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(Eu) Somos

Lived Experience of Pregnancy and Medicalization

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Master in Anthropology

by

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Per Amalia, sempre

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ABSTRACT

In the past fifty years, pregnancy has gained a lot of interest in social sciences in correspondence with the surge of *the body* as systematic category of analysis.

The pregnant body seems to become a hyper-body on which simultaneously operate biopolitics, economic forces and social imaginaries, all engaged in the creation of a new, dynamic ethic of reproduction.

This thesis is an in-depth exploration of the unfolding of my lived experience of pregnancy on the background of the biomedical landscape. Moreover, it analyses the sharing of this experience with three pregnant women that, like me, immigrated in Portugal.

It is developed within a phenomenological and critical frame, and takes the form of a dialogue, a dialectical alternation between the autoethnography of my pregnancy and the reflections it triggered in terms of embodiment, medicalization and socialization.

The pregnant embodiment that emerges is a liminal one: challenging postulates of subjectivity and individuality, it reflects the complexity of being at once an "I", (*eu*) and an "us" (*somos*).

Keywords: *pregnancy, embodiment, medicalization, phenomenology*

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INTRODUCTION

In the past fifty years, pregnancy has gained a lot of interest in social sciences in correspondence with the surge of *the body* as systematic category of analysis.
In these stances, the pregnant body seems to become a *hyperbody* on which simultaneously operate biopolitics, economic forces and social imaginaries, all engaged in the creation of a new, dynamic ethic of reproduction.
From in-vitro fertilization to umbilical cord stem cells banking, from medically assisted procreation to surrogate motherhood, a rich technical terminology has soaked common vocabularies, making biopolitics of reproduction a central issue in "industrialized bureaucracies" dominated by the biomedical system (Hacking, 1995:351).
Pregnancy itself has become a multifaceted phenomenon, a refraction of these centripetal forces that ultimately unite in a common denominator: the pregnant body.

This thesis stems from my lived experience of pregnancy.
It originates in the shock of the discovery, the acceptance, the wonder at the transformations it ensued, the need to make sense of it.
It is developed within a phenomenological and critical frame, and takes the form of a dialogue, a dialectical alternation between the autoethnography of my pregnancy and the reflections it triggered in terms of subjectivity, embodiment, medicalization and socialization.
But it is also the story of my sharing this experience with three pregnant women immigrated in Portugal.
The boundaries of each section that composes it – personal narrative, phenomenological description, critical analysis – are blurred and porous.
This reflects the experience of pregnancy itself, a critical embodiment that reveals, as I argue, the collapse of pre-determined settings.
The context in which the fieldwork has taken place is the city of Lisbon and its immediate outskirts, two obstetric wards and a local health centre, but then again a living room and the back room of a beauty salon, a future daughter's bedroom and an office.
The research has in fact been developed as an in-depth exploration of lived experiences of pregnancy through the engagement in the daily lives of the participants involved.

A condition for the carrying out of the six months of fieldwork has been its corresponding to the timing of my pregnancy, ending a few weeks before giving birth.
Being approached through a phenomenological stance, I have let the ethnography flow with the circumstances, thus being open to eventual changes in its initial configuration.
There are two aspects that have undergone main "restructuring" during the course of the research.
The first is the immigration context: drawing from my condition of pregnant and immigrant in Portugal – though, being European, a *privileged* one - I have sought to share this experience with women in a "similar" situation. I have contacted associations of immigrants and spread the word among some of the nurses from the health services I referred to for my pregnancy. Not wanting to be directly associated with the biomedical setting, being it a central problematic of my analysis, I have avoided contacting women directly during my monthly check-ups at the obstetric ward.
Finding pregnant women available and willing to participate has proved to be a difficult task, mostly for the resistances I have found among the associations that support pregnancy and maternity. Even if this is not the place to go into details, I think it is important to observe that the ostracism I have experienced has been mainly operated by the administrators of those organizations, not allowing me to come into direct contact with the women who turned to their services. This is an aspect I have not deepened (due to the shape the ethnography has taken during the fieldwork), nonetheless it's one that I think deserves more attention.
Finally, the three participants that have been willing to share their experience of pregnancy with me, have been contacted through a nurse with whom I had a more familiar relationship during my visits at the hospital and through one of the immigrant associations I contacted.
I refer to them in the thesis with the initials of their names, wanting to keep their privacy without transfiguring their identities.
The migration issue transpires in the ethnography like a background that reveals itself on occasion: I have not categorized it, or affronted it directly but I have, to say it with Heidegger, "let what shows itself be seen from itself." (Mortari and Tarozzi, 2010: 24).
I have thus approached the question of being an immigrant pregnant women, exploring how this has affected our perceptions of local biomedical settings, our relationships with medical

professionals and if and how the distances from familiar environments have produced alternative nets of support.

The second aspects that has taken a decisive turn from my initial designs is the centrality that the autoethnography of my pregnancy has taken during the development of the fieldwork. The latter, in effect, coincided with the trajectory of my experience, and I found through its unfolding that I wasn't capable, and somehow didn't think it was *authentic*, to get distant from it. Therefore I have embraced the challenged to discover what, for me, was a new way to engage with the anthropological discourse, and "zoom backward and forward, inward and outward" in the tentative to find, in this experience, the anthropologist and the pregnant woman at once (Ellis and Bochner, 2000:739).

The dialogical textual device I have adopted betrays this problematic and represents as well an experimentation in reflexive, poetic, narrative, in my personal believe that pursuing a linear, *objective* style, writing "in order to have no face" wouldn't catch the deepness of the pregnant experience itself.[1]

To conclude, this is a phenomenological account of the embodiment of wanted or, in my case, *accepted,* pregnancies. Though *wanted* or *unwanted* are, in themselves, ambiguous categories, that "tend to gloss over the socially conditioned process of choice that accompanies the acceptance or rejection of a pregnancy" an embodiment of rejected pregnancy represents a different configuration of a woman's being-in-the-world, that needs to be addressed in its specificity and that would certainly challenge the developments and findings of this research (Lundquist, 2008:137).

[1] Foucault: *The Archaeology of Knowledge,* in Shaw, 2000:131

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CHAPTER ONE
PHENOMENOLOGY OF PREGNANCY

I

So I was pregnant, and I had been for a while. None of the changes that had taken possession of me lately had I interpreted right. Not the restless nights, not the sleepy noons, nor the sudden fits of cry.
Even the lack of menstrual cycle or the fullness of my breasts hadn't rang a bell.
I am not so naïve as it sounds, though.
For months, earlier, I had taken the pill. Or should I said, that the pill had taken me.
What was it that it said on the leaflet?

> *mood swings headache abdominal pain acne breast pain breast enlargement breast tenderness painful or irregular period weight gain increased appetite decreased appetite depression nervousness sleep disorder*[2]

These common side effects reportedly would have disappeared after a while; it was only a matter of waiting some months for one to fully appreciate the contraceptive capacity of the product.
I didn't have that patience, nor did I want it. The pill was causing havoc in me where there was no space for more turbulence. Storm on a storm.
I had to grasp again the border where my own passions ended and this combined hormonal induced battle commenced.

Not even a year before I suffered the biggest loss of my life.
The pain had been so intense that it seemed like my inner bodily functions were frozen too. I was mourning, my all being was mourning. It didn't come as a shock that no blood was coming out of me at that time.
In "The heart of what's the matter" (1977) Byron Good, exploring the semantic of "heart distress" (narahatiye qalb) prevalent mostly among women in Iran, reports how the causal relationships associated to the illness include menstrual blood, lack of blood and sorrow or

2 Yasminelle (Bayer) package information leaflet.

grief. In galenic and islamic theory the heart, as other parts of the body, belongs to a microcosmos whose functions reflect those of the spheres of the cosmos, thus conceiving a human being that exists at once with the world. I wondered how much galenism survived in the explanation of my suffering. I felt the world had stopped with me, or at least I didn't have attention for anything that kept flowing. And I did feel an oppression in my heart, a lack of breath that, together with the lack of menstruation, was tacitly understood by the women of my family as being part of our mourning.

When I felt I was able to move again, I left. I thought there was nothing much I could lose anymore, so just started from there. I followed my mate to Portugal, settled there, started learning a new language.

My period was back, though irregular, that's when I decided to give it a chemical help.

But all those uncontrolled manifestations of femininity – as my companion would put them, the mood swings, the angry silences, feeling blue – were already there, already me. The pill only added on fertile ground, and after a while I stopped tacking it.

So that's it, I was hollow, and now that hole was impregnated. I couldn't believe I was able to carry a life inside in this moment of my life. While coming to terms with death, I was evidently very much alive.

With this newly discovered situation, the recent past and its events, feelings, any non ordinary sign that could give a hint since when I had been pregnant suddenly acquired new interest. My moments alone, days, weeks and recent months had been quite undifferentiated to me.

Now I was trying to picture a temporal fresco of my latter life.

I re-interpreted the meaning of uncommon sensations I had had lately: times when I felt my heart quicken without apparent reason; the afternoon sleepiness, irresistible and welcome; those overly present sudden fits of crying. I could not discern whether they were caused by the deep sorrow I felt or this hormonal tempest that all the booklets on pregnancy talked about.

Again, I realized how much my view of the self was split: it was not just the dualism of mind and body that resonated from my narrative as "contemporary western woman".

To give meaning to this sudden strong, unusual feelings I was having, to explain these changes in a socialized way, I fell in the semantic of what Nikolas Rose calls the "neurochemical self"(Rose, 2004).

I found myself availing a discourse that contrasted a usual, "real" me, existing in an

incarnated mind, and a prevailing hormonal me, where the boundaries of what I could control (the "real" me) and what I could not (the hormones taking control of me) were cloudy.

A gynaecologist decreed my pregnancy dated back to my last period. He took out his mobile phone, started from the last day I had taken the pill, counted until the current day and calculated that I was exactly eleven weeks and three days pregnant. Then confirmed himself through the sonogram.

As simple as that, no need to pursue memories or any exotic symptoms.

And here I was: a stranger in white coat and plastic gloves was setting the limits of my inner revolution by blood loss and ultrasound invasion.

I needed to recover a minimum of integrity and find a key to give sense to this story by myself.

The idea of a pregnancy scared me: I never wanted a child before, felt less than ready right now and couldn't handle another sudden change in my life.

But at the same time – and there lay the true duplicity I was experiencing – I felt euphoric. A subtle sensation of empowerment was rushing through me and an idea that there was a part of me that was stronger than me. I could be down, feel unwilling to do anything or stuck in my moodiness, but something was reacting uncontrolled.

I was waiting, now anticipating.

A pregnant lived experience

As I set this research on my and other women's lived experience of pregnancy, drawing a phenomenological frame to feed the fieldwork, I find myself on the trail of Husserl's reductionism, to free my perspective of any preconception and go back to the *thing itself.*

To achieve this, according to the german philosopher, it is necessary to perform an *epoché*, a suspension of all the elements that would influence my considerations, and describe things as they are presented to my consciousness (Moran, 2000).

Reviewing with a critical eye what any previous knowledge I have of pregnancy consists of, two intertwined universes surface: memories on one side, as glimpses of personal accounts, things I have read or seen in some movies, impressed and crystallized in the course of my life; and, on the other side, the "technical" knowledge of the biomedical cultural background I come from, that stands in a dialogic relationship with those memories.

