thing [the pregnancy], but I don't tell him nothing. I just go on the weekend, the doctor tell me you have to make a sonogram, I say, 'I know I'm pregnant because I make the, I make the pregnancy test.' He say, 'Yeah, but you have to do it.' I say ok, and I make it, he say 'Now you are three weeks pregnant.' I say ok, and I take it, and I buy a little card, I put it inside and I give it to the father. He was ok. When he see, he say, 'What's that?!' (laughs) I say, 'That's your baby.' He say, 'What!?' and he start to cry (Interview 7-5-06).

When I asked if they had an ultrasound, the majority of the women went off to find the image and show me. Rose, whom I introduced in the last chapter, had four ultrasounds because of an early diagnosis of a sexually transmitted infection during her pregnancy.

L: So how many ultrasounds did you get?

R: I get, one, [counts to self] I got three. Because my complication, I get four ultrasound.

L: Because of the infection, or another complication?

R: Um, I think, about the infection, she drew one, early, to see how's the baby, if she is growing good and the second one she needed to see the size, the sex of the baby. The third one she can find out when I am going to deliver, my due date. And the last one they did, that's no good, that's not true. [This is a reference to a discussion she had with Portia at her last appointment, when I was there. There was some discrepancies with the due date, and she wasn't pleased with the new due date.]

L: So what did you think of the ultrasound? Tell me about what your ultrasound was like.

R: When I went over there, they told me to drink a lot of water, and the first technician, she was good. She tried to help you and she handle you need to pee. She tried to do so it quickly, and when she do it she explain everything. 'This your baby head, this your baby body, something happened, everything good.' I was so excited. That's the only thing because now you can't feel the baby. When you are sleepy or when you lay down, she move! You can see everything. I try to use some cd, and you put the cd, you got music or something and you put that over there, like on the left side. She stay on my right side, I think she hear it, everything. She hear, even when I am talking.

L: And the other technicians, they weren't as helpful, they didn't tell you so much?

R: No, no they didn't tell you. Like the last one, I told her, 'How many pounds is the baby?' She didn't say anything. I told her, I think she just get out of the university or something and she don't have much experience. I think, if she or they give me a file, a paper to fill out for her, that's going to be bad for her. I am going to complain. If I ask you, I go over there to do an ultrasound or something, if my baby got complications, if I don't know if you are a doctor or something, but you gonna be able to tell me oh, your baby is four pounds or something. She didn't tell me anything.

L: Did you get the pictures too?

R: Uh-huh. You want me to show you? [She goes into the other room and returns with the images.] All of them got the date, you don't see? These are on my bed, everytime (Interview 6-9-05).

Rose was frustrated with her experience at the hospital, feeling as though the sonographer was not interested in informing her about the fetus. Yet these tensions of ultrasound as pleasure versus diagnostic technology were returned to again and again, both in my interviews with Haitian women and with Cindy and Dr. Albert. Although Cindy felt that many patients only wanted to learn the sex of the fetus, she also felt "sorry" for ultrasound technicians who worked in the hospital.

At the hospital, they are not allowed to tell the patient anything because of liability issues. Here, I don't point out any abnormalities, Dr. Albert does that, but I can show the patients the hands, the feet, the anatomy, and the sex. I can tell them if things look good. It is too bad for patients who go to the hospital and get no real interaction with the technician (fieldnotes 9-5-06).

In addition, the ways in which ultrasound exams were staged and performed at Dr. Albert's office illustrates these ideas that sonograms are a "bonding" experience. From the early uses of ultrasound in pregnancy, bonding became one of the expected benefits of this new technology, along with subsequent expectations about maternal behavior.

Maternal Bonding and Ultrasound

A number of feminist anthropologists have analyzed the relationship between maternal bonding, ultrasound technology, and changing ideas of fetal subjectivity (Ginsburg 1998;

Hartouni 1997; Mitchell 2001; Petchesky 1987; Taylor 1997). Notions of maternal-infant bonding first gained attention in the mid-1970s with the publication of Klaus and Kennell's (1976) *Maternal-Infant Bonding*. Embraced by natural childbirth advocates, these ideas focused on those first few moments after birth as an important time for "maternal-infant attachment," which could become disrupted if they were separated, the standard practice in hospitals at this time. In the early 1980s, a number of studies looked at maternal attachment during pregnancy, particularly in reference to high-risk versus low-risk pregnancies (Cranley 1981; Kemp and Page 1987). As real-time ultrasound examinations allowed pregnant women to view their fetus, reports about ultrasound as a rewarding and enjoyable experience began to filter throughout the medical community. In a letter printed in 1980 within the *British Medical Journal*, a physician commented that, "[W]hen a mother undergoes ultrasound scanning of the fetus, this seems a great opportunity for her to meet her child socially" (Dewsbury 1980: 481). He went on to comment that these scans provide an opportunity to "enable mothers to form an early affectionate bond to their child" (481). In 1983, Fletcher and Evans take this notion of bonding one step further, postulating that the viewing of a fetal ultrasound could influence decisions around pregnancy. Based on their observations of two cases of women who were uncertain about maintaining their pregnancies, these authors concluded that:

Viewing the fetal form in the late first or early mid-trimester of pregnancy, before movement is felt by the mother, may also influence the resolution of any ambivalence toward the pregnancy itself in favor of the fetus. Ultrasound examination may thus result in fewer abortions and more desired pregnancies (392).

Whereas earlier work on maternal-infant bonding focused on when it was most likely to occur, later work (particularly in reference to ultrasound) became attentive to the idea of bonding as a strategy for behavioral change (Taylor 1997). As noted by Dewsbury (1980: 481) in his letter to the editor: "[ultrasound] should help mothers to behave concernedly towards the fetus throughout

pregnancy and may be expected to increase the bond in childbirth.” A number of studies began to appear at this time measuring the impact of ultrasound on maternal-fetal bonding, concluding that attachment increased after the procedure (Kohn et al 1980; Milne and Rich 1981). This area of research continues to be a topic of interest to this day. More recent work has focused on the use of two-dimensional versus three- or four-dimensional ultrasounds and its emotional impact (Ji et al 2005; Pretorius et al 2006; Rustico et al 2005).

Similarly to the use of fetal heart tone monitors in prenatal care exams, narratives of “bonding” as facilitated through diagnostic technology also incur narratives of responsibility. I was originally invited to Dr. Albert’s office because she was interested in discussing her Haitian patients with me. She was concerned because they seemed completely uninterested in prenatal diagnosis, both in her observations of them while receiving ultrasound or in referrals for amniocentesis. She commented to me, “The Haitians tend to be quiet with the doctors, and I feel like they don’t want to hear what I have to say.” Previous anthropological research on ultrasound examinations demonstrates the ways in which women’s behavior during sonograms is scrutinized and often evaluated based on race or culture. Rayna Rapp (2000) comments on how sonographers interpret women’s reaction to fetal images based on their race: assuming Southeast Asians are only interested in the sex of the fetus; African-American women are described as pushy and “difficult” during exams. Lisa Mitchell’s (2001) work in Canada reflected similar findings; sonographers’ accounts of ultrasound exams are informed by a specific cultural “script” about the “natural” behavior of pregnant women viewing ultrasounds. In particular, women who showed little emotion during the exam were assumed to be unmoved or unexcited about having a baby.

For a number of the Haitian women I interviewed, the ultrasound examination was one more diagnostic test requested by their physician or midwife.

Lo: I make the appointment for the sonogram. I see the lady ask me why the doctor send me there, I say, “I don’t know, they just give me the paper and the phone [number].” And at first they give it to me when I am calling the number it says the sonogram, coming to six hundred, six hundred-oh-two, cents like that. When I go back there [prenatal clinic], I am telling them it is too expensive for me. They send me to the next lady, I pay \$175 for the sonogram

L: Did they give you a picture to keep at all?

Lo: No, when she asked me, she asked me if I have a computer at home, and I say no. So I didn’t get to keep it.

L: Oh, they didn’t print it out for you?

Lo: No. It’s not that bad, if I have a computer they give me the picture, that’s good but I don’t have nothing to find, nothing to see (Loudjina 4-28-06).

I was surprised when Loudjina mentioned that she was not given a photo, and I asked Dr. Albert about Clinic patients and their experiences in ultrasound.

L: Do they usually want a picture to take, as well?

A: (pause) They don’t necessarily... I try to really you know, I try to make sure that my sonographer has taken a nice picture. Um, but they don’t always ask for it if I don’t give it to them. They don’t ask for the picture. So, (pause) but yeah we even have the ability to put it on a disc for um, patients who have access to computers, ‘cause some of them do and they have you know, especially the Hispanics, they are more in contact with their families out of the country, whereas Haiti I guess is more difficult to have contact with their family (Interview 8-18-06).

Recent research on ultrasound imaging outside of the United States has also demonstrated that experiences with prenatal diagnostic technology varies cross-culturally. Eugenia Georges (1997), in her work on ultrasound in Greece, illustrates the pleasure that women feel at “seeing the baby on television.” For these women, “seeing” the baby made them “feel” more pregnant. In addition, sonographic estimates of gestational age were valued as more accurate than embodied knowledge of pregnancy by both women and their physicians. Harris et al’s (2004) work in

Australia found similar conclusions to the work by Georges (1997), noting that the routine use of ultrasound has the power to alter women's embodied experiences in pregnancy (see also Mitchell 2001; Taylor 1997). Whereas the excerpt from my interview with Rose above voicing her frustration at her changing due date as diagnosed by ultrasound, illustrates that the authoritative knowledge of technology does not always trump embodied experience for Haitian women.

Tine Gammeltoft (2007), researching the use of ultrasound in Vietnam, found that an overwhelming majority of women were more concerned with whether the fetus was healthy and normal. She argues that "women's experiences of technologies in pregnancy reflect not just the quests and experiences of individuals but also wider sociopolitical fields of shared engagements, commitments, and pursuits" (136). Her work aims to situate Vietnamese women's narratives of ultrasound examinations within larger state concerns with the "quality" of the population. Very few of the women in her research were interested in ultrasound solely to view the fetus or to find out its sex. Similar conclusions were reached by Bashour et al (2005) in their work with women in Syria, who described the ways in which ultrasound provided comfort and marital security through reassurances about the health of the fetus for these women.

After I had spent about six months observing with Portia, she commented to me that she had noticed that most of the Haitian women were requesting ultrasound during the first prenatal visit. This was during a visit where a Haitian woman, who had already given birth to a number of children in Haiti, was having her first child in the United States. She commented, "They wouldn't have these services in Haiti. See how we enforce our values on them?" This comment is informative, beyond the observation that more women are requesting sonograms. First, there is

the assumption that there is no ultrasound in Haiti, and second, that access to technology is a “modern” value, that is being “forced” on these women.

A few of the women I interviewed had given birth in Haiti, and none of them had undergone ultrasound examinations. Yet many of the women pointed out that ultrasounds are available in Port-au-Prince or other large urban areas, particularly to women who can afford private prenatal care. Marie explained to me that many women may not have the money or resources to access ultrasound in Haiti:

Um, some people doesn't know what is it, some people know. The one who knows, might be, like to get it. They might [but] don't have money to get it. But, other people doesn't know what is it- like people live in the country- like in Jacmel where you know- some people doesn't know what is it. So you know, like talking about it, they don't know what is it, you know- 'cause a lot of people doesn't know everything (Interview 10-15-05).

