

QUEER COUPLES' NARRATIVES OF BIRTHING:
A B.C. FOCUS ON THE INTERSECTIONS OF IDENTITY, CHOICE, RESOURCES,
FAMILY, POLICY, MEDICALIZATION, AND HEALTH IN THE EXPERIENCES OF
QUEERS BIRTHING

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ABSTRACT

This thesis focuses on the narratives of 10 queer couples' birthing experiences in British Columbia. Not only does this thesis add to the continually growing anthropological interest in reproduction and kinship, but it also is able to reflect very practically on two recent changes in British Columbia: 1) the regulation of midwifery in 1998, and 2) the legal possibility of having two women named on their child's birth certificate, since 2002.

Three large themes arose from the research narratives: 1) the choices and experiences of having a 'medical' and/or 'natural' birth, 2) defining what 'kinship' and 'family' mean, and how roles and recognition are managed in a queer-parented family, and 3) how bureaucracies understand and deal with queer-parented families. In the end, this thesis provides an important and unique look at birthing and familial recognition in one of the most queer-friendly places in the world.

DEDICATION

To my children,
and all children of queer parents, whether through birth, adoption, or affiliation.

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INTRODUCTION

“The definition of birth as a medical event ... served to focus research on the physiological and often pathological aspects of childbearing. As a consequence, we have paid little attention to the social-interactional and social-ecological aspects of birth, which for members of a social species are of fundamental importance in orchestrating the biological event.” (Brigitte Jordan Birth In Four Cultures 1993: xv)

Miriam: We went through a lot for her to be here. She's not an accident, you know.

When people hear the word “childbirth” often images of stirrups, medical specialists in scrubs, and/or the memories of many painful hours of strenuous labour are what comes most vividly to their minds. If they are to think of *childbirth*'s relationship to *kinship*, images of a man standing next to the woman as she pushes, or of a few minutes later, when the woman covered by a hospital gown and the man crouched next to her hold their newborn baby, is what might come to mind. While birth is experienced in many other ways in our society, these images are central to how Westerners think about birth – a heterosexual couple and a medical setting.

As a queer¹ woman and feminist, I am uncomfortably aware of the prevalence of these images. When I was trained as a doula² in the fall of 2003, I recognized a

¹ I use the term ‘queer’ as an umbrella term for folks that may otherwise identify as ‘gay’, ‘lesbian’, ‘bisexual’, ‘trans’, ‘intersexed’, and ‘two-spirited’. I believe it also helps to break down the binary gender system, especially in being – or being attracted to – one particular sex. While I am aware of its negative connotations, especially in times past, it is now used as a political term which unifies (previously) marginalized folks of so-called ‘non-normative’ gender and sexual practices. This is done in an effort to bring people from the margins to stand together to counter the oppressive hetero-normative institutions and dominant powers. While not all of my participants identified as “queer” on a daily basis, they were aware that the research was using the term, and no one voiced concern over its use to discuss their experiences.

² A doula is someone who assists pregnant, labouring, and/or post-partum women. In ancient Greece *doulas* were well-respected women who were experienced in childbirth

shortcoming in the training. While we discussed the experiences of single and partnered women, and the possibility of assisting at lesbian women's births, there was no mention of how or why lesbian women might experience or make different choices regarding birth. As a woman who expects to birth³ a child later this year, the aforementioned scenarios contrast the situation I expect to play-out when I birth. Not only would I be extremely disappointed to experience birth in a hospital setting but also my partner is a trans-identified man. I, however, know that I am not alone in my 'difference'.

In the last three years, various people including: queer couples with children, queer folks who desire parenthood, and queer health-care workers, as well as midwives and midwifery students, have voiced similar concerns to me. When hearing of my research, they note the lack of materials discussing queer birth, and stress the importance of research in this field. In fact, one of the couples I interviewed noted that they had done informal research like mine prior to getting pregnant, to help them make decisions about donors and the birthing situation too. The study of queer couples' narratives of birthing thus presents an opportunity to explore some of the diverse choices and experiences that

and service to others. Doulas differ from midwives in their regulation and their level of training. This, in turn, affects what tasks each is legally entitled to do, especially with respect to a woman in labour. This will be expanded upon in Chapter 3.

³ I use 'birth' as a verb in an effort to 1) avoid the biomedical ways of speaking about birth such as 'delivery' and 'giving birth', and 2) to bring an awareness of the way the language of birth is used in our society, and influences how we then understand birth itself. Sheila Kitzinger notes: "Language expresses the way we think. It also *shapes* the way we think. Language can *make* a reality as well as reflect it... The language of birth is rich with clues to its social meaning in any culture. In northern technocratic cultures medical language still dominates and constricts perception of the birth process, and obstetric practice assumes that labour and delivery are the results of an equation between 'the pelvis', 'the powers' and 'the passenger', with the mother rendered more or less invisible, whereas uterine contractility and cervical dilatation are often discussed as if they occurred on a laboratory bench rather than in a woman's body." (2005: 57)

queer couples are having in British Columbia – a place not only with a variety of legal options surrounding birth available, but also home to some of the most queer- (family) friendly laws and policies in the world – while simultaneously exploring the interrelations of identity, choice, resources, public policy, medicalization, health, kinship, and queer birth.

While the last 25 years has seen a substantial increase in research and attention focusing on “lesbian mothering”, “lesbian-led families”, and “queer conceptions/insemination”⁴, there remains a representational absence regarding queer birthing. One of its only mentions is in Fiona Nelson’s *Lesbian Motherhood: An Exploration of Canadian Lesbian Families* (1996). In this book, Nelson recounts the story of a queer couple’s homebirth. Regarding a reaction of the attending midwife, Nelson states, “it is possible that the midwife was responding to this couple in the same way she responded to heterosexual couples, without considering that perhaps two women can give birth differently than a man and a woman generally do”(63). Despite the importance of this realization, neither academics nor activists have specifically focused on how birth may be experienced (differently) by a queer couple, beyond this mention.

⁴ For resources on “Lesbian mothering”, check out: Harris 2005; Comeau 2004; Sullivan 2004; Muzio 1999; Parks 1998; Tasker & Golobok 1998; Moraga 1997; Lewin 1995 & 1993; Romans 1992; Pollack 1990; Pollack & Vaughn 1987; Hanscombe & Forster 1981. For resources on “lesbian-led families”, check out: Epstein 2005, 1996a, 1996b, 1993; Foster 2005; Gabb 2004; Shanley 2002; Owen 2001; Dundas & Kaufman 2000; Dunne 2000; Benkov 1998 & 1994; Nelson 1996; Hayden 1995; Slater 1995. Here is a list of resources that cover various aspects of queer conception/insemination: Agigian 2004; Amato & Jacob 2004; Luce 2004, 2002a, 2002b; Mamo 2002; Toevs & Brill 2002; Bryld 2001; Murphy 2001; Pepper 1999; Saffron 1994; Hanscombe & Forster 1981. These resources are Canadian focused: Epstein 2005, 1996a, 1996b, 1993; Foster 2005; Harris 2005; Luce 2004, 2002a, 2002b; Owen 2001; Dundas & Kaufman 2000; Arnup 1997; Nelson 1996.

While studies and discussions of conception and kinship are important, birthing narratives represent an important and unique focus. This is because birth is both a rite of passage involved in becoming a parent, and because the birthing scene may be considered a public and outwardly visible event as a result of social interactions with public institutions such as hospitals, maternity clinics, and Vital Statistics Agencies. A study of the experiences and choices of queer birthing couples may thus not only be important for these reasons, but also because of its ability to reflect general cultural understandings of and interactions with queers in our society.

In western societies, the identities and practices of queer women explicitly challenge the heteronormative *status quo*. Farah Shroff (1997a) argues that, “Heterosexism permeates virtually every aspect of Canadian culture: language, guiding practices of all gatekeeping institutions, and social interactions” (287). Recent research has revealed that homophobia continues to be expressed by and in families, schools, fertility clinics, hospitals, courtrooms, taxi drivers, the mass media, research funding, and government policies (Epstein 2005, 1996a & 1993; Luce 2004, 2002a & 2002b; Kranz and Daniluk 2002; Nelson 1996; Lewin 1995 & 1993). Whereas this type of homophobia has had institutional backing in the past, some recent political transitions have altered this.

*

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Beth⁵: *Well, when we first got together, we've been together almost 24 years now. [M: Wow] When we first got together, one of the things that we talked about in the first year or 2, I think was that we'd like to have children. And we talked to both of our mothers*

⁵ All names from my fieldwork have been altered. The only name that appears unchanged is that of a lawyer who has agreed to have her name represented in my thesis. I am represented as “M” in the narratives.

about it. We had dinner together, us, four women had dinner together and talked about it with them. And both of them responded quite negatively about it, and were saying that it would be really hard for the child, and it, you know, wasn't really a good climate for that. And basically we got, kind of, talked out of it because we thought maybe that's right. Maybe it would be really hard for the child in school, and they would feel really different. So we didn't pursue it at all at that time.

Our parents' attitudes have totally changed a lot [since then]. I mean, they don't – I guess they realize the climate has changed out there. I mean there are lots of lesbian couples with children now, and the schools are not surprised by it anymore.

*

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Since the mid-1990s, government and social policies regarding “homosexuality” and “same-sex relations” have started to change (Epstein 2005; Kranz and Daniluk 2002; Kuehn and Findlay 2002). While “homosexuality” was decriminalized in 1969, in Canada, it took until 1995 for lesbians and gays to be protected under the equality provisions of the Charter of Rights (Findlay 2005). With this, change occurred much quicker. In 1996, British Columbia’s provincial government amended its Adoption Act to include “any person or any two persons [to] adopt” (Luce 2002b; also Findlay 2005; Owen 2001). The next year, the same government altered its definition of ‘spouse’ in order to legally recognize same-sex partners (Luce 2002; Owen 2001). It took until 2000 for the federal government to update the definition of ‘common law’ and ‘spouse’ (Kranz & Daniluk 2002; Luce 2002b; Owen 2001). Despite this, the legal recognition of same-sex marriage had to wait until July 2003, and June 2005, in the province of British Columbia and within Canada, respectively.

In British Columbia, the fight to have two mothers recognized on a birth certificate (if the child was conceived via an ‘anonymous sperm donor’) ended in August

2001, when the B.C. Human Rights Tribunal determined that the B.C. Vital Statistics Agency's practice of not allowing this was discriminatory⁶ (findlay 2005; Kranz & Daniluk 2002; Luce 2002). A Canadian Leger poll conducted that same year "indicated that more than 50% of the Canadian population felt that gays and lesbians should be denied the right to parent" (Epstein 2005: 9). The aforementioned legal changes, in addition to the social climate of having "more than half of the people around us believe we should not be allowed to be parents" (Epstein 2005: 9) have definitely affected the context and timeliness of my research. The fact that I am 'inside' this context sometimes made it hard for me to realize how unique and comparatively positive our social and legal environment is and has been. It is necessary to emphasize and understand the role the social and legal contexts have had in affecting the participants' experiences and narratives of this research project.

I came to this research to find out about the experiences, accounts, and motivations of queer-identified individuals with relation to birth. More specifically, I wanted to create an increased awareness among queer-identified individuals who are planning on birthing and wanting to know about (and learn from) the experiences of other queer-identified individuals. I also wanted to be able to foster an increased respect and understanding of individuals who are birthing and who do not fit into the culturally accepted and expected sexual and gender norms of perinatal care providers (including

⁶ Québec, Manitoba, and New Brunswick are the only other places in Canada where 2 women can be legally recognized as parents on a birth certificate, with each province having different measures regarding how and when this can occur (Wente 2007; Epstein 2005; Canadian Press 2002; Greenbaum, et al 2002; Séguin 2002). In June 2006, the Ontario Superior Court similarly noted the injustice in not allowing 2 women to be named on birth certificates of babies conceived through assisted insemination, and gave one year for the provincial government to change their provisions for birth registry (Makin 2006). As of early March 2007, the change is yet to occur.

GPs, midwives and doulas) and birthing spaces. Further, I believe it is valuable for queer communities in general to have this information available/accessible as it relates to queer negotiations with social and cultural institutions. While many may perceive my research to be comparative (ie: relating queer birthing to that experienced by heterosexuals), it has been more my intent to simply acknowledge queer birthing for what it is, in its diversity, rather than limit its study by comparing it to “normative” practices.

Through my interviews with 10 couples over a 9-month period, three particular themes emerged. First, while many of the couples stressed that they felt their experience was probably not that different from heterosexuals’ experiences of birth, their narratives addressed how queer families are inherently different and thus their experiences of birthing can actually be different. Second, most of the couples expressed their belief that pregnancy and birth are healthy phenomena that do not require medical interventions, and thus they discussed issues of medicalization and their choices to (most commonly) utilize midwives and doulas. Last, the couples all expressed confusion and stress over the bureaucracy of having their families recognized by the (hetero-normative) state, whether it be through Vital Statistics, the management of Employment Insurance (EI), or simply at the hospital. With regard to all of these issues, the couples did not hesitate to offer advice for other couples, and often thought their (sometimes contradictory) advice was just as suitable for heterosexuals as it is for queers, thus demonstrating the lack of ‘universal experience’ in either queer or heterosexual experiences of birth.

CHAPTER 1

THEORY, HISTORY & ANTHROPOLOGY: THE CONTEXT OF THE STUDY

The topic of my Masters research emerged out of my interests in kinship, medicalization, reproduction, gender, and sexuality, and thus I felt it was necessary to ground my research in feminist and queer theory. I recognized that addressing the representational absence of queer birthing would be relevant to the ongoing development of studies of kinship, reproduction, gender, and sexuality, as well as within medical and feminist anthropology, while perhaps shedding light on these studies from a different and important angle. Moreover, reflecting back to my interviews, the couples spoke about kinship and their choices regarding birth in ways that demonstrated their awareness of the social history and significance of ‘kinship’ and the pull between ‘medical’ and ‘natural’ childbirth, and what each represents (and has represented) to women, to feminists, and to queer individuals. Thus, it is important to review these histories and the theories that have accompanied them, to better understand the context in which the couples’ choices and experiences are/were situated.

KINSHIP & REPRODUCTION

In *Reproducing Reproduction* (1998), Helena Ragoné and Sarah Franklin note that, “[a]nthropology was founded amidst what has been described by some as an ‘obsessive’ interest in matters of kinship, procreation, and succession” (1). Traditionally, kinship and reproduction were studied to gain insight into social structure, including relations and regulations (Gough 1975). In “The Origins of the Family” (1975), Kathleen Gough’s

main purpose was to explore and speculate about the origins of kinship, with specific attention of the role of The Family in society. While she notes that, “no one really knows the origin of the family” (1975), Gough reviewed research on non-human primates, “the tools and home sites of prehistoric humans and protohumans”, and modern hunters and gatherers (1975: 51), in an attempt to find evidence of family structures and their origins. What Gough found was that, “The family is a human institution, not found in its totality in any prehuman species” (1975: 73). Instead, she notes that the family emerged around the same time as language, tool use, and group cooperation, as similar brain functions are required for all of these (Gough 1975), “sometime between about 500,000 and 200,000 years ago” (Gough 1975: 62). Moreover, Gough notes that family became a practical arrangement as the sexual division of labour, based on physical capabilities (such as nursing, childcare, and work close to home for women, and hunting for men), meant that “neither man nor women [could] survive long without the work and produce of the other sex, and marriage is the way to obtain them” (Gough 1975: 65). Further, she explains that the...

...[r]ules banning sex relations among close kinfolk must have come early [as] they [have] at least two functions. They help to preserve order in the family as a cooperative unit, by outlawing competition for mates. They also created bonds *between* families, or even between separate bands, and so provided a basis for wider cooperation in the struggle for livelihood and the expansion of knowledge. (Gough 1975: 61)

Similarly, writing on the family under capitalism, Collier, Rosaldo and Yanagisako (1993) note:

...so it takes more than making babies to make a Families... rather, The Family (thought to be universal by most social scientists today) is a moral and ideological unit that appears, not universally, but in particular social orders. The Family as we know it is not a ‘natural’ group created by the claims of ‘blood’ but a sphere of human relationships shaped by a state

that recognizes Families as units that hold property, provide for care and welfare, and attend particularly to the young – a sphere conceptualized as a realm of love and intimacy *in opposition* to the more ‘impersonal’ norms that dominate modern economies and politics. (14)

A link between kinship and social structures becomes obvious from Gough (1975) and Collier et al’s (1993) discussions of the social purposes of kinship structure, relations, and regulation. This link is also evident in the various explicit discussions of reproduction that have emerged over the years.

Reproduction is undoubtedly usually associated with women, and thought of in a sexual or “continuation of the species” sense rather than a cultural or economic one. Collier, Rosaldo, and Yanagisako (1993) explain that in terms of kinship, even 19th century...

...functionalists, themselves concerned to understand all human social forms in terms of biological ‘needs’, turned out to strengthen earlier beliefs associating action, change, and interest with the deeds of men because they thought of kinship in terms of biologically given ties, of ‘families’ as units geared to reproductive needs, and finally, to women as mere ‘reproducers’ whose contribution to society was essentially defined by the requirements of their homes. (13)

More recent kinship and gender theorists, however, have pointed out that reproduction involves much more than biology.

In *Conceiving A New World Order* (1995), Rayna Rapp and Faye Ginsburg explain the importance of studying reproduction in a broader sense than just biology. First, they explain that “classic theories of kinship and exchange have fetishized women’s roles as wives and mothers, neglecting the significance of women in broader cycles of cultural production” (Ginsburg & Rapp 1995: 15), They elaborate noting:

By using reproduction as an entry point to the study of social life, we can see how cultures are produced (or contested) as people imagine and enable the creation of the next generation, most directly through the nurturance of

children. But it has been anthropology's longstanding contribution that social reproduction entails much more than literal procreation, as children are born into complex social arrangements through which legacies of property, positions, rights, and values are negotiated over time. In this sense, reproduction, in its biological and social senses, is inextricably bound up with the production of culture. (Rapp & Ginsburg 1995: 2)

Their understanding connects biological to cultural to economic re/production – connections that are key to a variety of kinship theorists.