The latter represents the orthodoxy within which my idea of pregnancy has developed.

I recall, as a child, hearing the story of my mother expecting me: the obstetric admonishing her for gaining too much weight; the lack of ultrasound technologies at the time, where "I *felt* you were a girl anyway, I would always talk to your father referring to you as a she"; her ten months long pregnancy, "you didn't want to come out, so they had to give me an injection and three hours later you where born". The presence of doctors and medical practices were pivots in her narrative.

Vice versa, my grandmother's vocabulary of her pregnancy was *domestic*, involving neighbors, family's women and giving birth at home. She showed me frames of a time where women would give birth virtually anywhere, and doctors were often antagonizing figures in her stories.

Narratives of relatives and friends become the skyline onto which I project my own experience: some painful, other funny, they all concur in picturing the possibilities of the progress of my pregnancy.

This oral transmission that moulds my understanding of being pregnant, I find, I cannot ignore. I can't perform an *epoché* of my memories and I can't reset the emotions that derive from it, becoming a *tabula rasa.*

What I can bracket though, for the purposes of my research, is the "technical" knowledge

constructed around it, based on biological postulates and medical explanations under whose terms the category of pregnancy has been normalized.

In biomedical and body politics discourse, reproduction is understood as belonging to the realm of nature, as much as other events of life: growing up, becoming an adolescent, getting old (Lock and Scheper-Hughes, 1987).

Social studies have on several occasions highlighted how the identitary rhetoric of biological sciences bases its own legitimacy on its supposedly natural foundation, constituted on the legacy of a positivistic epistemology built on dichotomies such as nature/culture, body/mind, objective/subjective,rational/irrational (Csordas,1990; Lock,1993; Martin,1987).

“Conceptual dichotomies – observes Margaret Lock - inevitably metasticize into one another” (Lock, 1993: 137).

Where a cultural critical analysis of biomedicine serves its purposes on deconstructing biomedical claims of neutrality and objectivity, a phenomenological stance permits to take a step back and catch the lived experience of pregnancy unfolding, allowing the researcher to become “a phenomenological heuristic tool” (Mortari andTarozzi, 2010:15).

What is interesting, to phenomenology, is the way things disclose themselves to us revealing their “dative evidence”, thus going beyond the dichotomy being/appearance, fundamental dialectic of other sciences whose founding aim is proving rather than experiencing.

> *To return to things* themselves is to return to that world which precedes knowledge, of which knowledge always speaks, and in relation to which every scientific schematization is an abstract and derivative sign-language, as is geography in relation to the country-side in which we have learnt beforehand what a forest, a prairie or a river is. (Merleau-Ponty, 1962: IX-X)

In particular, I shall embrace a path that, ignited from Husserl's basic principles of reduction and intentionality, then entrenched in human existence and historicity through Heidegger's transformation of phenomenology, has later found in Merleau-Ponty and the corporeality of human condition its mature expression. It is the same path whose ramifications have inspired contemporary feminist philosophy with regards to women's body and its specificity, contemplating the experience of pregnancy as emblematic.

Husserl, considered the founder of modern phenomenological investigation, initially understood his ground-breaking phenomenology as a transcendental method, based on the description of the invariant aspects of *phenomena* as they appear to consciousness, “an

approach that investigates the objects of experience in order to draw up a theory of experience" (Mortari and Tarozzi, 2010: 12).

Husserl's idea of the transcendental consciousness was that of an irreducible thinking ego that makes possible objective enquiry, a subject that is always in the world; as he put it through *intentionality*, a consciousness of objects.

Later on in the development of his thought - that was always *in fieri,* revisiting the same question that had sparked his initial speculation, that of reduction - he came to see phenomenology as a "pure eidetic science, a science of essences" standing at the base of the whole of philosophy. (Moran, 2000: 125).

Essences were not to be taken as an idealistic object of philosophy, but the means through which it becomes possible to inquiry that world in which we are thoroughly engaged, a mean without which it wouldn't be possible to reach that distance from its facticity.

What had been interpreted as the idealistic drift of Husserl's phenomenology marked the turning point of many of his followers right from the beginning. It lead to a diaspora that spread the discipline in its numerous ramification. Anyhow, in its founder's intentions, the field of interest of phenomenology was from the beginning set to be as wide as the world, giving it an aspect of "infinite meditation", an unresolved problematic whose "unfinished nature [...] is inevitable" (Merleau-Ponty, 1962: xix). As Paul Ricoeur put it, "phenomenology is the story of the deviations from Husserl" (in Moran, 2000: 2).

Probably the first and most important heretic turn from Husserl's thought is that of Heidegger, his most influential pupil, that critically transformed and rooted phenomenology back to existence. The focus question, that he claimed had been misunderstood and given for granted throughout the history of philosophy, is *what it is to be human*. Heidegger polarized the answers to this question starting from the title of his masterpiece, *Being and Time*; his initial task was to dismantle centuries of philosophical constructs.

Against the traditional philosophical idea that time is understandable only in relation to eternity, he emphasized how we can rather only understand time from our mortal condition, our finite point of view: time finds its meaning in death.

Against Husserl's transcendental consciousness, that plays the role a superior, irreducible thinking subject, he opposed Dasein - literally "being there" - as the inherently social being "for which Being is an issue" (in Moran, 2000).

Heidegger argued that the givenness of Husserl's phenomena is already a theoretical construct, whereas his attempt was to take phenomenology a step back to interpret the pre-theoretical conditions for there to exist intentionality.

Stressing how experience is always situated already in a world, in a time and in ways of being, he formulated the notion of *Being-in-the-world* as a non intentional, or pre-intentional openness to the world. His effort to trace back the basic conditions of existence, to be in the world, in a time and "thrown in possibilities" confirms the need of an operational reduction for a phenomenological enquiry to take place.

Merleau-Ponty (1962) underlined the debt that Heidegger's existentialism owns to Husserl asserting how "Far from being, as has been thought, a procedure of idealistic philosophy, phenomenological reduction belongs to existential philosophy: Heidegger's 'being-in-the-world' appears only against the background of the phenomenological reduction."

With respect to the topic of my research, I should try to frame pregnancy within phenomenological coordinates, trying to identify where an experience of pregnancy leads in terms of essence and, using an Heideggerian vocabulary, in terms of *care*.

As I have already mentioned, a phenomenological reduction requires the bracketing of preconceptions, the cessation of any formal ideas - whether it be scientific knowledge or "common understanding" given-for-granted assumptions or postulations - to ground the research on lived experience.

At this juncture, the paradox of a double meaning suddenly surfaces: *to bracket a (pre)conception* here could refer both to the suspension of any prejudices or bias related to the element of my research, as much as to the "essence" of this element – *conception* - as the starting condition of pregnancy.

In pure transcendental consciousness, an objective enquiry of the lived experience of pregnancy should be possible through the phenomenon of *conceiving* as it is presented to the self. Conception, in fact, should be the common ground of any pregnancy.

But drawing from Heidegger's formulation of fundamental ontology as the search of what unites and makes possible the diverse senses of *being*, I ought to intertwine my description with *care*; specifically, I shall refer to "the beings for whom such a description might matter" casting the different perceptions of pregnancy in a horizon of time and subjectivity (Moran, 2000).

The phenomenological description of this experiences is inherently related to the perceived transformation of the body, the awareness of the changes, the relative emotions, relationships with other people involved and the social negotiation of one's presence. It is, moreover, consolidated on the pregnant woman as the one carrying the phenomenon of transformation.
Formally, the investigation should have a pre-set temporary arch corresponding to that of a physiological pregnancy, starting with a conception and ending with a birth.
My lived experience, though, doesn't correspond to the biological time of the pregnancy: it is the *awareness* of being pregnant that gets it underway, and the last days of preparing for childbirth, that, as a retirement from the outside world, mark its end.
Heidegger explained phenomenon as something that is concealed while at the same time, *for the most part*, it's showed. What shows itself has a hidden essence and phenomenology is the method to uncovered it; in his words, "to let what shows itself be seen from itself, just as it shows itself from itself" (Mortari and Tarozzi, 2010: 24).
Even the outward growing evidence of a pregnant belly doesn't show all that is concealed within it. To describe mine and other participants' experiences of pregnancy, I argue, means not to follow the objective, biological time of childbearing, but to trace the lived experience of *expectancy.*
"Expecting" holds in its spectrum of significance the double meaning of *waiting* and "anticipating with confidence of fulfillment".[3]
Expectancy changes with the internal rhythm of pregnancy, starting for me with the surprised and irregular beat of first knowledge (that in my experience as in those of the women I shared my research with, could be described as a protective stance of our newfound situation), gaining force but variability along the course of its development, and slowing down, as to reserve strength, towards the end.
The time, as the experience, of pregnancy is then specific and idiosyncratic, not predetermined by the rules and limits of its biological counterpart.
Gestation, in its wider sense of carrying within, goes even beyond those limits, as I project my pregnancy over my past, and bond it to the feminine lineage of my family. Where earlier I was a daughter and a niece, I see myself becoming a daughter-mother, as my mother, my

3 Definition taken from Wordnet, a lexical database of English language from Princeton University. http://wordnet.princeton.edu/

aunts, my grandmothers before me.

As a woman, I have potentially been carrying with me the paradigmatic conditions of gestation. Pregnancy is the fulfillment of that possibility.

Expectancy and gestation mark the differences of what women perceive as the timeline of their pregnancy.

Quoting Fujita, Van Der Zam[4] observes that "expectation is a subjective aspect of waiting; it is *how we wait*. With expectation, there is *a strong inner activeness in spite of outer passiveness; there is a belief in the occurrence of the expected event; and the expected event is sensed to be imminent and clearly imagined*".

Where the waiting started for me only in the moment I realized I was pregnant (several weeks after the biological conception), K.'s expectancy can be traced back to at least a year before the time of this research. The narrative of her actual pregnancy starts, in fact, with a miscarriage she suffered months before, whose traumatic memory extended and affected her present experience.

V.'s story traces back even further: she'd been waiting since her first son's birth, which occurred twelve years earlier. Other aspects of her life, as migrating to Portugal and working to reach a stability, had postponed her actual pregnancy. Her first years as an immigrant had been harsh, and only recently she and her husband were rejoined by their son. Theirs was a planned pregnancy though, the last piece to put into place once all previous plans had been fulfilled.

As for T., her expectancy was a loose project; she told me time had come for her to desire and welcome a child, so she just set herself to become pregnant. It happened, eventually, "when it was time for it to happen".

Lived experiences of pregnancies could not be limited in the nine-months-timeline like pattern. Subtracted from the objectifying gaze of biomedical schemes, these narratives get a broader extension, setting their own confines tied to episodes of life.

The perception of women's own experiences though, I argue, is not even deposited in a detached transcendental consciousness or in a ideal being that summarize the various possible ways of being. The subjective limits that draw the line of each pregnant temporality are embodied rather than imagined. Memories themselves are not an appeal to the past as much as

4 Online: http://www.phenomenologyonline.com/sources/textorium/van-der-zalm-jeanne-pregnancy/

feelings and emotions sedimented in one's body.

Narrating my own experience during the encounters with V., K. or T, the shock I felt when I found out I was pregnant was still alive within me: I still kept, when I recalled it, that rush of life that caught me against all the odds, or what I thought were the odds.