In addition, some NGOs working in Haiti have added ultrasound to their diagnostic capabilities, even in the countryside. Since 2004, *Maison de Naissance*, a joint project of Healthy Mothers, Healthy Babies in Kansas City, and the University of Missouri, is a birthing home in the rural area just outside of the city Les Cayes. They have integrated ultrasound and fetal heart tone dopplers into their maternal health services, although it is solely used to ascertain the fetal position and not to discover the sex or fetal anomalies (Cindy Oberhaus 2007, personal communication).

Among the women that I interviewed, a few described the experience of “seeing” the fetus, although most of them were not provided instant reassurances about its health.

The technician looked at her entire body to make sure everything was ok. They're not allowed to tell you if there's something wrong. He showed me her spine, her kidneys, heart. He was looking at her insides (Eugenie 1-18-06).

I have sonogram. Yeah. I had it um, Friday, so I don't know. They had it, they were gonna send the doctor the result. So I don't know what's going on. I have a picture. But I can't see anything (laughter). No, they gonna tell the doctor, not me (Sherley 10-17-05).

For many of the women, the ultrasound experience depended on the technician translating what they were seeing. Many pulled out their own images to show me, and their narration of the ultrasound focused on the anatomy.

Ok, this was my very first ultrasound at 11 weeks – all you can see is the head. This is the head and this is the little hand, at eleven weeks. There is not even a feet! Well there is, but you can't make that out. This one, 22 weeks, this is the one at [hospital], at 22 weeks. This is her legs, and this one is where he told me the sex of her, her being a female, a girl. This one, this one here, this was her nose, this is hand covering her face, and this her eyes, and that's her big head right here, she has fat cheeks like her daddy. And this was another one, same image but her hand is down right now. This her nose and her two eyes. So you can't really see much, and here, this is her legs, this is a replica, a duplicate of this one. This is her legs and her buttock right here. But unless they explain it to you, you won't know. I mean 'This is this, and this is this,' and I was like, ok. (Eugenie 1-18-06).

I couldn't really tell, but I ask her, what is this, what is that. And especially from the heart, was like, what part is this? That's the heart, she told me, that's the heart (Danise 1-30-06).

Yeah, the first time it was, look like him. His head was so big, his mouth stay open, like he ready to eat. Yeah, I saw his foot, I saw his head, his mouth (Marie 10-15-05).

They show you which part of the body or the organs that is, things like that. They talk to you, they let you know what is going on, what is there. Cause it is really hard for you to read the ultrasound. Cause the first one I thought where her stomach was that was her head but they were like, no that's her stomach, cause it was sort of complicated to read it (Rosemarie 12-30-05).

They show me, but I did not understand. It may be in my other purse. There, that's the first one. Let me go get the second one, it's in my other purse. I show it to my friends, my family. And this is the second one. I don't understand this thing. Actually, my husband was there, and while he [the doctor] was doing it, he was explaining everything, to my husband, so I listened to all the stuff. This is the baby head, this is the baby's abdomen, this is the baby's eyes, all that. Yeah, but I don't understand nothing (Lise 3-30-06)

They spoke in regards to the heartbeat. They tell you the different parts because the first time around the parts are not formed. The second time they flipped the monitor and pointed out the sex. The second time around everybody went (Roseline 5-31-06).

To return to Dr. Albert's description of Haitian women as uninterested in her diagnoses on fetal health, my interviews with Haitian women illustrate the ways in which the experience of ultrasound extends beyond the actual exam. For most Haitians, raised in a country where education is highly valued and revered, doctors and providers are treated with deference and

utmost respect (Maternowska 2006). As I described in Chapter Three, all of the Haitian women I observed at the Prenatal Clinic remained quiet and seemingly uninterested in the prenatal examination. Little emotion was demonstrated while listening to the fetal heart tones, and I initially imagined that this was why Dr. Albert had called me, because of her concern that her Haitian patients were uninterested in the ultrasound experience.

Although she could understand that they remained quiet during their examinations, her concern was with what she perceived as their overwhelming interest in knowing the sex of the fetus.

A: The other thing that I've, that I've sensed from um, the Haitian population that is very disturbing to me is um, they seem to be very upset with the news that they're having a girl.

L: Really?

A: I have had on more than one occasion, men storm out of here angry when, after I've told them that they're having a girl. So, to the point where I'm very reluctant now to tell them the sex, especially before the age of termination, you know, [be]cause I wonder what they do with that information when they go home. You know? It's that I sense that they blame the woman, in that the woman seems afraid, you know? Of telling her husband, or I've told the woman in the man's absence that she's carrying a girl and it's like she doesn't want to tell her husband (Interview 8-18-06).

I found this surprising, since most of the Haitian providers I spoke to had no experience with this, nor did any other Haitian friends I spoke with. They seemed as surprised as I was at Dr. Albert's comment. I e-mailed Cindy Obenhaus, the Program Director at *Masion de Nassiance* in rural Haiti, to ask about the use of ultrasound to ascertain sex at their clinic in rural Haiti. She responded, "[w]hen we have had obstetricians come volunteer at MN [*Masion de Nassiance*], we have had three staff members who were pregnant and we were able to tell them the sex of their babies. They were very curious about it and wanted to know. They also seemed to prefer boys over girls." She concluded that this is because "males have a better future than girls in Haiti" (Personal communication 8-9-07).

During my interviews, questions about ultrasound typically elicited an automatic response about the sex of their fetus. Marie-Lucie pointed out that this happens in Port-au-Prince as well, “Yeah, now even in Port-au-Prince people go for ultrasounds. Just to know the sex of the baby” (Interview 3-18-06). Many of the women I spoke with commented on wanting either a boy or a girl, but usually because they had one or the other already.

I am going to have another boy. I was waiting for a girl, but that’s okay. I will have God give me what I deserve. Yeah, that’s okay (Danise 1-30-06).

I wanted a boy, I have a girl. He [God] send me a girl, it’s [another girl] coming again (Loudjina 4-28-06).

Because I need a girl. Why don’t he [God] just give it to me? Not just [the] same thing (Gislene 5-10-06).

I wanted a girl [laughter] and I wanted to know. So I had a boy, so I was like, ok. [laughter] Just to be prepared in case I didn’t get what I wanted, you know. So to get accustomed to fact that it was not a girl (Roseline 5-31-06).

Oh, I wanted a boy, I didn’t even want a daughter first. I said no I want a boy. A son and a daughter, but I have a daughter. I mean thank God, bless her (Yousline 6-8-06).

It’s another girl. Yeah, I was like, if it’s a girl, it’s a girl, but I wanted a boy. It’s a, it’s another girl, and I’m like well, my third one, cause it’s gonna be another girl (Islande 6-20-06).

As echoed by the excerpts, many women believe that the sex of the baby is up to God; similar to the proverb that “God brings children,” God also governs whether you will have a girl or a boy. Marie-Lucie commented that, “some people tell you there is a certain way to have sex, to have a boy or a girl. But nothing is; you can’t really, like, scientifically, make it happen. It’s up to God.”

Some women believed that you could tell whether the baby was male or female based on the position of the fetus, although they used ultrasound to verify this hunch.

[Did you get an ultrasound?] I sure did, four. Yeah, it’s a girl. Just to make sure, because people say with my stomach it was a boy, you know I am supposed to be having a boy (Rosemarie 12-30-05).

Yeah, I knew it's like, I knew my daughter was a girl and I went to [the clinic] and they say "Mommy you want to [know]?" and I say "yeah." I know it a girl. And the same thing happened with him. They said "Do you want to know?" and I said, "Yeah, I know it's a boy" and they said, "How do you know?" I said I know cause back home we believe that it's where you feel the baby. That if it's left it's a boy, if it's right side it's a girl. Yeah. [laughter] He's always kicking on the left so I knew it was a boy (Yousline 6-8-06).

While many women wanted a girl or boy based on the sex of the child(ren) they already had, most women were interested in knowing the sex of the fetus because they wanted to "prepare" through shopping.

I wanted to know what I was going to have! Before I buy clothes and everything (Danise 1-30-06).

You don't want to buy stuff for boys and then have to return it everything, when you know, it's not a boy, it's a girl. It's better to know the sex, so you can get everything (Lise 3-30-06).

At first, I said, nah, I'm gonna keep it anonymous. I wanted to find out as a surprise. But when I go places and see clothes I said I wanted to know. So I could start buying clothes and stuff like that (Ketly 6-19-06).

I wanted to know and she, and then she [the sonographer] told me. I wanted to buy my stuff. Make sure I buy the right things (Islande 6-20-06).

When I asked Kathia, the Healthy Start Provider at the Prenatal Clinic about Haitian women's interest in knowing the sex of their fetus, she also argued that women want to be prepared:

For Haitian women it's important to know the sex. They don't like the element of surprise. They want to be prepared. They want to have everything as far as clothes and everything. They wash all the clothes before the baby wears it, they wash them all by hand before it touches the baby's skin (Interview 3-22-06).

Ultrasound examinations have become a routine part of prenatal care in the contemporary United States, and are considered a valued aspect of the pregnancy experience, such that many women will spend much needed cash on the technology. Yet my interviews with providers and Haitian pregnant women illustrate the tensions that exist in the construction of ultrasound examination as both diagnostic and pleasurable. Providers and technicians lament that patients are only interested in "seeing the baby" yet they also structure the ultrasound examination as a

pleasurable experience, insuring the patient receives multiple “good” images and investing in technology to promote the technology. These tensions have become all the more pervasive as ultrasound technology has moved outside of the clinic and its realm as a diagnostic tool, and into the world of entertainment.

3-D Ultrasound

Keepsake imaging is the newest wave in pregnancy experiences. Located in shopping malls or in strip malls, these “fetal photo studios” often have names like “Peek-a-View,” “Baby Insight,” “Fetal Fotos,” or “Womb with a View.” These studios advertise solely as “entertainment” for the pregnant woman and her family, and encourage the accompaniment of guests as noted on the “Precious Peeks” (in Doral, Florida) website: “We can also comfortably accommodate up to 5 guests, however there is no limit to the number of guests a [sic] expectant mother can bring with her! Everyone is sure to have a great view on any of our 3 viewing screens including our large projection main screen” (www.preciouspeeks.com/4d-ultrasound.html). Yet this staging of ultrasound as both a clinical procedure in a pleasurable space has stimulated controversy over the sorts of “experts” who are considered to be best suited to translate these images. For Larry Shields, an obstetrician-gynecologist in Seattle, "It's an unregulated industry that's using medical diagnostic equipment without supervision," (quoted in Ostrom 2006).

The use of medical devices in the United States is regulated by the Food and Drug Administration (FDA), and under pressure by physicians and radiologists, the FDA released a statement in early 2004 cautioning against ultrasound “keepsake” images. In 2002, the FDA announced that anyone administering ultrasound to consumers without a medical prescription is breaking the law, and this is an unapproved use of a medical device. Citing unknown risks to fetal health, the FDA argues that the only “legitimate” uses of ultrasound are: diagnosing pregnancy; diagnosing fetal age; diagnosing congenital abnormalities; evaluating the position of

the placenta; and determining the existence of multiple pregnancies (Rados 2004). In 2005, the American Institute of Ultrasound in Medicine (AIUM) convened a Task Force to release a statement on the use of “keepsake” imaging in pregnancy. The AIUM reaffirmed their “prudent use” statement that ultrasound images should only be given to patients in the course of a medically indicated ultrasound examination. [Figure 5 – 3]



Figure 5–3: Keepsake ultrasound image, 3-D/4-D Scan

Many physicians, including those on the Task Force, acknowledged that many patients enjoy the images to view at home and share with their family: “There is no independent, confirmed evidence of harm from diagnostic medical sonography. It probably is ethical to offer [keepsake ultrasound] to patients if there is no danger that we can discern” (Voelker 2005: 26). Radiologists and physicians are most concerned that keepsake imaging will be performed by unlicensed and untrained personnel.