Gender, kinship, and economics are closely related and intertwining notions. For many theorists, kinship exists due to the gendered division of labour (Yanagisako & Collier 1987; Gough 1975; Rubin 1975). Gayle Rubin (1975) notes that, “Kinship and marriage are always parts of total social systems, and are always tied into economic and political arrangements” (207). Moreover, Susan Greenhalgh makes reference to political-economic demographers who: “stress the links between macro political and economic processes such as the development of capitalism and the modern state, and micro reproductive behavior” (1995: 4). Certainly within the discussions of economics and kinship, Marxist and Engelsian theories are prominent in linking production and reproduction to economics. Engels talks about how production and reproduction have a twofold character:

[O]n the one hand, the production of the means of existence, of food, clothing, and shelter and the tools necessary for that production; on the other side, the production of human beings themselves, the propagation of the species. (Rubin 1975: 165)

This reflects the “means/end relation between the family and capitalism [that] has prevailed in Western sociological thought” (Yanagisako & Collier 1987: 25).

While Pedroso de Lima's (2000) focus is on family businesses, her comment about the ties that bind within Portuguese familial enterprises can further be applied to

families in general. She states, "In fact, in this social context, family relations are built around a web of economic interests that bind people together whose interests in the enterprise are often opposed" (151). When one considers, as Rubin (1975) and many others (McKinnon 2001; Pedroso de Lima 2000; Greenhalgh 1995; Yanagisako & Collier 1987) do, that capitalism feeds off the fact that, "it is usually women who do housework ... [and that] the labor of women in the home contributes to the ultimate quantity of surplus value realized by the capitalist" (Rubin 1975: 162-3), the link between kinship and gender is strengthened. Moreover, the notions of "production" and "reproduction" are not only economic factors but also gendered ones.

As Sylvia Yanagisako and Jane Collier note in "Toward a Unified Analysis of Gender and Kinship" (1987), gender and kinship are inherently linked or "mutually constituted" (32). Whereas Schneider (1980; also Pedroso de Lima 2000; Scheffler 1991; Rubin 1975) has emphasized the notion that sexual procreation is central to Western concepts of kinship, Yanagisako and Collier (1987) illustrate how gender is undoubtedly involved in this relationship as well. They note that:

...not only are ideas about gender central to analyses of kinship, but ideas of kinship are central to analyses of gender. Because both gender and kinship have been defined as topics of study by our conception of the same thing, namely, sexual procreation, we cannot think about one without thinking about the other. (Yanagisako & Collier 1987: 31-2)

This is made particularly evident in the early kinship theories that explained the social function of kinship as a necessary merging of people of differently socially gendered roles (Yanagisako & Collier 1987; Gough 1975; Rubin 1975).

Ginsburg and Rapp (1995) address how kinship and gender, even among those who attempt to live alternative or counter-discourse practices, may continue to be dominated by the mainstream ideals. They note that:

The most powerful work coming out of this perspective emphasizes that people cannot develop oppositional positions independent of the categories of the dominant culture, even as they attempt to destabilize them. This point is not always taken into account by those who romanticize resistance as a complete alternative to hegemonic impositions or those who see oppositional practices everywhere, without considering the relationship of intentionality to action or outcome. This complexity is evident, for example, in the case of lesbian mothers, who often strive to create households modeled on conventional American nuclear families. They intentionally deploy this normative household arrangement to legitimize themselves in legal arenas, even as their actions undermine the heterosexual assumptions of that form. (11)

Moreover, with the emergence of New Reproductive Technologies (including surrogacy and *in vitro* fertilization) and the rise of feminist and queer theory, increased attention and debate/controversy has been focused on kinship constructs and constructions of motherhood (Tjørnhøj-Thomsen 2005; Agigian 2004; Levine 2003; Franklin 2001 & 1995; Murphy 2001; Thompson 2001; Dunne 2000; Finkler 2000; Wozniak 1999; Hayden 1995; Peletz 1995; Strathern 1995& 1992; Shore 1992; Cannell 1990). As Cris Shore explains in “Virgin Births and Sterile Debates” (1992):

What makes these [New Reproductive] technologies so controversial is their social and legal implications. Not only do they ‘crystallise issues at the heart of contemporary social and political struggles over sexuality, reproduction, gender relations and the family’ (Stanworth 1987a: 4) but they challenge our most established ideas about motherhood, paternity, biological inheritance, the integrity of the family, and the ‘naturalness’ of birth itself. (295)

Interestingly enough, these questions and controversies bring us back to one of the most noted kinship anthropologists of the 20th century, David Schneider.

When David Schneider studied kinship in the 1950s, 60s, and 70s, he was mostly “concerned with American kinship as a cultural system; that is, as a system of symbols” (Schneider 1980: 1), and focused on ‘cultural norms’ and generalizable understandings of kinship. While Schneider claimed that there was an overall trend among anthropologists to focus more on the “social relationships”, his “insights into how U.S. kinship uses metaphors of blood and contract to condense and naturalize the biological and social bases of relationships” (Rapp 2001: 468) have greatly influenced feminist kinship studies (Pedroso de Lima 2002; Franklin 2001 & 1995; Rapp 2001; Segalen 2001; Thomas 1999; Hayden 1995; Peletz 1995; Schneider 1995 & 1980; Strathern 1995, 1992a & 1992b; Williams 1995; Shore 1992; Scheffler 1991; Weston 1991; Cannell 1990; Yanagisako & Collier 1987). Consequently, while Schneider mostly studied ‘cultural norms’, he also brought a new perspective to light, one that has heavily influenced recent kinship studies, especially those relating to adoptive, foster, and queer families, as well as families affected by New Reproductive Technologies.

Studying queer couples’ experiences of birthing provides a unique and important perspective to the study of kinship. Lesbian-led families are unique in their ability to exemplify the new studies of kinship due to their redefinitions of gender and parenthood and biological relations. As Hayden (1995) explains:

Lesbian mothers simultaneously affirm the importance of blood as a symbol and challenge the American cultural assumption that biology is a self-evident, singular fact and *the* natural baseline on which kinship is built. Biology is not understood here to stand on its own as a defining feature of kin, nor does biogenetic connection retain any single, transparent meaning. (56)

Lesbian couples who have children thus subvert the traditional notion of kinship, while also benefiting from it, and redefining what kinship is. This became even clearer through my participants' narratives.

It was my hope that in my studies of queer couples' birthing experiences I would become privy to the various ways kinship is embodied by lesbian-led families at the time when society typically recognizes the start of a family (i.e.: at time of birth). It was also my hope to see (or be told of) the negotiations between the medical system and these families, to witness how challenges to traditional notions of kinship are navigated by dominant social and cultural institutions that generally privilege biological notions of kinship. The timing of my project has been crucial, as we are amidst a time when so many challenges to traditional notions of kinship are emerging, and social and cultural institutions and opinions are left to cope with them. My particular research, however, not only validates the experiences and kinship configurations of the couples that I met, but also validates the realities and values of queer couples' families and, more specifically, their birthing experiences.

THE MEDICALIZATION, ANTHROPOLOGY & HISTORY OF BIRTH

Studies of medicalization and the anthropology of birth are not new. In 1978 Brigitte Jordan published *Birth in Four Cultures*, and noted within it the importance of recognizing that birth "is everywhere socially marked and shaped" (1993: 3). She further explained that "since giving birth in most societies is women's business, a study of the ways in which parturition is managed in different cultures cannot but improve and broaden our appreciation of the organization of female networks, interests, and

strategies” (5). Since Jordan’s seminal book, birth has continued to be studied in anthropology, most notably by Robbie Davis-Floyd (2003) and Sheila Kitzinger (2005 & 2000). Both anthropologists acknowledge that birthing rituals, like other rites of passage, serve to “transmit cultural beliefs and values to the individuals participating in those rites” (Davis-Floyd 2003: 1; similarly Kitzinger 2000: 9-10), and have critiqued the Western medical model approach claiming that due to “standardized” care, women are “stripped” of their individuality and compared to a “norm” (Davis-Floyd 2003; Kitzinger 2000). Davis-Floyd (2003) and Kitzinger (2000), while advocates for more “natural” birthing practices, both acknowledge that there are benefits to medicalized care, and acknowledge that some women prefer it to the less technologically-mediated alternatives. The pull between ‘natural’ and ‘medical’ birthing practices was central to the choices that my participants made regarding their pre-natal and birth care. These choices and my participants’ experiences of them need to be situated in the long history of women-centred ‘natural’ care, and the more recent emergence of ‘medical’ care, to fully understand the factors at work in these choices and narratives.

While the biomedical model is prevalent today in birthing practices, women-centred and community-based care has a much longer history. Risse explains that before 4000 BC, “birth attendants were experienced mothers of the community helping their friends and neighbours” (1993: 51), in pre-literate societies. More recently and locally, “midwives ... played a vital and often highly respected role in social and health affairs, delivering most of the babies” (Shroff 1997b: 15) in pre-Canadian indigenous communities, and “Aboriginal midwives provided much-needed services for early Canadian settlers” (Bourgeault, et al. 2004a: 4). Midwives continued to attend most births

within both Aboriginal and settler communities through the late 19th and early 20th centuries until medicalization gained momentum, credibility, and respect. The fact that midwifery's strong history is often overlooked, or presented in a negative fashion, demonstrates the extent to which knowledge and maternal care has changed over time. In fact, medicalization has changed much of how bodies, well-being, and illness are viewed and experienced (Thachuk 2004; Lupton 2000; Tesh 1996; Turner 1995; Risse 1993; Foucault 2003; Doyal 1981).

According to Risse (1993), early health care – similar to early midwifery— consisted of community and individual-based holistic practices, and placed an importance on nature and spirituality; early health care focused on individuals' accounts of their own health and illness. With the establishment of the Greek and Roman empires, in the West, came the development of literate healers who were privileged. During the Middle Ages, healers and health care saw “increasing fragmentation and specialization of skills” (Risse 1993: 55), which compounded with the centralized training in established universities in the Renaissance. Coinciding with this new training was also a new understanding of the human body, and therefore the beginning of a different type of care for patients. Medical thought and practice began to change relatively quickly with the centralization of knowledge and training. Scientific medicine, methods and measurements gained authority over personal accounts in health care as a “rationalization of society” and pathologizing of anatomy took place (Lupton 2000: 58; Turner 1995: 206; Risse 1993: 64; Foucault 2003: 2; Doyal 1981: 31-5).

Turner (1995) notes, “the history of the medical profession over the last century represents an interesting illustration of the growth of medical dominance under the

auspices of the state, associated with the development of a professional body of knowledge” (208). Disease categories –a characteristic of standardization – debuted during the 18th century, and appeared “objective” and “scientific”, yet the categories were actually socially constructed, and “managed by bureaucratic agencies” (Turner 1995: 208). Regarding disease categories and the professionalization of medical care, Turner notes:

The power of the professions depends, at least in part, on the ability to make claims successfully about the scientific value of their work and the way in which their professional knowledge is grounded in precise, accurate and reliable scientific information. Therefore the way in which disease categories are socially constructed is of critical importance to the status and role of professions in contemporary society. In this respect, medical professionals have become the moral guardians of contemporary society, because they have a legitimate domination of the categorization of normality and deviance. (1995: 208-9)

In other words, “[t]he medicalization of society involve[d] ... a regulation and management of populations and bodies in the interests of a discourse which identifies and controls that which is normal” (Turner 1995: 210). While standards were established to make actions and conditions “comparable over time and space” (Timmermans & Berg 1997: 273), and provide an “objective” and scientifically-based groundwork, “norms” are more socially constructed than scientifically-backed (Root & Browner 2001; Lupton 2000; Rapp 2000; Butt 1999). While diverse bodies, conditions, and contexts exist, they are all compared to the “norm”, and “[s]tanding for normality ... is [often] the white, heterosexual, youthful, middle-class, masculine body” (Lupton 2000: 58). In short, a new level of regulating “norms” was established, which became known as “medicalization.”

As Conrad notes, the definition of *medicalization* “has not always been clearly articulated” (1992: 210), and part of this stems from the different ways people see its

role. *Medicalization* undoubtedly “describes a process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorders” (1992: 209). In other words, it might be defined as “medical social control.” In terms of the emergence and expansion of *medicalization*, Conrad notes that:

Analysts have long pointed to social factors that have encouraged or abetted medicalization: the diminution of religion, an abiding faith in science, rationality, and progress, the increased prestige and power of the medical profession, the American penchant for individual and technological solutions to problems, and a general humanitarian trend in western societies. While factors like these do not explain increasing medicalization over the past century, they have provided the context. (213)

While religion is often perceived to have been the moral guide in Western societies until the last century, “Numerous writers have suggested that medicine has ‘nudged aside’ (Zola 1972) or ‘replaced’ (Turner 1984, 1987) religion as the dominant moral ideology and social control institution in modern societies” (Conrad 1992: 213). Moreover, many theorists argue that women are much more the focus of the (patriarchal) medicalized gaze (Martin 2001; Williams & Calnan 1996; Conrad 1992).

Childbirth and other issues related to reproduction, are often cited as the primary sites of medicalization (Parry 2004b; Davis-Floyd 2003; Martin 2001; Kitzinger 2000; Davis-Floyd & Sargent 1997; Conrad 1992; Waitzkin 1989). Theorists argue that this is due to patriarchy and having control over women and reproduction (Parry 2005 & 2004b; Agigian 2004; Mamo 2002; Martin 2001; Murphy 2001; Franklin 1997; Inhorn 1994).

[F]eminist scholars and activists argue that nowhere has the medical model been more invasive and harmful than in issues connected to women including pregnancy, childbirth, birth control, abortion, surrogacy arrangements and the mapping of the human genome (Woliver). (Parry 2004b: 81)

Marcia Inhorn explains, “[t]hat women’s bodies are considered the locus of ‘disease’, and hence the site of anxious surveillance and intervention, is apparent in all of these studies of infertility [and reproduction, in general]” (1994: 460). Moreover, Williams and Calnan note that:

...women experience childbirth as ‘alienating’ ... as a consequence of the negative medical metaphors and images which pervade women’s bodies and the definition of them as ‘other compared to male ‘norms’.... (1996: 1610)

It is not surprising then that medicalization has changed the experience of childbirth and pre-natal care in multiple ways.

The authors of “Where to Give Birth? Politics and the Place of Birth” (2001) point out that:

The most significant change in twentieth-century maternity care was the movement of the place of birth from the home to the large hospitals. At the beginning of the last century virtually all births occurred at home; but the end of the century almost every woman who gave birth in an industrialized country (with the odd exception of the Netherlands) did so in a hospital. (Declercq, et al. 2001: 7)

The change in the location of birth was associated both with the development of different technologies and medicines, as well as the criminalization of midwifery, in various parts of Canada. In fact, for most of the 20th century, Canada was the only industrialized country “without formal provisions for midwifery practice” (Bourgeault, et al. 2004a: 3). Thachuk refers to Wendy Mitchinson’s work when she discusses the two positions historians have taken regarding the turn from midwifery to medicalized childbirth:

Early feminist historians posited that the decline of midwifery was a direct result of the medical profession actively wresting childbirth from the hands of women, while physician historians emphasized the benefits that the medicine has to offer and the role women themselves played in the transition to hospital-based births (Mitchinson 2002, 69-70). (Thachuk 2004: 57)

While the percentage of women who birthed in Canadian hospitals increased from 17.8% in 1926 to 76% in 1950 (Thachuk 2004), it was only two decades later when “the counterculture women’s movement of the 1970s witnessed a renewed interest in midwifery care” (Thachuk 2004: 59). This renewed interest was related to both a mistrust in the medical establishment in general, as well as the feminist movement’s call for choice and accountability in issues related to women’s bodies, and reproduction in particular (Bourgeault, et al. 2004b; Thachuk 2004; Martin 2001; Wrede, et al. 2001; Rice 1997; Conrad 1992).

The 1960s and 1970s were notably a time of grassroots organizing, emerging counter-cultures, and general challenging of the status quo (Bourgeault, et al. 2004a; Rice 1997). These years, served as the building ground for the legislation of midwifery across Canada, and in British Columbia in particular. The over-lying political currents of the 1960s and 1970s, were a “general lessening of trust in professional authority, an unprecedented decline in respect for medicine, and a growing recognition of the emotional, social, and spiritual components of life and healing in particular (Barrington 1985; Rooks 1990)” (Bourgeault, et al. 2004a: 7). Sirpa Wrede (2001) points out that “maternity care, with its medicalized and alienating approach to birth, was an apt illustration of women’s oppression by patriarchal social structures” (3). Moreover, with the west coast being “the counter-culture centre of Canada”, it is not surprising that the Canadian midwifery revival movement originated here in the early 1970s (Bourgeault, et al. 2004a: 9). In fact it was during the 1970s that both the Midwifery Association of B.C. (MABC) – a professional organization – and the Midwifery Task Force (MTF) – a group of midwifery consumers – formed and initiated their battle towards the legalization of

midwifery in B.C. (Kornelsen & Carty 2004). It was not until the early 1980s, however, that the first official legal recognition of midwives occurred in British Columbia.

While the first legal recognition of midwives occurred in the early 1980s, the actual process towards legalization and regulation of midwifery did not really start until the 1990s. In 1981, the first two midwives in B.C. were given legal permission to practice, but only at Vancouver General Hospital, and under the supervision of a physician (Rice 1997). In 1984, two more midwives were granted legal permission to join them (Rice 1997). This first legal acceptance fostered increased public and governmental support, leading midwives to practice as primary care givers, at Grace Hospital (now B.C. Women's) by the end of the 1980s (Kornelsen & Carty 2004). Many nurses and physicians, however, continued to experience and express discomfort and concerns regarding the practice of midwifery (Kornelsen & Carty 2004), through the 1980s and 1990s, when legal changes started to favour midwifery.

