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Nora Keathley April 7, 2020

Latinx Women and Labor in the Digital Age

Exploring Childbirth and Medical Authority Through the Use of YouTube

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Abstract
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This thesis examines how self-identified Latinx women navigate the institution of medical authority and birth medicalization as it pertains to reproductive care, specifically childbirth, and how they tell stories and share information about their experiences via YouTube. To do this, I consider the group of YouTubers, identified as "mom bloggers," who create and share both vlog-style and testimonial-style videos recounting their experiences in the delivery room. I examine the narratives of these women, and how they navigate authority and medicalization, through the lens of a history of colonization, a force that has widely shaped the medicalization of childbirth in the Western Hemisphere. I argue that, through their considerable command of narrative creation in the medium of YouTube, the women considered here not only create important representations for the greater Latinx community in a sphere dominated by the voices of upper-middle class white men and women, but also share valuable didactic information that has the potential to shape the way in which the people who watch their videos give birth.

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CHAPTER ONE: INTRODUCTION

"It's a scary experience, you know my mom always said…when you give birth tienes un pie on earth and un en el panteón." Speaking animatedly to the camera, glowing under studio style lighting in her minimal yet glam California home, YouTuber Blanca, screen name Evettexo, tells her devoted 700k followers a lengthy story about the birth of her daughter Camila. Generally speaking, when visiting Blanca's channel, the viewer is greeted with a veritable reservoir of makeup and hair tutorials; however, amongst her reviews of the newest eyeshadow palettes lay several notable exceptions to the genre of her channel. In two videos, Blanca shares footage from the labor and delivery room during the birth of her daughter Camila and her son Max, a far cry from her normally scripted and chatty videos of herself applying makeup. Instead of seeing Blanca delicately contouring her face, we see her doubled over in pain as she balances on a yoga ball, her hair in disarray, and her forehead covered in sweat. Like other influencers who have chosen to film and share the most private moments of their lives, Blanca speaks frankly and emotionally about each of her experiences with labor and delivery in a show of remarkable intimacy and vulnerability.

Videos that women film of their labor and childbirth can be strikingly emotional, and are filmed to make the viewer feel as though they are in the delivery room, along for the ride of hard medical decisions, moments of pain and defeat, but also great joy. In these videos, new mothers are also eager to recount in a longer narrative form the particular moments of their birth that were unusually salient. For example, Blanca claps her hands together repeatedly in emphasis as she recounts the moment of her labor when she thought she would not continue, but found the strength to change the direction and thus the narrative of her experience: "I was on that bed and I

was like, I'm a boss ass bitch, I'm gonna fucking do this shit, like I got this, like I was literally saying this out loud, like, Blanca you're a boss ass bitch you got this shit...I kept pumping myself up."

There are many women who fall into the category of the "mom blogger" and who, unlike Blanca, focus all of their online content on their identity as mothers. In the earlier days of the internet, women shared their experiences with motherhood on long form written blogs, but more recently their medium of communication with their followers is primarily Instagram and YouTube. Shifting into the highly visual medium of YouTube has changed how women who document their experiences as mothers represent this experience. Most videos these women make feature a combination of vlog style footage showing the rawer aspects of their daily lives, as well as voice over or testimonial style footage about their lives as mothers. In the case of many women who document their lives online, and especially in the case of women who market themselves as "lifestyle bloggers" or "mom bloggers," they may also choose to upload extensive content on their experiences with pregnancy, labor, delivery, and postpartum life.

Perhaps more important than how this information is communicated is *who* exactly has the ability to represent their experiences regarding motherhood in the age of YouTube. Mediums like YouTube create a channel through which content is widely and, by and large, democratically distributed to the masses. This means that in all genres, whether it be YouTubers who focus on cultural criticism, beauty and fashion, or science and philosophy, individuals have an opportunity to disseminate information on subjects that they did not have a voice on before. In addition, individuals are able to share their personal experiences and narratives in a way that previously would not have reached many people, or only in third-person stories not told on their own terms. In the face of a culture that prioritizes white narratives and usually fails to elevate and project the

voices of women of color regarding reproduction and motherhood, users of platforms such as YouTube have made significant contributions to our wealth of knowledge around motherhood and birth amongst non-white women.

Project Overview

In my research for my senior honors thesis in the Department of Anthropology, I have reviewed the labor and delivery vlogs as well as the testimonials videos of 22 different women on YouTube who self-identify as Latina, all in order to generate a broader picture of the lived experience of Latinx people in the context of reproductive care as represented by their respective narratives. Through access to these two types of videos, I have been able to analyze how women create structured narratives of these medical events in their "raw" vlogs, as well as how they represent their perceptions and memories of the event and its effect on them.

I have chosen to focus on Latinx women because of my studies in Spanish and my deep investment in equitable access to quality healthcare. The Latinx community in the United States faces some of the greatest barriers of access to healthcare, the lowest rates of insurance coverage, and an appalling lack of consistent preventative primary care (Office of Minority Health, 2019). Not only does the Latinx population often receive insufficient translation services, but accessible clinics can be few and far between (Eamranond, 2011). Even when care is accessible, many Latinx people feel that they receive inferior care and that their pain is not taken seriously (Carrasquillo, 1999). Furthermore, there is a wealth of evidence documenting the troubling reality that women of color face higher rates of maternal mortality and higher rates of complication during childbirth (Rabin, 2019).

This digital-based ethnography seeks to expand upon the knowledge of what it means to be pregnant and give birth as a non-white woman in the United States. To do this, I employ an

ethnographic style of research and writing, relying on the fairly recent technique of collecting data that individuals self-report to the internet. In this project, I try to present in an academic context the lived experience of giving birth as a Latinx woman in the US by using data that is already available and made public by the women whose experiences my writing aims to highlight.

Within a review of the literature relevant to this project, I will review feminist film theory and explore what it means to be a filmmaker and a creator in the age of streaming video, a time when easy access to an iPhone camera and a YouTube account can allow an individual to widely disseminate their filmed product. I will go on to review the theory on colonial aspects of medicine, dating back to the colonization of the Americas, as a means of tracing the process of the medicalization of childbirth, and I will consider how this affects the reproductive care experience of women of color today, as applied to the women who create the videos that are the subject of this research.

My initial research question for this project focused on how Latinx women made decisions regarding the healthcare that they received surrounding pregnancy and childbirth, and how they felt about the decisions that they made and the care that they received. I hoped to interview a series of women who had recently given birth in Atlanta and who identified as part of the Latinx community. However, I ultimately chose to work with YouTube videos of "mom bloggers" because of my own discomfort regarding my initial data collection strategy of speaking directly to women in the field. Soon after I received my IRB approval and began recruiting subjects for my project, it became apparent that women would not be eager to talk to a perfect stranger about one of the most intimate experiences of their lives, much less with someone from far outside their community. I want to be clear that I did not proceed to

aggressively recruit for this project not because I think that this research is unimportant. I believe it is inherently important that those in the healthcare system, as well as our broader community, have lengthy conversations about what it means to be a woman of color and give birth in this country. I feel it is particularly important to add to the literature on the experience that women of color have while giving birth, apart from the fact of their mere survival, for the implication that survival is the extent of what women of color deserve is dehumanizing. But I did begin to question my own role as an observer, a researcher, and an advocate. Over the winter break, I spoke with an anthropologist outside of Emory whom I consider to be a mentor. She reminded me that it is acknowledged in Anthropology that the presence of an observer changes the environment that they are observing, and that in some ways this is the trade-off that is made for adding important work to the academic literature. While I think that this has been part of the tradition of anthropological research and is not always problematic, the most common conversations that I have had this year with my thesis cohort in the department of Anthropology have been about the changing ethics and ideals of cultural anthropology, and how we want our theses to reflect what we see as being the future of quality and respectful anthropological research. Ultimately, even though my project would have added to literature that I believe to be very important, it was not appropriate for me to continue to recruit in spaces where my presence as a white woman was clearly disruptive.

I hope to pursue a career in obstetrics, and this thesis centers on the subject of labor and childbirth because of my fascination with the medical and cultural aspects of the experience. Considering my interests, it is likely no surprise that I was aware of the presence of labor and delivery videos on YouTube long before I shifted my project in this direction. Eventually it occurred to me that, just as there are other subsets of the mom blogger community (e.g., religious

mothers, vegan mothers, off the grid mothers, etc.), there was a reasonable chance that there was a community of women who made their identity as Latinx mothers a central part of their YouTube channels. I was thrilled with the breadth of content that I found.

It told me something when, in seeking interest for my study, it was only white practitioners who worked with the community who were willing to speak with me, and not those from within the community themselves. The intent of this thesis was not to summarize or give voice to practitioners who work with the Latinx community, or to focus on their categorization of reproductive care, but rather to center on the patient perspective, and the complex lived experience of being a Latinx mother seeking healthcare in the US. My approach intends no disrespect to those who pursue cultural anthropology research that involves their integration into a group to which they do not belong. Mine is rather a personal decision, based on the direction in which I hope to see cultural anthropological research progress, but also based upon the fact that I was able to access the data that I hoped to analyze and write about in another way. YouTube videos gave me an opportunity to feature these voices in a robust way that I could not have attained from traditional interview style research. Taking these concerns into consideration, I now focus my research on how the Latinx woman YouTubers included here create narratives of their birth experience to share, why this narrative creation is important, and what it can tell us about the state of giving birth as a Latinx person in the United States. I hope that the methodology that I used to answer my research questions and add to the anthropological literature can also serve as proof that, particularly in the digital age, many questions that anthropology seeks to explore can be answered – and, arguably, can be answered more accurately – without the infiltration or exoticization of different communities.

In the following chapter, I will review the literature on what it means to have a successful birth, and why. As there is more reporting on the maternal mortality problem within the United States it is important to expand this definition, because while it is crucial that we are calling attention to the harsh reality of maternal mortality, when we define a successful birth as mere survival we accept the reality of negative experiences or other reproductive rights violations for women of color in particular. I will also trace the history of colonial medicine in the Americas as it pertains to childbirth, as a means of emphasizing the highly cultural roots of the process of childbirth medicalization. I will discuss literature on how we can understand birth as a ritual process, equally so in its medicalized form, and highlight the consequences of the attending care women are offered during the course of this ritual, and the long-term implications of this for the mother. Most importantly, I will focus on how the medicalization of birth was, and still is, a cultural process with a culturally convenient endgame in the way that it helped, and continues to help, perpetuate colonial attitudes towards women's bodies, particularly the bodies of women of color.

CHAPTER TWO: LITERATURE REVIEW

How Do We Define a Successful Birth?

There is now a breadth of literature emphasizing the fact that a "successful" birth experience should amount to more than merely the survival of mother and infant. According to Dr. Neil Shah of Harvard University, "It is important to remember that people have goals other than simply emerging from childbirth unscathed…Safety during labor is the floor of what people deserve. What we should all really be aiming for is the ceiling: care that is not just safe, but also supportive and empowering" (Haelle, 2019). There is substantial evidence that the birth and postpartum experience is psychologically informative for a woman's future (Simkin, 1991). As *Reproductive Health* reports, "A traumatic birth can have serious impact on postnatal mental health and family relationships. Short-term consequences of adverse experience of care include pain and suffering, and long-term consequences cited in the international literature include post-traumatic stress disorder, fear of birth, negative body image, and feelings of dehumanization" **(**Vedam, 2019). The threat of psychological implications places even greater importance on identifying and practicing methods of care that minimize negative experiences around childbirth. However, as of yet, research on the psychological importance of the birth experience has centered on populations of middle- and upper-class white women. The current demographic represented fails to capture how cultural, racial, and socioeconomic differences also have an impact – not just on maternal mortality rate, but on the overall experience of pregnancy and childbirth.

As most people who give birth report, the hours of labor and childbirth are a highly salient emotional experience for the mother. Many women remember this experience as one where they demonstrated their strength and confidence, and where they felt deeply in control of

and connected with their bodies. In this way, giving birth can be extremely empowering, and can result in long term self-confidence. Midwife Peggy Simkin's study on women's long-term self-perception based on their labor and birth experience confirmed what many women already reported anecdotally: that the experience of giving birth, the power one has in that experience, and how one is treated, all have long term effects on women's self-perception. Simkin opens her paper, "The birth of a woman's first child has an enormous lifelong impact one her" (Simkin, 1991: 203). To prove this assertion, Simkin followed a group of women who enrolled in her childbirth class, completed reviews for the class, and later sent her a report on their labor experience following the birth. Simkin followed up with this same group of women 15 to 20 years later, asking them to reflect on their birth experience and how it had affected their lives going forward.

The first thing that Simkin noted in her study was that women had a remarkable memory for specific details of their birth experience – what happened at a specific time, or what a doctor or nurse said to them, and how it made them feel (Simkin, 1991: 209). Furthermore, Simkin reported that, in general, women who had more positive birth experiences left feeling more confident and self-assured, and this self-experience translated to other parts of their life, and not only in the short term. Unfortunately, the same was true for women who had negative experiences during labor and delivery. For example, as I saw in my own research, when Blanca reflects on her choice to have an epidural during the birth of her first son, she says, "I was very sad, I was very disappointed in myself...I wanted to do that for myself and just give myself that thing, that makes me just feel like, you did that, you were able to do it, mind over matter". This comment presents a stark contrast to the feeling that Blanca describes when she recalls the experience of her second birth with her daughter Camila, during which she opted not to use the

epidural: "you just feel this emotion where you can't even explain it, but you go from like being in excruciating pain to yourself again, like I felt so normal, I felt like myself...I was floating...I'm looking at my daughter and I'm just like, I did this".