Certified sonographers participate in training that is typically a year-long course through a technical college. Other opportunities include short-term trainings that can be completed in a few weekends or four-year bachelor degrees through community and state colleges. Cindy, the

sonographer that I observed at Dr. Albert's office, had recently completed a year-long training at a local technical school. She preferred the atmosphere of the private clinic to that of the hospital, particularly as she enjoyed sharing with patients her knowledge of fetal anatomy, which as noted above, she explained was more difficult in hospital settings.

Because of the increased attention to "keepsake" imaging facilities, many of these centers now require written documentation of prenatal care and/or a previous diagnostic ultrasound before they will perform the "entertainment" scan. One of the women I interviewed, Eugenie, had a 4-D ultrasound scan done in Broward County. She explained the center's requirements:

The one I went to, they won't do it unless you bring them previous ultrasound pictures, because they don't want to be held liable for anything. With the I went to, you had to sign a consent that said you are actually pregnant. And they don't just take that consent, you have to bring them previous ultrasound pictures from your doctor before they will go ahead and do it. They won't do it without the previous picture. If you don't have it they won't do it, cause they want to make sure there is a baby in there. Cause she told me some people just show up thinking it's a game. This was the technician I spoke to, she said, 'No, we have to have it. That there is actually a baby in there. That you have to sign a consent and all that' (Interview 1-18-06).

Various state legislatures have also begun to create policies around keepsake imaging. California passed legislation in 2005 which requires women who have keepsake ultrasound to sign a waiver stating that they know that the FDA opposes the procedure. Legislation was also introduced in New York State that would make it a misdemeanor to administer an ultrasound without an order from a physician, nurse practitioner, or midwife (Voelker 2005).

Rosemarie, who was thirty-three weeks pregnant with her first child, told me she thought about getting a 3-D ultrasound but decided against it at the last minute: "Actually, I was supposed to get a 3-D sonogram, but I want it to be a surprise. I picture her, like me or the father, hopefully, it come out to be like one of us" (Interview 12-30-05). Eugenie, the only woman I interviewed who had received a 3-D/4-D ultrasound was very excited to share with me the images, and explain how meaningful the experience was for her.

E: But if I show you the pictures I took, at Peek-a-View, it's a much clearer picture. You can actually see her face, her movement, her eyes. You can see her face, you know. The DVD, she is actually moving. She stuck her tongue out, she moved her head. At one point, the light was getting to her, she didn't want to take pictures because she was getting bothered by the light. Like this, she turned, and I'm like I am about to beat her because I am paying two hundred dollars and she is wasting my money! [laughs] Yeah, but, it was more... I tell you at seven months, at seven weeks, I felt immediate bonding to her. When I went to Peek-a-View and I felt her moving inside of me, that made me want her more. From that point, I was like, I want to have this baby! [hand slap]

L: Did you go to Peek-a-View before you could feel her?

E: I could already feel her, she was kicking by five months. She was kicking me already, she was moving, like God, she was moving and moving. At Peek-A-View, the day of Peek-A-View, she was moving like there was no tomorrow. And the same thing when I had to go to the sonogram, because I had drank a lot of water prior to, she was, I guess she thought she was in a swimming pool, she was doing cartwheels! So, but at Peek-a-View, she really, I mean just sitting there looking, monitoring, at this person inside of you, moving around and doing all these kinds of things, wow. Especially when she stuck her tongue out, I was like – no she didn't! She opened her mouth, I was like, I gonna beat her! [laughs] Yeah. So, I felt, at that point, I told my cousin who was with me, oh, I want to have my baby now! When I can see her doing those things inside, I want her to be out in the world doing those things. I was curious I wanted to see. And the thing is, her dad is real tall. So, he's um, he's about six –two. He's a calendar boy, he's a firefighter calendar boy [laughs]. But um, she is going to be just as tall as him. Looking at the DVD picture, you can just look at her neck, her neck is so tall. She is folded inside of me, her knees and her hands are like this, folded into, like a piece of paper kind of thing. I was like, gosh, she's going to be so – I was just curious to know all these things about her. I don't know if I am disappointed, but I am like, she could've had my height! She could have had my look! But she is going to be tall, you know. There's like all things like, today, with modern technology, you can actually see what your kid is doing. And the bonding, much more closer to the baby, because it's like, I'm looking at you, I can see what you are doing. You know, that kind of thing (Interview 1-18-06).

For Eugenie, seeing the 3-D/4-D ultrasound allowed her to recognize characteristics of the baby's father in her daughter and facilitated "bonding" with her future child. But what I think is most intriguing about Eugenie's experience is how it remained relatively unique among the women I interviewed. She was the only woman I spoke with who referred to "bonding" in reference to her ultrasound experiences, and the only one who argued that "seeing" the fetus made her "feel" more pregnant. She speculated that this may be because she had none of the traditional symptoms of pregnancy – there was no morning sickness or food aversions.

E: I guess with today's modern technology and you can see the kid, it makes the bonding that much closer. At seven weeks when I first saw it, I felt immediately bonded to her. From that point I wanted that baby. If I didn't go to that doctor appointment [where they did an ultrasound] I probably wouldn't know I was pregnant because I had no symptoms. But once I knew I was pregnant, I suddenly felt pregnant and I became more conscious. No more alcohol, ok? The partying I did, but not as much as before. Now I was very conscious of oh my God, I can't do this, I can't do that. But as far as symptoms, so far I had no symptoms, no morning sickness, no throwing up, none of that. I had no symptoms what so ever.

L: That's why you didn't even realize you were pregnant?

E: Exactly. And I didn't have the doctor's appointment to go to, I wouldn't know I was pregnant. I am pregnant *now* because my stomach is showing, because my breasts, you know. But outside of that, because I had no symptoms – you saw me jumping around and all over. I was running down the hall and [her boss] was like – 'you're pregnant, stop running!' And I was like, oh right. But yeah, in terms of it became, in my mind, oh God I'm pregnant, so there are things I cannot do. Granted I was still doing things but like drinking I stopped. Immediately. I didn't want to be around people who smoked, I still don't want to be around people who smoke. That might endanger my baby. I just thought I would take more precautions of a lot of things I was doing. Now the eating, I couldn't help that, I just eat all the time (Interview 1-18-06).

Although Eugenie's narrative is unique among the women I interviewed, it remains instructive as it demonstrates contemporary discourses about maternal responsibility and behavior in pregnancy. As I argued above, early proponents of ultrasound posited its benefit for shaping positive maternal behavior. Innovations in ultrasound technology, particularly the 3-D/4-D keepsake imaging has contributed to changing notions of fetal life in the contemporary United States. Eugenie's experiences illustrate how changing perceptions of fetal subjects have important implications for maternal subjectivity; in both clinical and non-clinical spaces, ultrasound imaging has the power to instill feelings of responsibility within pregnant women.

While ultrasound imaging has become a powerful technology of maternal responsibility in the biopolitics of the contemporary United States, this chapter has demonstrated that women's experiences with ultrasound remain diverse. Most of the Haitian women I interviewed had a positive experience with ultrasound, and embraced the technology as a means to visualize the

fetus. This did not necessarily override their embodied feelings of pregnancy, instead often enhanced their pregnancy experience. Ultrasound imaging, as a means to ascertain fetal sex, provided women with a way to prepare for their future child, or reaffirm particular kin ties. Fetal images were embraced as part of the pregnancy experience, and imagined as baby photos, yet my interviews with Haitian women did not evoke the dominant narratives of responsibility that have become omnipresent within maternal and child health policy in the contemporary United States. I do not wish to argue that Haitian pregnant women living in South Florida are “resisting” contemporary constructions of maternal and fetal subjectivity in the United States. Instead, in this chapter I illustrate the plurality of narratives which exist at the intersections of fetal imaging, care of the self, and the construction of fetal and maternal subjects. By taking a closer look at Haitian women and their utilization of biomedical diagnostic technologies, I wish to complicate the dominant discourses shaping the debate on fetal life and maternal responsibility in the United States. These discussions contribute to a feminist analysis of the conceptual categories that are often treated as self-evident within public debates about life, fetal rights, and abortion.

CHAPTER 6
RESPONSIBLE CHOICES: THE MORAL DISCOURSE OF ABORTION

America stands for liberty, for the pursuit of happiness and for the unalienable right of life. ... In the debate about the rights of the unborn, we are asked to broaden the circle of our moral concern. ... This is the generous and merciful spirit of our country at its best. This spirit is reflected in the Partial Birth Abortion Ban Act of 2003, which I am now honored to sign into law.

--- George W. Bush, President of the United States (November 5, 2003)

On April 18, 2007, the U.S. Supreme Court made a landmark decision, choosing to uphold the federal ban on partial-birth abortion. This law outlaws the method of late-term abortion known as “intact dilation and extraction” (D&X)⁶¹ which is performed in a minority of third-trimester terminations. Lauded by abortion opponents as another victory in the “culture of life,” abortion rights supporters lamented this decision as another step in the incremental erosion of abortion rights. Legal analysts noted that the Court, much more attentive to debating issues of privacy in earlier decisions, instead focused on small, detailed discussions of the actual procedure.⁶² While the Court has long argued that the state has a legal interest in deciding the parameters of abortion after the first trimester, or more recently, post-viability, Justice Anthony M. Kennedy argued in his majority opinion⁶³ that it is in the state’s interest to be knowledgeable about the actual procedure of partial-birth abortion, and in turn, “ensuring that so grave a choice is well informed” (2007: 29). This statement highlights the discourse of morality which has

⁶¹ The term “partial-birth abortion” is disputed by the medical profession; organizations such as the American Medical Association and the American College of Obstetrics and Gynecology have argued that this term does not exist within medical practice, and was coined by the anti-abortion movement to galvanize support for its cause (ACOG 2006; AMA 2007).

⁶² The text of the bill (graphically) describes the procedure as follows: “A moral, medical, and ethical consensus exists that the practice of performing a partial-birth abortion—an abortion in which a physician deliberately and intentionally vaginally delivers a living, unborn child’s body until either the entire baby’s head is outside the body of the mother, or any part of the baby’s trunk past the navel is outside the body of the mother and only the head remains inside the womb, for the purpose of performing an overt act (usually the puncturing of the back of the child’s skull and removing the baby’s brains) that the person knows will kill the partially delivered infant, performs this act, and then completes delivery of the dead infant—is a gruesome and inhumane procedure that is never medically necessary and should be prohibited” (S 3 2003: 1).

⁶³ *Gonzales v. Carhart*, No. 05-380. U.S. Supreme Court April 18, 2007.

become fundamental to the current debate around abortion within the United States, such that the government has a legitimate interest in banning this procedure to prevent women from casually making a “grave choice.”

Examining this discourse of morality, this chapter will investigate implicit narratives of risk and responsibility which become fundamental to shaping contemporary maternal subjects in the United States. In particular, I am interested in how this particular discourse of morality is tied to contemporary notions of fetal life, one driven by the proliferation of fetal images in contemporary American culture. I focus on recent interest in the prevention of “unintended pregnancy,” and the ways in which these policies assume certain kinds of moral, liberal subjects. Women, however, are imagined generically; the differences between women which could shape the impact of these issues have not yet been critically examined. By exploring the local moral worlds of pregnant Haitian women living in South Florida, this chapter will situate contemporary debates about abortion which focus on “morality” and “unintended pregnancy,” and the ways in which these terms assume particular liberal, responsible maternal subjects. Using media material, congressional legislation, public health policy, and ethnographic data from South Florida, this chapter will trace how these discourses assume that women will behave in rational, responsible ways to plan their reproductive futures, and how these assumptions intersect with Haitian migrants’ lived experiences in South Florida.