In 1990, the provincial government passed the *Health Provisions Act* enabling various unregulated groups resources facilitating regulation, including appointing a Royal Commission on Health Care and Cost (Rice 1997). In their 1991 report to the government, "the Commission recommended [among other things] the introduction of nurse-midwifery as the first logical step" (Rice 1997: 157) in legalizing midwifery "as an autonomous profession" (Kornelsen & Carty 2004: 111). In "Reality, Opinion and Uncertainty: Views on Midwifery in BC's Health care System" (1999), Jeanne Lyons and Elaine Carty, explain the next step the government took:

In 1993, at the International Confederation of Midwives 23rd International Congress held in Vancouver, B.C., the government of British Columbia announced its intention to implement midwifery as an autonomous profession within the health care system. (4)

In 1995, the provincial Cabinet announced “approval of regulations governing midwifery and establishing the College of Midwives of British Columbia” (Rice 1997: 163), and in 1996, the Minister of Health announced full public funding for midwifery clients starting January 1, 1998 (Kornelsen & Carty 2004; Lyons & Carty 1999; Rice 1997). While considered a victory by many birth attendants and families, others questioned if the “spirit of midwifery” was threatened through its regulation (Kornelsen & Carty 2004; Thachuk 2004; Daviss 2001; Lyons & Carty 1999; Rice 1997)

In North America, because midwifery has often been a grassroots, woman- or community-centred practice, its regulation through a bureaucratic organization has both reassured medical staff of the legitimacy and competency of midwives, as well as caused many previous supporters of midwifery to question whether its fundamentals have been pushed aside or lost altogether (Kornelsen & Carty 2004; Thachuk 2004; Daviss 2001; Lyons & Carty 1999; Rice 1997). While regulation meant that midwives could finally legally practice in the province, it also meant compromises were made in order to gain increased public, medical, and governmental support. Since 1998, midwives are required to attend births both in homes (of their clients) and in hospitals, in order to maintain their licenses. Consequently, midwives need to maintain positive (non-threatening) relationships with physicians, for fear of losing their hospital privileges (Westfall 2002). Further, regulated midwives need to follow particular standards of practice, schedules, and indications – whether or not they believe them to be right. Betty-Anne Daviss notes that “finding a way to maintain their ideals and their holistic, nonmedical style of practice as [midwives] attend more and more hospital births [is perhaps their most difficult challenge to date]” (2001: 83). Similarly, Angela Thachuk explains that the “potential co-

optation and medicalization of midwifery practice, increased distancing between the midwife and client, and further augmentation of a governing hierarchy, collectively linger as a threatening presence” (2004: 56). Rachel Westfall explains:

A particular style of midwifery has been adopted, one which is apparently more concerned with integrating midwifery with the existing health care system than with providing women with an alternative to medically managed birth. (2002: 53)

Alison Rice acknowledged that this was recognized by midwives in her 1997 chapter “Becoming Regulated: The Re-emergence of Midwifery in British Columbia.” She also noted, however, that “the paradox of seeking regulation as a means of gaining freedom to practise and choice for women has received little attention” (151). These tensions have not only been recognized through the fact that many women with years of experience attending births have chosen not to register with the College of Midwives and thus are no longer practicing, while many regulated midwives have proven unreliable or unknowledgeable in hospital settings⁷. Despite the changes in midwifery practice, nurses and physicians remain(ed) guarded regarding legal and regulated midwifery practice.

As briefly mentioned earlier, many nurses and physicians experienced great discomfort when midwives started to practice at Grace and Vancouver General Hospitals in the 1980s (Kornelsen & Carty 2004; Rice 1997). Their concerns did not dissipate once the government announced the regulation of midwifery. Instead, as Jeanne Lyons and Elaine Carty (1999) point out, during the midwifery and home birth information sharing tour of the province in late 1997 – just months before regulation took effect – many physicians and nurses held “a belief that anyone who is not a physician is not qualified to

⁷ This was brought up by a few of the couples I spoke with. Two examples of this are given in Chapter 3. It has also been noted in casual conversations I have had with current and formerly practicing midwives/birth attendants.

provide adequate care to a pregnant woman and her newborn” (22). Lyons and Carty explain that:

While some physicians are very supportive of midwifery and some have given generously of their time and energy to support the implementation of midwifery, it appears that the majority feel at least somewhat threatened and some are frightened or angered by the integration of midwifery into the health care system” (1999: 21)

In the almost eight years since regulation (and coverage under the provincial Medical Services Plan), most doctors have developed very positive relationships with midwives, and recommend them to their pregnant patients⁸.

The unique needs and situatedness of the women and families I interviewed was key to my research. Thus, as the next chapter explains, I considered the history of birthing, as well as the historically marginalized position of women, and particularly queer folks, as I designed and carried-out my research, in order to provide space for the “less told” stories to be expressed.

⁸ A few of the couples I interviewed mentioned this, and midwives I know have verified their positive (business) relations with physicians.

CHAPTER 2

METHODS & METHODOLOGY

The development of feminist, queer, and qualitative methods over the last 30 years has meant research with an explicit aim to represent previously marginalized and misrepresented people has gained much attention and credibility. In “Can There Be a Feminist Ethnography?” (1991), Judith Stacey discusses how in the early- to mid-1980s...

Feminist scholarship began to express widespread disenchantment with the dualisms, abstractions, and detachment of positivism, and were rejecting the separations between subject and object, thought and feeling, knower and known, and political and personal – as well as the reflections of these separations in arbitrary boundaries of traditional academic disciplines. Instead, most feminist scholars advocated an integrative, transdisciplinary approach to knowledge, one that would ground theory contextually in the concrete realm of women’s everyday lives. (111)

As traditional research practices rarely took women’s accounts, experiences, and analyses into consideration, both as a result of their design and their aims, feminist research emerged with this as a goal, with the “[explicit] political aim of challenging gender oppression and improving women’s lives” (Gillies & Alldred 2002: 32). Over time, feminist methods expanded to embrace an “analysis of forms of power and oppression” (Franklin, et al. 1991: 1), not limited to gender. With this broader view came an understanding that multiple factors affect oppression, and...

[d]ifferences based on ethnic identity, nationality, class and sexuality [became] increasingly important within feminist work, leading both to the documentation of experiences and to challenges to theories and concepts within feminism based on limited models of the category of ‘woman’. (Franklin, et al. 1991: 3-4)

Moreover, in terms of ethnography, increased involvement by ‘insiders’, whether through collaboration in research design, involvement in editing their own transcripts, or through auto-ethnographic work, has altered the way research is being conducted by feminists and non-feminists alike, by breaking down some of the power imbalances and exploitation or misrepresentations of earlier research methods – at least theoretically⁹.

Contextualization is often perceived to assist in the breaking down of power imbalances, through providing the background for what is going on. This is key to qualitative studies. Mason explains:

Through qualitative research we can explore a wide array of dimensions of the social world, including the texture and weave of everyday life, the understandings, experiences and imaginings of our research participants, the ways that social processes, institutions, discourses or relationships work, and the significance of the meanings that they generate. We can do all of this qualitatively by using methods that celebrate richness, depth, nuance, context, multi-dimensionality and complexity rather than being embarrassed or inconvenienced by them. (2002: 1)

Contextualization has been important in the development of queer methods, as well as feminist methods.

Similar to women, people of ‘non-normative’ gender and sexual expressions were not treated well in their first exposure to research methods. Instead, research was used by ‘outsiders’ as “instrument[s] of pathological diagnosis” (Kong, Mahoney & Plummer 2003: 92), and to “study perversions.” Joshua Gamson explains in “Sexualities, Queer theory, and Qualitative Research” (2003) that:

The history of social research on sexualities has elements familiar from the histories of women’s studies, ethnic studies, and the like: It is a history intertwined with the politics of social movements, wary of the ways ‘science’ has been used against the marginalized, and particularly

⁹ Judith Stacey discusses the challenges to the practical application of these theoretical concepts in “Can There Be a Feminist Ethnography?” (1991).

comfortable with the strategies with qualitative research – which at least appear to be less objectifying of their subjects, to be more concerned with cultural and political meaning creation, and to make more room for voices and experiences that have been suppressed. (540-1)

One particular way to “make room for voices and experiences that have been suppressed” is through narrative.

Narrative, or the “account of the way in which human life is storied” (Miller 2005: 8), is a qualitative research method that has been widely embraced within feminist and queer research, and is “increasingly visible in the social sciences” (Lieblich, Twal-Mashiach & Zilber 1998: 1). Part of this increasing visibility and wide use relates to the fact that, as Amia Lieblich, Rivka Twal-Mashiah, and Tamar Zilber explain in *Narrative Research* (1998),

Narrative research ... differs significantly from its positivistic counterpart in its underlying assumptions that there is neither a single truth in human reality nor one correct reading or interpretation of a text” (2)

Narrative research is now often used to explore major life events, such as coming out as gay, lesbian, or transgendered (Ben-Ari 1995), and is very commonly used to research people’s experiences of motherhood, becoming a mother, or of childbirth itself (Miller 2005 & 1998; Juhasz 2003; Jordan 1993; Daly & Reddy 1991). Moreover, Ellen Lewin (1993) explains:

...personal narratives offer us a chance to see how women *account for themselves*, make sense of their situations, and designate themselves in relation to others – how they, in fact, negotiate their identities in collaboration with or in opposition to prevailing cultural expectations. (14)

Lewin’s quote resonated with me as I thought of how to develop my research. In designing my research, I considered various methodological approaches, but decided that due both to the fact that my research participants are queer women, and that I am

studying a major life event, that feminist and queer research methods were necessary to consider, and that narrative would be the focus of my research. Moreover, using feminist, queer, and narrative research seemed to fit best with my objectives in this study. At the same time, however, I realize that:

fieldwork represents an intrusion and intervention into a system of relationships, a system of relationships that the researcher is far freer than the researched to leave. The inequality and potential treacherousness of this relationship is inescapable. (Stacey 1991: 113).

This has, therefore, played into my considerations of appropriate methodology for my research.

This Study

RESEARCH PURPOSE

The purpose of this study is threefold. While the general purpose of this research is to investigate the experiences (through narrative) of queer peri-natal couples, it can be broken down into three more specific purposes: 1) to validate¹⁰, 2) to document, and 3) to make materials regarding the choices, experiences, and resources available which discuss queer birth available. Underlying these is my general desire to create more of an awareness and understanding of these experiences, for queer communities, health

¹⁰ By “validate” I mean take what my participants say and acknowledge it for what it is. My point was not to critique or analyse what or why they were saying, but to just give them a space to have their experience heard and acknowledged. I chose this approach because their experiences (and other queer birthing experiences) had yet to be recorded at all, and I felt it was more important to have these voices/experiences represented in the way the participants themselves voiced them, rather than asserting my power and judgement over them. I am thankful and indebted for their sharing, and realize that while not always explicitly stated in our interviews, the couples participated to be represented and heard, not to have me critique or pass judgement on their experiences and choices – rendering these individuals from a socially and legally marginalized group further to the margins.

providers and birth attendants, as well as the general public. Thus, I felt it was important to ensure that multiple perspectives were presented and discussed by my participants. All the same, I recognized that no matter how homo- or heterogeneous my sample turned out to be, it would not be a ‘representative’ one.

Having a ‘representative sample’ was not central to my research. First, obtaining a representative sample would be next to impossible as there is no agreed upon statistic regarding the characteristics of queer parents in British Columbia – it is not even clear how many queer parents exist in B.C. Moreover, if such a compilation of statistics existed, it would be hard, not only financially and time-wise, to recruit a representative sample, but also due to the somewhat closeted or hidden nature of queer individuals in a heterocentric society. Secondly, my goal was to generate rich, contextual data for the purposes of preliminary exploration in this field, rather than to conclude that such-and-such percentage of queer couples choose a particular type of care, have caesarean sections, and/or divide parenting roles in a particular manner. Therefore, hearing diverse narratives, which would likely bring to light issues and experiences not unsimilar to other queer (or even straight) couples, was more important than having a sample of participants (and narratives) that is statistically representative.

MY METHODS

When I was first planning my research I realized that people would possibly narrate their experiences differently if more (or less) time had passed since the birth had occurred. For this reason, I decided to have two similar but different samples. The first sample would participate in 2 interviews, the first when pregnant and the second post-

partum¹¹. The second sample would only partake in 1 interview. To qualify for participation in this latter group, the couple had to have birthed within the last 3 years in British Columbia. Recruitment and the style of interview was the same for both sample groups.

Between July 2005 and March 2006 I interviewed 10 couples, in a total of 16 interviews. Participants were recruited via the convenience sample technique known as snowball sampling. An initial email describing my research, including the purpose, location, and participants' qualifications was sent out through email listservs that were further passed on. People also learned about my research through word of mouth. Either way, potential participants contacted me (by email or phone) if they were interested or had questions.

All of the interviews occurred in the homes of the participants, and were tape-recorded, after the informed consent forms were signed. The interviews were all conducted with both parents simultaneously, allowing both partners to narrate their own experiences, as well as add information and anecdotes while listening to their partner's experience. The interviews lasted from between half-an-hour to slightly over 2 hours, in length. After I transcribed the interviews, and deleted and/or changed identifying information, each couple had the opportunity to offer feedback, clarification, and/or editing with respect to their own transcripts. Once approved, transcripts were coded for key themes and stories, and thematic analysis was undertaken.

Thematic analysis allows for "broad patterns [to become] recognizable" (Westfall & Benoit 2004: 1401). I chose this type of analysis after I conducted my first three or

¹¹ This decision was inspired by Robbie Davis-Floyd's research, in which she noted: "Whenever possible, I interviewed women both before and after their births." (2003: 3).

four interviews, when I realized very similar themes were emerging in all of the interviews (so far). After deciding which themes were going to be focused on, I used highlighting felt pens to colour code the themes in each transcript. I colour coded in the margins as some sections of narrative corresponded to more than one theme. After seeing (through highlighted colour) and comparing the narratives for each of these themes, I was able to recognize the smaller themes that emerged as well. The larger themes that emerged then formed the 3 main chapters of this thesis¹², while many of the smaller themes formed the sub-sections within these chapters.

THE SAMPLE

While I attempted to obtain a heterogeneous sample, in terms of geographic location, age, education level, class, ethnicity, and birth choices and experiences, this was only partially accomplished. Despite efforts to contact potential participants from various regions of the province, all of the interviews occurred with current residents of Greater Vancouver or Victoria. In terms of education, my participants were all well educated (in terms of a formal education), with 4 of them having taken at least some college courses or finished a diploma, 10 of them with at least a Bachelor's Degree, and 6 participants working on graduate studies at either a Masters or a PhD level, or having completed a graduate degree. In terms of the racial and ethnic backgrounds of my participants, they were fairly homogenous with 18 of the 20 participants being Caucasian, 1 of South Asian

¹² The three chapters focus on these themes: 1) the choices and experiences of having a 'medical' and/or 'natural' birth, 2) defining what 'kinship' and 'family' mean, and how roles and recognition are managed in a queer-parented family, and 3) how government bureaucracies understand and deal with queer-parented families.

descent, and 1 of First Nations' heritage. The participants ranged in age from 31 to 51, and the couples had been in their current relationships between 2.5 and 24 years.

The 10 couples were either between 31 and 38 weeks pregnant, at the time of our first interview, or they had birthed within the last 3 years. With the 6 couples that were pregnant during our first interview, I conducted follow-up interviews between 4 and 13 weeks post-partum with them. In all, 13 births were talked about: 6 planned home-births (4 of which were subsequently transferred to the hospital) and 7 planned hospital births. Moreover, 11 of the 13 births involved midwives, and 4 had planned active involvement from a General Practitioner (GP), Obstetrician and/or Gynecologist (OB/GYN). Further, 3 of the families had used known sperm donors, and 7 of the families had used anonymous donors to conceive.

While it would probably be easier for the reader if I provided a chart or described each of the couples that I interviewed, I have only given aggregate data due to how closely knit the queer-parenting community seems to be. From my understanding, 9 of the 10 couples who participated found out about my research through 1 of 2 email listservs, and many of the couples had connections with other participants. The fact that these 9 couples were so connected to each other, whether just online or in-person, demonstrated to me not only the need to keep their identities obscured, but also I believe helps to account for some of the similarities in their opinions and choices – especially since the 1 couple that had no connection to the other 9 had such a different experience and education level. In the end, I have tried my best to maintain everyone's anonymity, even more so because one of the couples expressed great frustration in regards to how their anonymity had not been maintained in a previous research project.

LIMITATIONS

As with any research, a variety of limitations were placed on my research, mainly relating to financial and time constraints, and the sheer size of the thesis. Considering I was completing this research for a 2-year Master's program with one small fellowship, I knew that my fieldwork would have to be relatively inexpensive and quick. This meant that while I had a couple from northern British Columbia express interest in participating, I could not financially afford to travel to see them. As it was, I tried to pair interviews on Vancouver Island with trips to see my partner's family there – to save on ferry costs. While my participants are quite homogenous on many levels, they each presented unique narratives, and thus, multiple perspectives were voiced and are available here for others to hear. While my findings are no doubt valid, it is possible that someone conducting a similar study would have different outcomes if their sample was different, in any way, from my own. Related to this, I had at the outset wanted even more voices to be expressed in my thesis.

I had first hoped to interview at least one midwife as well as a lawyer, to gain their perspective on differences on queer birth, kinship, and legality. As it was, however, I had to leave out a lot of information that I gathered from the interviews with couples. Moreover, as my time “in the field” went on, I realized that their perspectives would not fit within the main focus of my research.