When K. told me of her miscarriage, she was bent forward, eyes fixed on a point, envisioning the clot of blood that was her foetus; the sorrow transpired from each words and expression of her face.

At last, when I operate a phenomenological reduction, at the bottom of the words and concepts and constructions about pregnancy, there lie *bodies.* Complex ones, as it is, because they're doubled. They are alive with thoughts and perception, engaged in the world while turned inwardly towards the changes occurring within.

The wonder that I felt at such changes, that too was embodied. Moreover, I could reflect my experience and my perception in those of the others I shared it with, but ultimately what I understood in these comparisons was filtered and rendered through my flesh.

It is the incarnated existence that is forefront in the experience of pregnancy, an embodiment of transformation.

Merleau-Ponty maintained the idealism behind the pursue of a total reduction because through it we're not returned to a transcendental subject, as Husserl would have had it, but to a subject that emerges from the world: “The most important lesson which the reduction teaches us is the impossibility of a complete reduction. [...] If we were absolute mind, the reduction would present no problem. But since, on the contrary, we are in the world, since indeed our reflections are carried out in the temporal flux on the which we are trying to seize [...] there is no thought which embraces all our thought.” (Merleau-Ponty,1962: xv).

Drawing from Merleau-Ponty, I argue that a phenomenological reduction of the experience of pregnancy finds a subject situated in her corporeality.

We know nothing of consciousness if not in the embodied form of our existence. But as such, this corporeality is never neutral. It stems from the specific world we inhabit, our memories, relationships, our cultural embodiment. The ramifications that extend from there, the perception of our own body, the socialized status of our pregnancy, how it is dealt with and valued, all stem and find accomplishment in the body.

II

The moment I truly realized and accepted I was pregnant I felt something shifting inside: it was as if the resistances stepped down and I suddenly embodied the awareness of it.
Me and Nicola started spreading the word among friends and parents, joking on it, teasing each other as if drunk about it. We were probably realizing the truthfulness of this unexpected situation through playing with it, and this light-hearted way of taking it flew in every aspect of the experience.
"It changes your life", "you can't think of anything else right?" I was told and asked those days. But I wasn't really thinking that much. I felt we were living for the day, the prospect of a future suddenly included all the possibilities, and a change, directed somewhere, was occurring.
Daily, I discovered new shades to this development: I could "feel" my lower back, my breasts, the sides my belly. They were awakened, as sensitized. I felt warm, soft, cozy, and I enjoyed to bask in these feelings.
Weeks later, when the pregnancy was just a little bulge protruding from me, sometimes I would wake up from the cramps in my legs. When going uphill, even slowly, my heart would beat fast. I couldn't bent down without feeling uncomfortable about it.
Where before, unless I evoked its presence, it was mostly a silent companion of my existence, my body was now emerging and drawing my attention.
I was brooding, there was another developing inside of me and it wasn't visible from outside.
It was a knowledge for few, a presence of which I did not feel the touch, but was attached nonetheless in some internal part of me.
Already, though, I was growing to accommodate what I harboured inside; even when I was focused on different tasks, in the background of my self-perception my transforming state was vividly present.
Then a day like any other, during an activity like any other like climbing the stairs or resting in bed, I started feeling like caresses of sparkling water somewhere far deep inside my womb.
They accompanied my movements and lingered, then disappear to unexpectedly turn up again. When surrounded by people in the busy daylight of the city, my inner companion would make herself known and only I would know.

It was a strange, new 'aloneness' being by myself though not being one.

The fact that I could feel it, that this presence was incarnated and alive and touching me from within, gave a new facet to my own being-in-the-world.

I would tell Nicola "here! Now it's here, put your hand", and though he would comply, excited at the prospect of feeling, sooner or later, from outside too, I couldn't share the wonder I felt in being one and plural at the same time.

I didn't feel like a vessel. There was more to it, like a brewing, a reciprocal growing of agents.

Then my belly grew for the world to know, looking with knowing eyes and catching my doubled presence. Then and there, I became a pregnant woman.

There was attention toward my physical efforts, there were seats being freed for me to sit and rest, queues would open up at my protruding front.

I felt porous and my body contours were ever changing and undefined.

The concept of 'dividual', formulated to express personhood in South Asian societies, came back to my mind, somewhere from a past time as a student (Pizza, 2005).

> *To exist, dividual persons absorb heterogeneous material influences. They must also give out from themselves particles of their own coded substances – essences, residues, or other active influences – that may then reproduce in others something of the nature of the persons in whom they have originated.*[5] *(McKim Marriott, Hindu Transactions: Diversity without Dualism)*

My corporeity was a declaration of my inner condition, that was undoubtable, and I was open to the external understanding gaze.

But differently from the texts I had read about it, where it was used as a notion to defined a concept of person that is in a flux with society, my 'dividuality' was mostly directed inside, my permeability turned inwardly.

Now, when I took my partner's hand to trace the movements of our restless creature, he would find a kick, a push, at times a reaction to his probing.

This moving within me belonged to another, I couldn't control them, but still they were me, I was the boundary and possibility of their agency.

Someway, I was more then I had been before: surely heavier and occupying more space, but I had two hearts beating inside, too.

5 Online: Pier Giorgio Solinas: www.antropologica.unisi.it/images/a/ad/L'in-**dividuo**.pdf

A doubled embodiment

To account for pregnant embodiment, in the terms that a phenomenological stance enlightens about it, I should start by framing the broader trajectory of the body in social sciences.
However, this is not the place to exhaustively engage in the evolution of modern concepts of body and embodiment; I will hint at a few, emblematic references that give me the leverage to situate the pregnant body in a phenomenological discourse.
The interest toward the specificity of female embodiment, and, within it, toward pregnancy as a particular and liminal modality of existence, can be tracked back to the encounter of feminist studies with "Foucault's paradigm-shifting accounts of power" (Young, 2005:4).
Where before it had gained limited attention, it was only during the 1970s that critical studies on power and biopolitics drew scholars' considerations of female embodiment to unexplored lands (Oliver, 2010). Emily Martin suggested that the new widespread interest in corporeality and embodiment in contemporary social studies reflects the centrality that Western societies reserve to the body and, moreover, the profound changes it's undergoing (in Csordas,1994).
Though it has now reached the status of a systematic category of analysis, its appearance in anthropological studies of the first half of the XX century has, "despite its ubiquity" been rather sporadic (Lock, 1993:133).
We find it in Mauss' 1936 "Techniques of the body": here the body materializes as the first natural instrument of human kind, a casket of modalities of existence that are socialized through the *habitus.* The construction of this body, of which, already, Mauss complained the absence in the mainstream of anthropological analyses, was curbed in a conceptual dualism – the "ontologization" of Descartes' methodological separation - that conceived it as an object (Csordas, 1990); an object for the scrutinizing gaze of the anthropologist, yet starting to get some attention in the discipline.
It is interesting to notice how his unfinished "biographic enumeration of body techniques" begins with the techniques of childbirth and midwifery (Mauss, 1936).
Again, the body is revealed in Leenhardt's 1940s' anecdote among the kanak people in Melanesia, one that is often cited in medical anthropology's works on embodiment (Csordas 2003, Pizza, 2005).
Questioning a local healer about the impact that European civilization had had in their

cosmocentric culture, where the missionary/anthropologist suggested it had introduced a notion of the *spirit* he was answered that, instead, it was *the body* that they didn't have before. The physical delimitation of the body operated in the European culture, Leenhardt deduced, had opened the door to its conceptual objectification. The possibility of this objectification was all intrinsic to a "Western" culture that, drawing from its philosophical and scientific historical development – the Cartesian *Cogito* at its foundation - had come to conceive a natural separation between mind and body, subject and world.

Finally, it is with Merleau-Ponty and his "Phenomenology of Perception" (1962) that the idealistic and empiricist approaches, that sustained the structural western dichotomies, were critically revised. The French philosopher embraced the task to recompose the fracture starting from the relation between world and existence, that he found in the body.

Merleau-Ponty underlined the intrinsic correlation of the subject with a world that "I rediscover 'in me' as the permanent horizon of all my *cogitationes* and as a dimension in relation to which I am constantly situating myself" (1962:xiv).

This rediscovery of the coinciding *momentum* of existence and world was obtained through recognizing the *primacy of perception*, that grasps existence at birth. Perception, in Merleau-Ponty, is the first modality of contact we have with the world, when it unfolds before us and we grasp it in a pre-reflexive way, before the act of giving significance to it. "Perception is not a science of the world, it is not even an act, a deliberate taking up of a position; it is the background from which all acts stand out, and is presupposed by them." (1962:xi).

Taking perception as point of departure, Merleau-Ponty finds that the perceiving subject is not an ideal consciousness, but an embodied person: the body is the permanent condition of experience. We are engaged in the world through our corporeity, where "the perceiving mind is an incarnate mind" (*The primacy of perception,* in Moran, 2000:418).

The body that comes out of the 'Phenomenology of Perception' doesn't stem from a reflective analytical operation: the moment it placed the world as an object would already be an act of significance. This body is characterized by unity and indeterminacy: all its functions are there in a synthesis, there's no rationale separation of them; at the same time, they are contingent in the sense that they are continuously re-forged "through the hazard encountered by the objective body" (Merleau-Ponty, 1962:198). Its experience underlie intentionality, that is, it pursues its projects in terms of "I can", that opens to capacity, possibility.

Thus, in perception, Merleau-Ponty individuates a pre-objective relationship of the subject to the world, and the embodiment that results is such by virtue of its engagement.

This point is fundamental in Csordas' formulation of a phenomenological anthropology of perception, whose aim is to seize “that moment of transcendence in which perception begins, and, in the midst of arbitrariness and indeterminacy, constitutes and is constituted by culture”(Csordas, 1990:9). Culture, thus, stems from corporal processes, and, starting from the unity that the body (re)gains through Merleau-Ponty's work on perception, Csordas proposes a paradigm for a cultural phenomenology that places embodiment as the “existential ground of culture and self” (Csordas, 2003).

In Csordas' theoretical construction, embodiment is the combination of two distant positions: Merlau-Ponty’s overcoming of subject/object differentiation by collocating perception at the base of the process of objectification and Bourdieu’s collapse of body/mind separation through the concept of *habitus*, that is the system of unconscious collective practices unified under the principle of the socially informed body. Culture stems from corporal processes, and where the body is regarded as a “discreet organic entity”, it is embodiment that has a primacy in its revealing the corporeal existential condition (Csordas, 2011: 137). Csordas recognizes that gender complicates and broaden the question of embodiment as methodological device, and acknowledge the role of feminist scholars in showing that women's experience can reverse body's based constructions that “make maleness or masculinity the default value” (Csordas, 2011:144).

From the body as object of cultural interest to embodiment as *locus* of cultural production, an analysis of pregnant embodiment offers critical and problematic questions that seem to challenge previous positions.

A cultural analysis of pregnancy finds a woman inhabiting a body *in progress*.

This developing entity, conceived as separated - the woman, her body, the foetus - is reflected on, cured and cared for, checked and manipulated through medical practices, socially constructed, protected, made up and reproduced in digital images, commercialized in maternity departments.