The conception of my senior thesis is largely a response to Simkin's study and the studies that it inspired, but also the shortcomings of Simkin's work. That study, and many studies that have continued Simkin's work, focus almost exclusively on upper and middle class white women. I hope that the data I collect this year can begin to rectify this gap in the literature, by highlighting the narratives of self-identified Latinx YouTubers from a variety of socioeconomic backgrounds who use the sphere of YouTube both to narratively recount their experience with labor and birth, as well as be part of a new kind of channel for sharing didactic information with other women in their community as it pertains to reproduction and birth. The way in which the medium of YouTube and the work that these women create offers a valuable alternate both in terms of recounting experiences with a community as well as sharing information and opinions in a way that shapes how other women approach birth, is the subject of my qualitative analysis for this project.

Historical Lens

The high rates of maternal mortality for women of color cannot be divorced from a history of gynecological violence against women of color, and a history of oppression and sexual violence against indigenous women in the Western Hemisphere. Biases in gynecological care and violence in these fields has been well documented in countries such as Mexico (Castro, 2003). Meanwhile, in the US, there are fewer studies documenting such phenomena in the field of gynecology and obstetrics, despite a similar and connected history of colonization, oppression, and violence. To examine how colonization is deeply entrenched in current practices around

childbirth and motherhood for women of Latin American descent, I will conduct an in-depth analysis of cultural shifts in colonial Mexico, and how these accompanied, and are reflected in, childbirth medicalization.

In the 1990s and early 2000s, anthropologists and public health officials proposed and celebrated a method of "culturally competent care" as a way to reduce the inferiority of care that minorities reported to receive. Culturally competent care entailed a push to educate physicians and other healthcare providers on how differences in a patient's culture affects their experiences and interactions with their own health as well as the healthcare system. In recent years, however, much of anthropological literature has reflected that the cultural competency method, while well intentioned, has failed to reduce gaps in care for minorities and those of other cultures (Hester, 19). In short, like much of the minority population, Latinx women continue to receive insufficient care, and this is because the cultural competency method does not rewrite a system of medicine that reflects the violence of colonialism. To establish how colonization continues to affect medicine, and specifically childbirth, for women of Latin American descent, I will review literature on childbirth in the Old and New World, colonization, and how Old World cultural ideals that promoted colonization came to be reflected in New World medical systems around birth, a medical system which is still in use today.

While all instances that require medical intervention are undeniably deeply entrenched in not only scientific but also cultural beliefs, perhaps no experience embodies this fact better than pregnancy and birth. Women have had assistance in the birth process, mainly from other women close to them, across the world and throughout documented history. Anthropologists eagerly note that some of the earliest art forms depict women pregnant, in labor, or giving birth. The connection between mother and child has been treated alternately as sacred, natural, and

political, including in many nation's highest courts, where landmark decisions have been made regarding women's reproductive agency. The reproductive practices and attitudes of each country or region are affected not just by access to care, globalization, and scientific discovery, but also by unique cultural traditions. Because of these differences in tradition, it is particularly interesting to examine reproduction and birth practices and attitudes in a time and place where sudden cultural shifts have taken place, and to consider how these monumental changes radiate into healthcare practices today. Perhaps no moment in history embodies this shift better than the initial contact between the Europeans and the Americas and the ensuing period of colonialism. While medical practice and reproduction were undoubtedly changed by the interaction of scientific knowledge between Old and New World, I argue that a bulk of this shift in medicalization of birth in the New World was the result of changing cultural ideals and power structures bought about by the introduction of Catholicism and *marianismo*, and by a gendered and racialized understanding based on the colonial schema of the indigenous body as inherently flawed. I believe that we still see the violence based upon these cultural assumptions today, not only in Latin America, but also in the healthcare Latinx women receive across North America.

I will use Mexico as a case study for reviewing the historical and theoretical background because of my personal interest in and prior reading on the region, and because of the breadth of colonial medical texts and accounts conserved from this region. Throughout this work, I will return to three central assumptions. The first is that "medical" birth, something we posit as being influenced exclusively by science and scientific need, is in fact deeply entrenched in culture, and that medicine reflects a culture of colonization and Old-World ideals. The second is that, because of the entrenched colonial ideals reflected in medicalized birth, the care Latinx women receive is often violent. Thirdly, this essay will also rely on the assumption that birth is an important

experience in a woman's life both medically as well as psychologically, and that long-term implications of the birth experience differentiate the medical experience of reproduction and birth from other moments of medical intervention throughout the lifespan (Simkin, 1991). I will also make the point, upon this understanding of the salience of the birth experience, that it is crucial that attention be given to reducing negative birth experience, and focusing such efforts on the women who are most likely to suffer these negative experiences.

Birth as Ritual and the Liminality of Labor and Delivery

Women's choices surrounding reproduction are based on more than medical opinion, and this medical opinion is in turn based on cultural beliefs. In Claudia Malacrida's essay "Competing Discourses of Motherhood, Sexuality, and Selflessness", she reflects on the interview-based study she conducted with recent mothers regarding their birthing choices. One of the major conclusions of the study is that, "The women's interviews indicated that their birthing choices are reflective of tensions embedded in normative femininity; conflicting ideas relating to purity, dignity, and the messiness of birth; and contradictions about women's bodies as heteronormative sites of pleasure and sexuality on one hand and as asexual, selfless sources of maternal nurturance on the other" (Malacrida, 748). Malacrida's observations in her 2012 study provide a framework through which to examine women's choices around reproduction and birth as ones that are complicated, not merely by the abundance of medical information they receive while pregnant and reproducing, but also by the unique cultural ideals surrounding the kind of power and worth that purity signifies in their culture, and what sexual and, in turn, reproductive ownership of their body looks like. Using this framework, we can understand reproduction and childbirth not only as a major medical and life history event for a woman, but also as a performative cultural and ritual experience.

When examining how anthropologists define "ritual," it becomes evident that labor and birth can be understood as ritual practices, and specifically that the process of labor and birth can be seen as a state of liminality for the pregnant and birthing person. According to anthropologist Arnold van Gennep, we can divide rites of passage into three key stages. These stages are separation, liminality, and incorporation. I argue that birth and labor are interesting and important specifically because of the fact that they exist in this borderland or liminal space (van Gennep, 2004). As van Gennep would argue, what occurs during the ritual in the stage of liminality forms the basis for the subsequent moment of incorporation, in this case the new status as "mother," thus establishing a new way of self-identifying and interpolating oneself. The idea of liminality as part of a rite of passage is a more theoretical way of understanding the importance of what transpires in the labor and delivery room during this moment of liminality and transition. It also offers a theoretical backbone to what Simkin observed in her study regarding how the experiences of women in labor and delivery continue to shape their sense of self for decades into the future. Understanding the importance of this state presents an interesting question: what then is the significance of the actions and interactions of practioners and observers, as well as the pregnant person themselves in these liminal spaces, and how do these actions then affect the pregnant person's experience of self-reconstruction? This indicates that those who take part in this rite of passage, whether they be close loved ones and those from the immediate community, or medical professionals, contribute to the eventual incorporation of this experience into a woman's self-identity.

While "rituals" surrounding birth are more likely to be explored in essays on historical accounts of birth, or in countries that the global north considers to be "less developed," it is clear upon examination that no matter where or how someone gives birth, this event can be interpreted

as a cultural performance. In her essay, "Re-inscribing the Birthing Body: Homebirth as Ritual Performance*",* author Melissa Cheyney discusses homebirth practices in the United States to show how they are "intentionally manipulated rituals of technocratic subversion designed to re-inscribe pregnant bodies and to reterritorialize childbirth spaces (home) and authorities (midwives and mothers)" (Cheyney, 519). The quote from Cheyney's work reflects how she believes home birth is one way to change the ritual of childbirth, and it does well to establish the understanding that childbirth in general can be understood as a ritual in any number of contexts, and that both the content of this ritual and the cultural ideals it specifically informs can have an effect on the experience of the mother.

Cheyney goes on to reflect on Robbie Davis Floyd's anthropological work on ritual from the 1990s and her belief that, "childbirth, as it has been performed since the industrial era, is not simply "evidence-based medicine" but, rather, a reflection of a larger patriarchal and technocratic society that constructs women's reproductive bodies as inherently faulty and in need of medical management" (Cheyney, 520). Cheyney and Floyd argue the belief that this shift in childbirth begins in the industrial era. I will examine the work of scholars such as Nora Jaffary, who make a case for changing birth rituals in colonial Americas, specifically Mexico. I will build upon Jaffary's work by arguing that this colonial framework of birth ritual is still visible today, including in communities in the United States.

Pre-Colonial Birth

To understand how practices and beliefs surrounding reproduction and childbirth have changed since pre-colonial times, we must first understand the tradition of reproduction and childbirth in Mexico before colonial intervention, and how this pre-colonial system of medicine reflected certain cultural ideals. In Nora E. Jaffary's text *Reproduction and Its Discontents in*

Mexico, the author presents information on the pre-colonial medical and cultural practices around reproduction and childbirth. It is important to acknowledge that documentation about pre-colonial medicine is contained in few texts, and thus one must be careful about making broad generalizations regarding the nature of reproduction and birth in the precolonial era. Knowledge of what occurred and was common practice during reproduction and childbirth in pre-colonial Mexico is primarily derived from the accounts of Bernadino de Sahagún, specifically his most famous work, *Historia general de las cosas de la Nueva España,* where the friar catalogued and summarized pre-colonial texts and history of central Mexico. Sahagún's accounts also elaborate extensively on pre-colonial medical practices, specifically in the Florentine Codex. A quick browse through the Florentine Codex, a document containing roughly 2,500 illustrations of plants native to Mexico and their traditional uses, clarifies that the Nahua system of medicine, in particular, followed a kind of organization and empiricism it is not always credited with. Furthermore, recent studies have established that many of the plants used and detailed in both the Florentine Codex as well as the Códice de la Cruz Badiano --another text that details pre-colonial medicinal plant usage as summarized during the colonial period-- do in fact have applicable pharmacological uses, proving the scientific merit of at least part of the Nahua system of medicine (Gimmel, 2008). It is clear from Sahagún's text that knowledge of plant use for reproductive purposes was well understood and established in the pre-colonial era.

Jaffary's accounts, as well as the accounts of botanists and medical anthropologists, confirm that this pre-colonial knowledge about therapeutic botanicals transferred to, and was incorporated into, colonial and postcolonial reproductive care. It is evident that this knowledge system prevails even in contemporary medicine in C.H. Browner's 1985 ethnographic account detailing a community in San Francisco, Oaxaca, "The use of herbal remedies for the treatment

of reproduction and the management of reproduction is still nearly universal in San Francisco, despite the fact that the Mexican government operates two health centers in the head town, one of which offers inpatient facilities including prenatal and maternity care" (Browner, 485). Browner also provides a detailed analysis of what herbal remedies are used at each stage of pregnancy, and what percentage of the population utilizes each of the documented remedies. From this survey, Browner concludes that, "Despite the availability of modern medicines, herbal remedies are strongly preferred for use during all phases of the reproductive cycle and for the treatment of female reproductive health problems" (Browner, 492). Here, Browner confirms a central argument of Jaffary's book on reproduction in Mexico, that in spite of large regime changes and shifts in medical authority, important elements of precolonial medicine prevailed into the postcolonial and contemporary period.

Issues of Authority

One principal difference that has been documented regarding reproductive beliefs in pre-colonial Mexico, as opposed to beliefs in pre-colonial Europe, are those regarding the moment of conception. In *National Geographic*'s short informative article on Aztec reproductive beliefs, the author begins, "Where do babies come from? The Aztecs' answer to the classic child's question was that they came from the 13th heaven – the highest heaven of all. Here, in this store of unborn souls, they waited until the gods decided to place them in their mother's belly" (Molina, 2017). Futhermore, in precolonial Mexico "Los nahuas asumían la procreación como una responsabilidad compartida…piensan que el feto formado a partir de las semillas de ambos padres se alimenta de semen" (Alcántara Rojas, 2016: 38). Reproduction was not merely considered to be a shared responsibility between parents but a responsibility of the entire community if they were to ensure a healthy birth, "Si algo dejan en claro los siete discursos que

se pronunciaban en esta ocasión es que el primer embarazo no era visto como un asunto individual que sólo competiera a la mujer involucrada, sino como un proceso de carácter social, del cual dependía el mantenimiento de un linaje, y en el cual debían participar por igual la preñada y su esposo y los padres y las madres de ambos para que éste tuviera un buen término" (Alcántara Rojas, 2016: 40). Here, Alcántara Rojas establishes reproduction and birth as a somewhat public and communal affair in pre-colonial Mexico, in addition to its transformative ritual aspect for women, who emerged from labor venerated as warriors.

These accounts of pre-colonial birth come in some contrast to one of the primary assertions of Jaffary's book, that a major shift in postcolonial notions around reproduction and birth was from a private to a public matter (Jaffary, 2016). Jaffary makes a convincing case for this shift in where birth is regulated by looking at how reproductive "infractions" were dealt with over the course of the colonial period. Mainly by examining legal records and by looking at the kind of testimony and sentencing that certain reproductive "infractions" warranted, Jaffary is able to assess over time how the state of Mexico (and, presumably, its people, since most of the crimes cited were reported to the authorities by those in the community) processed and saw fit to punish abortion, infanticide, midwifery, and the violation of virginity. Jaffary argues for a trend in postcolonial Mexico where matters of reproduction, childbirth, and the female body moved from being a matter of privacy to one considered of concern to the public, and one that could and should be regulated by the public. However, reflecting upon the accounts of Alcántar Rojas, as well as other accounts of pre-colonial birth, it appears that perhaps the major cultural shift around reproduction and birth in the colonial era is not with regards to privacy. Jaffary's argument that Old World views imported during colonialism affected practices and attitudes around reproduction and birth in Mexico is a sound one.