Deciding Partial-Birth Abortion

In writing the majority opinion in the Partial-Birth Abortion Ban decision, Justice Kennedy’s concern for the moral health of women is dominant throughout this opinion:

Whether to have an abortion requires a difficult and painful moral decision. While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow. ...It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow

more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast developing brain of her unborn child, a child assuming the human form (2007: 28 – 29).

These comments echo current moves by anti-abortion activists, who have begun to reframe the debate in terms of protection of women as well as the protection of the unborn. This paternalistic strategy merges new ideas about women's rights with old philosophies regarding women's roles, arguing that by prohibiting abortion, the state ultimately protects women's emotional health from their own bad choices as mothers (Siegel 2007).

A number of feminist activists have argued that the discourse around abortion has long been driven by its opponents (see Morgan and Michaels 1999). Frances Kissling, the president of Catholics for Free Choice, noted “[I]t has long been a truism of the abortion debate that those who are pro-choice have rights and those who are against legal abortion have morality; that those who support abortion rights concentrate on women and those opposed on the fetus” (2004 – 05: 1). Building on these notions of morality are currently strategies which involve the introduction of legislation such as “informed choice” bills and increased attention to “post-traumatic abortion syndrome.” Echoing Justice Kennedy’s assertion that abortion can lead to “severe depression and loss of esteem,” informed choice legislation typically requires physicians and providers to inform women of both the potential physical and emotional side effects of abortion.⁶⁴ Justice Kennedy’s comment that “[I]t is a reasonable inference that a necessary effect of the regulation and the knowledge it conveys will be to encourage some women to carry the infant to full term, thus reducing the absolute number of late-term abortions” (2007: 29 – 30) demonstrates the ideal strategies behind such notions of informed choice, that if women are “educated” about the potential physical and emotional risks inherent in abortion procedures, that they will ultimately

⁶⁴ An increasing amount of this legislation also requires physicians or providers to provide information on fetal development, and in some cases, perform an ultrasound for the woman to view if she chooses.

choose responsibly and decide against termination. Yet as demonstrated by informed “choice” legislation, this notion of women’s bodily integrity and right to make decisions around pregnancy termination is no longer solely within the discourse of those who wish to protect abortion rights. Instead, “choice” has become one of the cornerstones of the pro-life discourse: both through the slogan “choose life,” and its frequent use in the names of pregnancy crisis centers throughout the United States. As May Bagnell, the Executive Director of the First Choice Women’s Center⁶⁵ in Homestead, Florida commented to me, it is an “irony is that ‘pro-choice’ is really only the choice for abortion” (personal communication, 12-21-05).

In her dissent against the majority opinion in the partial-birth abortion case, Justice Ruth Bader Ginsburg wrote, “[O]ur obligation is to define the liberty of all, not to mandate our own moral code” (2007: 15). This is a restating of the joint opinion written and attributed to Justice Kennedy in the 1992 abortion decision in *Planned Parenthood v. Casey* (Greenhouse 2007). Yet the Court’s majority opinion regarding the partial-birth abortion ban strongly argues that the government’s legitimate interest “in respect for life is advanced by the dialogue that better informs the political and legal systems, the medical profession, expectant mothers, and society as a whole of the consequences that follow from a decision to elect a late-term abortion” (Kennedy 2007: 30).

Meanwhile, outspoken abortion rights supporters such as Naomi Wolf, William Saletan, and Frances Kissling have begun to argue that by ignoring the morality inherent within decisions around abortion, you begin to cede important political ground. These activists argue that we need to “face the fetus” by recognizing the value of fetal life, and support women by making abortion

⁶⁵ First Choice Women’s Center is a pregnancy crisis center.

“safe, legal, and rare”⁶⁶ (Saletan 2004, 2006). To this end, abortion rights supporters have argued that there needs to be a “common ground” within this debate, and they assert that the prevention of abortion should be the most important strategy. Given that high rates of “unintended pregnancy” contribute to the majority of abortions in the United States (and throughout the globe), a number of strategies focused on family planning and increasing access to contraception have been introduced on both the federal and state levels.

The Morality of Abortion

In recent years, particularly since the advent of the George W. Bush administration, a growing number of bills have been introduced, and in many cases subsequently passed, which erode women’s access to abortion services in the United States. While abortion rights advocates have lobbied against much of this legislation, increasing numbers of these advocates have also begun a different kind of conversation regarding abortion throughout the “liberal” media. As pro-life advocates increasingly turn the conversation toward fetal viability and the sanctity of “life,” abortion rights advocates have begun their own discussions around morality. Yet these discussions of morality also rely on particular “truths” of fetal life, accessible through ultrasound imaging.

After the passage of *Roe v. Wade* in 1973, legalizing access to abortion, a number of religious organizations interested in supporting access to legal abortions formed the Religious Coalition for Reproductive Choice (RCRC). Calling themselves “Pro-faith, Pro-family, Pro-Choice,” the RCRC is an umbrella organization made up a number of denominations, including the Episcopal, United Methodist, and Presbyterian (USA) Churches, and Reform and Conservative Judaism (Tuhus-Dubrow 2006; www.rcrc.org). One of the most outspoken

⁶⁶ This phrase is attributed to President Bill Clinton and summarized his platform on abortion. Senator Hillary Clinton, 2008 presidential candidate, has continued the use of husband’s phrase in campaigning.

representatives of religion and choice is Frances Kissling, the president of Catholics for a Free Choice (CFFC) for the past twenty-five years.⁶⁷ When recently asked about her views on the pro-choice movement in America, she explained that “[O]ne of the big misunderstandings is the idea that we don’t care about moral questions. I don’t think that’s true” (quoted in Saletan 2007: 1). Her own prolific writings have focused on the “human right of women to decide whether or not to continue a pregnancy” (Kissling 2004 – 05: 3).

Larger pro-choice advocacy groups such as NARAL Pro-Choice America have not ignored issues of religion and morality either. NARAL has long advocated that a woman considering abortion should make this decision in conjunction with her support network, often citing that this is not a decision to be made by lawmakers or courts, but a decision by a woman, her doctor and her family. Recently, Kate Michelman (recent past president of NARAL) made a statement adding a fourth representative to this decision, noting that abortion is a “private decision between a woman, her doctor, her family, and her god” (Tuhus-Dubrow 2006: 2).

William Saletan, the chief national correspondent for *Slate*⁶⁸ and an abortion-rights supporter, has become one of the more outspoken commentators on the “war on abortion.” In his 2006 op-ed piece on the anniversary of *Roe v Wade*, Saletan summed up current abortion politics in the United States: “[O]ne side is so afraid of freedom it won't trust women to do the right thing. The other side is so afraid of morality it won't name the procedure we're talking about.” He notes that missing from all those checks that supporters write to Planned Parenthood Federation of American (PPFA), NARAL Pro-Choice America and the Center for Reproductive Rights is the word abortion: “you can’t eliminate the abortion question by ignoring it” (2006). The

⁶⁷ Frances Kissling stepped down as the president of CFFC in March 2007.

⁶⁸ Slate is a liberal-leaning on-line news and culture magazine. (See www.slate.com)

abortion debate has been fundamentally changed with our increasing exposure to fetal life. In a recent essay on the increasing use of ultrasound by those who wish to “convince” women against abortion, he argues that women who are considering an abortion need to face the “truth” contained in these images. “But you should look at it, and so should the guy who got you pregnant, because the decision you're about to make is as grave as it gets” (Saletan 2007: B02). He explains, “The image on the monitor may look like a blob, a baby or neither. ... All it will show you is the truth” (Saletan 2007: B02). For Saletan, there is a responsibility to seriously consider realities of fetal life in decisions about abortion.

Naomi Wolf, who identifies as a third-wave feminist and writes about popular culture, weighed in on the abortion debate in her essay, “Our Bodies, Our Souls” (1995), which appeared in the *New Republic*. Wolf argues that by “refusing to look at abortion within a moral framework, we lose the millions of Americans who want to support abortion as a legal right but still need to condemn it as a moral iniquity” (1995: 26). To Wolf, feminism responds to women and situates its rhetoric within women’s “real-life” experiences. And according to women’s stories and experiences, she argues, Americans want an abortion-rights movement that is willing to publicly mourn the “evil” that is abortion. Wolf reminds us that “feminism at its best is based on what is simply true.” Therefore, the images of little footprints are “in fact the footprints of a 10-week-old fetus; the pro-life slogan, ‘Abortion stops a beating heart’ is incontrovertibly true. ... the pictures are not polemical themselves: they are biological facts” (29). As Morgan and Michaels (1999: 3) note, Wolf’s “born again feminism” is situated within specific notions of the politics of abortion, one in which feminists are viewed as having alienated the center with a focus on women’s “right” to abortion, where as those considered pro-life are garnering increasing support for their recognition of morality and the value of life. While much of the

rhetoric evoked by Kissling, Saletan, and Wolf focuses on acknowledging the “value of fetal life,” a concurrent argument throughout these discussions is on women’s need to take responsibility for their reproductive “choices” and the underlying need to prevent abortion.

Finding a “Common Ground” in the Abortion Debate: Prevention First

Reproductive rights advocates are not alone in calling for the recognition of the morality inherent in decisions to terminate a pregnancy. Hillary Clinton, a U.S. Senator and 2008 presidential candidate, gathered powerful media coverage after her 2005 speech in honor of the thirty-second anniversary of *Roe v Wade*. Speaking to a group of New York State family planning providers, Clinton outlined her views on abortion and women’s reproductive health. She argued that we should be able to find common ground on this issue, by increasing access to quality health care for women and reducing the number of unwanted pregnancies (clinton.senate.gov 2005). The *New York Times* declared on its front page: “Clinton Seeking Shared Ground Over Abortions” (Healy 2005) and the *Washington Times*, one of the nation’s more conservative papers, noted “Hillary in the middle on values issues” (Curl 2005). Clinton has long supported the abortion platform of her husband, former President Bill Clinton, that abortion should be “safe, legal, and rare” and built on that notion in this speech with the comment that the right to abortion “either does not ever have to be exercised or only in very rare circumstances.” Saletan celebrated this as pro-choice advocacy for “safe, legal, and never” (2005).

This idea of a “common ground” on abortion is promoted in the pairing of pro-life Senator Harry Reid and abortion rights supporter Senator Hillary Clinton and their introduction of the legislation the “Prevention First Act” as an amendment to the 2005 budget resolution. As introduced by Reid: “[W]e can find not only common ground, but common sense in the Prevention First amendment we are offering today. Whether you are pro-life or pro-choice, our

amendment advances goals we should all share: reducing the number of unintended pregnancies, reducing the number of abortions and improving access to women's health care" (Senate Democratic Communications Center 2005: 1). This amendment, specifically designed to increase funding for family planning through Title X, was a companion to the Prevention First Act⁶⁹ (S. Bill 20) introduced into Congress by Reid in January 2005. S. Bill 20 is a package of preventative health and education measures designed to decrease rates of unintended pregnancy. After being introduced in 2005, the bill was referred to the Committee on Health, Education, Labor, and Pensions, although no action was taken during the 109th Session of Congress. The bill was reintroduced by Harry Reid in 2007 (in the 110th Session of Congress), was again referred to the Committee on Health, Education, Labor and Pensions, where it is currently awaiting debate.