More then in its habitual routine – or differently - the pregnant body is objectified: it mirrors the social landscape that produces it, it absorbs the biomedical observation that evaluates it, it *lives* through the fecundity it represents.

Nonetheless, it is never neutral: even in the biological reduction of its natural existence that depicts it as a system of separated organs, as an apparatus of reproductive functions, this body is already forged within the "self-creating process called human-labour" (Donna Haraway, in Csordas, 2003:2).

A phenomenology of pregnancy, instead, discovers an experiencing *embodied* woman.

That body on which the analytical gaze individuates cultural, political, social forces at work, disappears; what emerges in its place, is a lived pregnancy in action.

Where description replaces analysis, it's not just about performing a spatial transfer, a shifting in the point-of-view. It is about operating a radical reformulation of how the pregnant body stands in relation to the "external" world that produces it.

While the social and cultural landscape is still caught up in its flux, a phenomenological stance re-collocate the subject in its original position, inhabiting and participating in the same flux, because "We are caught up in the world and we do not succeed in extricating ourselves from it in order to achieve consciousness of the world." (Merleau-Ponty, 1962:5).

Moreover, the "objective world" doesn't abdicate in favor of an analysis directed toward an inner self; this would render the phenomenological effort meaningless.

The subject/object dialectic's crumbling away and the world's *disclosure* through a description of a pregnant, incarnated existence, are grasped at once.

In the previous paragraph, I have coincided the *experience* of pregnancy with the subjective time of expectancy, differentiating it from the physiological time of childbearing.

Expectancy, as anticipation and awareness of carrying within, marks a first transformation of the pregnant embodiment, that is revealed in its duplicity, or better, in a doubled subjectivity.

Where the *phenomenology of the origin* has formulated a transcendental subject, characterized by its unity, a phenomenology of pregnancy, I argue, put this assumption in crisis.

Delimited by the boundaries of my flesh, the developing creature is one with me while being different; its *situatedness* corresponds to mine, and its *bodyliness* is intrinsic to my own. I'm not just a container that protects its growth, for the latter is connected to my subsistence.

"In so far as it sees or touches the world, my body can therefore be neither seen nor touched" (Merleau-Ponty,1962:105). On the contrary, when my pregnant body disappears in the background of my actions, it reappears in the movements that I feel within. I feel touched from inside but at the same time it is my body contour that is touching.

The perception of my own body is different: my core now is on the womb, and the rest seems to move with it. Positioning myself on a chair, the posture is altered to guarantee space to the abdomen. I avoid obstacles or sudden moves in the same pre-reflexive way I engage the world with my habitual motility.

But when my belly grows, and the boundaries of the body exceed their expected place, I make an effort to adapt to the new space I occupy.

My agency is reflexive, for my movements, my weight, my actions remind me constantly of my condition. My body becomes ever present in my consciousness.

A phenomenology of pregnancy demands a reformulation of embodiment as encountered in perception. The body as a fixed, static entity, with predetermined features, has been replaced by a fragmentary, dynamic, *gendered* and problematic one.

In her widely acclaimed article *Throwing like a girl* (1977), American philosopher Iris Young, in setting the stage for an existential phenomenology of female body experience, lamented how feminist studies had produced little to no works on theoretical methods for reflections on female embodiment.

As Young states, "Western metaphysics has postulated the idea of an autonomous individual subject, a self-enclosed ego that inhabits but is distinct from a body. Reflection on the existential qualities of the female body upset most of the assumption of this ontology" (Young, 2005:10).

Her critic starts with an evaluation of female motility whose confidence is (self)undermined by the contradictions women live in patriarchal societies, that reflects in their bodies, experienced as capacity (transcendental) and, at the same time, as objects (immanent).

In women's embodiment she individuates ambiguity, discontinuous unity with its surrounding, "inhibited intentionality": "Feminine bodily existence is an inhibited intentionality, which simultaneously reaches toward a projected end with an "I can" and withholds its full bodily commitment to that end in a self-imposed "I cannot" (2005:36).

Within this framework, in 1984, she elaborates *Embodied pregnancy: subjectivity and alienation,* a phenomenological description of pregnancy as lived in industrial and commercial societies. Drawing from her own and of a number of other women's experience, the pregnant body is analyzed in its fluidity, fragmentation, and perceived lack of outer boundaries.

Pointing out that Merleau-Ponty, in his *Phenomenology of Perception,* though collocating it in the body rather than in an abstract constituting consciousness, pursue the idea of a unified self as a condition of experience, Young argues how challenging a phenomenology of pregnant embodiment is for male-postulated theories.

Reflecting on how body subjectivity is split in pregnancy, she writes:

> As my pregnancy begins, I experience it as a change in my body; I become different from what I have been. […] I feel a tickle, a little gurgle in my belly. It is my feeling, my insides, and it feels somehow like a gas bubble, but it is not; it is different, in another place, belonging to another, another that is nevertheless my body [...] I experience my insides as the space of another, yet my own body (Young, 2005:49).

The integrity associated with and implicit in subjectivity seems to collapse in a pregnant embodiment. The physical margin of the body becomes open and porous, and this experience relates not only to the inner self, but to its external boundaries as well.

Moreover, to the phenomenological "operative" intentionality as "that which produces the natural and antepredicative unity of the world and of our life" (Merleau-Ponty, 1962:xx) Young opposes double intentionality in pregnant consciousness that "contrary to the mutually exclusive categorization between transcendence and immanence that underlies some theories, the awareness of my body in its bulk and weight does not impede the accomplishing of my aims." (Young, 2005:51).

The pregnant embodiment seems to be a critical one: an embodiment that undermines existing theorization on subjectivity and self, opening new perspective to the existentialist *being-in-the-world.* It questions the validity of the body as a unique constituted entity and arises its ontological frailty.

Often influenced by transdisciplinary approaches (feminist and gender studies, disability studies, performance studies) recent theoretical drifts concern the body as a questionably given physical entity and stress the fragmentary character and *hybridity* of human existence shifting the attention, as Van Wolputte (2001:252) puts it, on "the corporeality of the scarred and vulnerable body".

III

Nausea. In nine months of pregnancy, I never suffered from it. The popular imaginarium depicting a morning sickened woman, overwhelmed by smells and tastes, rushing to the toilette to empty herself and still left uneasily filled, thus founding out she's pregnant - I guess I was lucky, nausea was a symptom that didn't belong to my newfound body's experience.

I didn't suffer from it, but I did experience it.

It was during one of the long afternoons I shared with K. for my research on pregnancy.

After spending the day in her house in the outskirt of Lisbon, sitting on the bed of her future daughter's room, chatting, relaxing, and imagining upcoming changes, she walked me to the bus stop through a path behind her building, a nice walk through the grass of an improvised soccer field.

It was at dusk, and the kitchens of a fast-food chain facing the field were at rush hour operosity.

I didn't really notice it, the thick smell of fried oils floating through the air as if in lines, until K. strongly grabbed my arm bending forward and stopping there.

She was pale, a suffered expression on her face, and her whole body was fighting to resist something, as in concentration.

I didn't need to be told what was ailing her: it was as if I knew exactly what she was feeling. The smell from the kitchens suddenly stood up-front in my senses, and I kept my breath instinctively, even though I wasn't particularly disturbed.

Everything else – the grass beneath our feet, the buildings surrounding the field, the darkening sky, the noises coming from the street became secondary, an horizon upon which the smell emerged as a principal character.

We were enveloped in it, and the nausea was a full-fledged response of K.'s body. As for me, I was living a passive experience: though not affected physically, I was mirroring her stance and probably her emotions as well. Being pregnant meant being continuously present to my body's dynamics, and overly aware of others' pregnancies.

I realized I was stooping too, soaking in the impression of uneasiness I was getting from K., of how such a natural state as being pregnant could take the resemblance of an illness.

Getting used to some discomforts was part of the transformation a pregnancy required, this I

had learned and easily accepted. My heart would quicken its pace every time I went uphill in the uneven streets of Lisbon, sleep was interrupted several times at night, often my stomach would burn after a meal.

Nothing, though, had been so overwhelming.

Out of our stuporous state, I urged her forward, reaching the end of the field for fresh air.

It took her some time to be back to normal, and I was unhappily glad to be the one giving support this time.

I was further on in my pregnancy with respect to her, and I had noticed in previous encounters some sort of unspoken hierarchy between us: I was offered to sit on the best chair, offered drinks without having to stand up, pampered and spoiled like I was something to protect. I wasn't used to it, not to this level at least, and now I was finally able to reciprocate.

K. had talked to me about her sickness, she had taken a five months leave from work and even spent a week in the hospital because of it. She couldn't eat anything at that time without vomiting, and her pregnancy had been considered at risk. Her mother came to Portugal from Brazil to help with her daily duties.

Now she was taking pills, even though she didn't like the idea. The nausea was still there, but at list she didn't vomit anymore. The popular first trimester's sign of pregnancy had exceeded its expected duration, making it hard to deal by herself.

A stark difference from the previous moments, I realize then how K. was at the mercy of the outside world, sensitive to everything that surrounded her: it was a totalizing experience.

Through nausea the world entered her body, taking possession of it, unsettling its plans.

As Sartre put it, through Antoine Roquentin's character:

> "The Nausea has not left me and I don't believe it will leave me so soon; but I no longer have to bear it, it is no longer an illness or a passing fit: it is I."[6]

K.'s nausea was not just bothersome, it was paradoxical: her body was trying to expel something that she strove hard to keep within. I felt, in that instance, the sorrow it brought her to be fighting with her own being. It was silent but it was there, and it was concealed in something as natural as breathing. Her body was porous and all-encompassing, and the only defense she had against the external attacks was blocking the way-in and out of air. It could only last a bit.