Looking at the evidence offered by Jaffary and others, I argue that an alternate possibility is that there was not so much a shift in attitudes and privacy around birth, as there was a shift in understanding of who was the authority in the sphere of birth and reproduction. The issue of authority over the reproductive body is one that the women in this study grapple with, and one that the larger world continues to navigate both within the medical field and beyond. In fact, who possesses central authority over the reproductive body is perhaps one of the most contentious political issues as it pertains to abortion, but is also one that is played out in the relatively more private sphere of the physician-patient interaction. This shift in authority through colonialism and the medicalization of childbirth is crucial to understanding what it means to give birth in the Western Hemisphere today, specifically as a Latinx woman.

To assess the potential accuracy of this argument, one must look both to the evidence from pre-colonial Mexico as well as from pre-colonial Europe. Multiple pieces of evidence from precolonial and later scholarship indicate that, in pre-colonial Mexico, mothers and midwives were treated as the central authority over the birth experience and the female body. For example, in Alcántara Rojas' work, she centers the birth experience around mother and midwife. She also solidifies the mother as a central authority figure in the birth by citing Sahagún's account of birth as a moment where the woman reaches a state comparable to a warrior and, furthermore, that in this moment mother and midwife retreat, reflecting that they are the central authorities and the only people necessary during the birth experience, "Al sentir los dolores que anunciaban el parto, la mujer, que hasta ese entonces había vivido vigilante y vigilada, tenía que asumir en soledad, auxiliada nada más por la partera, su nuevo rol social de "mujer guerrera"; una mujer fuerte, capaz de vencer o morir, merecedora del honor de criar a sus hijos o de acompañar diariamente al sol en su lucha cotidiana por renacer del "lugar de los muertos" (Alcántar Rojas, 2016: 42).

This account of Nahua women as being venerated as warrior-like is important for considering how, despite gendered roles, in pre-colonial Mexico women had an authority position during childbirth comparable to the position of men in battle – a position that elicited great respect from their community. These observations are similar to those presented by Cheyney in "Homebirth as Ritual Performance," that authority is a crucial part of a ritual framework. In this essay, the author states that part of the reason that homebirth can be a meaningful and powerful ritual is the fact that it repositions the ritual of medicalized birth and re-inscribes the mother as the authority over her own body. This idea that mothers are the authority and have the best knowledge of their own body is one of the beliefs at the center of the natural birth movement, held as a way to contest what is seen as a fault of the medicalized birth system.

In early modern Europe, woman also delivered primarily at home and with the assistance of a midwife (Kontoyannis, 2011). By certain criteria, midwives in Europe occupied a similar role to the Mexican partera: they assisted women within their communities through the prenatal experience, the birth, and for roughly one month postpartum; they received no formal training and instead learned through birth experience; and most worked informally, assisting when someone in their community required birth knowledge. Looking at this information, it would seem that the experience of birth in the Old and New Worlds was not notably different, particularly as it pertains to authority. A midwife and mother were the main actors in the birth performance in Europe as they were in Mexico. However, the matter of authority comes into question when one considers the oversight and regulation of midwives in Europe, as well as their social standing. Per Maria Kontoyannis and Christos Katsetos's essay on midwifery in early modern Europe, "The church, especially the Catholic, encouraged midwives' public role. This way they had the opportunity to control subjects through midwives' helping hands"

(Kontoyannis, 2011: 32). This understanding of midwives' role within the context of a larger religious agenda in early modern Europe changes the schema of authority within the event of childbirth and replaces mother and midwife as authority figures with the authority of the Church instead.

Marianismo, The Catholic Church, and Issues of Female Purity

A second shift in ideology that took place as a result of colonial culturalization was with regard to what it meant to be a good mother and a good woman in Mexico. This shift is reflected not only in the colonial record, but also in a breadth of literature that addresses how these cultural shifts continue to shape the experience of being a Latinx woman today. In the first chapter of qualitative analysis I will emphasize how women use genre conventions of birth vlogs to emphasize to the viewer the presence of a strong heterosexual family unit, presenting a somewhat narrow picture of the role of woman and mother in the family. It seems that at the time in pre-colonial Mexico, much like in Europe, being a good mother and a good woman were identities that were almost always intertwined. Robert Stable, in an outdated but nevertheless valuable 1971 paper on the Mexican family, offers valuable insight into how familial structure, and authority within this structure, changed with colonization. He writes, "The colonists of New Spain brought with them a highly integrated pattern of social life, built around the family and the church. Each of these institutions aided and supported the other; both were authoritative" (Staples, 1971: 179). He goes on to reflect even more explicitly, "In the Spanish culture, the role of the woman has always been a subordinate one" (180), and argues that these ideals are also present in the culture of postcolonial Mexico.

Reflecting on familial and gender roles brought from the Old World to colonial Mexico, Stable determines that colonizers brought with them defined ideas about gender and motherhood. Thankfully, we have more extensive written texts from pre-colonial Europe that offer deeper insight into ideals of women and mothers. Firstly, as Stable notes, issues of the family structure and of women's role and authority were informed by, and in many ways overseen by, the ideals of the Catholic church. It is useful, then, to examine how early modern Catholicism defined a good woman and a good mother, and how this affected cultural beliefs. Perhaps the largest takeaway from Catholicism in this period is that being a well-regarded woman entailed the state of motherhood. This is a concept that scholars refer to as "marianismo." Marianismo refers to a movement within early modern Spain, as well as other Catholic countries, where the Catholic community held an overwhelming veneration for the Virgin Mary, sometimes to the degree greater than the veneration for Christ and God, to the dismay of certain authorities within the Church. Marianismo first received critical attention in a 1974 essay by Evelyn P. Stevens, where she details not only how Mary came to be venerated in Catholic communities, but how this veneration of the Virgin, and the characteristics for which she was celebrated, translated to expectations for women. The most celebrated characteristics of the Virgin Mary, which were then elevated as important attributes of femininity, were piety and a commitment to faith. Women can demonstrate this commitment in their role as virgins – establishing their purity of both body and mind – and then later in life in their role as mother and caregiver. Stevens notes that marianismo made its way from early modern Europe to the New World: "Tanto el marianismo como el machismo son fenómenos del Nuevo Mundo con antiguas raíces en las culturas del Viejo Mundo. Muchos de los elementos contribuyentes pueden encontrarse en aún hoy en Italia y en España" (Stevens, 1974: 18). On the one hand, marianismo links maternal

qualities with feminine qualities: purity, selflessness, self-sacrifice, subordination. On the other, hand, women might recognize in marianismo qualities of autonomy and authority, especially over their own bodies and reproduction. The former of these two has historically dominated in Western culture, but many young women in the present look to the latter features of strength and self-determination that Mary also embodies.

Childbirth Medicalization

These ideas transported to the New World about motherhood, purity, and autonomy made their way not only into colonial culture, but into medicine, specifically the way in which childbirth was medicalized in the colonial and postcolonial era. Several major shifts in cultural mindset occurred that are reflected in the process of childbirth medicalization. The first are issues of authority and gendered roles already reflected upon, but perhaps the greatest manifestation of this shift was that from female midwives to gynecologists and obstetricians. In Jessica Martucci's paper for the AMA Journal of Ethics, *Beyond the Nature/Medicine Divide in Maternity Care,* she emphasizes, "The transition away from the traditions of lay midwives and social childbirth in the home towards university-trained male midwives and, later, obstetricians was one that proceeded gradually during the 17th through the 19th centuries as the medical profession grew along with its knowledge base and its cultural authority and prestige" (Martucci, 2018: 1169). With this transition from female to male practitioners and to the professionalization of medical practices, delivering babies and assisting in female reproductive care was suddenly viewed as a far more respectable career, while it narrowed the space for female practioners.

Furthermore, in the process of establishing childbirth as part of academic medicine, the new medicalized system of childbirth worked to create a more standardized system of care that

was used to increase efficiency for practitioners in the birthing process, and also to solidify the new authority of the practitioner, emphasizing that childbirth was an event that necessitated the intervention of a medical authority. We see this push for "efficiency" in childbirth perhaps most obviously today in the extensive use of induction methods, such as administering Pitocin to induce contractions, and interventions such as c-sections made during "stalled labor" a term that is medically poorly defined. Feminist scholars have reflected extensively on how certain rituals incorporated into the system with the medicalization of birth, rather than serving as necessary evidence-based medical interventions, have served as a means of controlling women and asserting authority (Cahill, 2001). Perhaps the most obvious example of this ritual control is the birth position and the use of stirrups during childbirth (a position that many of the women in the videos reviewed here assume during their labor and delivery).

Prior to the medicalization of childbirth, few women chose to give birth supine, and most opted for a squatting or kneeling position instead, sometimes aided by the support of a birth stool or assistance from birth attendants (Cahill, 2001). Giving birth in a more upright posture is medically advantageous for several reasons. Firstly, it allows for more freedom of movement, particularly of the hips, which not only helps to advance labor by allowing the fetus to descend station in the pelvis, but can also help to relieve the pain of contractions. But beginning in the colonial period and into the modern era, women have been expected to give birth lying on their backs, with their feet suspended in stirrups that extend from the hospital bed. As has been established by many studies, in reality not only does this position serve no medical purpose, it can actually lead to slowed and more painful labor (Ondeck, 2014). Feminist scholars argue that the true necessity of this position is the necessity of practitioners to maintain authority over women and establish control over their patients. In many hospitals to this day, it is required that

women give birth supine in the hospital bed, and in almost all facilities this is the default position during childbirth.

Lack of Intersectional Perspective

While feminist scholars have established an academic thread of examining ways in which the medicalization of childbirth has functioned as a patriarchal technology – examining increasing cesarean section rates, increased birth interventions, birth position, and pelvic exams during delivery – there is a lack of literature examining how these same elements of medicalized childbirth can be understood from an intersectional perspective, not only as patriarchal, but as a colonial technology. In the same way that restriction of the birthing position can be understood as a way to control the agency of, and thus take authority away from, women during the birthing process, it can also be understood further as a way to take authority from women of color. If looked at from an intersectional perspective, bearing in mind the history of colonialism, certain practices take on further meaning and can be viewed not only as a ritual of gendered oppression, but one of colonial oppression as well. For example, the restriction of movement of women of Latin American descent (e.g., women of indigenous and African descent, as well as European) is made more complicated by the historical abuses, specifically sexual, that this population has experienced. This is made even more complicated by the fact that women of Latin American descent not only continue to suffer this violence but are historically the product of sexual violence initiated by European colonizers against their indigenous ancestors. In this way, these women's agency, respectability, and value have historically been reduced by colonial culture, and this is further reflected in the culture of medicine. Just as many aspects of patriarchal culture continue to affect women in our rituals today, as in the case of medicalized birth and the tradition of "managing" women, aspects of colonialism and its abuse of indigenous women continue to

play out in these very same rituals. When a woman of color, and in this case a woman of Latin American descent, gives birth, her potential for a positive birth experience is mitigated by this multifaceted history of oppression that has constructed the kind of medical care that she is receiving.

This is not to ignore the positive aspects of medicalized childbirth, which have no doubt saved a huge number of mothers and their babies. Indeed, even the mastery of large forceps during obstructed labor helped to decrease certain instances of maternal mortality (Gülmezoglu, 2016). Further, while today's c-section rate is generally acknowledged as being much higher than is necessary (meaning that many women are needlessly receiving an invasive procedure), the ability of doctors to intervene and obtain positive outcomes during risky pregnancies, or births that become an emergency medical issue, is remarkable and should be celebrated (Roth, 2012). But these advantages should not obscure the harm often done by the unnecessary medicalized childbirth routinely practiced today.

Giving birth today and reproductive justice: an incomplete picture

For a woman of color in the United States, as well as in Latin America, giving birth today is oftentimes violent in ways even more explicit than the entrenched biases and colonial ideals of the general health care they receive. Doctors' choices in the delivery room are heavily influenced by the pressure to deliver efficiently and often to manage many laboring women at one time (Roth, 2012). Sadly, too often these institutional pressures, along with healthcare professionals' own priorities and biases, result in certain women receiving inferior care. A glaring example of this can be seen when we consider who is getting cesarean sections most often in this country. In Louise Marie Roth's essay, "Unequal Motherhood: Racial-Ethnic and Socioeconomic Disparities

in Cesarean Sections in the United States", the author writes, "The results suggest that high cesarean rates are an indicator of low-quality maternity care, and that women with racial and socioeconomic advantages use them to avoid medically unnecessary cesarean deliveries rather than to request them" (Roth, 2012: 207). Secondly, she reports, "The analysis reveals that non-Hispanic black, Hispanic/Latina, and Native American mothers are more likely to have cesarean deliveries than non-Hispanic white or Asian mothers" (Roth, 2012: 208). Furthermore, increasing c-section rates cannot be divorced from the higher maternal mortality rate that women of color face: "Three of the six leading causes of maternal mortality are associated with cesareans: hemorrhage, complications of anesthesia, and infection" (Roth, 2012: 208). While the American College of Gynecology and Obstetrics has recommended that women have a doula or midwife to advise about birthing choices and to thus help reduce traumatic birth outcomes, most women do not have access to these resources and, in addition, many hospital environments are not welcoming of additional birth support (ACOG, 2017).