MY POSITION/REFLECTIONS

As previously mentioned, I came to this research as a queer woman who expected to birth in the next few years. I also came as a lifetime resident of Greater Vancouver,

and as someone with doula training. Perhaps because of the history of pathology and ostracism in research related to queer folks (Gamson 2003; Kong, Mahoney & Plummer 2003), research within the lesbian community, and lesbian-parenting community in particular, has gained increasing interest, possibly to the point of saturation, resulting in some people being hesitant to be involved in my research. On the other hand, numerous participants stated that despite having participated in other research, they wanted to participate in this research project because they felt that research in this area was important. One couple mentioned their hesitancy to participate because in previous research their anonymity had not been protected. They were, however, still eager to have their story told. I believe part of the willingness of my participants to be a part of this study was that I am a queer woman, and I expressed to most of the couples, my desire to birth, and therefore my personal interest in this study.

During the interviews, I felt like we often spoke as peers, and that although I asked most of the questions and had them sign a consent form, we shared an understanding that often involved participants asking me personal questions in return. Our relationship was furthered by post-interview emails regarding their transcribed interviews, as well as by greeting each other in public if we saw each other. Despite the involvement of my participants in actively editing their transcripts, I have maintained a role of orchestrator, *per se*. I have had the final say of which slices of narrative are used and how they are presented.

CHAPTER 3

FEMINISM, MEDICALIZATION & MIDWIVES ... OH MY!

“We urge listening to the women... They are the ones who have unique access to their own experience of labor. And they are the ones who will be in relationship with that child once she or he is born.”

-Helen M. Sterk “Partners or Patients?” 2002: 167

This chapter discusses queer birthing as spoken of by the couples I interviewed. As such, it is the chapter that most explicitly looks at birthing itself, by considering the choices and experiences the couples made regarding the use of doctors and midwives, as well as in locating their births at home or at the hospital. At the same time, this chapter delves into the context within which the couples experienced their births, exploring the implications of living in a medicalized society where midwives have practiced legally, province-wide, for less than a decade. This discussion sets the stage for the following two chapters, which consider different aspects of how the broader issue of kinship has been experienced by the couples, with relation to birth: in their everyday life and bureaucratically.

“Medical” or “Natural” Birth: the continuum, the dichotomy

“...society and culture shape birthing women’s desires about what they *want* and the maternity care they *receive*”

-Cecilia Benoit “Introduction to Part III” *Birth By Design* 2001: 201

While not every pregnant woman or couple perceives themselves to have a choice regarding birth attendants, or location of, and interventions at their birth, every couple I

spoke with approached their experiences around having choice in these matters. In British Columbia there are two types of people who can legally “manage”¹³ births: doctors and midwives. Doctors, whether General Practitioners (GPs) or Obstetricians/Gynecologists (OB/GYNs) are legally entitled to manage births in hospitals, while midwives can (and in fact, are required by their governing body to) manage births both in hospitals and in homes (Westfall & Benoit 2004; Lyons & Carty 1999). In their choices surrounding selecting a care provider and the preferred location of birth, people often situate their decisions around discourses of “natural” and “medical”, just as my participants did. The “natural” philosophy embraces the notion “that ‘nature knows best’” (Westfall & Benoit 2004: 1402), meaning the woman’s body and baby need no assistance or intervention for birth to occur. Medical care, on the other hand, embraces more of a philosophy of “medicine knows best.” In most cases, people choose a birth that is a mix of both, as there is more that factors into their decisions than simply “natural” or “medical”, and they are able to benefit from the strengths of both approaches.

When asked about how the decisions were made about maternity care and preferred location of the birth, an array of answers were given by the couples. While some couples explicitly pointed out that recent government cutbacks limited their choices, others noted that aspects of their identity (such as being a ‘hippy’ or a ‘feminist’) influenced their decisions. Others still, commented on the important role that feeling comfortable or safe had in their decisions. Some couples wanted to avoid the standardized, impersonal “medical model” at all costs. On the other hand, many of the couples talked about how their ‘queer-ness’ affected their decision, outwardly

¹³ Although “manage” may seem like a strange word here, this is the legal-ease regarding the job of birth care attendants.

questioning whether or not they felt that their sexuality played into the decisions they made. Olivia noted how being queer was almost inherently related to being feminist, and thus suggested this affected most couples' choices.

Olivia: Most queer couples have some kind of feminist analysis, you know, even if they don't identify it. They still, they see, you know, they recognize power, power imbalance, that power's been taken away from you.

I find Olivia's comment resonates with what many – but not all – couples noted in terms of their choices. Another element that definitely affected many of their choices was the influence of their friends, families, and favourite birth and prenatal books.

The recommendations and advice from friends, family, and books seemed in some ways to over-ride the influences of other aspects. One example is how while many factors were involved in Julie and Nicole's decision to have a hospital birth, Nicole noted:

Nicole: Like I think it would be better to stay at home but... I couldn't do it and I couldn't imagine explaining it to people, because I know people... I think that they would be a little bit concerned and wondering what was wrong with us to actually stay at home even though the hospital is probably far dirtier and less healthy...

Likewise many couples noted that they used a doula because their friends had recommended them, and Liz and Miriam used an OB/GYN because their fertility clinic and a book recommended using one. Books were often turned to in pregnancy in an effort to become more informed about the choices and experiences the couples might encounter later in their pregnancy or during birth. Two particular books that stimulated a fair bit of conversation were *The Essential Guide to Lesbian Conception, Pregnancy and Birth* by Kim Toevs and Stephanie Brill (2002), and Rachel Pepper's *The Ultimate Guide to*

Pregnancy for Lesbians: Tips and Techniques from Conception through Birth: How To Stay Sane and Care for Yourself (1999).

Although couples often found other books (like Penny Simkin's *The Birth Partner* [2001]) more helpful, the two aforementioned guide books were a focus of much discussion due to the fact they are intended as a source of advice for queer women. When couples spoke about the books, they usually noted that Toevs and Brill made some interesting points, but nothing really new for them – considering the women had already received advice and knowledge from their queer friends – and that Pepper was very focused on single-parenting, or parenting with partner who had no intention to co-parent. In my own reviews of the books, I noted that despite the claims of the books' titles, both books spend considerable space discussing conception (from choosing a donor to “what if I can't get pregnant?”), and therefore do not leave much room for discussions of pregnancy, and even less space for birth. In fact, in Pepper's 211-page book, the chapter on birth is 15 pages and no mention about unique experiences that lesbians may or may not have is made. In Toevs and Brill's 23-page chapter on birth (of a 489-page book), discussions range from choosing childbirth education classes to different locations of birth to interventions to legal aspects of queer parenting – leaving little room for a discussion on birth itself. Toevs and Brill do make one mention of a possible difference for lesbian women, regarding birth. They note that at the time of birth, the non-birthing partner may resent her partner or her partner's situation if the non-birthing partner has previously tried to become pregnant and been unsuccessful (431). While an interesting consideration, both myself and the couples who talked about this book, felt unsatisfied with the information provided. Overall, the couples I spoke with felt other books made

for better resources, and felt that most of the time friends were the best resource of all, in terms of helping them to make informed decisions surrounding the types of births they wanted. Couples had different experiences accomplishing their chosen types of birth. Being able to fulfill their desires for particular types of birth proved particularly difficult for the couples living on Vancouver Island.

VANCOUVER ISLAND & CHOICE

Each of the three couples from Vancouver Island noted that insufficient choices or care was available to them, in terms of location of birth and midwives. All three of them experienced birth at the Royal Victoria General Hospital, the only hospital that has a maternity ward in Greater Victoria. None of these couples was content with birthing at the hospital, and felt if they lived elsewhere (i.e.: Vancouver), their choices of caregivers and birth environment would be much different.

Case #1

Judith: *We were living in an Island community. And, we were planning to have a home birth. Well, actually, we had a hard time getting a midwife because there was only 1 midwife in our community at the time. We started to see her...*

Olivia: *We started first kind of researching someone else who was up-Island too, and so, anyhow, we decided to go with the one in our community at first even though it wasn't a good fit.*

Case #2

Nicole: *The hospital thing for myself...I mean it's dirty and disgusting but besides that we've been fed so many horror stories about what it's like to have birthing in homes that we've decided that we're going to go to the hospital to do it. Even though doctors and nurses are not washing hands properly, the cleaning staff is doing a horrible job and people are getting nasty infections. But because we've heard so many horror stories about midwifery in the home and what if something bad happens in the home, we decided*

to go the hospital, when in fact the midwives are so knowledgeable, they know the position of the baby, they've been doing it since the beginning, and it's very rare that you actually have an intervention in a hospital....they do more interventions. But for me it's a scary thing, like I think it would be better to stay at home but I couldn't do it...I couldn't do it and I couldn't imagine explaining it to people, because I know people...to talk about midwifery in general is like "oooooh, midwifery, it's a scary thing, what about complications?" So there's such a bad attitude as it is towards that and I couldn't deal with it. As much as I think our families are very supportive. But I think that they would be a little bit concerned and wondering what was wrong with us to actually stay at home even though the hospital is probably far dirtier and less healthy...

Julie: She's not exaggerating, when we went for the hospital tour, we watched the very young cleaning staff chasing each other with these leaking garbage bags and laughing as they were leaking all over the floor...

Nicole: And dripping, and they didn't go back and wipe it up or anything.

Julie: And our prenatal class instructor told us to make sure that you wear slippers or flip flops all the time because of whatever and don't touch anything...and I went wow, that is so poor...my grandmother was a nurse and in her day, everything was scrubbed down everyday not by contractors. So just having to deal with that extra level of precaution, trusting that things are okay

Nicole: And then there were all these women who'd had C-sections and infections from the C-section and it's probably from the doctors and nurses not cleaning properly, even given the cleaning staff. It's a problem beyond that and our prenatal instructor says she sees it all the time. So we're kind of, we have fear going in there but we have fear not going in there so we're really kind of stuck I think. We probably were pressured more into the hospital thing because there are so many other outside pressures pushing us there.

Case #3

Chantelle: Well, we are planning a home birth. There are a few reasons we chose that. Victoria only has one hospital, one maternity hospital now. They used to have a really nice birthing centre in Saanich, and they've closed that down. So, that's the Liberal government for you.

~ ~ ~
Chantelle: The problem is what women need are good birthing centres. And if we'd had the baby in Vancouver, we would have gone to a hospital that has a birth centre in it. There isn't that choice in Victoria.

M: So, you think being over here really complicated things?

Chantelle: Yeah, I really do think that if we'd been in Vancouver, and we'd gone to a hospital, there would have been more help around, you know? I don't think I would have had to have a C-section. I mean, that's just my hunch, but I think more could have been done, before it got to a critical stage.

It is clear that all of these couples felt they lacked a real choice, and were not totally comfortable with the “choices” they made. Moreover, while Chantelle most clearly reflects on the political aspects of choice and availability, Olivia and Judith, and Nicole and Julie were also undeniably aware of them.

Sirpa Wrede, Cecilia Benoit, and Jane Sandall address these politics in “The State and Birth/ The State of Birth” (2001), when they note:

It is easy to forget that what happens in a maternity care clinic is a product of work done in legislative assemblies and ministries of health. State policies influence everything from the interactions between caregivers and clients to the clinical outcomes. (28).

While Chantelle mentioned the closure of the “nice birthing centre in Saanich”, this was not the only birthing environment to be shut down in recent years. Judy Rogers, the Director of Ryerson University’s Midwifery program has in fact noted that, “In British Columbia ...13 rural hospitals have closed their maternity wards since 2001 because they don't have the resources to keep them open” (Gunn 2007). It is clear that many women – queer or not – lack a real *choice* in most of British Columbia. Vancouver, in contrast to the rest of the province, has many more options available for childbearing families, both in terms of hospitals and midwives. Not surprisingly, Vancouver also has the most

diverse population, making it easier for queer families to be respected and understood, while defining themselves in contrast to the “norm.” This “contrast to the norm”, however, meant that many couples’ experiences either when trying to conceive or in early pregnancy were monumental in shaping their later decisions to avoid the “norm” of using medicalized care.

PRE-CONCEIVED EXPERIENCES

“Claiming your right to bring forth life into the planet, rather than have your baby ‘delivered’ is much more than just semantics. It takes education and trust. Claiming this power is definitely a lesbian and feminist thing to do, but often it seems harder for lesbians to claim than for heterosexual women... Making our conceptions medical events rather than intimate life experiences lays the groundwork for a medicalized birth.”

-Kim Toevs and Stephanie Brill *The Essential Guide to Lesbian Conception, Pregnancy, and Birth* 2002: 432

While I tried to focus as much as I could on *birth* itself, I found people’s stories needed to be told not only within their cultural (and historical) context, but also within the context of the personal journeys towards becoming parents. The juxtaposition that Toevs and Brill (2002) present was definitely expressed one way or another by the couples I spoke with. The impact of the couples’ medical conceptions and early pregnancy care, however, often had the direct opposite effect to what Toevs and Brill suggest. At various points in their interviews, most couples referred back to their efforts to conceive their child or their initial doctors’ visits.

Case #1

Beth: When the [Reproductive Endocrinologist] did his exam with me and interviewed us, he recognized that I didn’t have the greatest hormonal set-up for getting pregnant, and so he was saying to Theresa, ‘Well, you know, you are both women. Why don’t you get pregnant?’ And Theresa was saying, ‘well, you know, because I don’t want to’. And I was going, ‘And I want to. I want to be the birth mother.’ And he’s like, ‘Well, it would be a lot more logical.’

Theresa: Logic has nothing to do with it.

Beth: Yeah, so it was just interesting that he just saw us as interchangeable, or as just bodies that were interchangeable. But that's the only time I really did feel that somebody really didn't get any of this.

Case #2

Lindsay: Before Heather was inseminated she had to have an x-ray to make that sure her fallopian tubes weren't blocked, so they could flush her tubes and take pictures. And I had made up my mind that I wanted to be a part of every step of the way. And so we asked if I could go into the x-ray room with them, and they were just like fully, 'no, no, no, no, no, you can't come.' And then finally, they begrudgingly permitted me in the room and then they stuck me so far in a corner, away from everything, that I never, I couldn't be any comfort to Heather, and I certainly couldn't see. And I mean, I wasn't doing it on principle, I was really curious as to what the process would be. And yes, if, if I could be of any comfort, I thought it would be nice to be there.

Case #3

Leila: I tell them [the start date of my last menstrual period], August 4 or whatever. And the doctor goes, "ok", and I said, "and we inseminated on August 13th and 14th." And she goes, "and when you say 'inseminated' do you mean, 'had sex'?" And I thought, "Oh my god, I feel sorry for her boyfriend, or whatever cause that's a rather clinical way of saying have sex." And so I said, "No, I mean inseminated." Like I'm a lesbian, and I'm trying to get pregnant through insemination. And she said, "oh, is that like, in vitro fertilization?" And I said, "no, it's like insemination." With insemination you introduce sperm into the vagina during the time that, and, you know what they say. It is kind of like sex, but different, you know. Yeah, so there I was upset, cause she dropped this bombshell on me telling me I wasn't pregnant [after four positive home pregnancy tests], and I'm educating her about the differences between, you know, inseminating using a Petri dish in a lab, and you know, inseminating myself at home with my spouse. It was clear that she hadn't reviewed my file at all, she didn't know that I was a lesbian, she didn't know anything about lesbian reproductive technology. Certainly less than your average People

magazine reader, apparently. Cause it's not that unusual at all, and that was obviously somewhat disturbing and traumatic. And that was, the last time I went to my doctor.

It should be noted that neither Beth, nor Lindsay, nor Leila say the doctor was homophobic or unfriendly. They acknowledge that the doctor is unfamiliar with “lesbian reproductive technology”, and with lesbians in general. It is not that they were denied a service due to their sexuality, but rather that they were bunched in with heterosexuals, and thus their unique needs were not understood, and went unacknowledged and unmet. KJ noted that the fertility clinics were “...directed at [infertile] straight couples. We’re just slotted into that model.” Lindsay reflected that the fertility clinic was “probably when we bumped into homophobic experiences ... not a lot, but that’s kind of where it got started.” She also hinted that some of their problems were not based on homophobia but the *standardized* preferences of medicalization, which often do not support the involvement of partners in various processes.

The frustrations and feelings of disrespect at this point in their narratives are, unfortunately, not unique to the women I spoke with, but often reflected in the literature on women and medicalization. Three particular ideas relate to these women’s experiences. First, many scholars have noted that women and homosexuals have long been the focus of medicalization, due to their “non-normativeness” (Agigian 2004; Gamson 2003; King, Mahoney & Plummer 2003; Finkler 2000). Second, Amy Agigian points out that, despite this, “in/fertility seems to be a rare case when lesbians are not deemed to have a medical problem. Lesbian fertility issues remain invisible” (2004: 46; similarly Murphy 2001). Agigian continues by noting “medicalization and invisibility work together to disempower lesbians under the sign of taboo” (2004: 53). This plays

into the third notion regarding the relationship between medicalization and lesbians – the power of medicalization. As Kaja Finkler (2000) notes, “It has long been recognized that the medicalization process has become a form of social control” (179; also Agigian 2004). Given these notions, the standarization of fertility clinics, and in particular, their treatment of queer patients, should come as no surprise, regardless of how just such treatment is.

For many of the couples, this was part of why they chose midwifery service, a type of care they saw as less “standardized”, and thus more able to cope with individual needs while demonstrating an increased respect and understanding for non-normative families. Interestingly enough, the couple that chose the most medical experience did so in part due to a recommendation by their fertility clinic, to use an OB/GYN as their primary pre- and peri-natal care giver. While their experience fits into the “medical extreme” of care, most of the couples broke down the dichotomy of “natural” and “medical” by using midwives in the medicalized setting of the hospital. While 2 of the births narrated to me could be considered at the “natural” end (and others were planned to occur this way), and 2 at the “medical” end, most demonstrated the existence of a merging, and thus a continuum, between “natural” and “medical.”