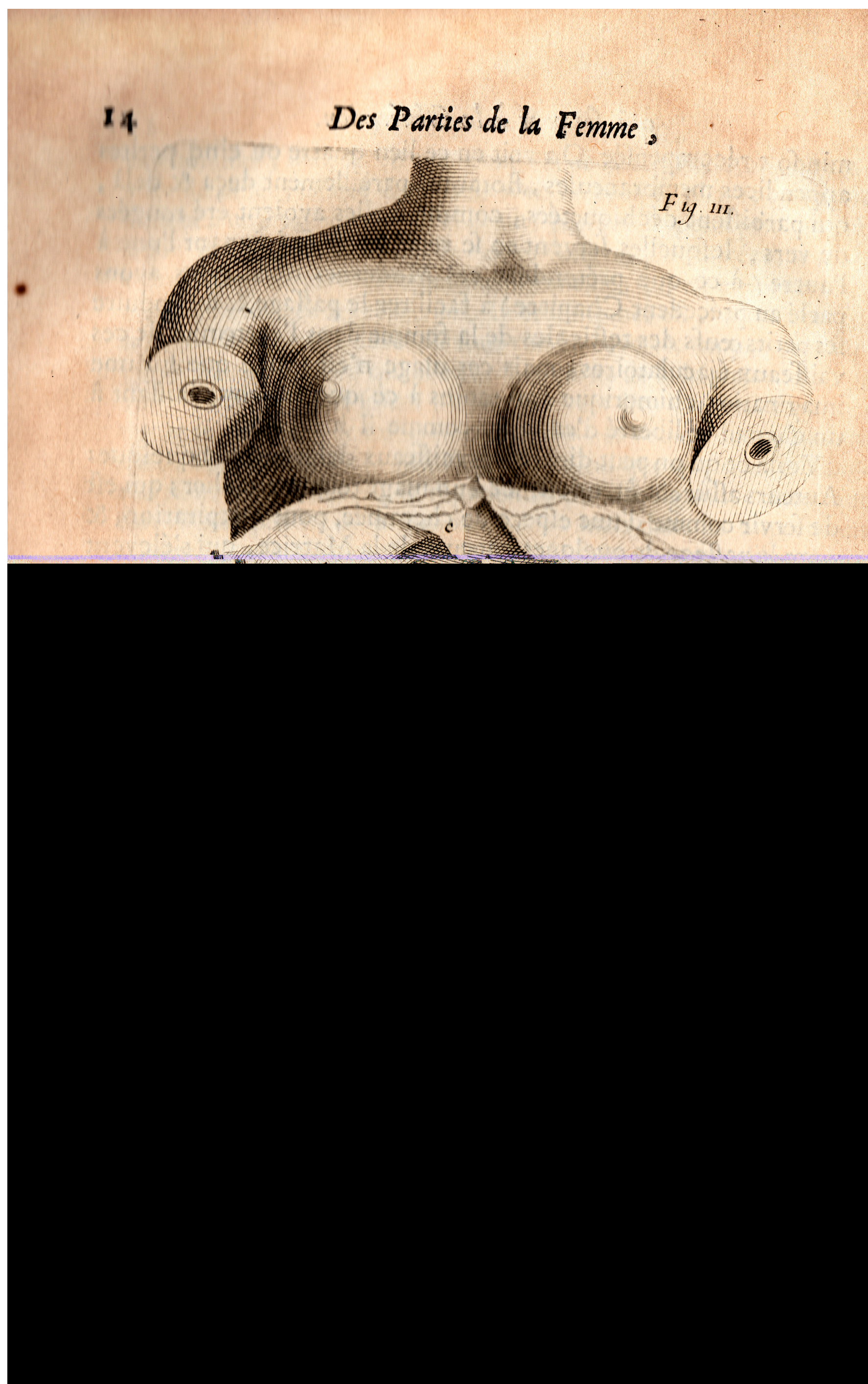
6 Sartre, JP, ed. (1964). *Nausea*. New York: New Directions.

This episode with K.'s sickness, in a quest for a phenomenological stance in my pregnancy's investigation, triggered an epiphany: I had a grasp of what Thomas Csordas (2008) defines "intercorporeality", or what Merleau-Ponty more broadly calls intersubjectivity, the unspoken connection we as human share through our embodiments.

I realized intercorporeality lies in the tension we experience toward other modalities of being-in-the-world, rather than in the pursue of similarity from our standing point.

''To describe embodiment as intercorporeality" observes Gail Weiss "is to emphasize that the experience of being embodied is never a private affair, but is always already mediated by our continual interactions with other human and nonhuman bodies'' (in Csordas, 2008:119).

I wasn't K. and my experience wasn't quite like hers. But I brought within me all the potential ways this pregnancy could take, and with my body so explicit and open, I could feel them incarnated – I was pregnant of possibilities.



Picture 1

***"Traité des maladies des femmes grosses, et de celles qui sont accouchées"*, François Mauriceau (1668)**

Courtesy of Biblioteca da Academia das Ciências de Lisboa

CHAPTER TWO
Beta HCG: THE MEDICALIZATION OF PREGNANCY

IV

Two pink lines were supposed to mark the passage from not knowing to acknowledging one's pregnancy. My first pregnancy test reported a clear pink line and a very faint one.
In the sceptical mood I did it, I thought it was malfunctioning.
Evidently (I told myself) I was not pregnant, the test was even a bit defective, and my girlfriends should have stopped making a fuss over the changes they saw in me.
But their penetrating, knowing gaze, I couldn't dismiss: they knew me in a way I didn't know myself, and they were seeing changes.
Yes, I had been sleeping a lot, my breast was fuller and sore and, as mentioned already, my period was irregular to the point of skipping a couple of months.
Back in Portugal, I hadn't thought much about it. Now, spending the summer holidays in my hometown, surrounded by people that "knew better", I couldn't ignore it anymore.
The package contained two test devices: to me, it was a declaration of its fallacy. Even the producer knew that one had to repeat it at least two times to have an approximation of the real result.
So when on the second test appeared two distinct pink lines, I was still sceptical, and a bit panicked. My partner, on the other side, was thrilled, happily unbelieving.
I knew what I had to do to be certain: I had to ask my family doctor to prescribe me a beta Hcg blood test. Years earlier I had worked with the NGO Medicine Sans Frontiers in a outpatients medical center for undocumented immigrants in Rome, I saw physicians doing this many times. It was the routine procedure to ascertain a pregnancy, so I anticipated his move.
The doctor didn't comment on my specific request: he looked at me with a knowing smirk on his face and congratulated for the news. I felt irritated, but avoided telling him I personally doubted I was pregnant and that, in any case, it wasn't right of him giving for granted it was a wanted pregnancy. What if I was seeking an abortion?
Two days later saw me and Nicola opening the envelope containing the results with the same

anticipating slowness a poker player reads his cards.

Were we expecting a yes or no type of answer to the test?

Maybe not, but not even just a six figures number standing cryptically at the centre of the page without any written comment to make sense of it. The small legend on the right was - probably due to our anxious disposition - unreadable. I didn't have an immediate access to any internet point, so, frustrated for not understanding, I rang my cousin, mother of two and an expert in my eyes, and asked her to interpret the result.

I wasn't with child if the value was less than 5. Our was 113.536.

Apparently, I was very much pregnant.

I tried to make sense of when it had happened, and found myself reconstructing my recent past. The signs, to me, were everything but clear. The commonly believed incontrovertible sign of pregnancy, the lack of menstruation, didn't really work – at least I thought – in my case. For months I had been irregular, then took the pill, then again irregular while taking the pill, so I stopped it a couple of months earlier. I didn't even remember having had any cycle after that. However, I did feel a lower back pain - that usually signalled the impending menstruation - a couple of times during these two months, and had some very light spotting just once in July, too.

I tried for days and finally found an obstetrician willing to receive me in the middle of August. An acquaintance told us he was an experienced physician, famous for having resolved a difficult childbirth by manipulating the parturient uterus with his bare hands. He was portrayed as belonging to an older generation, when doctors were more resolute and din't hide behind caesarians. I thought I wasn't prepared to be hearing about delivery yet.

First thing, acknowledging my doubts and confusion – was I two, three weeks pregnant? Maybe a month? - he asked me about my last period, which I could only trace back to more than two months earlier, the day I stopped taking the pill, because I was already bleeding. I admitted I was never one to remember exactly when my cycle would occur, couldn't fathom now after such a long time. He took his mobile phone and seemed to be using the calculator.

Then he told me to lie down.

I didn't know what to expect of the visit, but wasn't foreseeing a gynaecological perusal; could he tell I was pregnant by 'observing' me inside? I felt unprepared and had a strong feeling to protect my womb. Reluctantly, I did as he ordered. At least, the examination was

quick.

It seemed like my cervix was well closed, and I had been pregnant for approximately eleven weeks.

Eleven weeks! Was I so distant from my body not to feel such a change like having a being developing inside of me? He explained that pregnancies are calculated from the first day of the last menstrual cycle, and the delivery term by counting forty weeks from that date. Taking into account the approximation of women fertility cycle and subjective variations, the supposed calculation could only be confirmed by analysing the foetus development through a sonogram.

Once again, he told me to lie down, brought a monitor near the bed, spread cold gel on the lower part of my belly and started sliding the probe.

Shaking greyish shades played on the monitor and moved to the edge when suddenly – corresponding to a deeper push of the probe on my lower abdomen - a black background disclosed the image of a creature so clearly 'human' that left me out of breath.

I looked at Nicola founding his expression mirroring mine, and he couldn't stop the tears too. For there on the monitor was not the agglomeration of bubble-like shape that apparently we both were expecting, but legs, arms, and waving hands and fingers that made me think of a praising charismatic churchgoer. The doctor went on showing the state of the developed backbone, the beating heart, even made a supposition about the sex – which, by the way, we would't have wanted to know. We were still too shocked to appreciate his deepening though, that image hit us like a tone of bricks and the sensation stayed with us for a while. It was deeply emotional, to visibly acknowledge the existence of our growing child, to see it move, to watch the sinusoidal pattern of its beating heart.

It also was somehow ambivalent, the type of feeling it aroused: like a slap on the face received when one is in a stuporous state, it waked us up of our incredulity of those past days, but at the same time rob us of the pleasure of imagination. The doctor went on showing a 3D rendering of the foetus' which he printed for us on common paper as a token to bring home.

My mother once told me that when she was younger she worked in a clinical analysis laboratory where they used frogs to test a woman's pregnancy. A female frog was injected with a sample of the woman's urine and if it spawned within twenty-four hours, the pregnancy was confirmed. Even if it sounds like a 'prehistoric' method of medical analysis, it still

remains within the grammar of biomedical technics. The pregnancy was measured by an external, 'objective' and reliable mean, as opposed to the subjectivity of a woman's corporeality. But once confirmed the expecting status, no sonograms where available to uncover the inner secrets of a woman's bearing.

In "A cultural history of pregnancy" Claire Hanson describes how, in late XVIII century, lack of menstruation or morning sickness were not sufficient signs for women to publicly announce their pregnancy. Despite the presence of midwives and 'accoucher' (man midwives) - with all the controversy the latter figures brought along for advising the "touching to diagnose pregnancy" – one risked to declare her pregnancy and later find out she was just ill: that would have been a social humiliation. Analysing a correspondence between a noble married woman with "fifteen childless years of marriage and two miscarriages" and her aunt, Hanson reveals "a vivid glimpse of the anxiety and indeterminacy which characterised the experience at a time when it was impossible to have a certain diagnosis until a child could literally be seen in the course of labour" (Hanson, 2004:1). Even the pregnant woman's first experience of foetal movement, despite being considered a reliable sign, didn't offer certainty.

I wonder how different it would have been to discover my pregnancy solely by being present to my body's signals. I won't know, because I belong to a different time and a different cultural 'humus', where what's backstage – behind a curtain of flesh and embodiment – is made manifest by technical explanation and representations. Throughout my experience, to give sense to what was happening to me I relied on biomedical expertise. The biomedical cultural system is rooted in the universe of significance of my body, and my experience of pregnancy is culturally constructed within the semantic and produced by the practices of biomedicine.

Of technocratic reproduction

The pregnant woman is like a ship upon a stormy sea full of white-caps,
and the good pilot who is in charge must guide her with prudence
if he is to avoid a shipwreck.

`*Maladris des Femmes Grosses"*, François Mauriceau (1668)[7]

Pregnancy and childbirth are among those events of life that, subtracted from traditional, socialized practices or management, fall now in the ranks of biomedical regimen.

Social scientists talk about medicalization of pregnancy underlying the political (beside the cultural) nature of its historical development, where reproduction is understood as something of public, collective interest. We are living, as Foucault (1979) puts it, in a biopolitical age.