Though violations of reproductive rights have been reported on extensively in what the United States would regard as less developed countries, in the last five years more reporting has turned inward, to examine how the United States continues to fail domestically. In a recent report from NPR, the reporter summarized, "Reports from the U.S. included such things as women saying they were coerced into having a Cesarean section, and women reporting racism and discrimination. The report also noted a Human Rights Watch report saying that pregnant women have died while being detained in U.S. immigration facilities" (Brink, 2019). The article goes on to cite an interview with Cheryl Moyer: "This is not a problem that is confined to low-resource settings," Moyer says. "The manifestations may be slightly different, and the magnitude may be different, but it is safe to say that the women with the least power – those who are young, poor,

uneducated or from a racial or ethnic minority group – are often those at highest risk of maltreatment during labor and delivery" (Brink, 2019). Current evidence such as that contained in the NPR article about who suffers the greatest cases of maternal mortality and gynecological abuses supports many of the ideas central to Loretta Ross's work on reproductive justice. The basic claim of Ross's book, *Reproductive Justice: An Introduction,* is that access to "material resources is justified on the grounds that safe and dignified fertility management, childbirth, and parenting together constitute a fundamental human right" (Ross, 2017:10). As Ross says – and as is evidently still an element embedded in reproduction today – "women of color have been targeted in distinctive, brutal ways across U.S. history" (Ross, 2017: 11). This has been reflected further in the way that "reproductive capacity has constituted both a key engine for white power and wealth historically and a touchstone for those who want to distinguish the 'value' of women's reproductive bodies by race." (Ross, 2017: 11). Ultimately, since the colonial era, "the reproductive options that fertile people have are always structured by the resources they have – or do not have" (Ross, 2017: 11). In this way, race, as well as what certain groups of people have suffered as the result of colonialism, is not only involved directly in the creation of the medicalized system of birth, and thus in what our modern medical system looks like today, but in our highly stratified society it can also represent a lack of resources that "constitute a catalog of reproductive injustices: they name the reproductive dangers that many persons experienced in the past and that many continue to experience, in updated forms, today" (Ross, 2017: 13). Recent developments in technology, however, have afforded a move away from these inequitable medicalized systems of birth and labor to ones guided by a sharing of communal knowledge.

Discussing YouTube as a Medium

One of the main questions I have been asked while working on this project is, "What possesses someone to film themselves giving birth, one of the most intimate moments of their lives, and recount it to the internet at large?" This is a hard question to answer, and answering it is not the main endeavor of this study; however, it is clear that women have many different reasons for sharing this information. For many women posting on YouTube, the platform is seen as a way to connect to other women like themselves, and to share information with this broader community of women with whom they identify. Over the course of my data analysis, I will also discuss how the widespread sharing of these videos represents, for those women posting, a new level of power, authority, and self-confidence that comes with being in control of documenting oneself, particularly when one is a part of a group that traditionally has not had the ability to document themselves and disseminate this documentation on their own terms. These videos can also be seen to represent the power of narrative storytelling as a way to pass on information to others who are seen as part of an extended community or network, and also to further strengthen that community and one's place in it. In a broader context, I will reflect on the power of narrative storytelling for the purpose of processing major life events. Re-telling or even writing down the birth story is something that women often do with a doula or a partner after their birth. In the summer of 2019, while working in New York City, I enrolled in a doula training class, and my teacher there remarked that parents don't repeat the story of their experience with childbirth because they think it is the most interesting anecdote they could bring up; they retell the story over and over because they are trying to mentally and emotionally process this unique life experience. And, as we shall see, although the vloggers I study are non-professionals, they employ an impressive array of sophisticated narrative and filmic techniques to share their stories.

The introduction of steaming platforms like YouTube and Vimeo have made it possible to circumvent what had been a major critique of much documentary and ethnographic filmmaking: namely, that the subject of the film was not in control of their own representation. Rather, that representation was commonly shaped and disseminated by another person, typically an outsider in the subject's world, and often tied to some commercial entity. But internet platforms like YouTube and Vimeo remedy this on two fronts. First, they make widely available the privilege of broadly distributing video content on a scale that was previously reserved for the movie theater or television set. Now anyone with access to the internet and some manner of recording themselves can pursue filmmaking. The women whose videos I will use as data and narrative for this research come from a variety of backgrounds and employ equipment that ranges widely in quality to document their experiences. Second, and taking a broader definition of what filmmaking is than what is offered via commercialized outlets, we can say that what the women in these videos share is that they occupy the roles of subject, producer, and director. In this way, a population of women of color have a new kind of power to control a narrative of their own identity that is widely shared and to occupy space both in front of and behind the camera – simultaneously functioning as narrator and subject of the narrative. In this section, I will address these women as medical and cultural subjects, but also as artists and primarily as story-tellers, documenting their own bodily experiences.

Discussion of the representation of women in film, and minority women in particular, leads us into scholarship on the power of the male gaze in cinema, which has also been expanded to discussions of the "white gaze" (as originally defined by W.E.B DuBois) and which, in this piece, I will expand to the concept of a colonial gaze. The idea of the male gaze refers to the theory that, in most commercial filmmaking practice, both the narratives and the film form itself

perpetuate certain cultural biases about women. This gaze, then, represents the values of the broader patriarchal society, and through it on-screen women become two-dimensional objectified forms, devoid of agency or self-determination. However, many feminist film critics propose that filmmakers who are women and women of color can challenge this dominant gaze and its attendant values by taking up space behind the camera. In her essay "Women Use the Gaze to Change Reality," Katarina Hedrén, an African filmmaker, asserts that "male filmmakers tend to look at the world through male glasses and not pay attention to female perspectives [or] even female presence on the screen. The female body and psyche tend to be used as symbols, props and battlegrounds, rather than being considered in their own right" (Hedrén 2015, 185). Hedrén goes on to argue that the solution is the inclusion at all levels of more women in the production of films about women of color, not just for the sake of sharing the singular stories of these women but in hopes of creating a filmed world that captures and reflects more diverse experiences and realities (Hedrén 2015, 187).

Within the world of film study, psychoanalytic theories have been proposed to address the white-male power dynamic, both in front of and behind the camera, and the experience this provides non-white, non-male viewers. Psychologists and film theorists have asserted that "cinema is the site of experiences of omnipotence and impotence simultaneously...because the eye of the camera is determined by someone or something else... a double identification arises -- on the one hand with the eye of the camera, i.e., the subject of the gaze, and on the other hand with the actors and the roles that they embody...which, unlike the objects of the photograph, are perceived as an active subject." (Von Braun 2015, 25) However, these experiences of impotence and omnipotence are not divided equally among characters and producers, with the more passive

or impotent roles, both behind the camera and in the fictions that play out in front, traditionally given to women and women of color.

In Cristina von Braun's essay "Staged Authenticity: Femininity in Photography and Film" she argues that gender, and specifically femininity, is malleable, and that crucial opportunities for the expression of this malleability present themselves at specific historical moments in the transitions between successive media genres. Examples of such moments would be when photography transitioned to motion pictures, or the shift in consumption of television from weekly episodes to entire series on demand through streaming services. I argue that we find ourselves in one such transitional time now. Our visuals of the world are no longer dominated by the big screen and what someone in a position of commercial power has decided we will have access to. Through internet sharing, viewers have access to different communities and a variety of different film projects, with users not only able to access a wide variety of content, but also to enjoy the new experience of being able to take the camera into their hands and record themselves. While the hand-held smart phone or vlog camera may not conjure the image of Hollywood glamour that we associate with film, I argue that in creating video content online, vloggers have become filmmakers in their own right. The women in this project have engaged with the empowering aspects of marianismo, taking control of their laboring experiences and exercising authority over the representation of that experience. They have transformed from mere subjects into performers, directors, and producers, and have created a new community of film consumption outside the one that historically has not reflected their experiences.

Another important point when considering photography and film "data" is outlined by Peter Goin in his essay "Visual Literacy." In this piece, Goin reviews what he characterizes as

our relationship with photography and film as a "faithful witness." When referring to film product as serving merely as a "witness", Goin addresses an understanding of film that regards the images as a representation of objective truth, rather than as something that was also selectively captured and shaped by the photographer or filmmaker. In a particularly damning quote, Goin references an interaction he had with the editor of the journal *Visual Anthropology,* "who once told me that a photograph is meaningless until a 'scholar' renders it meaningful. I assume he meant that photographs are primarily objects of evidence" (Goin, 2001: 365). Here, Goin emphasizes the fact that captured images hold meaning, apart from their value as points for evidence. In response to this, Goin goes on to counter with an alternate, or rather expanded, understanding of visual data. He argues that "whenever a camera shutter opens and closes, recording a latent image on film, a fiction is created" (Goin, 2001: 363).

This assertion that the film and photography that we often refer to as 'fact' cannot be treated as an objective image of reality, but is nevertheless valuable in understanding the reality it depicts, is a central assumption of both Goin's work, as well as my own project. With regards to my own work of analyzing video data, this is not to say that no factual information can be taken from videos and photographs. For example, when I talk about birth medicalization even in videos that brand themselves as representing natural births, I will reference as fact the video footage of all of these women laboring and pushing in a hospital bed on their back. But Goin's point acknowledges an additional component of my interactions with these videos. As Goin says, "photography is a visual language employing syntactic rules and significance" (Goin, 2001: 366). That is, even in the most casual of home video style productions, choices are made (or not made) about which events to document, from which perspective (framing), in what order (editing), with what soundtrack (sometimes augmented later). These choices -- made consciously

and deliberately or not -- influence how viewers understand the events presented. The language and narrative of film, particularly as it pertains to structuring and framing stories, is a central part of how I will consider the YouTube videos surveyed in the qualitative review of my research.

In her dissertation "Motherhood 2.0: Digital Motherhood as Visual Culture," author Jennifer Schweller discusses the role of "mommy bloggers" and the ways in which motherhood is performed through visuals in the digital age. In her study, Schweller notes a channel of online interaction within the mom blogger community that is similar to ones that I will discuss in my own qualitative analysis. As she writes, "women are generally not just consuming information and/or blogs, but they are also the ones producing them. Mommy bloggers represent a looped system where both content and audience are generated simultaneously, with one often informing the other" (Schweller, 2014: 50). Here, Schweller emphasizes not only the nature of the discourse and the distribution of didactic material, but also the discursive response, which is also evident within the sub-community of bloggers that my research examines. This "loop" as Schweller labels it, will be discussed specifically within the context of first time mother Jeni's journey to "going natural," as she describes her birth experience. I argue that this "looped" system of the mom blogger community shapes, or at least has the potential to shape, the ways in which Latinx women choose to give birth, similarly to how natural birth resources targeted at upper-middle class white women have slowly shifted what women desire and request for their birth experience. Part of the way that the mommy blog creates this looped system of information is through the creation of intimacy. As Schweller says, the blog "seems to erode this distance between the idealized, mediated image of the mother and the mother who consumes this image. Despite the fact that these blogs still seem to act as how-to manuals for many mothers, the authors also claim to be as ordinary as any of the readers" (Schweller, 2014: 52). Working from

Schweller's understanding, I hope to expand the literature with my focus on video products instead of the written blog.

One of the main elements of qualitative analysis for this project will be a discussion of the organizational structure and editing choices evident even in vlogs that label themselves as "raw" or "uncut." I will use assumptions from Peter Goin's scholarship, which argue that while we can obtain factual information from looking at photography and film, we must also pay attention to, and can obtain valuable information from, the ways in which the person who captured the video or film also constructs a narrative for the viewer. In this way, as Schweller says, we can understand the mommy blog as a product that seems to "embody a discourse on motherhood rather than a sense of autobiography," and we can examine the structure and narrative making that women use to channel "this discourse through an affective performance that gestures at individualism through the pathos of personal crisis and individual experience" (Schweller, 2014: 52).

In the following qualitative analysis, I will consider how the women surveyed here use their individual experiences with birth and labor to add to a growing discourse on motherhood, and particularly how these women help to build a collective narrative that questions medicalization and medical authority over the birthing body. In my analysis for this thesis I build off of the work of Goin and Schweller by combining Goin’s argument about filmic evidence and Schweller’s insight into the discourse of motherhood that emerges out of mom bloggers, by applying these to a particular subset of women who film, report upon, and offer advice to others regarding their own labor and delivery experiences.

CHAPTER THREE: METHODOLOGY AND DATA COLLECTION

When I began assembling the videos and YouTube channels that would be discussed in this ethnography, I first had to learn to navigate the channels of "mom bloggers" and understand where to look for the videos that I hoped to encounter. Just as other YouTube video trends have become formulaic within their respective genres (e.g., the GRWM Get Ready with Me video, or the morning routine video), the videos that influencers create discussing and/or showing their labor and delivery also follow a pattern. Most women announce their pregnancy to their followers on YouTube and/or Instagram in the early months of their pregnancy, and they then post follow up videos every week or so discussing their symptoms, answering questions about the experience from their viewers, and sharing the anxiety and excitement as their due date approaches. Finally, women tend to post two videos that conclude the journey of their pregnancy, at least online. First, many women will post a vlog style video documenting the actual moments of them going into labor, in the hospital, as well as footage of the actual delivery of their child. Next, women will follow up with a testimonial style video, speaking to the camera several days to several weeks after the birth, sharing a narrative: recounting the story of the birth from their point of view. Women typically also use this second, concluding video to reflect on how they felt about the events that transpired in the hospital, whether that emotion be one of pride or defeat. Women may also try to share some of the harsher realities of postpartum life, including discussing their experiences with postpartum depression. This becomes an important part of the testimonial narrative, as many women felt their health care providers did not discuss PPD with them or give them sufficient resources about how to seek help or cope with PPD if they experienced it.