GOING AU NATUREL: home is where the heart is

The most natural birthing experience is often perceived to be an unattended or midwife attended birth at the family home. MacDonald (2004) explains that the resurgence of “midwifery sought to restore the definition of birth as a natural event, to reinvent women as competent birthers and attendants, and to restore the location of birth to the home” (49). In my first interviews, half of the couples expressed interest in having a homebirth

attended by midwives¹⁴. Reasons for this involved being in a “cozy”, familiar space; being able to have a water-birth¹⁵; and having a less standardized/medicalized experience.

Case #1

Chantelle: *I thought, you know, I don't wanna go in there and be in a small room, with a, in a really, hospital, medical environment. I want an active labour, where you can move around in labour, and be in more comfortable positions, in whatever works for you, instead of, you know, being stuck on the bed.*

Case #2

Leila: *Well we registered at both BC Women's and St. Paul's. I haven't toured either of them yet. We're touring them at the end of the month. But, ah, St. Paul's is just a little less ... Women's is a really corporate, and it's kind of weird.*

KJ: *Well, I don't know if it's corporate, but they've have a weird person running their advertising. They try to sell you the 'value added' package.*

Leila: *“TM.” Yeah, a lot like, would you like fries with that? It's the super-sized birth, at Women's. For \$150 you can get a private room, subject to availability, and a free 8x10. laughs*

KJ: *For \$150 and you're still lucky to get a private room, if you get a private room.*

KJ and Leila decided once Leila was already in labour that their birth was going to occur at home¹⁶. Leila and KJ's birthing narrative was told like this:

Leila: *Yeah, well, I'd gone into labour about 1:30 in the morning, you know, but really mildly, and we'd hung-out, went grocery shopping, and made muffins, you know those*

¹⁴ The College of Midwives mandates the presence of 2 midwives (or a midwife and an assistant, in rural areas) at homebirths, whereas typically only 1 is present at hospital births.

¹⁵ Water birthing tubs are available at some, but not all hospitals.

¹⁶ Leila and KJ had prepared for a homebirth, but were more prepared and expecting to birth at a hospital.

sorts of things. You know? [**M:** Making muffins?] Well they tell you to have an activity. Have an early labour activity to keep you occupied, so mine was making muffins.

KJ: Yeah, and right in the middle of the delivery, basically, there was a pie cooking. Cause she'd wanted the smell of pie cooking, [**Leila:** and I'd made an apple pie] before, yeah, so I put the pie in the oven about the time you were transitioning, about an hour before the birth, and almost burnt it, but the, ah

Leila: But bear in mind, bear in mind, yeah, I didn't care about that at that point, but bear in mind, I am the housewife and KJ doesn't really know like where things are in the house, like I have control in the kitchen, which is obviously changing and stuff, but at that point I'm like, "turn it on", you know, telling her how to turn the oven on [**KJ:** step by step] yeah, what temperature, take it out of the bag, remember the sugar

KJ: She's in the leg pool in the kitchen, yelling all these instructions at me

Leila: And then of course when I'm pushing, the smoke alarm goes off, because of course the sugar is burning off all over the place and burning on the bottom of the oven, and I'm like, "open the back door, go upstairs, take the battery out." You know while I'm pushing a baby out of my abdomen, [everybody laughs] yet I'm directing traffic, I'm just a control freak.

Case #3

Wendy and Kim, who had a hospital birth with their first, and a planned homebirth for their second, said they chose midwives both times – and a home birth for their second birth – because they “really wanted to have care that saw pregnancy as a normal function, not as a medical thing to manage.”

Wendy: [The home birth] was, oh my god, it was amazing. It was like, “here you are! Here we are, right in our home!” It was great!

Kim: This is great, to be at home.

Wendy: This, I was so glad to have him at home. Like it was phenomenal. Totally, way, way, way

Kim: It does not compare to our experience with Nathan. It is so, so different.

Certainly issues of privacy and having more control over the birth space were central in the decisions to have homebirths, and rely on midwifery care. Not surprisingly, these ideas also came through in the narratives of the successful homebirths. The joy the couples' voiced regarding their home births carried over to their post-partum midwifery care. Leila and KJ most enthusiastically spoke about this continuity of care.

After having a very positive home birth experience, KJ and Leila thought that they might see their midwives once or twice. Instead, a variety of issues arose for the couple – unrelated to them having a homebirth – with which their midwives could help. KJ and Leila were happy to find out their midwifery care did not end with the birth of their son.

KJ: *We thought we'd only see them once or twice afterwards and that'd be it, but we've had midwives here, oh, the first 7 days, and then*

Leila: *Everyday they'd come and do home visits to weigh him and check-up, and see how we were doing. Like, it's really a great service. I just love it.*

Later in the interview when asked about recommendations they would make to other queer couples, they added:

Leila: *That's the one. Everyone we've talked to, we've made that recommendation, my parents are the same. My Mom is like, "Oh my god, those midwives are great!" Yeah, no, they are brilliant. And it's covered by BC Medical, so there's just no reason not to, you know*

KJ: *They come to your home for a few days. Otherwise you have to go to a doctor, and I just couldn't imagine doing that.*

Leila: *Look at us [in our pajamas]! We can't even have you come 4 weeks later! Can you image us getting out?!?*

Leila and KJ's recommendation was echoed by many of the couples who had hospital births, as well. Moreover, the recommendation of midwifery care was made equally for queer and non-queer parents, as the benefits of midwifery care went beyond any issue regarding gender or sexuality.

THE HAPPY MEDIUM: midwives in hospitals

Of the births narrated to me, 9 of the 13 involved midwifery care at hospital births. This seems a very common practice in melding "natural" and "medical", with queer and non-queer couples and individuals, alike. Farah Shroff uses an example to illustrate why it may specifically be a preference for lesbians to use midwives at hospital births.

One lesbian mother who had her baby in a hospital described the role which the midwife played as being one of a 'cultural interpreter'; she knew she could count on her midwife to defend her choice to have her female partner with her during the delivery and get hospital staff to acknowledge her partner as one of the child's parents. Where the choice is available, lesbians having babies frequently choose home birth because it is a way to get away from what some lesbians describe as 'the heterosexists environment in hospitals.' They were very drawn to the woman-centred approach which midwifery offers. (1997a: 288)

Midwifery was certainly the preferred choice for 11 of the 13 births, and couples named a variety of reasons why they chose that type of care.

When each couple told me who their prenatal care provider was, I inquired as to how they came have that type of care provider. For the couples that used midwives, their decisions were based on various expectations, experiences and ideologies. Lindsay noted: "I just, it just never occurred to me to think beyond a feminist framework, and so probably, we framed our choices around the birth that way." Nicole noted a few different influences on she and Julie's decision to use a midwife, including an academic

background in anthropology focusing on gender and reproduction, as well as the fact that their friends had had a positive experience using midwifery services. Similarly, Diana noted that (her partner) Nadia's cousin "had three children using a midwife. And we sort of looked up to her, and what she did, and she said it was a really great experience." Most couples, however, noted their desire to have a "less medical" experience. Nicole said that she and Julie "chose a midwife because the medical model of giving birth seems to be focused on the doctor's needs rather than the woman's needs." All these couples used midwives in combination with hospital births to find a happy medium between the benefits of birthing in an environment close to medical interventions, if necessary, and the benefits of personal care provided by midwives. In all, most of the couples had positive experiences with their midwives. Four couples who had particularly positive experiences in mixing midwives and hospitals were Heather/Lindsay, Julie/Nicole, Wendy/Kim, and Judith/Olivia. Each of these couples expressed a different aspect of midwifery treatment that they really appreciated.

Case #1

***Heather:** When we were with the midwife, we just asked questions about how much power we'd have in the birthing room. And she was really clear that it would be between the 3 of us. That, we needed to be as communicative as possible with her, ahead of time, about, you know, some really significant things that we wanted. And then, the concern was that the medical staff not be too involved in it because, the system has particular views of birthing, in general, and then, queer birthing experiences, we kind of extended that to be that they'd have really specific ideas about that as well, about it should go, whether or not we wanted it to be like that. So, that we were going to be relying on a midwife, even though we're in a hospital, was really assuring to me. And she was very supportive. It was good that way. Like, even though we were in a hospital, there was a sense that nothing was going to be taken away from us.*

Case #2

Julie: [Having a midwife] made it less of a clinical experience for me, and in fact the midwifery student, Paula, did most of the coaching and did most of the speaking. Hannah, our midwife, was obviously coaching Paula, but Paula was talking to me so it actually made me feel less scared that here I was in hospital giving birth! Okay, this person who is learning to be a midwife is helping me, and it's okay for her to be in this important role. I guess it made it less frightening for me that there wasn't a physician there, making sure everything was okay.

Case #3

While Wendy and Kim birthed their second baby at home, they had chosen a hospital as the location for their first birth, under the care of a midwife.

Wendy: We really wanted to have care that saw pregnancy as a normal function, not as a medical thing to manage. And uh, I was a bit nervous cause I didn't know a lot about midwives when I first got pregnant. But after we did some researching, we knew that we really wanted this to be treated as a healthy process, so that is what attracted us, but then reading more and realizing, okay, we still have all these choices to make about pain management, if we decided to go with medication.

Wendy: Yeah, we chose to deliver at a hospital. We made that conscious decision, because I hadn't given birth before, and my mother had lost her first. So I really wanted to be in a hospital, just in case, with medical nurses and the midwives.

After three days of fairly intense labour, Wendy had birthed their first son around breakfast time, and was taken up to her room shortly afterwards.

Wendy: We got taken up there after breakfast, and I remember the midwife or the doula, one of them saying [to the hospital staff], 'you have to get her something to eat. She hasn't eaten in 3 days, right?' They were like, 'oh well, uhhhh. It's already been served' 'Get her something to eat right now!'

Case #4

Judith went into labour 7 weeks early, and after arriving at the hospital, it was revealed her baby was breech¹⁷.

***Judith:** The obstetrician said, 'well, obviously it's going to be a C-section'. And, um, she was breech. And it was actually the midwife who first said, "why?" and that got me thinking, and talking with the midwife, that we were going to try, as long as the baby's measurements were good. Cause, they were worried about the head measurement to hip ratio, if her hips are big enough to let the head follow. And, ah, we brought it up with the obstetricians, he proceeded to lead into a guilt trip with us.*

Judith and Olivia, however, with the backing of their midwife were able to successfully challenge the obstetrician, and continue to try for the birth they wanted. Judith and Olivia noted that their midwife's advocacy for them did not stop there. Instead, it continued when they needed milk for their premature baby.

***Judith:** Midwives are really focused on what you want, even if you get one that hasn't worked with queer couples before their focus is really about you getting what you want. And about, empowering you. But just having them, even if you end up in the hospital, just having them there, cause you know, you don't know you can do things differently, once you are in the hospital, you feel like you are at the whim of everybody who's there, and in some ways you are, until someone says, 'wait a sec, you don't just have to take whatever doctor comes down the hall'. Like we had a horrific woman coming from the special care nursery telling us that she knew best, basically, and it freaked us right out. Yeah, and we said, 'well what formula? And what about, what about donor milk?' and she had all these reasons that absolutely contradicted each other, whatever she could say to get us to shut up, you know, and that formula is best for the baby. And, whatever, and that, 'donor milk is not safe, right, it could be contaminated' and then, 'it needs to go to the really small ones'. Oh yeah, you're gonna give contaminated milk to the really small ones? She was just grabbing at straws, right? Anyways, she just freaked us out. Yeah, anyways, and*

¹⁷ Breech positioning refers to a baby that is feet or buttocks down, as opposed to head down. With the medicalization of birth has come an understanding among physicians that the safest (and only) way to deliver breech babies is through Caesarean-section, to the point that doctors in training are now rarely taught how to deliver a breech baby vaginally.

then, luckily it was my one of the midwives that said, 'you know what? You can just pick another pediatrician.'

Olivia: *and then Jenny [the midwife] said, 'I'll just go down and get you some milk'*

This ability of midwives to continue to meet their clients' individual needs, even post-partum, stuck out in many couples heads, however, not every couple that employed midwives was satisfied with the care they received.

Two couples, in particular, noted their not-so-positive experiences with midwives at their births. Beth and Theresa's negative experience occurred at the hospital during the birth of their first child, while Chantelle and Cynthia's occurred at their planned home birth.

Case #1

Chantelle: *Well, one of the midwives was really late, cause she was attending another birth. So another midwife came in that I'd never met before and she was, she had this really weird 'tough love' approach, which was not working for me. She sort of, her whole approach was kind of like, 'what's wrong with you?' She actually said, 'don't you know how to push?'*

Cynthia: *I think the midwives didn't listen as well as they might have because we had said that we wanted to go to the hospital earlier, when it was quite apparent. Because I knew what the stages [of labour were] and I knew the hours. Like after she'd been pushing for 3 hours, that I knew that the baby should have come already. And then, at that point, we said [we'd like to go to the hospital], they tried to dissuade her and they did dissuade her to go. And then at the hospital, the midwife was kind of arguing with the doctor about whether or not Chantelle should have a c-section, but Chantelle, at this point, had said that she wanted it. So I don't think they were as supportive as they might have been. That kind of pissed me off.*

Case #2

Beth: *When we got to the hospital the midwife was really disempowered by the staff there. And she wasn't a particularly assertive person. She was a very nice person, but she*

was new, and she didn't, she hadn't built any kinds of relationships with them, and she was not an advocate for us.

Theresa: *She had great service, but not great in the hospital.*

The fact that Beth and Theresa, and Chantelle and Cynthia's midwives were not as supportive, assertive, and in-tune with their desires, as the couples had hoped, really stuck out in their narratives. This is probably due to the belief that these characteristics are thought to be definitive of midwifery care. It is interesting to note that in response to their experience with midwifery care, Beth and Theresa chose to be under the care of a doctor for their second pregnancy and birth, rather than try a different (more experienced) midwife. Beth and Theresa's second birth along with Miriam and Liz's birth were the only 2 pregnancies and births under the care of only doctors.

DOCTORED RESULTS: the medical safety net

When doctors deliver babies in hospitals, the births are more medicalized. Miriam/Liz and Beth/Theresa had different reasons for using the most medical route, but in the end were both quite satisfied with the results. Within the medical approach, Beth and Theresa were under the care of a General Practitioner (GP), while Miriam and Liz relied on an Obstetrician/Gynecologist (OB/GYN). Each couple located their choice in the "medical"/"natural" continuum.

Case #1

Beth: *So also we found out, of course, that OB/GYNs, you know, that they are looking for problems, and their Caesarean rates are actually higher than GPs and, and of course, midwives are the lowest. But we didn't feel safe going with a midwife, so we decided that our best option was probably going with a GP, and also to get a doula.*

Case #2

Liz: The fertility clinic suggested to go with a gynecologist.

Miriam: Yep. Well, they like to pass the information on. So they basically said, 'go with an OB/GYN'. It just seemed right. They just talk about it in, you know, the books – What to Expect When You're Expecting [by Heidi Murkoff] – we have a couple of books that we go by.

~ ~ ~

Liz: I just wanted [her to have] a c-section, I didn't want her to go natural. I know too many of my friends, or guys at work, their wives have had natural childbirth, and they have lack of oxygen cause something happened naturally during childbirth. And, we just went too far to have that happen. So I said, "I want a c-section." So, when the doctor told her c-section, and Miriam goes, 'That's what you want, right?', "yup", and so, I was very happy. I don't like natural, I'm sorry.

Miriam: No, you know I didn't want to do anything at home, or anything funky. You know, the medical system is there, and you know, if I'm in stress or the baby's in stress, I don't want to leave any gap of time that there can be a problem. Just cause we had gone through so much already [with trying to conceive and scares during pregnancy].

Safety and comfort definitely were factors that played into many of the couples' choices. Overall, it seemed that the most positive birthing experiences for all of the couples were the ones in which they felt safe, comfortable, and respected, regardless of the environment.

CONCLUSION

Obviously many factors were involved in how the couples made decisions about their prenatal care and birthing location. One issue that I have not addressed in depth, and many couples did not explicitly talk about was how their queerness affected these choices. One couple who explicitly brought this up was not sure of the affect.

Chantelle: *Do you think we've done anything different than, cause we're lesbians?*

Cynthia: *I don't know, I don't think so.*

M: *I mean, it's very hard to say that, "if I was not a lesbian!" [laughs], you know*

Chantelle: *Yeah, exactly.*

Cynthia: *I think it is true. I think if you weren't a lesbian, I think you would be in the hospital*

Chantelle: *you think so? Cause I was, I was quite a hippy...*

Their uncertainty, and the reason for it, are important to note. While other couples speculated on whether they were more feminist or desiring a less medical approach due to their queerness, it is in fact difficult to say that any of their choices were made specifically because they were queer, especially when they do note so many other factors that affected their decisions. The role of queerness in their decisions and experiences lay in stark contrast with how it played out in these families' everyday lives, as they negotiated kinship and the role of the non-birthing mother.

CHAPTER 4

DEFINING OURSELVES: GENDER, STEREOTYPES & QUEER KINSHIP

We make babies with strangers in one-night stands or on the doctor's insemination table, with friends in a friendly fuck or a loveless mason jar, with enemies who at times were husbands or boyfriends, or with ex-husbands whom our children call papi and whom we may still consider family. We cannot make babies with one another. Our blood doesn't mix into the creation of a third identity with an equal split of DNA. Sure, we can co-adopt, we can co-parent, we can be comadres, but blood mami and papi we ain't.

-Cherrie Moraga *Waiting in the Wings*, 1997: 15

Sarah: *It was a reminder that we were different than most pregnant couples, because we did the first day of the course, and then we came back the next day, and Barb was taking attendance. And she said, "Sarah and Maureen? Of course, we're not going to forget you!" and all of a sudden I was like, "Oh right, we're lesbians! We're different from every other couple in this room!" And I know it, but you know, my life is normalized!*

There are an estimated 250,000 lesbian parents in Canada (Epstein 1996a). Many more families in Canada have gay, bisexual, trans, intersexed, or two-spirited parents¹⁸.