The Blackwell Encyclopedia of Sociology Online defines medicalization as:

> “the process whereby previously non-medical aspects of life come to be seen in medical terms, usually as disorders or illnesses. A wide range of phenomena has been medicalized, including normal life events (birth, death), biological processes (aging, menstruation), common human problems (learning and sexual difficulties), and forms of deviance.”[8]

The definition makes explicit the shift that 'natural', expected aspects of life undertake by being medicalized (thus becoming disorders or illnesses) and implies their politicization.

Drawing from Foucault (1963) I argue that medicalization is the meeting ground of political and biomedical discourse. It determines the production and jurisdiction of bodies and the delimitation or normalization of their agency. Being historically connoted, today it has developed in “novel ways” of conceiving individual and collective biological existence. In line but expanding Foucault's discourse on biomedically constructed body, Nikolas Rose (2001) suggests that “contemporary biopolitics has become molecular politics” arguing that “molecularization of biology has been an irreversible epistemological event” (2001: 1-14).

In the passage from the eugenic body of the first half of last century to the genetic revolution of later years, biological sciences have come to identify the phenomena of life at the molecular level. The shift from an explanation of the body informed by (and constructed on)

7 From Barker, K. K., (1998) “A Ship Upon A Stormy Sea: The medicalization Of Pregnancy”,

8 http://www.sociologyencyclopedia.com

the clinical gaze, to the individuation of life and its functions at the microscopic scale of genomics, has had repercussions not only within research laboratories, but has shaped the way operational branches of life science perform on bodies and health.

The molecular drift stands at the base of the *technification* of biomedical management of pregnancy and childbirth, addressing biotechnologies' capacity to intervene at the level of genes and re-engineer human genomes (Davis-Floyd: 2005b). These new reproductive technologies are performed at a transnational degree and supported by specific political and economic arrangements. They have big implications in governments' administration of human fertility and in the capitalization of health industries.

In this frame medicalization - intended as the union of biomedical and political agencies on different aspects of human lives – concurs to blur national geographies under the homologation of its practices in the receptive, *globalized* market.

Social scientist often refer to the "spatialization" of biomedical system apostrophizing a general Western culture. I would rather adopt a term along the lines of what Rose (2004) addresses as "psychopharmacological societies", or what Hacking (1995) calls, referring to the production of new taxonomies, "industrialized bureaucracies".

Where the former summarizes those world communities whose self-definition stems from the intermingling of neurochemistry and biomedical nosography, the latter crystallize the political and economical systems that render possible the development of powerful, socialized, world-level dialectical "human kinds". Both capture some aspects of the combination between biomedical practices, economic macro-dynamics and political dimensions.

Robbie Davis-Floyd has coined the expression "technocratic model of birth" when referring to North American biomedical practices on reproduction and delivery, noting how "obstetrical routines applied to the 'management' of normal birth are also transformative rituals that carry and communicate meaning above and beyond their instrumental ends" (Davis-Floyd, 1993:298).

Drawing from Davis-Floyd, to refer to the biomedical model of management of pregnancy as developed and accepted in communities and societies broader than the usually referred to as "western" one, I propose the use of *technocratic reproduction.* Where the "technocratic" term gather biomedical and political aspects – reading it as contemporary development of its etymological combination of "skills" and "power" - "reproduction" reminds, as Emily Martin

polemically suggests, the industrial production metaphors. Agreeing with feminist scholars of the 1970s that women's subjectivity and agency in pregnancy and birth disappear in biomedical management and terminology, she notes how "parenthood can be seen as an imitation of work" and argues that "by now we have not so much a sad mimicry of production as a destructive travesty" (Martin, 1987:67).

In medical textbooks the parturient body is narrated as functioning as a mechanical contrivance, with "the uterus as a machine that produces the baby and the woman as labourer who produces the baby. Perhaps at times the two come together in a consistent form as the woman-labourer whose uterus-machine produces the baby." (Martin, 1987:63)

Medicalization of pregnancy and childbirth takes place in a complex system of hyper specialization and intervention on fertility and fecundity through biotechnologies (birth control devices, sonograms, amniocentesis, in-vitro fertilization to name a few), market-oriented researches and national policies that echo and adapts to the international standard.

Technocratic reproduction spreads well over Western society, claiming its efficacy through the epidemiological fall in birth mortality rates and rise in overcoming fertility-related problems. Though praxis and ethics in biomedical technics of reproduction do vary from site to site, as I will deal later on, biomedical protocols are generally characterized by their exportability and, as widely recognized, by their ability to grip and integrate on local systems.

In the "industrialized bureaucracies" of "(psycho)pharmacological societies" pregnancy pertains quite exclusively to biomedical discourses.

To understand how the practice of medicalizing pregnancy takes place, to "size it in the bud", I shall refer to the bureaucratic commitment it entails. Though it may variate in relation to changes in the different country policies, protocols give me the possibility to generalize.

The pregnant status is endorsed in biomedical politics through a blood test that measure a biochemical marker, the *human chorionic gonadotropin* (beta hCG), a hormone produced during pregnancy by the developing placenta. Usually, to have an official certification, the specific blood test is prescribed by general practitioners of the public health system. This confers the right to exemption from taxes in those countries that provide health care coverage for maternal and child health.

As observed before, in some countries the beta hCG positive certificate is the seal that guarantees a temporary permit of stay for health reasons to undocumented immigrant women.

In this instance, the status that the pregnancy confers falls under what Didier Fassin defines the "biopolitics of otherness", underlying the inequalities of citizenship policies in Europe.
Drawing from Agamben's concept of "bare lives", Fassin tracks the re-surfacing of invisible non-citizens (the undocumented immigrants) in European countries by virtue, exclusively, of their biomedical existence (Fassin, 2001). In this case the State takes temporal charge of the pregnant woman's body as carrier of a potential new citizen.
It is important to note that, at least in Italy, the permit is guaranteed only *after* the 12th week of pregnancy, when the woman cannot seek an abortion or once she has surpassed what is considered the more risky period. This legislation exudes ambiguity: maternity is something to be protected, even over the status of illegality of the pregnant woman, but not in its statistically risky stage. As to say that illegal pregnant women before reaching twelve weeks are not pregnant enough for the law.
Technocratic reproduction bureaucracy echos the position the pregnant body occupies in its societies, where new life seems to represent the only acceptable solution against population ageing, as opposed to the resistance that immigration policies make to the recognition of more extensive citizenships. The body of a pregnant woman, its content, is represented as something to protect, facilitate and foster through the accessibility of biomedical facilities.
Once recognized the state of pregnancy, the expecting woman, now become a patient, can usually refer to a general practitioner, a family service or the maternity ward in a public hospital.
An average pregnancy development is then articulated by medical calendars organized in monthly check-ups to track its progress; gynaecological examinations, especially towards the end, when preparing for childbirth; three standard sonograms that mark each trimester the pregnancy is divided in, fetal echocardiograms; a series of blood and urine tests that keep under control physiologic variations. Compliance to the scheduled exams is not compulsory but generally highly recommended.
In her ground-breaking work "Pregnant Embodiment: Subjectivity and Alienation" Iris Young tackle the question of the critical phenomenology of the pregnant subjectivity and the alienating manipulation of biomedical practices. Starting from her own pregnant experience, she observes that "medicine's self-identification as the curing profession encourages others as well as the woman to think of her pregnancy as a condition that deviates from normal health.

The control over knowledge about the pregnancy and birth process that the physician has through instruments, moreover, devalues the privileged relation she has to the fetus and her pregnant body" (Young, 2005:47).

Social studies have widely covered pregnancy and childbirth, often polarizing biomedical discourse and women agency. As Rayna Rapp argues (2001), it is in the convergence with feminist activism and scholarship that reproduction has been brought to attention as a field of embodied inequalities and as a site of active investigation and intervention.

Biomedical management of childbirth and medicalization are at the forefront of anthropological discourses on reproduction (Martin, 1987; Davis-Floyd 1993) as are analysis of embodiment and disembodiment in medicalized model of birth (Akrich and Pasveer, 2004). Feminist authors often advocate a different model of childbirth where women recover their agency and a sense of the self that gets lost in biomedical practices. The definition itself of "natural" model of birth has, in some cases, been put under critical examination in relation to its implicit discourse of (auto)control and discipline, and a replica of mind over matter dualism (Barker 1998, Davis-Floyd 2000, Martin, 2003).

Often covering reproduction and childbirth at the macro-level of institutional biomedical context biomedical practices and social construction, it is less common to find studies that "catch" embodied medicalization *underway* in lived experiences of pregnancy.

V

A few days after finding out I was expecting, A. called me on the phone:
“Have you already done the B-test?”
“What is the B-test?”
She was a dear friend of mine since adolescence and, a month before me, had discovered to be pregnant. Apparently, we had conceived in the same period.
“I've done it today, it's as effective as an amniocentesis, but much less invasive! It's a combination of a scan and a blood test, and with the nuchal translucency screening test they observe if the bone at the neck level is thick...you know, it's for the Down syndrome and other abnormalities...”
“Yes, my sister-in-law already recommended this... translucent something yesterday, when I told them I was pregnant....where do I do it?”
“Talk to your gynaecologist, but you must hurry! It is only valid if done before the 13th week!”

Just gained awareness of being pregnant, I had already learned various new “technical” words. They seem to be the 'must' every first-time pregnant woman had to know.
I was advised to take 'folic acid' supplements, to help prevent 'spina bifida' and 'neural tube defects'. I had to avoid lifting up heavy weights, to avoid 'placenta abruption'. I was even given a booklet explaining the changes my body was going through: it was producing double the amount of blood to feed the uterus, that would grow forty times its original volume during the pregnancy (apparently that's what made me so tired) and the heart had started its journey to turn horizontally and make space for the growing belly. This last news I found quite disturbing to know.
Me and my companion were still in that bubble of shock and wonder and anticipation of the prospective changes our lives were going to go through, so we both had the sensation it was spoiled by the reaction of people around us. We were novel to this, and felt put down by the fact that everything seemed to turn around 'clinical stuff'.
It was as if, pregnant status guaranteed, we were now set to fight against invisible enemies with resounding names, heavy spectra flying like vultures around every pregnancy –

miscarriage, malfunction, deficiency. And the only weapon we could rely on, were the clinical ones.

I was glad my instinctive reaction and that of Nicola coincided. I wouldn't have liked an overly protective and anxious presence beside me during this experience. We both felt that, for us, this was not the best way to deal with it, and even when accused of naïveté from family and friends, we kept a guarded stance with regards to the alarmism we perceived around us.

It was already enough that we had to deal with monthly visits to the physician from now to months to go. We would do the routine check ups trying not to be too strict on it. In a word, we were looking forward to go back to Portugal and be able to take our decisions without so much pressure on our shoulders. I had no problem explaining and defending the decision not to rely too much on medical advices, but I couldn't stand the anxiety, the alarmism, the "doctor-knows-better" attitude around every aspect of my pregnancy.

Memories resuscitated from my past, again, of when I was working with Medicine Sans Frontiers in Rome. We received hundreds of immigrant pregnant women, from all over the world, to certificate their pregnancies and follow the protocols to obtain a provisory stay permit for health reasons. Many of them, when being prescribed with beta hCG test, first semester sonogram and the other exams, reacted telling us "I am pregnant, not ill!". Apparently, I had absorbed their stance well and made it mine.