The Prevention First Act (PFA) has a number of components aimed at reducing unintended pregnancy, and therefore "preventing" abortions. This act would increase the funding for the national family planning program (Title X), as well as expand Medicaid contraceptive services to cover more low-income women. It would also require private insurance to provide the same coverage for contraceptives as for other prescription medications; ensure that women who survive sexual assault receive factual information about emergency contraception; increase awareness about emergency contraception and its availability over-the-counter; provide funding to establish and expand teen-pregnancy prevention programs; and provide funding for "Real Education about Life" (REAL) federal program of sex education for teenagers (S. Bill 21 2007). While this can be considered one of the key pieces of "pro-choice" legislation to be championed by abortion-rights supporters in a number of years, the bill does not ensure access to abortion,

⁶⁹ The Prevention First Act is similar to the "Putting Prevention First Act" (S. Bill 2336) first introduced into Congress by Harry Reid in April 2004.

nor does it declare abortion as a woman's "right," instead, this legislation focuses on *preventing* abortion through the prevention of "unintended pregnancies."

Situating Morality and "Unintended Pregnancy"

While this chapter has examined the larger push of the "pro-choice" movement to focus on morality and unintended pregnancy, this is not to say that all reproductive justice activists are as avid to assume the "truths" of fetal life as self-evident. For instance, Katha Pollitt, a regular columnist for *The Nation*, took issue with Saletan's call for acknowledging the morality of abortion, writing that his arguments do not "suggest to me that injecting more anti-abortion moralism into the debate will help keep abortion legal and accessible. I'd say it is too moralistic already" (2006). It is not that I wish to represent one side or another as having the best analytical perspective on the politics of abortion in the United States; instead, during the remainder of this chapter I will demonstrate that the notions of a "moral" maternal subject has long been fundamental to the focus on "unintended pregnancy."

The prevention of unintended pregnancies is nothing new in the field of maternal and child health. The term "unintended pregnancy" is defined as pregnancies that are considered "mistimed," which occurred earlier than desired, or "unwanted," in that they occurred when no children or no more children were desired. Historically, policy makers and public health researchers have argued that 100% of abortions are the result of unintended pregnancies (Henshaw 1998; Trussell, Vaughan, and Stanford 1999); recent data have shown that 49% of pregnancies in the United States are unintended, with this rate above average among women aged 18 – 24, and who are unmarried, low income, have not completed high school, and self-described minorities (Finer and Henshaw 2006).

The concept of unintended pregnancy has not remained static throughout time. In the early twentieth century, births that occurred within the context of marriage were considered "wanted"

and births outside of marriage were “unwanted” (Campbell and Mosher 2000). At this time, contraception was rudimentary and difficult to access, leading activists such as Margaret Sanger to advocate for a decrease in unwanted pregnancies, particularly in conjunction with increased access to birth control. She commented: “Children brought into the world by unwilling mothers suffer an initial handicap that cannot be measured by cold statistics. Their lives are blighted from the start” (1922: 17). After World War II, concern about the rapid population growth in the United States led population specialists to get better projections of birth rates, leading to “The Growth of American Families Study,” administered in 1955 and 1960. For the first time, demographers realized the need to distinguish the effects of *timing* on birth outcomes. Yet it was not until the 1965 National Fertility Study that researchers began to investigate both timing and “wantedness” of pregnancy. The unit of analysis shifted from the couple’s fertility history to the individual birth or pregnancy. In addition, it introduced the distinction between pregnancies that were unwanted at any time and those that occurred sooner than wanted (Campbell and Mosher 2000). What we see here is that wantedness came to be judged in relation to an expression of the “desire” or even “pleasure” of individual parents rather than as an evaluation of ideal family structures.

Rates of unintended pregnancies are currently assessed through two large sources of data in the United States: the National Survey of Family Growth (NSFG) and the Pregnancy Risk Assessment Monitoring System (PRAMS). The NSFG is administered through the National Center for Health Statistics and was most recently conducted in 1995 (Cycle 5) and 2002 (Cycle 6); the current cycle, Cycle 7, began interviewing in June 2006 and was to be completed in March 2007. Cycle 6 was based on an area probability sample, designed to produce national data, as opposed to state level data. In-person interviews are conducted by female interviewers

with women and men (aged 15 – 44), gathering information on family life, pregnancy, infertility, marriage and divorce, use of birth control, sexual experience, and women’s and men’s health. The 2002 cycle resulted in over 12,500 interviews, with women making up 61% of this sample (www.cdc.gov/nchs/about/major/nsfg/nsfgback.htm).

PRAMS is a surveillance project of the Centers for Disease Control and Prevention (CDC), and uses state-specific, population-based data on maternal attitudes and experiences before, during, and shortly after pregnancy. These surveillance projects are carried out by state departments of health and the State of Florida initiated its PRAMS project in June 1993, with the most recently analyzed data collected in 2003. The PRAMS project mails surveys to a random selection of Florida residents who gave birth to a live-born infant, two to five months after they give birth; if there is no response after one month, a phone interview is attempted. For the 2003 cycle, close to 2000 women were surveyed using the CDC’s PRAMS data collection instrument (Florida Department of Health 2005).

Measuring Unintended Pregnancy

The PRAMS Survey subsumes notions of “mistimed” and “wantedness” within one question: “Thinking back to just before you got pregnant, how did you feel about becoming pregnant? I wanted to be pregnant sooner; I wanted to be pregnant later; I wanted to be pregnant then; I didn’t want to be pregnant then or at any time in the future” (PRAMS Phase 4 Questionnaire 2000 – 2003: 2). The NSFG 2002 questionnaire has two different sections dealing with these issues: “Birth Desires and Intendedness” which asks a series of questions about a woman and her partner’s plans for children in the future, and “Contraceptive History and Wantedness” which inquires whether the most current pregnancy was planned or wanted through a number of questions. Sample questions include: “Do you think you probably want, or probably

do not want to have a(nother) baby at some time in the future?” and “So would you say you became pregnant too soon, at about the right time, or later than you wanted?” (NSFG 2002: G-2).

While the concept of “unintended pregnancy” has been measured for over fifty years, some researchers still question whether the idea of unintended pregnancy is conceptually clear, and whether pregnancies are being correctly classified (Bachrach and Newcomer 1999; Klerman 2000; Luker 1999; Sable 1999; Zabin 1999). As researchers prepared the 1995 NSFG questionnaire, demographers and others began to wonder what the intendedness question actually measured. As the proportion of unintended births continues to remain steady and at times increase, despite widespread access to contraception, it was assumed that the questions were misunderstood by a significant number of women. In response, a number of other questions were added to the 1995 NSFG, including questions about how happy the respondent was when she found out she was pregnant. This was to be answered on a ten point scale, ranging from strongly agree to strongly disagree. The responses to these new questions were analyzed in conjunction with the previously administered questions, and found that the responses to the happiness and ambivalence measures were consistent with the traditional wantedness questions (Klerman 2000).

Even while a growing amount of research over the past ten to fifteen years has questioned the methods of measuring “unintended pregnancy,” this term began to have increasing importance throughout policy and legislation. The federal government, as well as professional and advocacy groups, has decided that this concept is important to the health of the American public. And as demonstrated by legislation such as Prevention First, preventing unintended pregnancy has become one of the cornerstones of decreasing rates of abortion in the United States. Yet as frequently noted by a number of feminist scholars, threaded through these

discussions are notions of personal responsibility. Ruhl comments, “pregnancy is occasionally planned, occasionally unplanned; if unplanned it does not necessarily reflect deep personal irresponsibility on the woman who finds herself unexpectedly ‘caught’” (2002: 651). Yet current discussions of unintended pregnancy represent its occurrence as a failure of responsibility and a possible source of danger. As noted by Pollitt, “[I]ronically, improvements in contraception have made unwanted pregnancy look more like a personal failing. ... You can just see how unwanted pregnancy will join obesity and smoking as unacceptable behavior in polite society. But how is all this censoriousness supposed to help women control their fertility? If half of all pregnancies are unplanned, it doesn't make sense to treat them as individual sins” (2006).

Beyond its role in discussions about the morality of abortion, pregnancy intention is often linked to maternal behavior and care during pregnancy as well as birth outcomes. In the literature on maternal and child health, unintended pregnancies have been associated with delayed prenatal care, use of alcohol and tobacco during pregnancy, low birthweight babies, adoption of breastfeeding, adverse maternal behaviors related to infant health, and infant mortality (Brown and Eisenberg 1995; Joyce et al 2000; Kost et al 1998; Marsiglio and Mott 1988; Weller et al 1987). Brown and Eisenberg (1995:1) argue that the “consequences of unintended pregnancy are serious, imposing appreciable burdens on children, women, men, and families.” Yet none of these researchers have situated these notions of “unintended pregnancy” within the lived experience of those who may articulate a radically different moral world than that understood by policy makers and activists. The following section will explore these issues among pregnant Haitian women living in South Florida.

Unintended Pregnancy among Haitian Women

Haitian women have also participated in the PRAMS survey in Florida. The Florida Department of Health combined datasets from 2000 – 2003 to create a large enough sample size

to analyze the data on post-partum variables among Haitian women living in Florida. Of more than 300 women who responded to the survey, 60.8% of these women reported their pregnancy to be unintended. These data were not disaggregated based on “mistimed” or “unwanted” pregnancies. For comparison, non-Hispanic White women⁷⁰ surveyed during the same time period reported 38.6% of their pregnancies were unintended (Florida Department of Health 2005). The data support what has also been reported from demographic surveys in Haiti, such as the Haitian Survey on Morbidity, Mortality, and Utilization of Services (EMMUS) for 1994 and 2000. In the EMMUS-II, more than half of all births were unintended, with 34% reported unwanted, and 21% reported mistimed (Guttmacher Institute 1996). Similarly, in the EMMUS-III, over 55% of all pregnancies were unintended, with 30% reported as unwanted, and 26% reported as mistimed (Haiti-2000 2003).

While my research did not initially ask questions about “pregnancy intendedness,” this discussion came naturally out of conversations about discovering the pregnancy or the decisions on sharing the news of a pregnancy. For many women, an “unplanned” pregnancy was merely the result of thinking that they were unable to have any more children. Nadine, a 21 year old woman pregnant with her first child, said that although this pregnancy was unplanned, it was not “unwanted.”

N: No. She was not a mistake; she was accidental. They told me I couldn’t have kids.

L: You weren’t using family planning?

N: No. I went to a regular OB appointment and they told me something was wrong. And they did these tests and told me I may not be able to have kids. ...Took the test and I was pregnant. I thought she was kidding (Nadine, 7-11-06).

⁷⁰ This PRAMS Special Report compared Haitian women to non-Hispanic White women. While it would be interesting to see these rates compared to other race/ethnicities, the PRAMS 2003 Surveillance Data Book subsumes “Haitian” women into “Black” therefore not allowing for comparison.

For Roseline, who has one child of her own and two adopted children, her current pregnancy was unexpected.

L: When did you become pregnant?

R: This time around, sometime in November. I was exercising, working out and looking good. And I said to my husband I think something's wrong. It's been seven years; my youngest son is seven. I had a cyst and we had been trying for several years and they told me I couldn't have any more children. So my mind was at that level and I focused on career and the kids. I wasn't thinking about another child. He was planned; this one was a surprise. I went to one doctor and then a second one just to make sure. It was the weirdest thing (Roseline, 5-31-06).

Some of the women I spoke with were not pleased to discover their most recent pregnancy. For some women, this pregnancy had followed too quickly after a previous birth.

L: Were you excited about the pregnancy, were you happy about the pregnancy?