The last 30 years have seen a significant increase in the visibility of diverse family forms, and with it a growing acceptance that the "traditional nuclear family" is no longer the only natural family form (Luxton 1997). Until recently, the terms lesbian and mother

¹⁸ Trans-folks are people who may otherwise identify as transsexual, trans-gendered, or genderqueer. Most trans-folks feel a disjuncture between the social expectations of gender associated with the genitals they were born with, and may attempt to alter the physical parts of their body via hormones and/or surgery, to match who they feel they are in the inside.

People with intersexed condition, formerly known as hermaphrodites, have one or more characteristics that blurs their biological sex (by the Western dichotomous standard). Two-spirited people are people of aboriginal descent who embody both male and female spirits. These people were often historically recognized as very important, and spiritual, individuals. Today, outside of indigenous populations, two-spirited people are most simply understood as people of aboriginal descent who are also gay/lesbian, trans, or intersexed.

were often viewed by people in our society to be oxymoronic, contradictory, or mutually exclusive (Comeau 2004, Berger 2000, Nelson 1996, Slater 1995, Lewin 1993). In fact, Wendy noted she participated in my research because she “really want[ed] to challenge the straight, heterosexual privilege that it’s their prerogative to have children.” She added, “I feel it is anyone’s prerogative to have children.” This chapter focuses on the ways the couples/families managed in their “prerogative”, to experience birth, claim kinship, and define parenting roles with two female-bodied adults. In contrast to the next chapter that will look at how queer kinship is negotiated and recognized within (government) bureaucracies, this chapter considers the almost everyday ways the couples I spoke with define(d) themselves, both similarly and in contrast to “traditional” notions of kinship and parenting. More specifically, it considers 1) the role of the non-birthing mother at the birth of their child; 2) the couples’ understandings of *kinship*, and more so how having children affected or changed that understanding; and 3) the way the couples organized their parenting roles, and how they – as parents and a family – were recognized in public, in relation to families with one Mom and one Dad.

THE ROLE OF THE NON-BIRTHING MOTHER AT THE BIRTH

Chapter 3 discussed a variety of elements regarding choices and experiences of birth, but did not touch on one specific element that is different for lesbian couples – the presence of the non-birthing mother. In *The Essential Guide to Lesbian Conception, Pregnancy, and Birth*, Kim Toevs and Stephanie Brill note:

Birth is amazingly universal, regardless of the mothers’ sexual orientation. Preparing for birth as a lesbian, bisexual, or single woman is similar, although not identical, to preparing for birth as a partnered heterosexual. (2002: 429)

The preparation, experience, and role of the non-birthing mother, however, is unique, in that she is a *female* partner to the birthing woman. Her experience of the birth may in some ways resemble that of the male partner of the birthing woman, but it differs considerably in other ways. One example of this is reflected upon in Fiona Nelson's *Lesbian Motherhood* (1996). In this book, Nelson describes a homebirth attended by a midwife, in which the lesbian women, on an emotional capacity, "inhabited each other's bodies as this birth became future births and somewhere in the middle of it all the *two of them* gave birth to their son" (64). Similarly, Toevs and Brill discuss this *difference* in noting:

...if one partner in a couple was unable to conceive or hold a pregnancy and now the second is ready to give birth, this can retrigger the non-pregnant mom's feelings of inadequacy, resentment, or envy that she isn't the one who's about to have the baby. (2002: 431)

While neither of these situations was mentioned by my participants, the couples did speak about having women-only attended births, and the supportive role the non-birthing partner had, that would not *necessarily* be unlike that of a man assisting at his partner's birth.

In the pre-natal interviews, I asked couples about the role the non-birthing parent would have at the birth. At this first interview, the pregnant partner was between 32 and 39 weeks pregnant¹⁹, and many of the couples had yet to have their hospital tour (if they were planning a hospital birth) nor really think about the question I was asking. During their respective first interviews, two of the non-birthing partners responded that they were not sure what their role would be, besides trying to stay out of the way. Other partners

¹⁹ A "typical" pregnancy is said to last 40 weeks, give or take 2 weeks.

responded that they would comfort their partner (i.e.: rub her back, hold her hand). For couples who had a child already, the partners often referred back to what they did at the first birth, and perhaps mentioned what they would do differently this time. Regardless of the answer at the prenatal interview, when I spoke with the couples post-partum, it was clear through their narratives that the non-birthing mothers played active and knowledgeable roles at the births.

While births rarely occur as planned, the partners' knowledge and support proved to be inevitable and irreplaceable to the birthing woman, even if it went unnoticed by the official care providers. Two particular narratives stand out as examples of this, and are not unlike some of the other experiences.

Case #1

Maureen: *[My role was] kind of cheerleading. I've attended a birth before so I knew what I was in for. Sarah had [also] attended a birth before... And you know, I was going to hold her and she was going to lean on me to contact. And [it ended up that] she didn't want me to touch her for the whole time. I felt like a giant failure. [everyone laughs] I had nothing to do. I'm not playing any role, and in fact, I felt that I was pissing her off because I'd go to like, put my hand on her back, and she'd go 'No! Don't touch me!', and [she] was leaning mostly on furniture or walls and really wanted something solid to lean against. And I started to take it personally. But then when I swooped in with my crisis management [laughs] my lecture, I was like, 'Ok, I have a role here' lecture, but of course, she didn't pick it up at all.*

Case #2

Cynthia: *Well, I'll just be helping her out. She'll be doing the work and I'll just be the helper person... I don't want to be getting in the way, and pretending that I'm doing the work. So, I'll just be there for support and make sure she breathes, and stuff, yoga stuff, and yeah, that's about it.*

Her knowledge and confidence changed before the birth of her son, after which she noted:

Cynthia: I think the midwives didn't listen as well as they might have, because we had said that we wanted to go to the hospital earlier, when it was quite apparent. Because I knew what the stages and I knew the hours, like after she'd been pushing for 3 hours, that I knew the baby should have come already.

While I cannot concretely explain how or why this knowledge or confidence changed, it may be linked to something three of the couples talked about – having an all-female experience.

Something that is not possible with a husband or boyfriend attending the birth of his child is to have only female energy present at the birth. While certainly an “essentialist” (and/or “new age”) notion, a few of the couples noted that the “queer” difference with their birth was not only having a female-bodied partner present, or her active role at the birth, but having only “female energy” present, which was seen as beneficial. Rachel Epstein (2005) explains that, “For me personally, the birth of my daughter in 1992, at a homebirth surrounded by a dozen close [female] friends/family, was a high point in my life” (7). When I spoke to Epstein in person in 2003, she noted similar ideas to those expressed by my participants, that having mothers, sisters, a female-bodied partner, and female-bodied attending staff and/or midwives, brought family/community together and made the experience feel less medical and, therefore, was accompanied with feelings of comfort and belonging. Not surprisingly, these notions were also prominent in my participants’ discussions of kinship and family.

WHAT IS KINSHIP? WHAT MAKES A FAMILY?

Lesbian mothers simultaneously affirm the importance of blood as a symbol and challenge the American cultural assumption that biology is a self-evident, singular fact and *the* natural baseline on which kinship is built. Biology is not understood here to stand on its own as a defining feature of kin, nor does biogenetic connection retain any single, transparent meaning. (Hayden 1995: 56)

When the couples I interviewed talked about their notions of “family” and “kinship”, they did so in ways that both contradicted mainstream ideas about what family is, as well as embraced some of those core “normative” ideas. While many of the couples talked about either how they were “family” before having children – challenging both the notion that 1) children are necessary in a family, and 2) it takes an adult woman and an adult man to create a family – no one underplayed the significance of their families of origin in their present family. In many ways these responses contradicted past research in this area, and also contradicted themselves. I see these contradictions not as problems, however, but rather as demonstrating the complexities of human relations and of the constant flux and progression of life.

In *Lesbian Mothers* (1993), Ellen Lewin notes that the commonly asked question: “‘Do you have a family?’ has become a commonplace euphemism for having children and, usually, a husband. Like others in our society, lesbians associate having children with ‘starting a family’” (95). What most of the individuals responded with when I asked if they considered themselves “family” before having children, was “yes”²⁰. All couples also spoke of how having children changed their relationship with their families of origin, and many spoke of the role of “community” in their understanding of “family.” Moreover, within their narratives, many of the couples also referred to their legal

²⁰ The fact that 19 of 20 women said they considered themselves “family” before having children does not mean that they were recognized as such by others.

connection – through marriage or legal name change – that substantiated their familial connection with each other. While this is more the focus of the next chapter, the subtleties can be picked up through the narratives expressed in this one, especially with respect to their families of origin.

Kath Weston's (1997) research on family among gay men and lesbians in San Francisco also sets a framework for understanding how *community* and *biology* relate to queer understandings of family. In *Families We Choose* (1997), Weston notes that: "Familial ties between persons of the same sex ... are not grounded in biology or procreation [and] do not fit any tidy division of kinship into relations of blood and marriage" (Weston 1997: 3). As Hayden (1995) notes:

Weston argues for the *distinctiveness* of a certain configuration of gay and lesbian kinship in which biological ties are decentered and choice, or love, becomes the defining feature of kin relationships. (41)

Weston, in effect, posits "chosen families ... in explicit opposition to ... straight, biological families" (Hayden 1995: 44). While *love* has not gone unnoticed by previous kinship theorists (to the contrary it has been largely recognized), Weston puts a new spin on it. As previous theorists have looked only at love in combination with biology as the foundation of kinship, Weston tries to look at queer kinship and its emphasis on love as a completely separate entity from that in heterosexual or biological kinship (Weston 1991; also Hayden 1995; Peletz 1995). While Weston frames her work as a study of queer families as *Families We Choose* (1997), she neglects the fact that for many queer families biology does play a significant role.

Hayden points out in "Gender, Genetics, and Generation" that, "the creation of lesbian and gay families with children cannot be discussed in exactly the same terms as

chosen families” (1995: 45). While not all lesbian-led families conceive of ‘family’ or ‘kinship’ in the same way, Hayden argues that “where chosen families may *decentralize* biology” (45), “lesbian mothers employ notions of biology, in the context of donor insemination, to articulate their own sense of uniquely lesbian kinship” (42). Moreover, lesbians’ emphasis on the biological relations of their family must be understood within the larger cultural context. Whereas society, the medical professionals, and particularly fertility specialists and doctors have continued to view lesbians as non-reproductive beings, ethnographic research has shown that lesbians have stressed the biological nature of their kinship relations in an attempt to socially legitimize their families and their bodies (as reproductive) [Agigian 2004; Murphy 2001; Dunne 2000; Hayden 1995; Lewin 1993]. While this might be seen as ‘giving-in’ to the dominant conceptions of kinship, I perceive it more as a subversion or redefinition of it. While some of the couples I spoke with discussed how ethnicity, eye colour, and hair texture or type played a role in their decisions regarding picking a donor and seeing themselves (and being recognized) as ‘family’, they also argued that much more than ethnicity, or physical appearance went into being a family²¹.

None of the couples I spoke with gave a direct definition of “kinship” or “family”, although they talked about how their notions of kinship related to community, belonging, and a sense of commitment. In fact, in the post-partum interviews, while the couples may or may not have said that they felt like “more of a family” once they had a child, most noted things similar to Heather.

²¹ One particular couple consciously chose to use a donor who was a different ethnicity than either of the mothers. The women emphasized that their shared interests with the donor (like appreciation of the outdoors and being physically fit), were more important in making them a family than did having a similar (familial) appearance.

Case #1

Heather: *Even though there was no real fragility to our relationship at all, it became even more permanent that, you know, we're doing this together. There's no way, I mean, Lindsay is fond of saying, "I don't wanna be a single parent", and neither do I. So, we're in this together, and it's something that we're all doing together. And it's, it's a big adventure, but this is very much us being together relationship, attending to it always, just to keep it strong, for each other, forever.*

Case #2

Leila: *What else about our notions of kinship? I mean, I think before I had him, I tried to reach out to, there's a queer parenting group out in town, and I sort of registered online to see what they do, and you know, they have a potluck every month, they have clothing exchanges. They do social stuff. So I have been lurking on that, to see what sort of things they do, and when he gets older, I may access that as a resource. I think, because, my meaning of kinship does involve, does acknowledge the fact that we are queer parents, but even right away now I feel I have more in common with just parents, parents, than queer people. You know what I mean? Now like kinship goes from a community, an assumed community of sameness to parents, because we have more in common with parents than with queer people, and queer parents, wow bonus, that's great, they can understand the complicated nature but really, it's about parenting, you know, it's about going through this experience and prioritizing one person throughout your entire life. So, that's definitely a change, a shift in the notion of kinship and community.*

Case #3

Chantelle: *Oh we're totally a family already. Yeah, we have been for years, and we never, you know, got formally married or got a commitment ceremony, although we did change our names. We have the same last name. We legally changed our names.*

Cynthia: *7 years ago, over 7 years ago*

Chantelle: *And we've been together 9 years but we've been family for a long, long time*

Cynthia: *Yes, 2 weeks after we met [everyone laughs]*

Chantelle: *So, I don't think, we're not the type that are like, "Oh, this makes us family, and we have to have kids." In fact, it took me 8 years to convince Cynthia to have this one kid, so [laughs] I mean even if we never had a kid we'd still be a family.*

~ ~ ~

Chantelle: *Cynthia comes from a HUGE family, and I was always really accepted in her family. Well, she was accepted in mine too, but I don't spend as much time with them. But with her family, we lived up North for many years, on her reserve, and I was Auntie to dozens of kids. It was really great. I mean we were really recognized as family, and we, our relationship was really recognized on the reserve by the whole community.*

~ ~ ~

Chantelle: *I think it changes things maybe for other people, cause just talking to my Mom earlier, and she's talking about Cyn and I as a couple way more now, cause she's wanting to talk about the her grandson. He's her first and only grand-child, so she's coming out to even old friends of hers who didn't even know I was a lesbian, cause she's not wanting to lie, and she wants to talk about what's interesting, what's exciting for her.*

While notions of kinship may have been present before having children, it is evident that the birth of their children strengthened the bond between the couples. The other underlying message was that the roles and understandings between families of origin and the couples often changed with the birth of a (grand)child.

When asking the couples if their notions of kinship changed with the birth of a child, they often replied with a comment on the strengthened bond between the new parents and the new grandparents. While this was a welcome and easy adjustment for some families, it was more complicated in others.

Case #1

Nadia: *I had made a comment of like Diana and her mum seem to be, talking more and closer in a sense, and I was having issues with my Dad and he has become grandfather of the year, and overwhelmingly so. So it seems to have strengthened all our sides and all the facets of our life seem to have come together.*

Case #2

Julie: For me it was a big thing to make the decision to take a step back and say this is my family. Nicole is my partner and this is our experience, and I don't have to call my parents right away [when I went into labour]. It was important that I didn't.

Not surprisingly, a re-establishment of roles and relationships with families of origin coincided with figuring out parental roles, labels, and gaining public recognition as a “family” in public. While the next chapter focuses on the bureaucratic side of these issues, the next section introduces these issues through the continued focus on the everyday experiences and decisions of these issues.

PARENTAL ROLES & RECOGNITION: Partners, Parents & Kin

Danielle's mother, Dana, peers over her book, curious about how they'll resolve this struggle. After a few minutes, with no progress in sight, she matter-of-factly suggests, 'Why don't you both be mommies?' to which her daughter, exasperated, responds, 'You can't have two mommies!' Dana is nonplussed. 'But Danielle, you have two mommies!'

The three year old is brought up short. 'Oh yeah,' she says, 'I forgot'.

About five years later, Dana recalls this scene as the instant in which the power of mainstream culture revealed itself to her. It showed me that even at three, culture is so strong that it denies your own reality, so strong that you deny what's right in front of your face.

(Laura Benkov *Reinventing the Family* 1994: 1-2)

Due to the hetero-centric (historical) nature of our society, dividing parenting roles between two women, coming up with appropriate parenting labels for them, and being recognized by strangers as “parents” and “family”, are issues for queer parents and queer families. They continue to be issues despite the facts that 1) the *gayby boom* (Luce 2004, 2002a & 2002b; Epstein 2005, 1996a, 1996b & 1993; Owen 2001) started over 20 years ago, and 2) most of the parents I spoke with lived in Greater Vancouver or Greater Victoria – places known to be Meccas for queer families. Gillian Dunne (2000) explains:

When women parent together, the absence of the logic of polarization to inform gender scripts, and their parity in the gender hierarchy, mean that... 'We have to make it up as we go along'. (13)

In terms of the couples I spoke with, figuring out appropriate labels for each other was harder than dividing parenting roles or tasks.

Discussions about parenting roles emerged from other discussions, like ideas of kinship, experiences of homophobia, or whether the couple had made choices differently because they were 2 women, instead of a man and a woman. Most often couples compared their expected or existing parenting roles in contrast to what they heard heterosexual women complain about in social settings. Whether at prenatal classes, postpartum yoga, family gatherings, work or 'mother and tot' groups, the predominant notions, that the couples I spoke with heard, around the division of labour among differently-sexed parents, was that men were not doing their share²².

Case #1

Theresa: *Well, from what we've heard in the pre-natal class, I believe that I am giving more support to my wife than a lot of the other males are giving to their wives, or at least planning to prior to, whether that changed once the child arrived, I don't know. But, when the males I've been talking to at work who have kids, have had kids recently, it's, even the ones that you feel are more 'touchy-friendly' that way, they don't seem to 100% get it, as much as, I think, a female-female couple gets, how much impact childbirth actually has on a mother, and their body, how all-encompassing it is.*

I mean, after I went back to work, we were living close enough, I was coming home at lunch time to help. And I don't know any male, even the ones that live close enough who would routinely do that.

Beth: *I remember with Caroline, when she was really, really little, she was totally, absolutely person connected. I mean to Theresa or me. I mean, if I put her down for a*

²² This was also noted by Ellen Lewin's participants, in *Lesbian Mothers* (1993).

minute, if my arms were dead tired, even to go to the bathroom, she would be broken up over this whole thing.