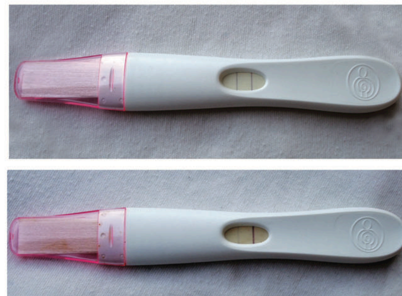
I observed that, as long as it implied responsibilities, people's advices, mimicking those of doctors and medical booklets, addressed me as the subject: "you have to take this medicament", "you must pay attention to your fluids", "do not tire yourself too much!". The narrative reference changed when the discourse was oriented on the physical revolution a pregnancy (in its absolute sense) triggered. Then, forefront in the speeches there was a body, as a nobody's body, to become the subject of the matter. There I disappeared in favour of a self-sustaining entity from which I was detached, as a passive witness of an inevitable process.

"Your body - like any pregnant woman's body – is producing hormones to close the cervix and protect the foetus inside the uterus". "The heart is pumping more blood, so the womb is bedewed to guarantee a good development". "Through the effect of the hormones produced, the joints are loosening to allow the stretching of the pubic area: 'you' must pay special attention not to get injured, as you're more prone to imbalance right now".

The creation of a gap between me and my body in these narratives reflected a well absorbed biomedical discourse about biological and physiological functioning on one side and ethics and responsibility on the other. As Rose summarizes, "biological identity generates biological responsibility" (Rose, 2001:19).

The biomedical discourse polarizes the pregnant subject in two separate universes; one is tangible, and respond to the physical and biological laws. It falls under the domain of science. The other is unpredictable, potentially dangerous to the first so it has to be channeled towards the good practices of health maintenance.

It sounded as my separate parts and organs would function – with a good compliance to specialists' guides - 'despite' my existence in them.



Data Nascita	Sesso	Codice Fiscale	Numero Libretto
11/07/1977	F		

Accettazione 325 Data 12/08/2011 - Ref. N. 1
DE LUCA FRANCESCA
Provenienza: Centro Prelievi Nettuno

Descrizione Esame / Test	Risultato	U.M.		Valori di Riferimento	Metodica
IMMUNOMETRIA					
GONADOTROPINA CORIONICA (Subunità Beta)	113536	mU/ml	*	<5 I - X SETT. 5 - 225000 XI -XV SETT. 16996 - >225000 XVI-XXII SETT. 6860 - >225000 XVIII - XL SETT. 1583 - 65911	

Esami validati da:

SBH(9/2/2012): (–) | (–)

EXAMES LABORATORIAIS

	≈12s	25 sem	33 s
DATA	25/8/11	28/11	1/2
Hb	11,7	11,0	11,3
HcT	36,4	32,1	32,9
VGM	N		
HGM	N		
COOMBS INDIRECTO			
GLICÉMIA JEJUM	73		74
APÓS 50g GLICOSE			
HBs AG	Neg		(–)
VDRL	Neg	(–)	(–)
HIV	–		(–)
TOXOPLASMOSE	Não Im	NI	NI
RUBÉOLA	Imune		
UROCULTURA		(–)	(–)
CMV	Não imune		
PLAQ.	241.000	212	214.

DATA			
INSOLUBILIDADE ... / TP/APTT		9,7/24,8	
TITULAÇÃO DE ANTICORPOS Rh			
P T G O		72 84 75	
Creatinina	0,5	0,6	0,5
Ác. Úrico	3,3	3,2	3,3
VHC	Neg		(–)

Picture 2

A biomedical history of pregnancy: pregnancy test, Beta Hcg, "livro da grávida"

Embodying medicalization

In "Becoming a Neurochemical Selves", Nikolas Rose opens his analysis of contemporary medicalized self-representation with a lapidary question:

> How did we become neurochemical selves? How did we come to think about our sadness as a condition called 'depression' caused by a chemical imbalance [...]? How did some of us come to understand changes in mood in the last week of the menstrual cycle - depressed mood, anxiety, emotional lability and decreased interest in activities - as premenstrual dysphoric disorder [...]? (Rose:2004).

Questions of the same "temper" could be transferred to lived experiences of pregnancy within a biomedical context: how did we become used to picture expressions of happiness or preoccupations as our selves being hostage of an overproduction of estrogen? Why do we conceive the technocratic model of reproduction as the only plausible way to deliver without risk? When did we start divesting child bearing of its experiential, idiosyncratic aspects to primarily relegate it to a corpus of pre-determined norms and values belonging to a vocabulary – the biomedical one, in relation to which we have no power of negotiation?

In a revealing analysis on (white, middle-class, heterosexual) women childbirth's narratives, Karen Martin (2003) observes how, even during labour and childbirth, an "internalized sense of gender" drives and disciplines women bodies and performance. Drawing from a combination of Foucault's notions of technologies of power, that "determine the conduct of individuals and submit them to certain ends or domination" and technologies of the self - "the technologies of individual domination, the history of how an individual acts upon himself" (Foucault, 1988:17-18) - she proposes "internalized technologies of gender" to underline the embodied construction of a gendered subjectivity that reflects constitutive discourses and practices.

In the dominant cultural view, delivery is often depicted as the moment when a woman gets nearer to her instinctive, "natural" side, as opposed to the more rational and controlled one, thus replicating the body vs mind dualism. Despite it is widely accepted its being carried out in an medical structure and under the guidance of physician and intervention of biomedical technologies, childbirth is considered an *act of nature*, one that discovers the birthing woman at the same level as any mammal. In this picture, the woman in labour is prey to her instincts:

she gets angry, screams, yell and is clouded by pain. Deconstructing this ordinary vision, Martin shows how women's narratives betray a sense of modesty and a necessity to stick to feminine role, feeling “compelled to fulfill […] normal gendered social obligation” (Martin, 2003:58), such as controlling their voice level or trying to be attentive to doctors requests, and “despite the physical demands of labor and childbirth, they continued to be nice, kind, relational, and selfless” (Martin, 2003:61).

Common, shared vision of pregnancy is charged of the same duplicity as that of childbirth: even being considered a natural event in the course of a woman's life, the fact that it is entirely dealt with within the horizon of a technocratic model of reproduction is not perceived as contrasting or ambivalent.

This socialized rhetoric of pregnancy as a natural phenomenon on one side, that needs a bio-technological management on the other, reflects in the ways women live and embody medical practices.

During the course of my research *and* pregnancy, the visibility of my pregnant belly induced many women – acquaintances as much as strangers - to recall and share their own experiences, particularly accounts of their delivery. It struck me how often, regardless of the age of the person, this narratives reflected a construction of the self that had incorporated biomedical discourses. What came out of many of these memories were bodies that, at the end of their pregnancy, were unable to deliver if not with the intervention of surgery: “even though - you can see – it looks like my hip bone is quite large, the pelvis, inside, is too narrow... I arranged a caesarian with my doctor”; “both my children were natural birth […] I went to the hospital and had the injection, so the contraction started and I had my baby in a few hours”.

Even my mother's narrative of my own birth became clearer during this period of research. Her second pregnancy's account had always been played joking about my laziness: “you didn't want to come out, you like it in there”; “you waited ten months. But then it was quick: they gave me an injection, then a strong contraction, that took my breath away, and you were out!” Now, deepening the narrative for the sake of my curiosity, aspects that she had thought irrelevant, or implicit, were made explicit: she was *unable* to feel the contractions because with her previous delivery the uterine walls had been torn. Her uterus had become rigid and insensitive and the birth had been induced. Even her first childbirth had to be induced because

she was holding liquids: “When the obstetric broke my waters I *flooded* the delivery room”.
Foucault talks about a “hermeneutics of the self” rooted in Western culture that reaches far in our understandings and is “integrated with various types of attitudes and experience so that it is difficult to isolate and separate it from our own spontaneous experiences” (Foucault, 1988:18).
Revealing embodied biomedical discourses during the fieldwork of my research on pregnancy was not an easy task, probably because it was difficult to discern the components that informed my and others' experience while they were unfolding. It required an effort of critical self-reflection that I found was easier to perform while hearing other participant's narratives.
Embodied medicalization transpired in various aspects of our pregnant experiences that we all shared: we spoke of the development of our pregnancies in weekly terms, adapting to a biomedical temporality and endorsing a computation of time that didn't belong to non-pregnant everyday life (we would often translate the weekly counting in monthly terms to understand where we stood in the nine-months journey). We conceived the sudden fit of hunger, mood changes and strong sensations under the same causal explanation: issues related to hormonal production; we spoke of our pregnant bodies through the values resulted from medical exams: the fact that I was (classified) a “P97”, as I'll explain later, became a reason of shared concern. More subtly, were the characteristics pertaining to our perceived physical assets that speaks volumes of how much the biomedical semantic was incorporated.
K.'s dealing with her protracted sickness, for which she was hospitalized during the first months and that kept her on alert for the rest of her pregnancy, reflected a self-portraying of herself being *inadequate* to conceive. In her narratives, she often associated the overbearing nausea to pain, even if it was not *painful:*
“My sister-in-law in Brazil is 24 weeks pregnant. She's 28 years old, last week she was at the Carnival! You know how Carnival is in Brazil...Well, she rang me and told me she went from party to party...'Sometimes I forget I'm pregnant', she said...She has so much energy! I'm very tired, have a lot of nausea, I'm in a lot of pain!”
The miscarriage she had had one year earlier – of which she became aware through the pain – was, in her interpretation, characterizing her current pregnancy as a difficult one. This perceived causal connection made her place restrictions on her agency.
Being pregnant was generally understood in our discourses as a moment of vulnerability,

when different problems could appear, and the need to rely on physicians' prescription was given for granted: it raised issues of trust and compliance.

V., in particular, lived her pregnancy with some trepidation, and had been to the hospital several times to make sure everything was fine with her baby. The obstetrician often admonished her for being too anxious, telling her she needed to relax because this baby needed to be born after the 37th week, when it would have reached full development.

The reason for this clarification on the doctor's part was that V. always thought she was going to give birth ahead of schedule.

Her first child, born twelve years earlier, had been a preterm baby of seven months. Several times she told me “My body cannot keep a baby for longer”.

This causal explanation characterized her whole experience: the blood loss in the first trimester, the Braxton-Hicks contractions (painless hardening of the womb) felt since an early stage of the pregnancy, her mother arriving from Brazil to stay for one month to help her “with the baby” when she was seven months pregnant.

After Christmas' holidays, when I sought her out to meet her, she sent an email:

“I can't meet you right now” - she wrote- “I'm just out of the hospital... Last week, at dawn, I woke up to go to the toilet and felt slight pain down my abdomen, as a colic. I thought it would pass soon, so took a bath to relax and went for the sofa to lie down a bit, but the pain got stronger, to the point that I had to wake R. up and ask him to take me to the hospital. R. said I was very pale...I couldn't hide the pain I felt, it was so strong! I would have had my monthly check-up just that morning, but could't wait and went through the emergency... They checked me up and my cervix was closed, not even one centimeter of opening! I asked them to do a CTG and they saw that effectively there were contractions there...and I knew, I could feel them myself, it was painful.