M: Yes, I was shocked.

L: You were shocked? Why? You weren't expecting to get pregnant?

M: I just had that one (Mirlene, 6-8-06).

For many young Haitian women, education is an important part of achieving success in their life and pregnancies at any age can prevent them from achieving these goals. Rose, a twenty-one-year-old living with her aunt and cousins in Broward County, explained how her pregnancy was interfering with her education:

R: And I went back and I find out I was pregnant, and I got five weeks pregnant. I wasn't ecstatic.

L: You weren't ecstatic?

R: No. [emphatically]

L: Weren't ready for that?

R: No, that's too early for me.

L: When did you want to get pregnant?

R: After school. After I learn something (Rose, 6-9-05).

A number of the women I spoke with not only expressed frustration at the timing of their pregnancy as interfering with their education, but a few had unhappy families as a result.

L: Are you happy now about the pregnancy?

K: I'm just coping. I'm not really happy. I just take everything as a gift as it comes and I say I will learn something from it. I've already learned a lot.

L: Is your family coming to terms with your having the baby?

K: My sisters and my uncles, yes. My dad and mom, sometimes they get frustrated and they throw things at me. For them it's a done deal and that's what's killing them (Ketly, 6-19-06).

Finally, another important component to "unintended pregnancy" is family size. For some women, feelings around a current pregnancy can be related to whether they were planning on having any more children. Loudjina, who has one son living in Haiti and one daughter in Florida, said that this current pregnancy was one too many.

L: Did you decide to have a baby now, or did it just happen?

Lo: It, it just coming.

L: Were you excited to be pregnant, were you happy?

Lo: Not happy, happy [said quietly].

L: Not happy?

Lo: No.

L: Why weren't you "happy, happy"?

Lo: [sigh] Because I have one son, one daughter, I think that is enough only. ...that's okay, I am just keeping it. I am keeping it here (Loudjina, 4-28-06).

Loudjina's comments and some of the examples above demonstrate what it means for women to internalize family norms and then feel they must achieve these norms. These interview excerpts demonstrate the myriad experiences of pregnancy intention and wantedness that can be associated within each woman's pregnancy and contextualizes how broad statements based on

quantitative measures do not completely describe many women's lived experiences of pregnancy.

As noted above, an important companion to discussions around abortion and pregnancy intendedness has been the use of contraception and women's responsibility for reproductive planning. The following section will situate these discussions within the larger framework of the discourse around birth control in the United States, and the ways in which contemporary debates incorporate this notion of "planning" and evoke a particular kind of subjectivity for women of reproductive age in the United States.

The (Feminine) Responsibility for Reproductive Planning

Early arguments for the "right" to contraception, argued most forcefully by Margaret Sanger in the United States, focused on women's liberation and freedom: "Birth Control is not merely concerned with population questions. ... Birth Control concerns itself with the spirit no less than the body. It looks for the liberation of the spirit of woman" (1922: 26). Sanger insisted that contraception is essential for women's physical and mental well-being, such that their sexuality not be tied to reproduction. As discussed above, these associations between "unwilled" or "unplanned" pregnancy and poor birth outcomes remains relevant even today. While speaking with the New York State Family Planning Providers in January 2005, Hillary Clinton commented: "We should all be able to agree that we want every child born in this country and around the world to be wanted, cherished, and loved. The best way to get there is to do more to educate the public about reproductive health, about how to prevent unsafe and unwanted pregnancies" (clinton.senate.gov 2005).

As opposed to notions of women's freedom as articulated by Margaret Sanger, current advocates for abortion rights instead formulate this discussion in terms of "a moral discourse that calls on individuals to act toward the creation of life responsibly" (Kissling 06 – 07: 1). In

support of the PFA and its aim towards reducing unintended pregnancies, NARAL argues that this legislation “reflects the values of freedom, privacy and personal responsibility” (NARAL 2007: 1). Hillary Clinton echoes these notions of freedom and responsibility when she remarked: “Now with all this talk about freedom as the defining goal of America, let’s not forget the importance of the freedom of women to make choices that are consistent with their faith and their sense of responsibility to their family and themselves” (clinton.senate.gov 2005). The importance of contraception becomes particularly salient in the linkages made between the right to abortion and the importance of acting responsibly. Naomi Wolf calls on feminists to recognize these responsibilities: “Feminist rights include feminist responsibilities; the right to obtain an abortion brings with it the responsibility to contracept” (1995: 32). Yet concurrent with these discussions of (female) responsibility is the discourse around personal failure: failure to contracept, failure to prevent unintended pregnancy, and failure to prevent abortion.

Saletan counsels a “simple” path to increased support for abortion-rights in the United States, by decreasing the rate of abortion and the recognition of the value of life in America. In a recent editorial on the anniversary of Roe v Wade, he commented:

The pro-choice path to those results is simple. Help every woman when she doesn't want an abortion: before she's pregnant. That means abstinence for those who can practice it, and contraception for everybody else. Nearly half of the unintended pregnancies in this country result in abortions, and at least half of our unintended pregnancies are attributable to women who didn't use contraception. The pregnancy rate among these women astronomically exceeds the pregnancy rate among women who use contraception. The No. 1 threat to the unborn isn't the unchurched. It's the unprotected (www.nytimes.com 2006a).

Working within these notions of the women who “deserve” access to abortion, Naomi Wolf (1995) chides the “millions of college students, professional men and women, and middle- and upper-class people... who have no excuse whatsoever for their carelessness” and who are not the “moral equivalent of the impoverished mother who responsibly, even selflessly, acknowledges that she already has too many mouths to feed” (32).

Some of the key aspects to modern notions of family planning and pregnancy prevention are situated within particular theories of subjectivity. Reason and rationality form two of the fundamental aspects of liberal subjects, and they inform the theories that govern the “rational choice” doctrine within contraception. In addition, modern liberalism relies on the willingness of citizens to self-regulate, that is, to take personal responsibility for regulating their behavior (Rose 1993). Liberal citizens have been granted the freedom to make choices because they can be trusted to make the right choices (Ruhl 2002). As evident in the excerpts above, women are expected to take responsibility for the prevention of unintended pregnancy, particularly if they believe they deserve the right to access abortion. According to these commentaries, abortion is no longer a “callous decision” (as if it ever was), and responsible women must face the moral implications of their decisions, recognizing the value of fetal life. Wolf and Saletan are constructing their pro-choice discourse within certain notions of a maternal feminism (Morgan and Michaels 1999). Interestingly, this maternal feminism would pull on the same notions that generated much media attention over Justice Kennedy’s comment in his recent opinion on partial-birth abortion that: “Respect for human life finds an ultimate expression in the bond of love the mother has for her child” (2007: 28).

Yet women alone are not expected to act as liberal citizens. While self-regulation is a key part of liberal governance, individuals are also identified as the target of governmental action (Burchell 1993). Women must act responsibly in regulating their fertility and preventing unintended pregnancy, and the State will assist them. As noted by Hillary Clinton in her speech in 2005: “[T]here is no reason why government cannot do more to educate and inform and provide assistance so that the choice guaranteed under our constitution either does not ever have to be exercised or only in very rare circumstances” (clinton.senate.gov). For Saletan (2006), the

solution is simple: “Give more money to Title X, the federal program that finances family-planning. Expand health insurance and access to morning-after pills. Educate teenagers about sex, birth control and abstinence. Many of these ideas are in the Prevention First Act, which Democrats ritually file and Republicans ritually ignore” (www.nytimes.com). As the state takes decisions about women’s health and access to services out of the hands of physicians, providers, and the women themselves, it is also important to explore how women themselves perceive their role in “planning” their reproductive lives, and the sorts of issues which govern these “choices.” How do pregnant Haitian women’s narratives intersect with this discourse on taking responsibility for the prevention of unintended pregnancy?

Family Planning among Haitian Women in South Florida

Here I will ground the larger policy and legislative moves around reproductive health, specifically this push towards contraception as a means of preventing abortion, within the lives of Haitian women living in South Florida. Clearly, as my research focused on pregnancy, all of the women in my sample were either not using contraception or had cases of failed contraception. As discussed above, many of the stories shared with me by Haitian women included cases of what would be conceptualized as “mistimed” or “unwanted” pregnancies. Yet this section will begin to contextualize the realities of “planning” pregnancy for many women, that the decision to use or not to use contraception is guided by myriad factors, not all as simple as “educating” women about family planning.

It is important to recognize that much of the discourse around the use of contraception to prevent unintended pregnancy is focused on “modern” methods of birth control, such as oral contraceptive pills, barrier methods (such as condoms or diaphragm), hormonal injections (Depo-Provera), the IUD, or sterilization (tubal ligation). Similar to Richey’s (2004) work in Tanzania, U.S. approaches to unintended pregnancy prevention focus on the provision of these

“modern” or biomedical contraceptives⁷¹ for limiting and spacing births. This is reflected in the research from Haiti as well, the 1998 Haiti Family Planning and AIDS Prevention Survey (Van Rossem and Meekers 1999) focused on women’s knowledge about “injectables,” “pills,” “IUD,” and “condoms.” Yet a number of providers pointed to Haitian women’s use of the rhythm method or natural family planning, because of its endorsement by the Catholic Church. Mirlande, an activist with a local family planning clinic, told me about her health education experience in Haiti:

I went to the Catholic Church, at that time. I went to the monsignor and told him I’m doing this [teaching sexual education]. And he said the only thing I want you to talk about when you come here is the rhythm method, abstinence and something he called “gle.” I asked him, what is that? I went to Haiti and talked to a lot of people in family planning they told me what “gle” is, it is the secretion. You go for a little squirt in your vagina and you look at the secretion how thick it is (Interview, 5-15-06).

For many women, “family planning” encompasses all forms of pregnancy prevention. In Mirlene’s case, she was “shocked” at her current pregnancy so quickly after the birth of her previous child, and attributed it to “miscounting.” When I asked her if she was using family planning before this pregnancy, she told me: “I was using that [family planning] but I think I miscount. I think I forgot how to do it. So that’s why after that baby, there’s a place at the church I have to go to get the course again. But I forget about it. And there’s a website. I’ll have to check them out soon” (Interview, 6-8-06).

When I asked Mirlene how many children she wanted to have, she told me “I think that’s uh, I never really plan how many that I’m gonna have. They just pop up” (Interview, 6-8-06).

⁷¹ Yet there are some serious contradictions in the discourses of population control in the United States at this time—the Bush administration’s focus on abstinence-only sexual education has had large implications for the funding of Title X, and US AID policies abroad. Therefore, this focus on modern contraception as a means of preventing unintended pregnancy is being argued mostly by maternal and child health advocates and much of the Democratic and other “liberal” parties in the United States. As the “Christian Right” continues its politicizing modern contraceptive methods as forms of abortion, legislation such as the Prevention First Act languishes in Congress at both the federal and state levels. (See also Shorto 2005).

This was echoed by a number of providers who attributed women's lack of interest in family planning to the notion that "God brings children," and therefore it was not a woman's place to interfere. In addition, a number of women expressed discomfort over using the pill—it was too difficult to swallow, too many side effects, or they just did not want to use it. Dr. Jean, a family practitioner working in South Dade, commented about the use of Depo Provera and tubal ligation:

When I was [working as a doctor] in Haiti, the Depo shot was recommended. They are open to it because people are aware that having 20 kids is not the way. But they are open to it unless they stop it themselves because they don't like it. The only thing they're not open to is the tubal ligation. Some of them will go for it, some will not. Because they think when you do tubal ligation a lot of things happen inside you that would interfere with your normal physiology. It's a belief that they have. The blood won't come or it will give you problems or interfere with the blood flow (Dr. Jean, 9-22-06).