And so for Theresa to come home at lunchtime, and even for a total of half an hour, I could go pee, I could walk around the place without holding this baby, it made a huge difference. And so many of the other moms didn't have any of that. Like I went to the health department's 'mothers and infants' group, and it was probably about 30 moms who would come, we had rarely ever met the fathers. I think I met like 2 of the fathers, and Theresa came a couple of times. And they would be describing the issues that they would be having, and the problems that they were having, I realized I wasn't having a lot of those problems because Theresa was so involved, so much more so than any of them. Getting up at night, so many of them said that their husbands said, 'I work all day, and I'm tired, so when I come home I don't want to have look after the child.' And one woman said, 'my husband didn't even get it when I said to him, "you get 15 minute breaks at work. You've given me 12 minutes here!'" [M: wow] She said he complained after 12 minutes that she wasn't back in the room to pick up the baby when, when he came in the door. And she said: 'You get 15 minute breaks, and you don't even give me one 12 minute break!'"

M: Yeah and, 'your job ends after 8 hours'. [laughs]

Beth: That's right. And you're tired. And my job goes on and on. And then he doesn't get up at night, because he says, you know, he has to get up for work. And all of the moms were agreeing that that's what their husbands were doing. And some of them would make a big deal out of they might get up once on the weekend, and give her a break from, from one night feeding. It's like, 'why am I pumping all this milk, if I'm the one who's ending up giving it to him anyhow?' So, Theresa, I think was extremely understanding, and I didn't realize that until I joined that group when Caroline was about 3 months old. And I realized there was a world of difference between the decisions Theresa was making and the decisions the men were making.

Theresa: Even though it is supposed to be a real advanced age when men, it still isn't reality. It's different, sure, from when our parents but it's not that much different.

Case #2

Julie: I mean the decisions that are made at this point are pretty minimal -- like what to do during the day, but I want to assure you that there aren't more important things happening while you are away [at work].

Nicole: I know that but he had his first bath without me and I wanted to be there, and yeah, he needed it, it was fine but I wanted to be there. It may not seem that important but I want to be there for all the little things like the first time he turns his head, it's just that I'm not spending as much time with him, and he spends more time with his grandmother than he does with me. And I can't imagine how people did it, mothers would be taking care of the baby themselves and the husband would be off working with little involvement with childcare. I have no idea how that would be done. Now you can have parental leave and if I had a permanent position at work I would be eligible to take the time off.

Julie: I think a lot of men can accept that they are the bread-winner and this is their primary role, whereas we're still trying to figure out our unique roles. We're both the Mums so it's different. I'm the breastfeeding mum and the birth-mother, so then what does Nicole's mum-ness mean? What will she do that is motherly as well?

This narrative illustrates so well the fact that these couples lack non-heterosexual/non-patriarchal “scripts” or “models” on which to base their parenting, and thus they are making very conscious decisions about the roles they are playing in their children’s lives. This lack of “script” or “model” also relates to how the couples negotiated choosing parental labels for themselves.

While parental labels were not raised, nor apparent, in all of the interviews I conducted, two key ideas were noted in the discussion: the uncertainty regarding how to label each parent, and the similar decisions that the couples came to, regarding labeling the parents. Not much has been written about the label of the birthing mother – perhaps due to the assumption that her label is not contested – but in terms of the non-birthing

mother, a variety of terms have been suggested, used, identified by theorists and researchers, including: (M)Other (Muzio 1999); Other Mother (Sullivan 2001); co-mother (Berger 2000; Crawford 1987; Wright 1998); co-parent (Berger 2000; Crawford 1987; Kuehn & Findlay 2002; Parks 1998; Slater 1995; Wright 1998); second parent (Slater 1995); step-parent or step-mother (Church 1996; Parks 1998; Wright 1998); non-biological parent or non-biological mother (Epstein 1996b & 1993; Kranz & Daniluk 2002; Nelson 1996; Slater 1995); and “lover of my child [and] lover of me” (Moraga 1997). Due to the focus on birthing in this thesis, I have typically differentiated – when appropriate – the partners as birthing and non-birthing parents/mothers. In any case, it can be seen that no language is deemed “traditional” for the non-birthing mother. It can be difficult for parents to figure out which term is best for each mother, or if they should indeed have the same or different parenting labels, or if indeed any existing label is appropriate for the non-birthing partner.

Case #1

Nicole: I will be a mother, just like Julie. We haven't quite figured out how we'll be labeled: mommy, mama, mom. We're both the baby's parents and we both have equal responsibility to this child, and will try to be the best parents we can be.

Case #2

KJ: Yeah, everyone in my life keeps going, what are you going to be called? At work someone suggested I get called Captain, then when the kid is 5 years old, he's gonna think everyone's got a Mommy and a Captain. [laughs] Just to be able to have that, I don't know, I think we're going to leave this to the baby to figure out. We're not one of those Mommy and Mama type relationships.

Leila: I mean your role, I guess like, it would be nice if our culture had a role of parent, instead of the binary thing, there's always gendered you know, division going on. I mean for us, even though our relationship is very gendered, in the traditional sense of the word, we can't slot ourselves into those labels, easily, without screwing up the kid. [laughs] I

mean we call each other Mister and Misses, but we don't want to tell the kid that KJ is Daddy and then really screw them up when he goes to school. I mean, he'll know who's the Daddy. But our culture doesn't allow for those notions of Daddy being female.

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Leila: *It's true, that's the problem. It's other people. Cause it's true. KJ's role is that of the father, in our relationship. You are the father, you are the "Daddy." You are almost more traditional than some of the guys these days... KJ is much more of a "Daddy" than any of them ever will be*

Despite the uniqueness of their situation, within my participants – which in actuality is not very unique – their ideas about cultural understanding and recognition of different roles and families resonated with most, if not all, of the other couples.

Being publicly recognized and understood as a family was key to all the couples. Sarah and Maureen spoke about this issue best when they addressed both the fact that they are lucky to live in a place where their family is reflected when they walk down the street, and also how Maureen – as the non-birthing parent – was often not recognized as a parent-to-be when Sarah was pregnant.

Sarah: *We've definitely got other queer friends who have children both men and women, and especially in East Van you can just walk down the street and you see that part of your identity reflected in other families and that's certainly powerful. Again, we're very lucky to live where we live. It feels pretty contained and pretty easy to be dykes with a child.*

Maureen: *I feel like us too, we're in a very diverse community. We have queer friends with kids and straight friends with kids, and a single mom, so it's a really nice sort of reflection of things around here you know, I can't imagine what it would be like to do something like this in a rural context, in a small town and not have your face reflected when you walk down the street*

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Maureen: I think for me something I didn't consider at all but a huge part of my experience while Sarah was pregnant was that no one really connected the dots. So in public people would be like "congratulations, how exciting, you're pregnant, you're going to be a mother, whoo hoo" and they'd be like whatever to who's next to her [me], like very few people ever made that connection that I was a part of that experience. So I felt pretty shut out. I'd ask all my guy friends whose partners were pregnant, "are you getting the handshakes from time to time from people?", you know, judgement. And I remember once at Kits pool we came into the change room Sarah was very pregnant. Sarah went into the washroom or something like that and there was a woman who was getting changed and she turned to me and said "is this your first?." And it just really struck me because I'd never had that and I was so excited to feel acknowledged. And it was like a big...and I'll always remember that woman because it was the only time that I felt that someone celebrated with me

Maureen's narrative of invisibility is not unique to queer non-birthing partners. While it has its unique situatedness, Danielle Wozniak speaks of a similar invisibility that foster mothers feel, in *They're All My Children* (2002) and "Gifts and Burdens" (1999).

In Wozniak's study of foster mothering in the United States, she found that foster mothers were rarely fully recognized as parents of their (foster) children. Wozniak notes that:

All the women who participated in this study experienced themselves as mothers in relation to their foster children and developed kinship bonds based on affective claims of belonging. Their caregiving relationships were premised on a conception of motherhood as an empathetic and inclusive experience in which their work was to apprehend and meet the needs, wants, and realities of the children in their care. (1999: 89)

Despite this, the mothers also reflected on the fact that not only did neighbours and school teachers question their commitment and "mother" status, but so too did family doctors and social workers. Wozniak explains that *as per* the state, "[foster mothers] exchanged physical and emotional care for money" (2002: 10-11), and that doctors and

teachers frequently asked the mothers why they cared so much about the children that were not even “their own.” The women’s own notions of “family” were undermined by most people they met, unless they “attempted to manage a spoiled identity through ‘passing’” (2002: 87) – an idea not that unfamiliar to non-biological queer parents– to simply be publicly recognized as the child’s legitimate parents. “Passing”, as it suggests, is not an honest identity or portrayal, and is often accompanied with feelings of guilt (Wozniak 2002; Burke 1993). It, however, is sometimes viewed as necessary when people have a understanding, recognition and respect for and of diverse types of parents.

As the title of this chapter suggests, queer parents are often “defining ourselves” due to the lack of models, and in an effort to squeeze within the cultural “wiggle room” of “family” and be recognized for what they know themselves to be. While being recognized and understood as *family*, however, is not limited to the daily interactions they engage in. Instead, (desire for) recognition goes beyond *personal* interactions and into bureaucracies that can afford rights and political acknowledgement of who they are. Sometimes these interactions have more long-lasting effects than the daily ones, as we will see in the next chapter.

CHAPTER 5

WHEN KINSHIP MEETS BUREAUCRACY: QUEER KINSHIP REVISITED

For many years, Western governments and policies have understood kinship in very strict terms, posing a problem for families with only one parent, multiple parents, families with multi-racial parents and/or children, foster families, and of course, queer kinship (Luce 2002b; Toevs & Brill 2002; Wozniak 2002; Owen 2001; Modell 1998; Moraga 1997; Cannell 1990). In recent years, policies have opened up, accepting diverse family forms. In fact, this past January a judge in Ontario ruled that a child could legally have three parents (Gandhi 2007; Wente 2007). This case featured a family composed of the child, his biological mother and father, as well as his biological mother's lesbian partner who had planned the boy's conception with the other two parents. This is a very interesting case, considering in most provinces and territories two women still cannot be named on a birth certificate as birth parents. The landmark decision, in 2001, regarding having two mothers listed on birth certificates in B.C., was expected to change how (queer) families were recognized by public and governmental institutions. While court decisions have increasingly, ruled in favour of queer families, my research revealed that five years later many wrinkles have yet to be ironed out. Even though queer families may experience less explicit discrimination at hospitals and with care providers, queer-parented families are often still treated as second-class citizens by government bureaucracies. This chapter explores the various experiences the couples I interviewed had with different government bureaucracies, namely hospitals, Vital Statistics, and

Human Resources and Skills Development Canada (HRSD, formerly HRDC), the federal agency responsible for Parental Leave.

HOSPITALS

“A hospital is by far the most common and complex birth environment for lesbians. In a hospital setting our families have to navigate many unique issues. This is primarily because there are so many new people involved whom you’ve never met. You can prepare for some things in advance, but most must be dealt with in the moment.”

-Kim Toevs & Stephanie Brill *The Essential Guide to Lesbian Conception, Pregnancy, and Birth* 2002: 442-3

As noted in Chapter 3, most of the couples I spoke with remarked that their decisions and experiences around birth and the bureaucracy of hospitals came at the end of other dealings with medical professionals, organizations, and clinics. This is an interesting finding for my research considering the perspective of the very little research or personal communication available in this area. In fact, it is often assumed that lesbians avoid birthing at hospitals due to the disrespect they will experience there. While Jacquelyne Luce does not speak much at all about birthing in her PhD dissertation regarding *Queer Conceptions* (2002b) or in “Imaging Bodies, Imagining Relations” (2004), she does comment on a sign she saw at a hospital in the B.C. Interior. She explains, “The sign on the door to the maternity unit reads, *Only Husbands Allowed*. A relic of the past, I’m told” (2004: 53). The only other experience I have read about, regarding lesbians and hospital births, was written by Cherrie Moraga. In *Waiting In The Wings* (1997), Moraga reports her diary entries relating to her son’s birth at 28 weeks gestation. Moraga remarks:

Ella called the hospital this morning to inquire about the baby, having to put up with the usual deterrents: ‘Who are you?’ The receptionist hears no male voice on the line, but a woman, my lover, seeking to know about our son. ‘Read the damn chart.’ Ella snaps back. ‘I’m the co-mother.’ *Co-*

mother – a concept about which even San Francisco hospitals haven't a clue. I cannot comfort Ella much when she is bruised by the hospital's ignorance. (63)

Luckily the narratives I heard about hospital staff's understanding of queer families were not like that of Moraga. Instead, their experiences were fairly positive, despite some misunderstandings.

Case #1

Beth: *The staff there was very respectful of us, and, um, our relationship. And, Theresa was treated like just as any other partner would be, and, um, actually, there's just one funny thing to do with that. Ah, when the Dad, Paul, came to visit the next day, and I think he was outside of visiting hours or something, and so he had to say, 'Well, I'm the father', and they were all kind of like, 'Just a minute! [laughs] We understood...'*

Theresa: *'We thought we had that family figured out.'*

Case #2

Lindsay: *Well, I loved having our midwife and once we were in the birthing process, I actually found the staff at Women's hospital quite friendly, like the nurse that was assigned to us was very nice and quite supportive, and you know, you didn't get any negative feelings for her. And I think sometimes what it comes down to is that even though, more and more there are queer couples birthing, still they, maybe the staff don't always have a lot of exp-, experience or exposure to it. And I don't think that it's always done on purpose, but they don't know how to make it a very inclusive process, just the way that a heterosexual couple might be, because it's 2 women. And one woman has clearly given birth to this baby, and one has not. And you know that that other person is not genetically related. Like, I think people just have a really hard time making that big leap of what constitutes a family, and things like that, and so we don't necessarily believe that it's all intended to be negative, but there were some just mean and spiteful people on the way too. Maybe because we challenged their ideas.*

Non-biological co-mothers and third parents bring unique situations to the table. One such example is having the non-birthing mother (attempt to) breastfeed their child. Three

couples I spoke with had looked into this. While one non-birthing mother went on to successfully gain information and support, then breastfeed her child, Lindsay did not. Instead, her lactation consultant discouraged her to breastfeed in a similar vein to the experience Beth and Theresa had with their Reproductive Endocrinologist.

Lindsay: *[The lactation consultant,] she's just like, 'Well, why would you want to breast-feed? There's 2 perfectly fine breasts right here.' As in Heather being the birth mother, and things like that, and she's like, 'You wouldn't be able to breast-feed for at least a month anyway', and she says, you know: 'Probably you wouldn't make enough milk to do anything'. You know, 'Maybe you'd get one or 2 teaspoons'. Like everything was so negative, it was like, she wasn't willing to help, you know, our experience in any way shape or form, like she was gate-keeping my body, about. And finally I'd had enough, I was really getting angry, because she was telling us what our experiences were going to be. And I said: 'Our experiences aren't part of your research. You may have done a lot of research on this, and you may have ideas about this, but don't tell me what my experience is going to be, we're trying to, you know, create this moment for ourselves. So we just left and so we never pursued it. And in the end it was okay, because I really had a lot of energy around wanting to breastfeed, and then having had that experience it kind of made me step back from it a bit, it, it worked out really well, like, I don't feel, I mean, if I never experience birth I might continue to wonder what breast-feeding is like, but, we were still able to connect and be together.*

Regardless of this experience, Heather and Lindsay felt their overall experience with hospital and medical staff was positive. Lindsay explained that while some treatment may seem negative, it is probably not meant that way. In fact, most couples' found hospital staff to be helpful and understanding, and two of the couples mentioned that nurses had been quite helpful in explaining "the birth certificate situation" to them.

BIRTH CERTIFICATES & ADOPTION

“**Birth certificates:** If you are partnered, the non-biological mother’s name will be added after a second-parent adoption is completed, if you have this option available and choose it. Currently, there are only two parent spots on a birth certificate. Some women see if they can get their name put in the ‘father’ box, but this doesn’t enhance their legal parental recognition in any way.”

-Kim Toevs & Stephanie Brill *The Essential Guide to Lesbian Conception, Pregnancy, and Birth* 2002: 444

Birth certificates play a fundamental role in how births, and those involved in them, are legally and socially recognized and accounted for. Birth certificates are used by Vital Statistics to acknowledge ‘new citizens’ and their families. When the BC Human Rights Tribunal acknowledged the discrimination that was occurring by not allowing all couples who use anonymous donor sperm to conceive to be fully acknowledged on the birth certificate, they also acknowledged the importance it played for families and parents to be recognized, whether queer or heterosexual. Their decision was groundbreaking in Canada, and lesbian couples sighed in relief that they would be recognized, as equal and entitled, just as heterosexual parents already had been. What I did not know until I conducted my interviews, was that while the legislation had changed, and a new birth certificate was created, two women would still face obstacles in applying as co-parents five years after the Human Rights decision was announced.

While each couple dealt with completing the forms in different ways, all recognized the inaccessibility of the correct forms. The forms were not available at the hospitals, nor from the midwives. When couples were given a mother/father birth certificate application, most assumed they were to simply cross out “father” and write in the non-biological mother’s name. Four couples were successful in doing this, all of whom had different reactions upon receiving the official birth certificate back, with one of them listed as the “father.”