When initially looking for channels to use, I searched for videos on YouTube in both English and Spanish (the appendix includes a complete list of phrases that I searched for initially). Certain videos were recommended to me by YouTube, either on the homepage or in the browser sidebar, usually when I was watching a related video. This led to a somewhat random sample of videos, but since I generally stayed within the first page of search results for each search, and was then directed to other videos based on these searches, it is fair to say that this sample represents the relatively more popular videos within their category.

An important step of gathering the videos that I used for this project was first to assemble a large pool of videos based on my searches that I suspected could meet the criteria of the study, before then sorting through the videos to clarify which videos/channels were or were not pertinent to my project. I conducted an initial screening of each channel to ensure that women had posted both vlog style videos as well as longer form narrative videos, as I am interested in both the raw documentation of the birth story and the narrative that women construct for themselves around the event. Next, I had to clarify that each of the women in the videos self-identified as Latinx. To do this, I watched their videos to make sure that they explicitly stated that this was how they identified; I visited the "About Me" section of their YouTube page; or I looked for their introductory videos where I thought they would be most likely to speak directly to how they identify. In addition, all of the women whose channels I used linked their Instagram accounts in the descriptions on all of their videos, so I also cross checked with these accounts. To do this, I would look through each woman's Instagram bio, which is where many people cite various aspects of their identity and heritage. This data collection strategy – necessary if I intended to make a statement about the identity of the women whose videos I collected – meant that I included only the videos of women who explicitly identified through their internet presence

as part of the Latinx community. This could suggest that the pool of women whose videos I am reviewing have a further trait in common: they see their Latinx identity as a central aspect of their presented identity on the internet. Thus, this study may not include the perspectives of women who film their labor and delivery but do not choose to explicitly identify as Latinx in their online presence.

A brief note on the language that has been and will be used throughout this piece as it pertains to the Latinx community, and the decisions I made regarding language while writing. It is crucial to acknowledge the reality that it is not only women who carry children, possess uteruses, and give birth. While currently in much of the literature, particularly in the medical literature, language emphasizes reproductive care for women, this language is not sufficient to acknowledge and capture the experiences of everyone who engages with and seeks reproductive health care. Not only is it important to use inclusive language to acknowledge and normalize the reality of the transgender and non-binary experiences, but cisgender language, particularly as it pertains to reproductive health, can have real consequences in terms of access to care. For the purposes of this piece, when I refer to the broader community that this research engages with I will refer to pregnant Latinx people. I chose not to use the more gender neutral "birthers" because, while it is inclusive, it focuses the identity of the person giving birth on their medical status rather than on their personhood. While talking about the people featured in the videos that I included in this project, I will refer to them as women, as this is how all of those represented here identify, and will refer to them as Latina, if this is how they self-identify, and as Latinx if this is how they identify, or if they do not specify. The importance of these women's cishet identity to the narratives that they create about giving birth and becoming mothers will be discussed in following chapters on qualitative analysis.

Another decision that I made in terms of the sample of 22 women used here was to limit the number of women who identified as Latinx but were of sufficient European descent that they undoubtedly enjoy certain levels of privilege – keeping in mind the realities of colorism in the United States particularly. I did include several women who fit this description in my analysis, but I limited how many of these videos I analyzed since they could not fully address the experience of giving birth as a woman who is visibly a person of color in this country.

I identified 22 different women who met the criteria of the study, but before deciding to include them I previewed several of their videos on pregnancy to see if their videos addressed the kind of experiences I was interested in. In the age of the infamous YouTube "haul" video, where the creator sits facing the camera and gives extensive reviews of a large quantity of recently purchased items, a great deal of women's pregnancy related content is focused on maternity clothes, what to buy for your baby, how to stock your hospital go-bag, or the process of setting up a nursery. While this type of content certainly would have been an interesting phenomenon to explore further, given my research question for this project, these kinds of videos were not particularly informative to me.

I took detailed notes on each of the videos that I ended up including in my final qualitative analysis. These notes are made up of a mix of general observation, paraphrasing the longer narrative that a woman told throughout a video, as well as direct transcription. In the testimonial style videos where women told the story of their birth experience, I utilized direct transcription as I was interested in the way that the women chose to tell these stories. In vlog style videos that documented the actual labor and childbirth experience, I made observations of what was taking place, especially the interactions between the patient, other laypeople, and hospital personnel. The videos and initial observations from these 22 women guided the

background of my thesis, as well as common thematic and structural elements that I decided to address in my qualitative analysis. My understanding of the data from all of these videos is represented in what I regard as particularly applicable and dominant across these many hours of video. For the purpose of the ethnographic portion of this thesis, I will analyze in detail the videos of five women. I chose to analyze in depth the structure and contents of a smaller number of videos produced by women than the originally 22, keeping in mind that most of these videos average about half an hour in length, in order to discuss more fully how and why women create narratives around their birth experience.

CHAPTER FOUR: Structuring Narratives of Motherhood

YouTube as Genre Driven

As with other types of YouTube videos, both the birth vlogs and testimonial videos of the women surveyed in this project tend to follow certain genre conventions. Considering "genres" within the world of YouTube is interesting because those who are familiar with YouTube freely define and categorize similar videos into genres, but without the well-defined nomenclature associated with literary or cinematic forms. Many times, these subcategories are defined in reference to a creator who is the most famous or most readily associated with a video type. In this way, when a young person references a YouTuber who uses the style of Emma Chamberlain, they are referencing not only the content that is associated with Emma -- the humorous vlog style video content of her daily life as a teenager -- but also the way in which Emma films and edits these videos together to create a narrative.

One way that Emma creates narratives in her videos is through the kind of content that she chooses to film and perform in the first place. This content includes anything from her goofing around in her bedroom, dressing up in costumes, or walking through the halls of her high school. As she has become more famous and wealthy, Emma continues to vlog in the same style as she once did, but instead takes viewers through her new life as someone with unbelievable wealth, independence, and notoriety. Interestingly, while Emma's channel has expanded and her lifestyle has changed, the manner in which she films and edits her videos has not. Emma has millions of followers and is an incredibly wealthy young woman, yet her video footage is often lower quality than one would expect. She doesn't light herself or the place that she is filming,

and her shots are set up and framed as if there was not much thought put into how one shot will flow to the next. She aims for a kind of nonchalance in her productions that she relays through a busy and conspicuous visual style. To do this, Emma sticks to quick cuts, sometimes shaky hand-filmed footage, few smooth or even intentional transitions, the insertion of sound effects, and dramatic zooms done in post-production. With this, Emma creates a visual style that the viewer is hyper aware of -- one that conveys the cool and laid-back, but also energetic, posture that is crucial to the narrative of a young woman she is trying to tell.

By browsing amongst some of the most popular YouTube channels it becomes clear that there are dominant trends in structure, editing, capturing video, and story-telling that get reproduced and begin to create subcategories that, like genres, are identifiable by shared conventions in their thematic, aesthetic, and/or structural content, as well as their methods of storytelling. In this portion of my qualitative analysis I will characterize structural and filmmaking narrative similarities among the videos surveyed here and summarize how this translates to the production of a common narrative across the birth vlogs. I argue that a large part of the power of these videos emerges in fact through their narrative nature. These videos are products that allow the viewer -- and particularly a type of viewer who has not been catered to in this sort of content before -- to find identification, comfort, inspiration, and mentorship by transplanting themselves into the narratives on-screen.

The Family Unit

Of the 22 women whose videos I initially watched and collected data on, five feature importantly in the ethnographic portion of what follows: Blanca, a makeup-vlogger and mother of two, whose support network of family helped her negotiate her interactions with medical

authority; Liz, who films the birth of her second child, and stands of a model of how these videos highlight multi-culturalism and multi-lingualism; Yasmin, who, during the birth of her first child, labors for 51 hours with her doula, and demonstrates the value of a professional birth attendant; Fabiola, who recounts her experiences with childbirth in the medical systems of the US as well as in her home country of Costa Rica; and Jeni, the youngest, who advocates not just for natural childbirth, but for the agency of all laboring people.

The first similarity evident among the many birth vlogs surveyed was the emphasis on a strong heterosexual familial unit. In almost all of the videos I watched, and in all the videos discussed here, women's male partners are featured prominently either behind or in front of the camera. While it may seem natural that these women's partners would be visible and vocal in their birth vlogs, this inclusion needs to be understood as a deliberate choice in filming and editing. While women could choose to film only themselves talking to the camera, or have the camera set up so that it is focused on them in the hospital bed, they often hand off the camera to their partner, letting them offer commentary and "direct" the shot. For example, during Blanca's delivery, her husband Luis is heavily featured, often holding the camera so that the viewer can see Blanca, but also interjecting a summary of what has happened since the camera was last on, or an update on how he or Blanca are feeling. In one clip, Luis holds the camera so that the viewer can see his face, with Blanca lying behind him in her hospital bed, and says, "This process is crazy and you will never understand it until you're here seeing it happen right in front of you…but Blanca's a strong woman so I know we'll be alright" -- and he moves to take her hand. Here, Luis highlights the familial unit of himself and Blanca as the two protagonists of the video, with the drama being their struggle as a couple through the challenges of childbirth.

While some of the women surveyed opt to include their husband only in the immediate moments that he appears on camera, others emphasize the heterosexual family unit during key points in the vlog by employing a montage of images or videos presented as a flashback. Blanca, who as discussed chooses to feature her husband Luis somewhat prominently in her labor and delivery vlogs, is one of the women who intercuts a montage of herself and Luis, including earlier moments from their relationship, in the sequence when her baby is born. In the vlog for the birth of her first son Max, we see Blanca lying on her back and pushing in a hospital bed, as we hear hospital personnel in the background instructing and encouraging her. After several clips of her pushing and laboring, we hear the voices in the delivery room fade as the video transitions to short video clips with music in the background. The montage consists of video clips from throughout Luis and Blanca's relationship, footage from their wedding, of them on vacations, and throughout the pregnancy. As the music fades, we hear Max's first cries in the background and the montage ends as gloved hands lift Max from off screen and up onto Blanca's chest. By choosing to include this material just moments before the vlog shows Max being born, Blanca constructs a narrative indicating that the journey captured here is not just about her becoming a mother, or her heroic emergence from childbirth, but of the story of herself and Luis becoming a family in the moment that their son is born.

As Schweller reflects in her work on digital motherhood, certain cultural ideals and images are transferred to the viewer or reader of the mommy blog, whether or not they are directly addressed. The emphasis on the family unit through filming and editing, and especially through flashbacks that show a history of the relationship of the heterosexual couple, highlights ideals about family structure, motherhood, and what it means to be a family. This analysis is important because it illustrates the manner in which certain narratives that reflect certain cultural

ideals to the viewer are told not only through the factual portrayal of events by the camera, but also through how creators use editing and creative choice to construct a narrative with a plot and protagonists, even in a vlog format. Considering how what is filmed and edited adds to the story of the vlog is also important to examine when it comes to identifying an audience, and particularly in identifying the loop of autobiography but also discourse around motherhood that happens in the world of the mommy blog.

Bilingualism and Imagining a Viewer

In the vlog for the birth of her daughter Bella, YouTuber Liz and her husband demonstrate another structural similarity amongst many of the videos surveyed, one that both adds to the narrative that the videos offer and helps to identify an intended audience. Liz and her husband both speak English and Spanish fluently, and during the course of the birth vlog, which primarily features just the two of them, they frequently switch back and forth between English and Spanish. Interestingly, in her testimonial video where she retells the story of the labor and delivery, Liz speaks exclusively in English, with the exception of a few singular words or short phrases. This difference in language use between the structured testimonial video and the vlog videos on these women's channels provides an interesting contrast in how these women choose to speak when they film a scripted video for their channel versus how it appears that they speak more casually. This dual language use marks another category of birth vlogs.

When Liz and her husband are first checked into the hospital, preceded by footage of them packing up to leave their house and driving to the hospital, we hear them converse casually in Spanish for the first time. During the course of the car ride earlier in the video, Liz, whose contractions are still bearable, holds the camera to show herself and her husband, and interviews

him while he drives, asking the common questions that the fathers are asked on camera in many of these videos, particularly how they are feeling about the impending birth. However, later, as Liz's husband holds the camera to show Liz sitting propped up in the hospital bed, he asks her in Spanish when their doctor will be coming, to which she responds in English that her normal OBGYN won't be there because it isn't her shift. Her husband follows up by inquiring in Spanish why the doctor doesn't have to come to the birth if Liz is her patient, to which Liz responds once again in English that it is nothing to worry about and that she likes the doctor on call at the moment. In the following clip, Liz's husband returns to speaking in English, but several clips later, when Liz's water has broken, she first says "that means that labor will probably start going a little faster and my contractions should be stronger after my water breaks." Liz's husband responds in English, also speaking to the camera, "I was telling Liz she should wait," in response to whether she should ask for an epidural now that her water is broken. They converse here in English before Liz says "estoy muy nerviosa," to which Luis responds in Spanish "respira respira respira".

Just as featuring a male partner on camera as a supporting character during the birth is a choice integral to building the narrative of the birth story, it is also notable that in some birth vlogs footage with dialogue in both Spanish and English is included. This language switching is part of reality, and also a part of the common narrative of being a Latinx person in the United States. The inclusion of this footage not only creates a narrative of a woman's birth experience with a Latinx woman at the center, making certain didactic information about birth and labor more readily available and tailored, but it also offers valuable information about the imagined intended viewer of these videos.