And "modern" contraception is of course not without its failures. Loudjina was using Depo Provera but had difficulties getting her shot because of Hurricane Wilma:

When the hurricane come in and the last year, it come and it blow all the country, that's what happened. We had no lights and things, and I go there and she [the nurse at the clinic] say wait for the period to come in, but I went and that's what happened (Loudjina, 4-28-06).

Haitian women's sexuality and fertility have long been a topic of discussion in the anthropological and public health literature. Particularly since the advent of the AIDS epidemic, Haitian women's sexual practices, "safe" or otherwise, has been the focus of the literature focused on maternal health in Haiti (Behets et al 1995; de Zalduondo and Bernard 1995; Farmer 1992; Fitzgerald et al 2000; Lowenthal 1987; Maternowska 2006; Schwartz 2000). These notions of risk for HIV ground much of what is counseled about contraceptive practices, even within the United States. My conversation with Dr. Daniel demonstrates how this knowledge of HIV risk structures some physician's response to family planning:

D: I'm not an advocate of family planning. It implies that because of it you're not protecting yourself. So therefore I'm not for the pill if it prohibits them from using the condom. I don't want them to get pregnant but most of all I don't want them to get HIV.

L: Do you think that's a serious risk in this community?

D: Absolutely.

L: Because the men don't stay at home?

D: That, and also because it's a poor community. So for money people will do things that they would not necessarily do if they could sustain themselves. STDs and HIV are a disease of the poor regardless of whether the men stay home or not. Because once you empower women to take care of themselves they will tend to pick these things up. Many of the women I test for HIV are married in monogamous relationships. They know their husbands are probably gonna give it to them, but the fear they have is that he's probably going to accuse them. So if a woman does not have family planning she might want to insist that the man use the condom. In 2006, regardless of the culture, I think family planning is a good thing on one side of the token, on the other side it's permissive to allow non-safe sex (Dr. Daniel, 5-19-06).

The work of Maternowska (2006) explores in depth the construction of Haitian masculinities and its consequence for women's reproductive practices. Issues of power and control are a large factor within the decision to use or not use contraception, and while none of the women I spoke with pointed specifically to their partners as controlling whether or not they use family planning, a number of providers spoke to me about men making the major decisions about birth control. Mirlande commented that when she gives community-wide health education talks about family planning, she finds that "the men would ask more questions than the women because he was the one that was going to decide should she take the birth control pill" (Interview, 5-15-06). I illustrated similar issues with Haitian men and control in regard to women's interviews about their personal health histories in the Prenatal Clinic (see Chapter Three).

This chapter provided a brief ethnographic exploration of some of the issues governing family planning choices that Haitian women living in South Florida confront. While a number of abortion rights supporters have used the media to promote their argument that "morality" needs

to be critically examined within the abortion debate in the United States, this chapter has illustrated that this notion of morality is grounded within a climate which relies on technoscientific ideas about the “truths” of fetal life. In addition, strategies to prevent abortion are shaped by particular assumptions about maternal subjects, which evoke particular narratives of responsibility and liberal subjectivity. Haitian women’s decisions about family planning are situated within their own local moral worlds, where gender relations, power, and desires for children structure women’s everyday lives.

CHAPTER 7
CONCLUSION:
BIOPOLITICAL IMPLICATIONS OF RISK AND RESPONSIBILITY

In this dissertation, I examined the links between the technologies of risk and the making of subjects, with Haitian migrant women providing an important case study in the biopolitics of risk and responsibility. The biopolitical legacy of HIV/AIDS has constructed Haitians in the United States as a biosocial collective, no longer simply defined by nation, race, or history, but one also shaped by the shared experience of stigma, political violence, diaspora, and notions of risk. To this end, this dissertation examined these narratives as means to get analytical and theoretical leverage on the conceptual categories, such as “mother” or “fetus,” which remain self-evident within contemporary biopolitical discussions about reproduction in the United States. Using Haitian pregnant women’s narratives of their own local moral worlds, I presented a feminist analysis which illuminates both the collective and individual nature of pregnancy experiences.

This dissertation builds on a legacy of scholarship by feminist researchers and analysts, and seeks to contribute to the discussion of reproduction and risk within anthropology. My previous research interest in reproductive health care in Haiti led me to combine my continuing concern with the politics of abortion and reproductive technology in the United States with a case study focusing on these issues among Haitian migrant women living in South Florida. While the dominant narrative thread in this dissertation has remained Haitian migrant women and their experiences, also central to this discussion is the increasing state movement towards fetal rights, and the implications for reproductive policies both locally and globally. Ultimately this dissertation is interested in the broader implications of changing policies and debates around abortion; but beyond the consequences of these policies for access to abortion services, I argue that reproductive policies which privilege fetal rights have important implications for the

everyday practice of reproductive health care – specifically family planning and prenatal care. An important component of this discussion is the way in which technology has become a means for those who argue in favor of fetal rights to substantiate their claims. Imaging technology and fetal images have become so powerful that even those considered in support for “abortion rights” feel that they must justify their advocacy for abortion within these “truths” of fetal life.

In looking at biomedical prenatal care and fetal medicine, I wish to broaden the work on reproductive technology to look at the everyday practice of prenatal care. I have been interested in the ways in which narratives of risk are played out within the prenatal clinic, and how technologies of risk shape ideas about maternal and fetal subjects. A number of feminist scholars have looked at women’s lived experiences in conjunction with the use of reproductive technology, but with the exception of Rayna Rapp (2000) and Emily Martin (1987), most of this work has focused on white, upper-middle, or middle class women using private clinics in the United States and Canada. In this dissertation, I argued that while Haitian women do not question the authority or the importance of biomedical care, what is theoretically interesting is to interrogate the fissures of these narratives – and I found most of these fissures in the realm of these technologies of risk. Much of contemporary maternal and child health policy and providers’ conversations with me were structured around notions of risk, but Haitian women narrated risk in very different ways. Women went beyond biomedical concepts of risk, drawing on notions of gender, nation, and desires for their soon-to-be born children’s lives in the United States and Haiti.

This dissertation contributes to discussions about biopolitical forms of governmentality, particularly within contemporary neoliberal policies on maternal and child health. I focused on the narratives of “subjectification,” the strategies through which individuals are compelled to

modify their behavior, or work on themselves, as expected in prenatal care clinics. These strategies are informed by notions of ideal liberal subjects – who possess self-discipline, assume responsibility for refraining from actions that may harm themselves or others, and take responsibility for managing their own risk. Individuals, using “technologies of self,” conform or modify their lives or behavior in order to avoid perceived risks. In order to situate these practices in everyday lives, I illustrated the biopolitics of risk and responsibility within the local moral worlds of Haitian pregnant women living in South Florida. In this way, my dissertation critically examines these intersections between local and global, and the making of maternal and fetal subjectivities in the contemporary United States.

My research builds on a legacy of the anthropology of science, science and technology studies, and feminist science studies. This project is situated within a growing body of anthropological research and writing focusing on the “politics of reproduction” (Ginsburg and Rapp 1991, 1995). This work destabilizes motherhood as a biological category and synthesizes local and global perspectives to examine the practices, policies, and politics of reproduction. Fetal and maternal subjects are not simply made from “above,” but are constructed through micro-practices which occur within homes, clinics, community-based organization, courtrooms, legislative debates, media discussions, and maternal child health policy meetings. Subject positions are endorsed, enacted, embodied, and contested within these various locations, and by a number of stakeholders. I have utilized multi-sited ethnography to explore these larger questions about reproduction, risk, and responsibility. The evidence for this dissertation “emerged” out of my interest in tracking many of the issues detailed above, but also out of a commitment to continue to develop the “rich toolkit” of feminist technoscience studies through an “attention to the social-technical webs that constitute reproductive practice” (Haraway 1997: 187; Rapp

1999). Haraway (1997: 191) advocates the use of the “speculum” of feminist science studies as a “tool for widening all kinds of orifices to improve observation and intervention in the interest of projects that are simultaneously about freedom, justice, and knowledge.” To examine the various and intersecting domains occupied by fetal and maternal subjects and technologies of risk, I moved between the homes of Haitian immigrants, meetings with local stakeholders both for and against abortion rights, public and private prenatal clinics, and local maternal and child health policy meetings.

In Chapter Two, I examined the intertwining histories of vital statistics and the biomedicalization of prenatal care, as a means to illustrate a convergence of epidemiological and clinical risk. Inspired by clinical practices which designate all pregnant women as “low risk” or “high risk,” I argued that designations of risk status are linked to changing notions of fetal medicine. The intersection of risk and vital statistics became very powerful with the advent of the fetal patient, leading to increasing attention to maternal behavior and health as directly related to fetal outcomes. Using Ian Hacking’s (1999, 2006) frame of “making up people,” I described the intertwining history of the collection and development of vital statistics in the United States with the biomedicalization of prenatal care. Central to this discussion is the way in which notions of “risk” – both epidemiological and clinical – begin to structure the practice of prenatal care, and the sorts of subjectivities that result from this convergence. To situate these histories, I critically examined the use of vital statistics by maternal and child health providers in South Florida to illustrate the assumptions which inform these processes and the subjectivities which result from them. Using the Florida Linked Vital Statistics Database, I “followed the numbers,” asking how these numbers have been collected, and how they have been deployed, in what contexts, for what aims, and using what techniques. In order to illustrate the disjunctures

between “objective” statistics and “subjective” experience, I examined one variable or “risk factor,” the utilization of prenatal care, to explore strategies in accessing prenatal care among Haitian women. These narratives illustrated ways in which Haitian women’s local moral worlds intersect with decisions about accessing biomedical prenatal care.

In Chapter Three, I moved from these intersections of “epidemiological” and “clinical” risk to focus solely on clinical narratives of risk. I took a closer look at clinical narratives of risk and the ways that they contribute to shifting notions of subjectivity by interrogating everyday practices within the prenatal clinic. By examining the daily tasks of documenting clinical encounters, listening to the fetal heart tones, and encouraging the use of biomedical prenatal diagnosis technologies, I illustrated the ways in which these everyday practices enact particular assumptions about subjectivity, which imagine maternal subjects as responsible individuals, ready to engage in specific technologies of self. Using ethnographic research from an urban prenatal clinic in Ft. Lauderdale, Florida, I critically examined the various “technologies of self” utilized by Haitian women living in South Florida, and their decisions to engage with biomedical technologies of prenatal diagnosis. In addition, I demonstrated the ways in which patient-provider interactions with the prenatal clinic are shaped by clinical discourses of risk. Situating this ethnographic data within interviews with Haitian pregnant women, my work illustrated how their experiences with biomedical prenatal diagnosis fractured assumptions about liberal subjects, about pregnant women as docile bodies, and maternal and fetal subjectivities. Haitian women’s experiences with the technologies of pregnancy represent not only their interests as individuals, but also their wider sociopolitical fields of shared engagements and interests. In addition, these narratives reflect on Haitian women’s local moral worlds, which are clearly negotiated through local and global cultural, historical, political processes.