Case #1

Leila: *We just filled it in with KJ as the father, cause we figured, they haven't changed their forms yet, it's the same when we got married, one of us had to be the bride and one of us had to be the groom. And we just figured, oh whatever!*

Case #2

Kim: *With Nathan there wasn't a parent-parent option, like there was the second time around. We talked about it, and decided to put my name on as father and it went through. My first name, obviously, can be a male or female name. It isn't so common for men, but it is also a male name. We half expected to be rejected. We know a number of other lesbian headed families, who have children roughly the same age as Nathan, and in most of those cases, a female 'father' was rejected. But in my case it wasn't. So, we were initially given a birth certificate with both of our names on it. We decided to hold back my initial adoption – the fact that my name is listed under father means nothing, it doesn't recognize my relationship with Nathan, because I'm female.*

Case #3

Chantelle: *And what's funny is when the birth certificate came in the mail, cause I had crossed things out on the form, so instead of 'name of the father', I put 'name of second mother', and instead of 'name of mother', I put 'name of birth mother'. But, they don't change the form, so when the form came back it said Cynthia is the father. So, Cynthia's gotten a lot out of that one.*

Case #4

Heather: *And when the birth certificate actually came, the first one said mother/father, even though you'd crossed it off and put parent/parent. And then I remember barbara findlay, our lawyer, saying she had a case, and she won the case which then made the BC government people, staff people, have to change the form. So she was surprised it said mother/father.*

On the other hand, three couples had their application returned to them when they attempted registration as “mother” and “father.” With their rejection came the “co-parent” form, for them to re-start the application process. Lastly, two of the couples

ended up phoning Vital Statistics before sending in the paperwork. As a result of their phone call, they had the co-parent application sent to them. The inconsistency that the couples dealt with, and the fact that still today the co-parent forms are not available at hospitals, through midwives, or through the Vital Statistics website is confusing and disrespectful. The problems with the birth certificates, and having the non-biological parent recognized, however, did not end here.

As previously noted, three of the couples I spoke with used a known donor to get pregnant. Legally, in situations of known donors, non-biological mothers are not to be listed on the birth certificate. While two of the couples ignored this legality, Judith and Olivia did not. The frustration of trying to have both Judith and Olivia recognized as mothers is clear in their narrative.

***Olivia:** Birth certificate, we had to go, it just went: Judith's the mother and I'm the father. Beacu- that was a complication afterward. We went to fill out the paper work and, we ended up phoning and saying, 'ok, how should we fill this out'? 'Oh, okay, you need a special form' [**Judith:** a co-parent] a co-parent form. So, then they send us the co-parent form, and we read the fine print at the bottom, and the fine print said, 'do you –' How did, how was the wording?*

***Judith:** the donor has to be anonymous*

***Olivia:** Yeah, and so we didn't fit into the category. So also again, I could not be recognized. So, I'm totally off the paperwork, except for on the record of birth. And, um, we're back to the same procedure as adopting Hannah.*

Moreover, Judith and Olivia pointed out that while the BC Human Rights Tribunal decision permitted two women to be listed as parents on the birth certificate, legal rights for the non-biological parent did not accompany this decision. Adoption is necessary to obtain these rights.

While lesbian parents in Québec were granted full legal rights with the change of the law there, regarding two mothers being listed on the birth certificate (Canadian Press 2002; Greenbaum, et al. 2002; Séguin 2002) the same cannot be said for parents in B.C. Same-sex parents in British Columbia are legally advised to go through adoption, for the non-biological parent to gain full legal status as a legitimate parent to their child. There were three couples who informed me that they went through the process of adoption. Heather and Lindsay explained why they went through the process.

***M:** So, was it Barbara Findlay that said you should go through the adoption process as well then?*

***Heather:** Yeah. She advised us, we had a long time. Because there was this whole issue of getting married, and does that afford us the same legal rights in terms of parenting, that it afford a straight couple? But it's so new, so there's no precedent, so she advised us that we should go through the whole adoption, not – but the traditional approach for same-sex parents used for adoption to have those rights guaranteed [**M:** like go through]*

***Lindsay:** Yeah, like lock, stock, and barrel. Like no questions asked. My big concern was that if something happened to Heather, that being, Heather being the birth mom, that I would run into problems for custody issues. And it's really hard to say, I mean, how that would turn out, but I wasn't willing to risk that, I mean, I just, there's just, I couldn't live with that.*

Unfortunately, bureaucratic red-tape affecting recognition of 2-birth mothers expands beyond birth certificates and adoption, as it affected the couples' applications for Employment Insurance (EI) Parental Leave as well.

PARENTAL LEAVE

There were 3 couples that spoke of their intent to apply for Employment Insurance (EI) Parental Leave. Two of these couples spoke at length about their

experiences, yet all of them raised it as an issue, in our interview, because the non-biological parent would be applying for the leave. That said, it is important to recognize that Human Resources and Skills Development Canada's (HRSD) understanding of who is eligible for "parental leave" does not recognize the non-biological parent within a queer parented family. As each family pointed out in their interviews, in terms of "parental leave" one must be either a biological or adoptive parent. At the time of birth, the non-biological parent is officially neither – as no adoptions in British Columbia can be finalized until the child is 6 months old – and thus the non-biological parent is ineligible for "parental leave." Heather and Lindsay managed their way around this, as Lindsay was named as "father" on the birth certificate and, due to her androgynous name, this was upheld and accepted by HRSD, in her application for Parental Leave. This was not the case, however, for Judith and Olivia, nor Wendy and Kim.

Case #1

Olivia: *For EI (Employment Insurance) you are either the adopted or the biological parent. So, if you read that on their website or on the form [Judith: if you are a heterosexual couple, you just say you are the parents²³] yeah, but technically, you'd be lying, that's what I'm just saying is that the fine print [M: to be all legal] yeah, so the situation is that I'm still, I haven't adopted Sage until, I guess, until she's 6 months or a year.*

Case #2

Kim: *We delayed my actual adoption of Nathan til Wendy went back to work, with the plan that I would then take adoption leave from work, so I would be home from work for the second year. So, we knew other lesbian-parented families that have made that choice.*

²³ In their argument, Olivia and Judith were not arguing that social fathers not be given Parental Leave, but rather that the system is inconsistent in its management of who parents really are, who is legally entitled to government benefits, and who can and cannot easily falsify information.

It was kind of a little dream we had, and we didn't know if it would backfire on us or not, but we thought, you know, if we were adopting Nathan from China, I'd be eligible for adoption leave from my employer, so I thought I'd apply. So I applied, and they gave me leave. And I said, "okay, let's see if I can get EI." And I went to the EI office, and I was very truthful, cause I didn't want to get bit in the bum in a year when they say, "you owe us several thousand dollars of, you know, incorrectly claimed EI cheques."

So anyways, when I went there, I talked with a staff person, and I was really, really clear and I explained my situation, and they looked at me like, "I had never heard this scenario before", and he said, "Your argument is perfectly valid. You have no legal relationship with this child. And therefore, why should you not be able to get EI like you would if you had adopted this child from another country or from the ministry or whatever." And I said, "exactly." So he went away and talked with his supervisor, and he came back and he said, "we've never seen this scenario before, but why shouldn't you, so we approve it." So I was home with Nathan for almost 9 months, and I say the down part of having to pay to adopt my own child was that I got to have another year home with him, and that was a huge goal of ours. So we simply repeated the same situation with Zachary. --- and I got EI again.

Judith and Olivia were not aware of the EI understanding of "parent" until it was time for Olivia to apply for Parental Leave, just before her daughter was born. I am not sure what they finally did, in terms of Parental Leave, but when I spoke with them, their frustration about not being properly recognized, or legally able to take Parental Leave until she adopted her daughter, was evident. While this was detrimental to Judith and Olivia's situation and plan, Kim and Wendy found a loop-hole and used this policy to their advantage – doubling the usual amount of Parental Leave given to parents²⁴. Kim and Wendy felt proud that their family could be recognized, maybe not just as a heterosexual-

²⁴ Federally organized Parental Leave is legally 1 year shared between parents. Kim and Wendy managed to acquire double the leave, as 1 parent took leave as a birth parent, and the other for adoption – 2 separate types of Parental Leave.

parented birth family, but for the unique qualities and situations that queer parented families possess and experience. All the same, it does not seem right that non-biological parents need to wait for their adoption to go through to be able to have parental leave through EI. In fact, it makes me question whether their needing to do so reflects an overall lack of understanding and preparedness of government policies to accept and respect queer parented families.

CONCLUSION

Birth certificates play a fundamental role in how births, and those involved in them, are legally and socially recognized and accounted for. Birth certificates are used by Vital Statistics to acknowledge “new citizens” and their families. In talking about death certificates, G.C. Bowker and S.L. Star (1998) note: “[t]he classifications entered on the certificate[s] are themselves systematically recorded so as to constrain the kinds of story that the statistics tell” (103). This equally applies to birth certificates as historically birth certificates have been believed to classify stories of genetics, although there are many people that believe they have actually told many stories of social parenting.

During the discussions of filling out paperwork to gain legal custody of the couples’ own children, the parents all expressed gratitude that these rights were finally available to people in their situations. At the end of her interview Sarah reflected on a lot of the ideas we had talked about, noting:

***Sarah:** We’ve come a long way baby right? I mean the same questions a couple of years ago would have had a very different...ramification and outcome so we’re in a pretty nice time that way as lesbians in our own country.*

It is interesting to note how differently lesbian parents are treated throughout this country. One example is that in 2002, when Québec's legislation was passed, allowing two-women to be recognized on birth certificates, legislation regarding full parents rights was simultaneously passed (Canadian Press 2002; Greenbaum, et al. 2002; Séguin 2002). A clause was also introduced that allowed past births to be re-registered, in a similar fashion. No such clause has ever passed in British Columbia. Québec's new forms were easily accessible within weeks of the legislation being passed (personal communication with Mona Greenbaum, co-coordinator of L'Association des mères lesbiennes in Montréal). The complexity of the situations in B.C. are astounding. As Nicole pointed out in her interview, "I don't know why they don't just have a standard [Parent 1, Parent 2] form anyway", as this form would work for both heterosexual and same-sexed parents, equally. I believe having different forms continues to reflect the marked difference in the government's perception of queer- and straight-parent-led families, something I will elaborate on in the Conclusion.

CONCLUSION

BUT DOES IT MEAN ANYTHING? WHERE CAN WE GO FROM HERE?

This thesis was first conceived in 2002 when a professor of mine, Jacquelyne Luce, was finishing her PhD studies and suggested that I do graduate work. At the time, I was not sure what I would study, although her research on “Queer Conceptions: Lesbian/Bi/Queer Women, Assisted Reproduction and the Politics of Kinship” (Luce 2002b) intrigued me. Luce’s PhD dissertation looked at lesbians’ experiences of conceiving or trying to get pregnant from 1980 through 2000. She expanded the anthropological connections between medical, queer, and kinship studies, while focusing on a population whose voices had typically been silenced both socially and anthropologically. Moreover, Luce’s work was ground-breaking as interest in the areas of queer reproduction was just beginning, despite the “gayby boom” having started nearly 20 years before. I find it not surprising that I not only was inspired by this professor, but that her research also directed my own. I often see my project as a continuation of her work, as what follows conception but birth? While my Master’s research was on a much smaller scale, I still see a lot of resonance between Luce’s PhD work, and this project: the identification of and giving voice to people who have been historically ignored in public as well as anthropological discourse; the links between politics, medicalization, kinship and queerness; and the acknowledgement of and focus within British Columbia’s unique status as a ‘queer Mecca’. Moreover, people I spoke with about my research often told me that my research reminded them of Luce’s, and that I should try to meet her or read

her work. While Luce has now turned her attention to other areas of focus, I see the need to investigate a third area of focus, and complete of a sort of trilogy, *per se*, ending with my PhD work focusing on queer experiences of infertility.

As noted previously, not only was it impossible to completely narrow my focus to *birth* during my interviews, but it was also impossible to explore all of the narratives and experiences that were illuminated in those interviews. While insemination stories, narratives of the role of the 'known donor' in the lives of their children, and lists of resources the parents found helpful were left out of this thesis due to space, I would not feel justified completing this thesis without discussion of one other major area has so far been neglected, and needs to be brought out from the shadows.

Three of the 10 couples I interviewed expressed narratives of infertility. When I think back to the 10 couples I spoke with, I find it shocking that all of the families involved only 1 birthing mother, at the time of the interviews. Despite this, 6 of the families talked about the possibility of the non-birthing mother being a birthing mother in the future, and 2 of the couples disclosed that the non-birthing mother had already attempted to conceive without success. Stories of infertility, while not the focus of this research, certainly had a role in the couples' narratives of birth. Three couples expressed their frustrations of dealing with complications in trying to get pregnant, and one of them told me at length about their almost 6 year journey of trying to conceive, ending with a successful *in vitro* fertilization. In stark contrast to the joyful stories of birth, that characterized the majority of the interviews, the narratives involving experiences of infertility were solemn.

Their narratives also reiterated a need that I had identified just at the start of my Master's program, when a friend disclosed to me their diagnosis of Polycystic Ovarian Syndrome (PCOS)²⁵. Narratives of infertility are neglected in our culture, and those of queer folks are further marginalized, making the individuals going through the experience feel that they are the only ones. While "access to sperm" is commonly understood to be the only "problem" lesbians experience when trying to conceive, it is not necessarily their only obstacle. Queer experiences of infertility are innately different those of heterosexuals due to the fact that we are "in a heterosexist society that questions [lesbians'] entitlement to [seek] motherhood in the first place" (Wojnar & Swanson 2006: 8). Luce explains that:

The chapters on lesbians in books on reproductive technologies address the issue of lesbian parenting and the reality that lesbians do not become parents by donor insemination. However, the processes and actual experiences of lesbians trying to become pregnant and/or parents are not the subjects of analyses. Thus, we have no sense of how many lesbians would have, like the presumably straight women using technology, faced difficulties conceiving or sustaining a pregnancy. (Luce 2002: 15)

This lack of acknowledgement and recognition of infertile lesbians was further demonstrated in my own experiences seeking services at a Vancouver fertility clinic, where nothing (image or printed word) reflected the fact that this clinic served queer individuals and couples. It is no wonder that feelings of isolation prevail among lesbians "following a miscarriage, a late-term abortion, or [experiencing] difficulties conceiving" (Luce 2002b: 49-50). The impact, however, of anthropological studies of queers' experiences of infertility is much broader than just those immediately involved, as it

²⁵ Polycystic Ovarian Syndrome (PCOS) and Polycystic Ovaries (PCO) are among the leading conditions of infertility in women, and in fact, are more prevalent in queer populations (Agrawal, et al 2004; Russell 2003; Kitzinger & Willmott 2002; Futterweit, Weiss & Fagerstrom 1986).

relates to political recognition of queer families and their unique reproductive needs; feminist perspectives on medicalization and, in particular, New Reproductive Technologies; the cultural understandings of “family” and “motherhood” or “parenthood”; and the anthropological connections between gender, sexuality, reproduction, kinship, medicalization, and cultural context. Of course, these also relate to queer experiences of birth.

BRINGING IT BACK...

“It is no accident that liberation struggles of all kinds are inextricably bound up with the effort to find voice. Often this entails rejecting the language of the dominant culture and naming one’s experience in one’s own terms.”

-Maureen Sullivan *The Family of Woman* 2004: 167

While the social and legal context of my research may not seem very relevant, I found that the more I read about queer families in other places or in times past, I realized that the context in which my research was situated was fundamental to its findings. As demonstrated by my participants, the unique social and legal acceptance of queer families in British Columbia facilitates an easier transition for what Maureen Sullivan calls “liberation struggles” and “finding voice” (2004). The confidence and freedom the parents demonstrated about being “out” certainly influenced their decisions and experiences of them. The choices that are available regarding birth, and the legislative policies and social acceptance regarding queer families in British Columbia are unique, and perhaps only challenged (at this time) by those of Montréal, Québec. In contrast to queer folks in more rural areas, or other places around the world, my participants did not mention any fear of facing explicit homophobia by their care providers or even for their

(future) children. I was actually surprised by the lack of homophobia expressed and experienced by those I interviewed.

Given this confidence and expected acceptance, the couples' satisfaction or complacency regarding government bureaucracies' treatment towards them shocked me. I think it is important that queer folks do not just feel lucky or grateful to be recognized as parents and family, but that we realize it is our right to be acknowledged as such. Before interviewing the couples, I had no idea that "lesbian" birth certificates were not easily accessible and that non-birthing/non-biological parents are not eligible for Parental Leave upon the birth of their child. The extra steps that these couples had to go through to gain access to the "correct" birth certificate application, to legally gain full rights as a parent to their children, and to take Parental Leave, reflects a second-class treatment by government bureaucracies. This sense is only strengthened by my knowledge that it this is due to our government's laziness²⁶, as opposed to simply "adjustment time" or "transition phase", as Lindsay described it. While we are lucky, in comparison to queer folks living in other places, we are still treated like second-class citizens by our bureaucracies, and that is not acceptable.

While I started this project with the notion that studying queer birthing would reflect on much more than the biological aspects involved, I really did not know what to expect. I trusted in the belief of Rapp and Ginsburg (1995) and Jordan (1993) that reproduction, and particularly birth, stand as "an entry point to the study of social life" (Rapp & Ginsburg 1995: 2), and feel my research was successful in unpacking some of the issues regarding the relationship between reproduction and the literal "production of

²⁶ At least in comparison to the speed with which bureaucratic changes regarding queer-folks in Québec occurred.

culture” (Rapp & Ginsburg 1995: 2). My participants were excited to share their stories and be heard, and I only hope that my reporting and analysis of them did them justice.

In the end, however, I must reiterate that the importance of this research goes beyond the obvious practical findings and implications of and for queer couples who birth in British Columbia, and their care providers. While this is undoubtedly important, its relevance to ongoing queer and feminist studies, and anthropology must not be overlooked. Studies of queer reproduction provide a unique and important perspective to the study of kinship, through the challenges to cultural assumptions and expectations of gender, sexuality, parenthood, reproduction, and biological relations. Researchers and theorists who study New Reproductive Technologies, foster families, adoption, inter-racial families, and childless families can all take something from this research, whether it be the role of biology in family, or how diverse families adapt to their surroundings and/or define themselves by creating new and different parenting roles and labels for themselves. While this research project was quite small, I expect to be able to further these investigations and relationships in the future, through the continued intermingling of studies of kinship, sexuality, reproduction, gender, and medicalization.

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