Many of the women surveyed here are alike not just because they are self-identified Latina women who felt it important to film and talk about childbirth, but also because creating videos for YouTube is either their full-time job or something that they in some way profit from. The viewer must keep in mind that the makers of these videos are creators not only in the sense of documenting and storytelling, but also in the sense that they are creators of a product. Approximately half of the videos surveyed here come from women whose channels have significant online followings. Of the five women discussed more extensively in the qualitative review, three of them -- Liz, Yasmin, and Blanca -- have 40k, 333k, and 700k subscribers respectively. Even in vlogs documenting their everyday lives, these women create content that is intended to be consumed by many others, and it is significant that these narratives are prominently multilingual and multicultural.

In all of the videos that I watched for this project, none of the women added subtitles when someone was speaking in Spanish, whether that be themselves speaking to the camera or someone else speaking in the background. As discussed in Liz's birth vlog, and as was evident in many others I reviewed, women and their partners and family frequently switched back and forth between English and Spanish, not only over the course of the video while talking to different people, but also within a single conversation with the same person or even within a single sentence. In Blanca's birth vlog, in the moments after her son Max is born, we see her cradling her swaddled newborn while she speaks to a relative on the phone in Spanish, relaying the details of the birth. In the video for the birth of her second daughter Camila, we hear a hospital employee introduce themselves in English and instruct Blanca on how to push, when suddenly a voice exclaims over her,"Ya salió?!" as Camila is lifted with gloved hands onto Blanca's stomach.

By examining the way in which language is used in these videos, we see that it is evident that the women creating them assume that a significant part of their viewer base speaks both English and Spanish with relative proficiency. Given who has access to these specific narratives of birth, we see that they are marketed towards other people seeking information on labor and birth that fall into this specific sub-community. This can also be seen in certain cultural references that women and their families make in the videos that are regarded as not needing any explanation. In Blanca's vlog for the birth of Max, we see multiple shots of the delivery room crowded with increasingly more and more people, visitors coming to offer food, support, and advice. In one shot, as the camera pans the room to show just how packed it is, one of Blanca's friends exclaims, "Mexicans -- gotta bring the whole family!" to which the room laughs knowingly.

Historically, information about reproduction and birth has been molded for consumption by and for white women with resources. The presentation of comprehensive and didactic videos by Latinx people regarding these same topics not only allows Latinx people to place themselves in certain narratives of birth and motherhood, but has the potential to change the way in which women give birth -- what their expectations are and what they ask for.

Starting with the natural birth movement in the 1960s and 1970s, piloted by women like Peggy Simkin and Ina Mae Gaskin, reforms in practices around childbirth have largely been built on criticisms of how medicalization of reproduction and birth operate on patriarchal cultural understandings of women and their bodies, and the need to manage and control these bodies. As discussed in the literature review, the intersectional nature of reproduction and womanhood, the experience of a large part of the population, has not been taken into account. There is a growing base of anthropological and other research that considers what birth medicalization signifies for

non-white women in other parts of the world, particularly in Central and South America. This research hopes to create resources that promote the narratives of these women and their experiences around reproduction. This has not been the case in the United States.

A large part of the conception of this project comes from research done by Peggy Simkin regarding the psychological salience of birth and from her book *The Birth Partner*, which I read over the summer as part of the required reading for my doula class. Though I found great value in *The Birth Partner*, a book written for midwives, doulas, and partners of people giving birth, considerations of the implications or race and class on how people choose to give birth, and on what resources and advocacy they will have accordingly, was absent from the text. I chose a doula class, taught by a Latina woman, Rina Ríos, because of Rina's dedication to centering conversations about culture, race, and class in her doula curriculum. In class, Rina showed us exercises to help open a person's hips and encourage them to relax with a *rebozo* -- a long and thick piece of fabric that can be used for carrying a baby tied to the mother's chest or back. The *rebozo* is also used for exercises leading up to and during labor. This prompted conversation about how as doulas we can encourage and support women who may want to incorporate their own cultural elements or traditions into their labor and birth. Rina also taught us about the importance of offering volunteer doula services, and about the movement, centered in New York City, to make doulas affordable and accessible to any person who may want one to assist in their birth The YouTube videos surveyed here, like Rina's class, present a picture of birth and reproduction closer to reality, where people find their experiences with birth and reproduction not only mediated by their gender, but also their culture, race, and class.

Going Natural - and helping others do the same

In much the same way that a book like Simkin's offers didactic information about pregnancy, labor, and childbirth, so too do the videos surveyed here. In Jeni's testimonial video discussing her labor and delivery, she demonstrates the way in which YouTube videos and the "loop" of mommy bloggers that Schweller discusses in "Digital Motherhood" create space for a Latinx viewer, and also have the potential to influence the way in which people choose to give birth. Jeni opens her testimonial video sitting in her home clutching a spiral notebook under her chin where she reports she has written down her "birth affirmations." Perhaps of all the women whose videos I watched, Jeni was the most outspoken about her choice to, as she phrases it, "go natural." Jeni's decisions around "going natural" and how her birth experience challenged dominant issues of medicalization and medical authority will be discussed in later analysis, but another important part of Jeni's narrative about her decision to "go natural" is how she both received and later dispensed information about the natural birth process. Jeni decided she wanted to experience a natural childbirth about a week before her due date, prompted by watching videos on YouTube of other women who had done the same. As she phrases it in the introduction of her testimonial video, she thought to herself, "If they can do it, I can do it." Jeni was anxious to broach the topic with her mother since, "Most of the moms that I know just went with the epidural." Jeni was pleasantly surprised by how supportive her mother was of her decisions, and partially credits her ability to give birth without the epidural to her mother's consistent affirmations, leading up to, and during the birth.

While she does discuss some of the details of her birth, Jeni devotes much of the rest of her videos to offering information to other mothers on her process of preparation and dispensing related advice. Jeni recommends that expectant mothers try "hypnobirthing," which she describes as a type of birth meditation that encourages you not to fight your body during labor, all the

while keeping adrenaline low. She describes to the viewer how she listened to recordings of these meditations in the week leading up to her due date and practiced relaxing along with the audio. When her contractions started she put on the same meditations as she prepared for birth. Importantly, Jeni notes to her viewer that there is no need to spend a huge amount of money on preparing to give birth naturally. She reports that the meditations that she listened to were ones that she found on YouTube and had been recommended by other mom vloggers. As she says, "I'm doing this for free. I'm not paying for that when I can just listen to these."

The fact that Jeni was both able to obtain and dispense information on the process of preparing for and enduring birth without an epidural highlights the actual and potential power of the individual YouTubers surveyed here, along with the "loop" they belong to. Jeni's access to this kind of information and, importantly, her decision to film a video relaying it, is particularly powerful. This is especially true considering that when Jeni brought up wanting to give birth without an epidural to her OBGYN, her doctor offered neither support nor resources: "I had an appointment 3 days before I actually went into labor, and I told my OBGYN that I wanted to go natural as well, and she just completely ignored me, like, didn't give me any advice. Just wasn't very considerate of the fact…and that's why I say you have to have a really strong support system because if I would've just went off of how my doctor reacted I probably wouldn't have gone natural." Here, we see that support and advice from other women on YouTube who were in a similar situation to Jeni was actually a resource for her as she gave birth, a circuit of information and resources that. Functioned like a local community to which. Jeni felt inclined to add herself. Jeni ends her testimonial video with an open invitation to other mothers who find themselves in need of information and support: "For all of the mommies out there that have any questions, feel free to message me, I'm willing to answer anything and everything, even the

personal stuff, because I know how it feels to feel like you don't have like a mentor, or if you don't have a doula or a midwife, or if your doctor was, like, you know, not so helpful like mine was. Basically, I did this on my own, and I know all of you can do it too."

Narrative Progression and the Heroics of Natural Birth

When analyzing how these videos use structure to convey their narratives, we can ask what this reflects about how the creator perceives a "typical birth" and, as much as they emphasize the uniqueness of their experience, how they follow certain narrative conventions to create a recognizable story. Every person's experience with pregnancy, labor, and birth is undoubtedly distinctive, and yet the ways in which we tell stories about birth -- selecting which moments to include -- perhaps because of how we have heard others tell these stories, can be strikingly similar. This is evident in the videos used in this project. Despite the fact that each woman has a different story to tell in the vlog and testimonial video, the selection of particular salient memories that build the birth story follow a common narrative structure. Most of the birth vlogs that I watched for this project, whether they are discussed in depth here or not, followed a similar narrative progression. Typically, the vlogs begin in the woman's home, usually in the early stages of her labor. At this point the woman is usually in charge of the camera, and she speaks to the viewer and reports on how she is feeling as she makes preparations for the hospital. Many women show themselves packing their hospital bag, clearly indicating that they are leaving to have the baby. Almost all women then show the drive to the hospital, with the camera balanced or held on the dashboard. At this point, if their partner is the driver of the car, which is often the case, the two talk about what will happen in the next hours, consider when their child might be born, and discuss their anxiety and excitement. Next, there is often a sequence of the woman waiting to be admitted. We then see her for the first time in a gown, often seated in a

wheelchair or on a portable bed. Many vlogs include a shot of the woman being wheeled through the halls of the hospital, denoting that she is being moved to the room where she will give birth. At this point, filming often switches from the mother filming herself to her partner, parent, or friend holding the camera so we are able to see her in bed. Here, whoever is operating the camera often presents a "tour" of the room, particularly focusing on where the baby will be placed, with the baby blanket and hat that have been prepared, as well as the monitors. One structural tool that many vloggers use to denote the passage of time during the hours of labor is by showing progression of contractions on the monitor, or showing how long the print out from the monitor has gotten.

The passage of time and the progression of labor is also represented by changes in the woman's contractions. Initially, most women report pain, but are still able to converse during their contractions. In the next clip of the woman, there is often a title inserted reporting how much time has passed, and footage of the woman in the hospital bed, at this point in much more pain and unable to talk through the contractions. Eventually, the video shows more emotional and visibly painful contractions, with the mother often doubled over in pain or clinging either to the side of her hospital bed or onto someone's arm. In the moments leading up to the birth there is often a clip where the mother announces that she feels the urge to push, and suddenly we see a flurry of medical personnel, most of whom we only see from the neck down. The presence of doctors and nurses is often represented by gloved hands and headless bodies in scrubs milling around the hospital bed, and by their verbal communication. Different women choose to include themselves pushing for different amounts of time. Some women show several short clips of them pushing, and some show the entire process from the first push to when their baby is born. For the final shot of the labor, we hear the voices of family, friends, and medical personnel increasingly

enthusiastically encouraging the mother to push, and then suddenly gloved hands holding a newborn, lifting the baby either from off-screen, or from underneath the draping that was used to preserve privacy during filming.

In chapter five, I will discuss how the videos surveyed in this project, and the women who create them interact with, challenge, and interpret medicalization of birth, and particularly the medical authority that accompanies this. We have already heard some of Jeni's experience of struggling to find the support of her doctor to have the type of labor and birth that she wanted. The more extensive interactions between Jeni and her healthcare providers, and how this plays out over the course of her delivery will be further explored, as will the experiences of other women. We will see how Blanca's family rallies around her during her delivery in a way that creates space to challenge medical authority, and Blanca's own interactions with nurses and doctors during her second labor with her daughter Camila. We will also hear about Fabiola who describes her birth experiences both in Costa Rica and in the United States, and who vlogs the birth of her second child in the United States. She unfortunately has a negative and traumatic experience with medicalized birth, and processes this in front of the camera in a video where she discusses and processes receiving an epidural, and her interactions with doctors and nurses around this decision.

One prominent structural and narrative similarity of these videos is the way in which many of the women attempt to break from medical conventions, which they often do by specifically emphasizing their interest in a natural birth. The stories of birth that these women tell are similar in that they consistently feature as a central narrative element a struggle with the medical institution and medical authority, which is made more unique by the fact that the women trying to work outside of these systems are women of color. As discussed in this chapter, most

mainstream natural birth literature, material, and discourse around the narrative of subverting medicalization and medical authority in the context of reproductive justice, features and is directed at white women. As I have argued, and will expand upon in chapter five, these videos create a new kind of narrative structure around birth that Latinx women can, and have, projected themselves into, in a way that allows the scaffolding for a new narrative venture that previously only advertised, featured, and invited white women.

CHAPTER FIVE: Medicalization, Authority, and the Mother

In chapter four, I discussed some structural features found among women's birth vlogs, and how women use this structure to craft narratives of their labor and birth experience. At the end of chapter four, I discussed how a central thread of the stories that many women told through their birth vlogs was how they strove for a birth that was less medicalized, and how this desire informed their interactions with medical authority. In this chapter, I will explore how this challenge of giving birth within the hospital institution while navigating institutional authority is represented in these women's vlogs, and I will also consider the results of these struggles. I begin by pointing out that, despite the fact that many women boast that they had a "natural birth," and that this is often a tag for the videos discussed here, all of the women whose videos I looked at for this project ultimately gave birth in a medicalized format. All of the women whose videos I watched -- the five discussed here, as well as the original twenty-two -- gave birth in a hospital. Furthermore, all the women here, as well as birth workers and people more broadly, have a difficult time defining what exactly constitutes a "natural" birth. Indeed, many people working in reproductive justice urge us to move away from these kinds of classifications of birth experiences.