In Chapter Four, I used Haitian women's narratives to illustrate the situations and life experiences which can influence local perceptions of risk. Moving out of the clinic and into the everyday lives of pregnant Haitian women living in Miami-Dade and Broward Counties, this chapter demonstrated the diversity of experiences among these women. Haitian women's narratives of pregnancies illuminate a transnational landscape of risks – as experiences of violence and danger stretch from turbulent political situations in Haiti, problematic immigration policies in the United States, and finally to gendered power relations within the household. While there are similarities in experiences among these women, their narratives serve to fracture dominant ideas about “culture” as a structural and constraining force in Haitian women's notions of risk and responsibility within prenatal care. This chapter also contributed to feminist writings about “experience,” and to an analysis of the ways in which specific social, historical, and political contingencies contribute to the making of subjects. Building on the work of Joan Scott (1992), I argued that Haitian women do not simply have experience, but they are also subjects constituted through these experiences. In addition, I contributed to discussions about gender and “power,” and in an examination of the biopolitics of risk, the investigation of local moral worlds illustrates the ways in which women reflect on the ironies of their situation, both locally and globally.

In Chapter Five, I return to the clinic to examine the disjunctures which occur as ultrasound examinations are structured as a technology of both diagnosis and pleasure. Weaving together Haitian pregnant women's narratives on ultrasound, I illustrated the plurality of experiences which exist at this intersection of fetal imaging and the construction of fetal and maternal subjects. Through this investigation of Haitian women's utilization of fetal imaging technologies, it is possible to reflect on the conceptual categories and discourses which shape

contemporary debates on fetal life and maternal responsibility in the United States. Most of the women I interviewed had a positive experience with ultrasound, and embraced the technology as a means to visualize the fetus. Ultrasound imaging, as a means to ascertain fetal sex provided women with a way to prepare for their future child and to reaffirm particular kin ties. While I did not wish to argue that Haitian women are “resisting” contemporary constructions of maternal and fetal subjectivity, it is significant that my interviews did not evoke the dominant narratives of maternal responsibility that have become ubiquitous within maternal and child health policy in the contemporary United States. Instead, in this chapter, I pointed to the plurality of narratives which exist in the intersections of fetal imaging, care of the self, and the construction of fetal and maternal subjects.

Finally, in Chapter Six, I turned to a more explicit analysis of abortion policy and its implications for the everyday practices of reproductive care in the United States. Examining the discourse of “morality” which has become one of the dominant means of situating contemporary discussion of abortion in the United States, I illustrated how this is tied to particular notions of fetal life, notions driven by the proliferation of fetal images in contemporary American culture. Implicit within this discourse of morality and abortion are narratives of risk and responsibility, tied to current projects which focus on the prevention of “unintended pregnancy.” Using material from the media, congressional legislation, public health policy, and ethnographic data from South Florida, I examined how these discourses assume that women will behave in “rational,” “responsible” ways to plan their reproductive futures, and how these assumptions intersect with Haitian migrants’ lived experiences in South Florida. As I have demonstrated throughout this dissertation, Haitian women’s decisions about reproductive health, including family planning,

are situated within their own local moral worlds, which are shaped by kin obligations, gender relations, and nationalist identities.

While much of this dissertation focused on pregnancy and prenatal care, the underlying motivation behind my research and writing remains an advocacy for reproductive justice, both locally and globally. Ultimately, I am interested in situating these narratives of the biopolitics of risk within changing policies around abortion and fetal rights in the United States. Nowhere is this more evident than in situations of poor birth outcomes; narratives of responsibility were strongest in my observations of the Fetal and Infant Mortality Review (FIMR) Case Review Team, a part of my work with the Healthy Start Coalition of Miami-Dade County. In particular, these meetings demonstrated the ways in which the politics of fetal rights has increasingly focused on maternal behavior as the cause for poor birth outcomes. The local FIMR is part of a national project, initiated by the American College of Obstetrics and Gynecology (ACOG), which focuses on understanding some of the factors that contribute to fetal and infant death. Currently, Florida has twelve FIMR projects state-wide, most often contracted through the local Healthy Start Coalition. Each local FIMR is comprised of community members and stakeholders who assemble to review information from individual cases of fetal and infant deaths, with the objective of determining if these cases represent larger system problems that require change, and if so, developing the recommendations for change, and finally, assisting in the implementation of change. In the case of the Miami-Dade FIMR, members include (direct-entry) midwives, physicians, neonatal and NICU nurses, SIDS (Sudden Infant Death Syndrome) parent-activists and social workers. Members meet regularly to discuss cases and develop recommendations.

At each meeting, FIMR members focus on three cases of fetal and infant death—typically two fetal deaths and one infant death. The FIMR will only focus on cases that involve a fetal

death of over 20 weeks gestation and greater than 500 grams birthweight. It is assumed that little intervention can be made in fetal deaths before 20 weeks gestation, also considered “pre-viable.” FIMR case files are abstracted from various sources (when available), including fetal and infant death certificates, birth certificates (in the case of an infant death), prenatal records, emergency room/hospital records, NICU records, autopsies, and caregiver interviews. Each case is summarized in a report, removing any identifying data such as physician names, hospitals, or any personal information, and distributed to members during the meeting and collected again at the end of each session. FIMR members discuss the strengths and weaknesses of each case, guided by a checklist generated through a computer database.

For example, in one meeting we discussed the case of a 36-year-old Haitian woman who had experienced a fetal demise at 29 weeks gestation. According to the limited information we had about this case, we knew that this woman used a translator to communicate with hospital staff (and therefore spoke only Haitian Creole), and was recorded as having less than an eighth grade education. She gave birth to a male fetus, exhibiting maceration⁷², which is a sign that the fetus may have already been dead a day or so in utero. According to the emergency room record, the woman noted that she had not received any prenatal care in the United States but had some care in Haiti. She was given a grief packet which included a photo and footprint. In addition, the hospital record noted that she held the baby and requested to have it baptized.

Of particular relevance to this discussion was the aftermath of this woman’s fetal demise. She ended up spending four days in the hospital due to a severe heart condition, “disseminated intravascular coagulopathy,” which is most often associated with obstetric conditions such as eclampsia or placenta abruption. In many cases, this condition can be fatal, and numerous

⁷² Maceration is when the skin of the fetus begins to slough off and is a common means for estimating time of death in utero.

comments were made by FIMR members that she was “lucky to be alive” or that “they [the hospital] saved her life.” More troubling was the conversation that was begun when one member noted that such a severe heart condition, particularly associated with a placental abruption, is typically the result of a chronic cocaine user. In the majority of cases, the data that we have are sparse, similar to that abstracted above.⁷³ Yet FIMR members routinely insist on creating broad behavioral and moral statements about the women who suffer fetal and infant deaths. In this case, the member complained that no cocaine screen was done, “particularly with that sort of history at 29 weeks,” and that cocaine screening should be administered to all pregnant women upon delivery.

This focus on drug screening was a common refrain throughout the period when I was participating in the Miami-Dade FIMR meetings. In almost every case of “sudden fetal demise,” members repeatedly asked about drug screens. Unfortunately, in the majority of cases of fetal death, it is close to impossible to ascertain the exact causes—most fetal death records cite “unexplained fetal demise” as the official “Cause of Death.” This does little to alleviate the grief experienced by parents in understanding their loss, nor does it make the task of the FIMR particularly easy. Yet this insistence on citing drug use in every case of “sudden” fetal death constructs narratives of “crack babies” and their mothers that were popular about a decade ago. As one FIMR member commented in the case of suspected cocaine user: “If this woman was shot and the fetus died than someone would be prosecuted—but this woman uses drugs and her baby dies and she goes free.”

⁷³ Again, although we cannot make inferences from the scant data in this case, my research, and the research of many others, attests to almost no drug use among Haitian women in the United States or Haiti, as well as almost no alcohol or cigarette use during pregnancy (PRAMS 2003; Odell et al 2006).

Narratives of responsibility were not always so dramatic – in one case of a fetal demise there had been no fetal movement for two days before the woman went to the hospital and was diagnosed with a fetal death in utero. Committee members recommended community-wide education about “kick counts” so that pregnant women were aware they should be tracking and recording fetal movement on a daily basis. This led to a local Healthy Start campaign using magnets, brochures, and radio ads. [Figure 7 – 1].

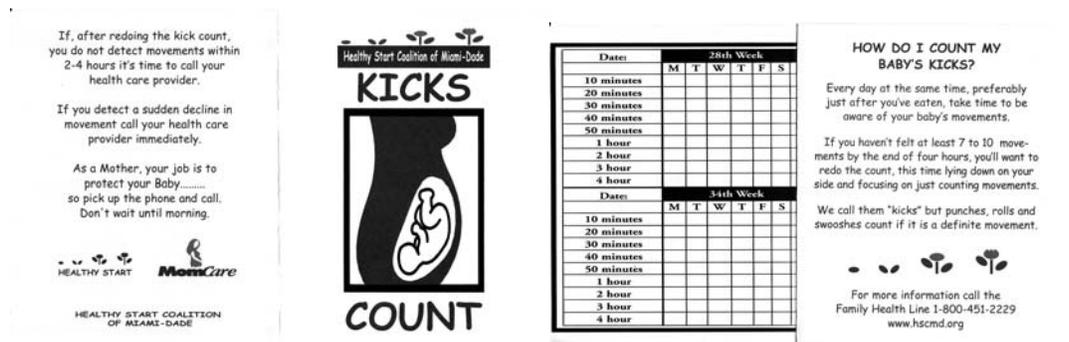


Figure 7–1: “Kicks Count” brochure, Healthy Start Coalition of Miami-Dade

Brochures were distributed to local health department offices, at prenatal care classes, Healthy Start contracted providers, and obstetricians’ offices. While I advocate for strategies to prevent fetal death and other poor birth outcomes, health education strategies such as the brochure above demonstrate how narratives of risk and responsibility have become interwoven with contemporary pregnancy care. While the majority of fetal deaths involve circumstances beyond the control of any woman or physician, pregnant women are increasingly blamed for poor birth outcomes. The “Kicks Count” brochure reminds women, “As a Mother, your job is to protect your Baby,” illustrating dominant discourses about fetal risk and maternal responsibility. The brochure provides a space for tracking movement, requiring that women be vigilant in their fetal (and self) surveillance.

This dissertation has argued that narratives of risk and responsibility are ubiquitous to contemporary reproductive health care in the contemporary United States. Notions of liberal subjects inform these narratives, so that pregnant women are expected to modify their behavior in order to diminish risks to the fetus and take responsibility for protecting their future children. Yet through an examination of the local moral worlds of Haitian pregnant women living in South Florida, I demonstrate that narratives of risk are not hegemonic. While providers and maternal and child health policy makers focus on clinical and epidemiological narratives of risk, Haitian women narrate a transnational landscape of risk and responsibility which informs their experiences in pregnancy and prenatal care. Their experiences and narratives can contribute significantly to a critical examination of the politics of risk and responsibility in reproductive policy in the contemporary United States.

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BIOGRAPHICAL SKETCH

Lauren Fordyce grew up outside of Washington, D.C. in northern Virginia. She went to college at the University of North Carolina at Wilmington where she discovered anthropology and completed a bachelor's degree in that field. After completing her undergraduate degree, she took a couple of years off before continuing on to graduate school. Moving to Seattle, Washington, she took a job working at the Northwest Institute of Acupuncture and Oriental Medicine, which reaffirmed her interest in alternatives to biomedical models of health care. After 2 years in Seattle, Lauren moved to Gainesville, Florida to begin her graduate degree in anthropology. She completed her master's degree in 2001, writing a thesis about maternal mortality in Haiti and Jamaica. Spending a number of years studying Haitian Creole and traveling to Haiti a couple of times led her to develop a research project about Haitian women immigrants and reproductive health care in South Florida. She conducted research in Broward and Miami-Dade Counties for 2 years, and recently returned to Gainesville to complete her dissertation. Lauren plans on a career in academia, while remaining committed to advocacy for reproductive justice both locally and globally.