This being said, it is interesting and also unsurprising that there is contentious rhetoric around natural birth. With the beginnings of the natural birth movement, leaders were able to gain traction by positioning their ideal of what birth would look like against that offered by the hospital. Some quarters of the natural birth movement can feel exclusive and judgmental, particularly when it comes to how the group sometime treats people who have chosen to receive pain management during birth. Nevertheless, there is no doubt that the natural birth movement has incited many positive changes for people giving birth in the United States, even for those

who do not explicitly identify with the movement or seek out information about natural birth themselves.

Ultimately, in all of the videos I study, even those that advertise themselves as "natural" birth vlogs, we see extensive evidence of medicalization, including many practices that, as I discussed in the literature review, are based upon long held cultural, rather than scientific, practices. Partly this is because what was once culturally convenient remains so. Doctors today often learn to "manage" patients, and particularly women and women of color, just as they did in the 1800s. As evidenced in the videos surveyed for this project, not only did all women give birth in the hospital, but all labored and delivered lying on their back in the hospital bed. The women who experienced "slower" or "stalled" labor, a category that is not scientifically defined, were attended by doctors or midwives using a variety of methods to induce or accelerate their labor.

None of the women in these videos had a birth that was "unmedicalized," nor should an "unmedicalized" birth be held up as the gold standard of birth experiences. As I have discussed previously, medical advancements have undoubtedly saved the lives of both babies and pregnant people countless times. Rather, what I found interesting in surveying the videos for this project was that many women recognized the landscape of medicalization around childbirth, and in some way chose to question it, push back against medical authority, or work outside of the medical institution. While it is impossible to say whether any of these women had a "natural" birth or not, all were conscious of the fact that, during their birth, they needed to navigate a medicalized system, one where they needed to be adamant about their needs and desires to ensure they received the kind of care and bodily experience that they preferred.

Returning to the Salience of Birth

In her testimonial video, YouTuber Fabiola speaks to a camera perched on a stool in her dining room as she rhythmically rolls a pram back and forth with one hand. Fabiola's first child, now a toddler, was born in her home country of Costa Rica, where she gave birth without the use of pain medications. In her first of two testimonial videos after the birth of her second child, Fabiola compares for the viewer the differences she experienced in giving birth in the United States versus Costa Rica. The element of her birth in the United States that she chooses to highlight in this video is that while the services she received leading up to her birth were similar to what they were in Costa Rica, the difference in cost astounded her: "Si no tienes seguro, tienes que pagar bastante dinero." Fabiola's comments highlight an interesting phenomenon that I encountered while searching for videos to include in this project. I found many videos made by recent immigrants from Latin America to the United States who highlighted for other women in the same situation the unexpected costs of giving birth in the USA, and what they should be prepared for. While up until this point I have discussed a general "lack of access to resources" that affects certain women more than others, we must acknowledge that, in the healthcare system of the United States, finances are one of the greatest limiting factors to people's reproductive decisions. This means that in a country where giving birth is so expensive, even for those with insurance coverage, the types of expensive resources that aid and mentor people in the birth process become that much more exclusive.

Returning to the importance and long-term implications of the psychological salience of birth, and particularly how encounters with medical authority affect these long-term outcomes as discussed by Simkin and others, Costa Rican immigrant Fabiola makes a series of detailed videos discussing her memories from her birth in Costa Rica and the USA respectively. Fabiola

remembers distinct details from each of her births that she shares with the viewer in her testimonial video. While she remembers moments of great joy, she unfortunately recalls vivid memories of feeling frightened and alone, both in Costa Rica and in the United States. In Costa Rica, Fabiola recalls that she was very nervous when she got to the hospital and felt as though she couldn't ask questions of the medical personnel. She remembers that the nurses who attended to her failed to ask her questions or pay much attention to her pain. When her water broke, a nurse asked her if she was sure that she hadn't just peed in the hospital bed. She remembers lying in a room alone, where other laboring women were separated by curtains, unable to relax as she listened to their cries. Here, sitting in her kitchen on a stool, rolling a pram with her newborn baby back and forth, Fabiola remembers how hard it was to hear other women in pain. She specifically notes that she herself didn't want to be a trouble to the hospital staff. Instead, she maintained calm, and recalls that even though she was in great pain, she was careful not to yell, or cause any sort of disruption.

During her birth experience in Costa Rica, Fabiola also suffered instances of medical care where her informed consent was not properly obtained. Fabiola notes that, while in the birthing room, she remembers the doctor as speaking very kindly to her, but she was distressed that a group of medical students observed her labor and delivery without anyone at the hospital asking for her consent to their presence. She notes that, if she had been asked, she would have readily agreed to the presence of students, but she was disturbed by the fact that no one bothered to ask her. After the birth of her child, Fabiola, like many women, needed stitches to resolve some tearing that occurred during the vaginal delivery. She remembers that while the doctor who delivered her daughter was the one who began stitching, that doctor quickly left the room, at which point a medical student assumed the responsibility of finishing the stitches. Again, Fabiola

was frustrated that no one asked her permission about this procedure or identified who would be performing it. In terms of the salience of her birth experience, it is sadly these moments where she felt that she lacked control that Fabiola remembers distinctively: "Yo sí recuerdo muy bien eso."

Here, I wish to emphasize again the fact that while there is a breadth of literature that focuses on reproductive rights violations in those countries that American anthropologists consider to be "less developed," such as Costa Rica, Fabiola herself details similar distressing experiences in the United States. After her birth experience in Costa Rica, Fabiola filmed extensively leading up to her labor in the United States, vlogged her birth, and posted two follow up testimonial videos postpartum. In her two-part vlog for the birth of her son in the United States, Fabiola emphasizes how greatly the regular changes in medical personnel over the course of her time in the hospital affected her experience. She reflects that the first nurse she encountered during her hospital stay, "fue de lo mejor...ella me ayudó demasiado con mis contracciones." In the vlog, we see and overhear this nurse standing by Fabiola's bedside, slowly directing her breathing, "Slowly in through the nose, breathe out the tension...you're like a pro." However, Fabiola felt that both of the subsequent nurses, as well as her anesthesiologist, were dismissive of her questions and concerns, rushed her decisions, and were unfriendly.

For the birth of her daughter Isabella in Costa Rica, Fabiola gave birth without an epidural. She recalls that, while she experienced great pain, she also felt that the experience was beautiful, and something that she takes great pride in: "Yo recuerdo con mucho cariño." As she prepared for the birth of her son in the United States, and reflected upon her experience delivering her daughter, she once again decided that, if possible, she would like to give birth without the use of any medications for pain management. However, as her labor continued,

Fabiola found that it was much more painful than her labor with Isabella had been, and she struggled with whether to ask for an epidural. As she says to her husband in the video, while we see her straining in pain and holding back tears, "Quiero la epidural, y quiero disfrutar este momento y también el parto, pero por otro lado no quiero epidural." Ultimately, as her labor became more painful, she asked to meet with the anesthesiologist; at 5 cm dilated, she received the epidural. Fabiola remembers that as soon as the anesthesiologist came into the delivery room she felt "un arrepentimiento." After the doctor left, Fabiola was able to fall asleep and rest for some time, but upon waking thought to herself, "me siento mal," and realized that she could not feel anything in the lower half of her body as well as much of her chest. She remembers how cold she felt and how she shivered violently, becoming increasingly anxious. When she eventually delivered her son, she could feel nothing. Hours later in the recovery room, she was still numb and was frightened that something was wrong with her body. When the doctor came to check on her recovery several hours later, he reflected that she must have been particularly sensitive to the anesthetic, a potential reaction that she had not been adequately informed about.

While Fabiola did not originally intend to receive an epidural during the birth of her son Isaac, like many people she allowed for her birth plan to be flexible during her labor and delivery as the circumstances changed. Though in her postpartum videos she expresses some regret about receiving the epidural, she seems to understand that she made the best decision in the moment, based upon the information that she had. It is only in this moment of her testimonial where the otherwise positive and forgiving Fabiola expresses real anger and disappointment. The fact that she was given insufficient guidance and support from her doctors while making what she considered to be a significant decision has clearly left Fabiola frustrated. It has also sowed seeds of distrust and resentment towards medical personnel, despite the fact that she has positive

memories of her interactions with some people in the hospital. Fabiola ends her testimonial by cautioning other women to be careful and make sure that they have received all the relevant information before making a decision, like whether or not to receive an epidural. In her experience with the epidural, Fabiola's birth serves as a perfect example of how even a birth where both parent and child are alive and healthy can still be a negative experience in a significant way. Though she has complaints about the way in which she was treated in Costa Rica during her birth, it is clear that the experience of the epidural she received in the United States and the interactions she had with nurses and doctors around this decision affected her deeply. As she concludes in reference to her birth in the US compared to her birth in Costa Rica, "Cosas más materiales acá fue… pero en cuanto a … simplemente saber que está en mi país y que está mi familia y, y todo..."

"Mexicans...gotta bring the whole family..."

When it comes to navigating the system of medical authority without a professional birth attendant, Blanca and her cohort of birth attendants stand as a perfect example of how having a local support system can change how a pregnant person interacts with the medical system and navigates relationships with medical authority. It is evident in each of these videos that certain authority figures in the hospital shape the birth experience. Many women remark with joy that they feel particularly lucky to have had a particular nurse or doctor. For example, Fabiola reflects in her testimonial about her birth in the US that her experience laboring changed significantly when there was a change in shift and she was assigned a new nurse. In the vlog for the birth of her second child, Camila, a crucial part of Blanca's experience had to do specifically with the medical authority figures that she had. But even more so than that, in her testimonial it is clear that the experience was most positively characterized by the moments in which Blanca spoke up

for what she wanted to happen, and the subsequent change in dynamic between herself and the nurse who attended her birth.

Blanca describes the nurse at the birth of her second daughter Camila as direct and firm. As she says, the nurse was "not here to play." While Blanca did not necessarily agree with the nurse's opinion that she should just go ahead and get the epidural, she was still impressed by the woman's directness, and also somewhat reassured by the fact that she was from Sinaloa. In her testimonial video, Blanca briefly touches on the fact that the nurse's national identity made her feel a degree of connection that opened a channel of communication, even though the two women initially struggled to get on the same page when it came to pain management decisions. In fact, this was the only of the vlogs that I watched where the doctor or nurse was identified as Latinx. It is entirely possible that other women were also attended by women who identify as Latinx, but these women are never shown on camera or identified as such. It is interesting then that Blanca, who in her testimonial video makes it clear that she is extremely proud of her birth experience, chooses to include this detail as part of the narrative of how she achieved a birth without medication.

Blanca, like many other women, recalls in her testimonial video that she wanted to wait and see what her body did on its own as she went into labor. As she describes her nurse, she paints a picture of a direct and to-the-point woman. As Blanca tells it, when the nurse first came to the room and introduced herself, “She was like, I'm not gonna lie to you, I'm not gonna sugar coat anything. I'm not here to babysit, if you want your epidural let me know when you want it, there is no need for pain." However, throughout the labor, as the two women became more acquainted with one another, Blanca pushed back against the nurse's authority, questioning her repeated suggestions that she go ahead and accept the epidural. In her testimonial, she recalls that

she asked the woman whether she herself had any children, and to her surprise the nurse reported that she had given birth to four children, all without epidurals. Blanca recounts saying to the nurse, "If you can do it, what can't I? And then she was like, ‘I don't think you can't do it, I just feel like...why go through pain,’ and I was like I'm okay though, and then she says ‘Okay, like I'm going to help you.’ And I feel like most nurses, they push for the epidural, like they get more money or something when you use the epidural, from what I've heard, I don't know..." Apart from Blanca's speculation about why medical authority push for people to accept an epidural during labor, her description of her interaction with this particular nurse demonstrates a marked change in the power dynamic between herself and this authority figure.

As Blanca goes on to describe, "She's like, ‘I'm gonna help you. I need you to stand up. I'm gonna put some pillows in front of you, and you're gonna lean forward and every time you feel a contraction you are going to shake your body back and forth and then you're going to have your husband rub your back and you're going to take deep breaths.’ So she was coaching me." In this particular instance, not only do we see a change in how Blanca and her nurse interacted, with her nurse assuming a more cooperative and supportive tone, but we also see a change in the process of medicalization. In the moment of this shift in the authority relationship between the two women, the nurse decides to aid Blanca in pursuing the birth she desires, and she in part does this by changing her tactics for pain management. This new type of pain management is more tailored and personalized, and this not only helps to shift the familiarity in the relationship between the women, it also relies less on medicalized understandings of how to manage the birthing body. It is interesting to observe that in the moment when the medical authority relationship is redefined, so too are the mechanisms used by hospital authority to aid the birthing person. While this is only one example of the connection between a medical authority and

instances of medicalization, it is interesting to consider, through the perspective of feminist literature on medicalization of birth, that when authoritative relationships between patient and healthcare personnel are restructured, the medical approach is also restructured.

Blanca, unlike some other women whose videos I watched, is also incredibly lucky in the kind of support system that she brings with her to the hospital. She says in her testimonial video: "I literally had a whole team of people, like people were coming in, the nurses were coming in and out and they were like, 'Oh you have a lot of people cheering you on here huh?' Everyone just stayed by my side." In the case of Blanca, we once again see how the subversion of medical authority can continue to positively shape the birth experience. As Fabiola reflects poignantly in her video, the most difficult part of giving birth in the United States was the absence of her family and their support. Even during her birth in Costa Rica, the most distressing part of the experience was the fact that she was unsure whether she should speak up and ask for her aunt to join her in the delivery room. For Blanca, particularly during the birth of her second child, it is evident, both in the vlog as well as in the video where she describes the birth, that she has many people acting as her partners during her birth. The most notable example of this, other than her husband Luis, is her sister, who, according to Blanca, attends and helps with the births of everyone in their extended family. In her testimonial video, Blanca reports that her sister "just makes you feel so calm," and that it was she who reminded Blanca during her labor that she could give birth without the epidural.

Just as Blanca's changing relationship with medical authority corresponded with a shift in medicalization aspects of her birth, so too does her sister's presence shape the authoritative nature of her interaction with a birth attendant and her relationship with medicalization. During one moment in her vlog video, Blanca holds the camera to film her face close up and tells the

viewer that her sister is helping her bounce on her plastic birth ball while holding on to the hospital bed. According to Blanca, her sister has told her that this will help to "open up." Still chatty and in good spirits at this point, Blanca reports, "What's crazy is that I thought I should be laying down, but it actually feels better when you're up and you're moving and you're not just lying there." In subsequent clips, we see Luis and Blanca's sisters squeezing Blanca's hips together and rubbing her back as she leans forward, gripping the edge of the hospital bed. During the time that she is in late labor and in the most pain, Blanca's sister quietly guides her through various positions, softly coaching her, all before doctors or nurses come to offer instruction.

For Blanca as for other women, a support network -- and particularly a close personal network such as family -- can positively shape their relationship with authority and medicalization. As Blanca describes it, having her sister coach her with an array of supportive strategies was helpful in making it through her labor sans epidural. Perhaps most importantly, though, is her sister's role as someone who not only encourages Blanca that she can achieve her goals, but as someone who, much like a doula, acts as a kind of mediator between the laboring person and hospital authority. As previously mentioned, the American College of Gynecology and Obstetrics highly recommends the use of a doula during birth because it has been empirically shown that having a birth partner in this way reduces maternal and fetal mortality as well as the c-section rate (ACOG, 2019). This is particularly powerful considering the fact that the presence of a doula is one of only a few things that ACOG feels with certainty reduces risks during labor and delivery. While no one has yet proved exactly what about the presence of a doula reduces mortality and morbidity, as well as various unnecessary procedures, many propose that it is the role that the doula plays in acting as a mediator between medical authority and patients that results in this decrease in negative outcomes. In my own doula class, this was one of the aspects

of the doula's job that my teacher emphasized. Part of the essential training a doula receives is learning how to help facilitate conversations between patients and providers, checking in with the patient and making sure they are comfortable and feel that they have received all the information they feel is necessary.

Of the initial much larger group of women who are included in this project, Yasmin is one of the only women who has a doula with her rather than family members or close friends to perform the birth attendant role. From the shots of the doula that we see during her vlog, she appears to be quite pale in complexion and not obviously a person of color. Here, the absence of members of Yasmin's shared racial and cultural community are served by someone not part of it, but who appreciates its importance and is still able to play a helpful, respectful role. Unlike many of the other women, Yasmin's delivery room is quiet, and reflects a reality of the modern era, that many people live far from the kind of extensive support network, particularly family, that offers crucial help during the birth process. It is easy to understand that, for Yasmin, having a doula would be helpful, and this becomes particularly apparent when Yasmin's labor becomes increasingly difficult. She labors for over 48 hours and pushes for two hours before being rushed to an emergency c-section. Like other women here, it was important for Yasmin to give birth without the use of the epidural, and her doula who quietly stays by her side is able to support her in this effort. It is unfortunate that services like doulas are often restricted in terms of accessibility, particularly for the many women who live far from the kind of family network who might accompany them and provide support and care during birth. There are initial efforts, particularly in NYC, aimed at trying to highlight the availability of doulas, specifically for Black and Latinx people. The extensive inclusion of the doula in this video of a Latinx mother arguably helps immensely with that effort. If a woman watches birth vlogs on Youtube and sees only

white women with doulas, it would be hard for her to imagine herself in that kind of birth narrative. Videos of birth vlogs where women of color use doulas can help to change that narrative.

Here again, however, the question of what makes a positive birth experience intersects with questions of access to resources. While there is a growing number of doulas and midwives who offer volunteer services or services on a sliding scale, this practice is not yet widespread. In addition, most doulas are trained in the tradition of people like Simkin, who fail to focus on how issues of culture and race affect the birth experience, as well as the kind of healthcare in general that individuals receive. This reality makes a strong argument for the importance of having a racial, ethnic, and socio-economic diversity of healthcare professionals, and particularly an increased diversity in leadership roles. In this way, more people could have the experience of Blanca and her nurse from Sinaloa -- though this sort of connection does not guarantee a positive patient-provider relationship, and positive patient-provider relationships can and should still exist outside of these circumstances.

This argument for a diversity of healthcare professionals as the means to reduce health care disparities in minority communities, in fact, returns to the very conception of this project, that despite education for healthcare providers on issues like cultural relativity, these practices, though well intentioned, seem not to have had much, if any, effect on how minorities report the quality of their healthcare experiences. Janelle Taylor reflects on this reality in her essay "The Story Catches You and You Fall Down" (the title, a play on the popular medical anthropological book *The Spirit Catches You and You Fall Down*). While doulas prepare for the position of supporter and mediator in a structured manner, this is a role that ultimately can be filled by anyone that the patient feels comfortable with and who are themselves able to separate from the

highly emotional nature of the birth to make sure that the parents feel supported and heard -- and this is what is demonstrated in the case of Blanca and her sister.

Jeni, like Blanca, emphasizes the importance of her local support system in her testimonial video in which she guides the viewer on "going natural." In her video, Jeni reflects that she feels that it was because of the presence and support of her mother and her boyfriend that she was able to give birth without an epidural. In fact, Jeni says that if she had to give one piece of advice it would be that you need "a strong strong strong support system, and also having a birth plan." The support of Jeni's mother and boyfriend is particularly evident in the vlog for the birth of her daughter, and it is particularly impressive that Jeni's boyfriend, Miguel, who like her appears to be very young, is so heavily involved in supporting her vision of a natural birth. In many of the videos I watched, many older men sat on a couch on their phone while their partner labored, but Miguel ,with his semi-adolescent mustache, intently watches the monitors in the delivery room, anticipating Jeni's next contraction.

Jeni and Miguel are cheerful and lighthearted, even as they are initially sent home from the hospital after the doctor reports that Jeni is not yet sufficiently dilated. However, in the next clip, we see Jeni and Miguel back at the hospital, with Jeni in a gown and seated in a wheelchair while Miguel holds the camera grinning widely and reporting, "We just got back to the hospital and she is 6 cm (turns camera to Jeni), like, how you do that?" Jeni smiles back at him proudly, with her hands resting on her stomach: "Yo I don't know how I'm doing this right now!" Here, as in much of the rest of the video, Miguel gently strokes Jeni's head and kisses her cheek as she exclaims, "I can't believe I did that," raising her head to receive a high five from her boyfriend.

As her labor progresses over hours, Miguel and Jeni's mother flank either side of her hospital bed, holding her hands and applying cool washcloths to her forehead. Upon Jeni exclaiming for the first time, "I can feel her coming down," we see a nurse, dressed in vibrant green and pink scrubs. Perhaps more than any other video, Jeni includes long clips of herself breathing through the worst of her contractions, as well as multiple long clips of her pushing. During this time, we watch Miguel and her mother help to hold Jeni's legs up to her chest as she pushes, while her mother leans over and whispers quietly to her daughter in Spanish. While the nurse who attends her birth comes off as rather cold and stern -- particularly when, during a painful push, Jeni moans and the nurse responds, "No noise, push" -- Jeni's mother and boyfriend form a calming and supportive circle around her. Jeni reflects by inserting a title into her vlog, Miguel was "the only thing getting her through" and that "he kept paying attention to the monitors so he knew when I was feeling the most pain." In the footage from after the birth, we again see Jeni sitting in a wheelchair, this time holding her swaddled newborn daughter. When Miguel asks how she is feeling, Jeni responds that she feels "like a champion," and though she is clearly exhausted she beams with pride.

Jeni's video is particularly special to watch in another way as it is the instance where there is most obviously a conflict between patient and doctor, and one where, in the narrative tradition of the "heroics of birth" represented in these videos, the patient triumphs. In her testimonial video, Jeni recalls that, in an appointment with her doctor, "I told the doctor, I'm gonna try and do it natural, and she kind of gave me, like a face, like, are you sure? And it is so funny because I had an appointment three days before I actually went into labor, and I told my OBGYN that I wanted to go natural as well, and she just completely ignored me, like, didn't give me any advice. Just wasn't very considerate...and that's why I say you have to have a really

strong support system because if I would've just went off of how my doctor reacted I probably wouldn't have gone natural." But, as Jeni says, "Once I put my mind to something, I'm like, I'm gonna do it, and I don't care what people say."

Not only in the way that she questions authority does Jeni challenge certain assumptions at the heart of medicalization. As I detailed in the literature review, a central element of the creation of a medicalized birth field was that the birthing body, and in that time the woman's body in general, was inherently faulty and in need of medical intervention. In the 19th century when male obstetricians began to replace midwives, a crucial assumption that the new field of gynecology and obstetrics put forth was that the birthing body required a level of expertise and authority to manage safely that only they could provide. In Jeni's testimonial, she guides us through her process of writing birth affirmations in her journal that she asked her mother and Miguel to repeat to her throughout her labor. One that she highlights for the video is the affirmation "believe that your body was designed for this". Here, Jeni explicitly contrasts her birth process with one of the most important assumptions of medicalization, that the body is inherently faulty and in need of "expert" medical intervention -- a position that Jeni's doctor repeatedly enforces.

It is disheartening to hear Jeni describe her process of forging her own path to get the proper information and create the experience that she hoped for during her labor and birth. She reports to the viewer in her testimonial that she did her own research on the epidural and found that it has the potential to slow the birthing process, particularly because since when a women in labor is numb it is not safe to walk or move around. In terms of the progression of labor, Jeni is correct in acknowledging that these are some of the drawbacks of receiving an epidural, otherwise considered to be a highly effective method of pain management. Undoubtedly,

receiving an epidural is the right choice for many people, but it is the duty of the provider that when individuals make this decision they truly do so without manipulation or coercion by being adequately informed of the process. We see this in the case of Fabiola, who was not made aware of the potential side effects before she accepted the epidural, and we see this reality again with Jeni when she has to do her own research to make her decision since her doctor did not present her with potential drawbacks.

Though many privileged white women may also face resistance and condescension from their physicians, it feels hard to untangle the fact that Jeni is a very young woman of color from the way in which her doctor dismisses her concerns, fails to offer her adequate advice or support, and is generally disrespectful of Jeni's wish to give birth unmedicated. In her testimonial video, Jeni describes the scene when her doctor finally arrived at the hospital and saw Jeni pushing on the bed: "'Why is she in so much pain?' and the nurse was like, 'She's on no medication, she didn't take the epidural,' and my doctor was like, 'Oh my god I can't believe you did it. Like, I didn't even believe that you were gonna do it,' and in my head I was like, I know you didn't believe me and that's why I did it." The moment in which Jeni recalls this is emotional and triumphant, as we see a young woman seated alone in her living room, reflecting on the ways in which she felt alone throughout this process, but incredibly proud, not just that she gave birth without using an epidural, but that she navigated and circumvented medical authority largely on her own.

In the end of her vlog, Jeni lays in a recovery room in her hospital bed and speaks quietly so as not to wake her newborn. Initially, she focuses on her success with the epidural: "This was the greatest experience of my life. I can't believe I went completely natural, no medication, and I'm so glad I did it. It was everything I expected it to be. I just, I feel so blessed that I'm healthy,

that my baby girl's healthy. I feel, not perfect, you know, but I think I feel way better than I would have if I took the epidural." However, both at the very end of her vlog as well as at the end of her testimonial video, Jeni pivots to talk about success and satisfaction in the labor and birth experience more generally, no matter how people chose to give birth" "I just want to say, for all the moms out there, whether you did it with epidural, c-section, naturally, VBAC...we're all freaking awesome." At the end of the testimonial video, Jeni finishes her thoughtful reflection of her own experience and her recommendations and guidance by once again opening the loop of motherhood discourse. As a last thought, she shares, "For all the mommies out there that have any questions, feel free to message me, I'm willing to answer anything and everything. Even very personal stuff, because I know how it feels to feel like you don't have, like, a mentor, or if you don't have a doula or a midwife, or if your doctor was like, you know, not so helpful like mine was. Basically, I did this on my own, and I know all of you can do it too."

CHAPTER SIX: Final Thoughts

As I explained at the outset, my initial plan for this thesis was to collect interview data, in person, from Latinx women detailing their experiences navigating reproductive health. I received IRB approval, and I then made flyers and informational leaflets inviting Latnx women to speak with me and posted these in Spanish speaking businesses in the Atlanta area. I also cold emailed health care organizations, both in Atlanta and in my hometown in Vermont, hoping to schedule interviews with practitioners as well as patients.

Though I did receive response to my recruitment efforts, it came only from white practitioners who worked with the Latinx community. Latinx women – my target study population – did not respond. When I spoke with Latinx women around Atlanta about whether they themselves or anyone they knew would be willing to participate in this project, I didn't receive any interest. This roadblock in my research plan led me to the conception of this thesis as it now stands, and to its conclusion: that qualitative data as self-reported by women belonging to the community of interest can serve as a crucial step in understanding how medical care is delivered to women and minorities.

The YouTube vlogs produced by Blanca, Liz, Yasmin, Fabiola, and Jeni stand as testimony to the power of women of color in charge of their own narratives of childbirth – the narratives they tell themselves, create with their practitioners, and share with others. The qualitative data that these narratives provide offer an important intervention into medical ethnography, for they offer us the experience of the subjects under study, offered on their own terms.

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