My doctor arrived after a while, and she told me I was going to be hospitalized just in case my baby G. decided to come out early...and I asked a drip for the pain too....So I stayed in hospital from thursday to monday, lying on the bed without getting up not even to go to the toilet...and that's how I have to stay now, even though I'm home I can't move around, can't do anything. My mother and aunt travelled from Brazil to help me out...I'm so hungry these days...you know what it means when one gets hungrier at this stage...”.

She meant she was approaching the end of her pregnancy, and her body was preparing for

childbirth. These painful contractions she had felt had arrived too much in advance; she had just entered her seventh month of pregnancy, as I had, it would have been a very premature birth. Since then, she was counting the days and became quite restless about “baby G. wanting to come out”. One month later, when her mother and aunt had to go back to Brazil to work, to her surprise she hadn't delivered yet.

The sources from which a general idea of pregnancy was forged, as I deducted from the interviews, were primarily family members and friends' narratives of their own pregnancies; medical encounters, and within them the advices of physicians or health practitioners that were regarded with trust; booklets on pregnancy, that were given in hospitals or *Centro de Saúde* (local health centre), often organized in the form of diaries that represented the weekly progression of the fetus and relative changes of the woman's body; websites - as easy to find as just writing “pregnancy” on a search engine - that, by entering the first day of the last menstrual cycle, would calculate the pregnancy stage and the delivery date, the fetus development in that precise moment and the expected modifications of the pregnant body.

Often these websites are equipped with internet forums of expecting women that create threads (messages grouped by topics) based on their pregnancy's stage, so beside the chosen nickname would normally appear the “week plus days” counting (es.: Lola 24+3). It is interesting to note how the participation to these forums is mostly triggered by unexpected *externalizations* of one's pregnant body (traces of blood in vaginal fluid, hardening of the womb, sickness), bringing the person to look for clarifications in other women's experiences.

Advices and explications take the form of a “popularized” biomedical approach, one against which physician would warn us, especially against the risk of auto-diagnosis and medicalization.

> *“Starting to feel a bit off balance? As your belly grows, your center of gravity changes, so you may begin to occasionally feel a little unsteady on your feet. Try to avoid situations with a high risk of falling […] You may also notice your eyes becoming drier. Using over-the-counter lubricating drops may help.”*[9]

The identities that come out of these forums are often those of vulnerable beings that look for signification of the changes occurring to their body. The interventions to explain one's experience take the shape of an internalized, “familiarized” biomedical vocabulary often used

9 Taken from the website “http://www.babycenter.com/6_your-pregnancy-17-weeks_1106.bc”

out of context, showing a “pagan” elaboration of a technical terminology that has become the semantic horizon from which women pick significance of their pregnant embodiment.

Even though the use of those websites from the participants of this research was mainly occasional and secondary, relying more on doctors, relatives and friends' advices, I think that their diffusion and relatively easy access represent an interesting aspect of the way pregnancies are being dealt with in contemporary biomedical societies, one that should be further investigated.

More than websites and booklets then, what recurred in our shared impressions about the course of our pregnancies were friends, mothers, relatives' experiences.

These narratives stood as a meta-dialogue that influenced the participants' choices and behaviors towards medical practices in terms of resistance or compliance.

K.'s mother had had four C-sections for her four children. She had developed gestational diabetes during her last pregnancy for which she gained a lot of weight and was forced to stay in hospital. At the time K. was old enough to run house chores, help her brothers and gain a vivid memory of her mother's suffering. She was now extremely attentive to her sugars intake and hoped not to need a caesarian too. She would say “I'll try all I might to avoid a caesarian. I don't want to be cut. I've seen my mother recover from a caesarian, it's painful and difficult. I want to do a natural birth. Only if it's too risky, I'll do a caesarian.”

On the other side T.'s reported her friend's narratives as a negative example of pregnancy management in terms of medicalization.

She had gathered many personal accounts about practices considered “normal” in Portugal, that her friends had undertaken while pregnant “..sometimes its people's habits... or because, I think, policies are different...I heard here a lot of physicians say 'ah, now it's been 38 weeks, the baby is big enough, we have to induce labour or the baby will grow even more”.

She was resolved that she would have gone to Austria a month before her due date “not so much for a medical security...because I think that hospitals are more or less the same, but here there are habits that I don't like […] There, when labour starts, I'm not obliged to lie down on the hospital bed...all it causes is the contractions to be more painful, the delivery to take longer...there's no advantage for the woman lying down, it's a position that only helps the doctors...”.

She came from a family of physicians, she was in contact with a midwife in Austria that she

regularly updated and consulted regarding medical prescriptions she was given, and she relied as well on books about “humanized birth”.

T. negotiated her family practitioners' prescriptions by comparing them with those of her doctor in Austria: she perceived the portuguese counterpart as being more medicalized and representative of an older way of practicing biomedicine. She didn't strictly comply to doctors' requirements when she understood them as being based on a questionable alarming-based model of medicine.

Her position is even more interesting considering that, as I will argue later on, hers was considered a pregnancy at high risk.

Pregnant embodiment of medicalization, I observe, is produced through a dialectic of compliance and resistance to biomedical practices, where personal narratives and agencies are shaped in relation to the subject background, her relationships, history and her perception of her own pregnant “being-in-the-world”.

The four of us, when sharing observations and experiences, talked about our pregnancies using terms taken by the biomedical landscape. Often this terminology was decontextualized when compared to physicians' use of it, and transported in a context charged with emotionality.

In this sense, the perception of a vulnerability of our corporeality played an important role on our choices regarding the ways we decided to manage our pregnancies.

In K.'s case, for example, a caesarian was not just a cut on the belly, but a manipulation of her flesh as much of her capability to deliver “naturally”, and the reiterating of a family history from which she hoped she could emancipate. When talking to her family practitioner, though, a caesarian was explained by being just a common surgical operation performed on the womb, one able to safe mother's and baby's lives if necessary.

V.'s embodiment was characterized by an over-compliance to biomedical practices. She preferred portuguese biomedical system compared to her previous experience in Brazil because “there are more exams, more attention from the doctors”. She had embodied her first pregnancy's development to the point that she perceived her body as being unable to keep the baby within for a full term pregnancy.

As for T.'s and mine experiences, our embodied medicalization took the form of a resistance to certain biomedical practices that we perceived as unnecessary and uncomfortable. We both

searched for an alternative management of pregnancy within the biomedical system, that still defined our experiences. Where T. found it by going back to Austria to give birth, I managed to encounter what I was looking for in Portugal.

The body emerges and expands during pregnancy, becomes porous and open to intervention.

In biomedical discourse, the pregnant body is made up by a certain ranges of values measurable through blood and urine texts, ultrasound images, amniocentesis, vaginal examinations and more.

The combination of these practices, though, is not sufficient to guarantee a safe course of pregnancy and biomedical agency doesn't find solution in them.

The body that surfaces in this narrative has to be manipulated and accompanied toward completion. Pregnancy booklets distributed in hospitals and health services, physicians, nurses, recommend the *collaboration* of the pregnant subject with doctors prescriptions. In these discourses the physician *guides* the pregnant woman through labour and final delivery. This shift posit her embodied experience from that of an active performer to that of a passive bearer and recipient. This rhetoric of collaboration finds fertile ground in an embodiment that has already absorbed its potentially being at risk, and here lies the vulnerability that a pregnant woman perceive of her condition when dealing with biomedical discourse. A vulnerability that, as Iris Young (2005:55) argues, brings to alienation:

> Alienation here means the objectification or appropriation by one subject of another subject's body, action, or product of action, such that she or he does not recognize that objectification as having its origins in her or his experience. […] I will argue that a woman's experience in pregnancy and birthing is often alienated because her condition tends to be defined as a disorder, because medical instruments objectify internal processes in such a way that they devalue a woman's experience of those processes, and because the social relations and instrumentation of the medical setting reduce her control over her experience (Young, 2005:55).

The implicit incapacity of the pregnant body - already growing and directed toward delivery - in biomedical discourse often translate in a quite unconditional compliance to the only "recommendable" forces that are there to *save* mother and child. The most visible feature of pregnant embodiment in biomedical discourse is the distance women get from their inhabited selves.

VI

“O livro da grávida é como a Bíblia, nunca perder e sempre leve com você!”[10].
So I was told from the nurse the first time I entered a Centro de Saúde in Lisbon, to be followed by a family doctor. I would soon have learned that this little green notebook was more important that my own presence during monthly check-ups.
I filled it with my general information and those of my companion, the first day of my last menstrual cycle, personal antecedents, marked by a yes or no box beside diseases such as diabetes, thrombophlebitis, renal or neurological dysfunction.
I wondered if I had to count as antecedent the fact that my grandmother had three gestational diabetes in her three pregnancies, but apparently the records revolved around me and nobody else. At each visit it was updated on my increasing weight, the externally measured height of the uterus, blood pressure, sonograms results.
From now on to the end of my pregnancy, I had to adapt to a new configuration of time counting, the weekly one. The third month ended more or less with the 12th week, this was easy calculated. From the 13th week on I started getting lost, I always felt the need to translate the weeks in months.
Each visit I also did the fetal heart auscultation. The value was measured by placing on the belly a stethoscope connected to an amplifier which spread throughout the room the baby's fast beating heart. It sounded like the recording of a runner's heart.
Sometimes I was not alone in that room, other women with other amplified beating hearts were there with me, but we wouldn't talk. We didn't talk in the waiting room as well, that of the hospital where I was then followed from my second check-up visit onwards due to the fact that the doctor from the Centro de Saúde had declared my pregnancy at risk (I had had a gynaecological problem that was later easily resolved). I didn't miss him though, the two times he received me he never took his eyes off the monitor of his computer, where he filed the information regarding me.
The monthly visit at the hospital's obstetric ward were solitary adventures.
The waiting room was usually gravid of pregnant bellies but there was no sharing of opinions or experiences, even though we sit there for hours. Normally I was called to be “measured”

10 “The maternity booklet is like the Bible, do not lose it and always bring it with you!”

by the nurses one hour after my scheduled appointment, then wait again for my name to be announced for the doctor's turn. In this span of time I have never assisted to pregnant women chatting with each other, only with relatives and friends that accompanied them.

I always felt the repressed need to talk with somebody of the peer group of waiting pregnant women. I came to believe that obstetrical hospital settings render the experience of being visited so exhausting that women find recovery only in their inner musings.

The first time I met doctor P. I felt reassured: she was a woman – I could feel more comfortable confiding my uncertainties; she welcomed me laughing about my pregnancy being considered at risk from the practitioner of the Centro de Saúde, thus minimizing my problem; she asked about my staying in Portugal, she was looking at me.

Despite the good start, though, the "examination" time was yet another story: she would present my 'case' to the apprentice on duty, read my 'livro da grávida' and comment on the updates. They would go through the package of tests and exams that I carried around and, as forgetting about my presence, start talking about me in a language difficult to decrypt.

It was during a visit such as this that I discovered I was a P97. Which, in the hospital practice sounded:"she's a P97. It's going to be a caesarian".

A week earlier I had had my second semester sonogram at the upper floor from the obstetric ward. Once called my name, I entered the ultrasound room where a female doctor was sitting behind a monitor. She asked to confirm my name, told me she was italian as well, from Sicily, then started muttering out loud: 'so... first exams done in Italy....negative to Coombs test, negative to toxoplasmosis, there's the nuchal translucency screening,...but no matching blood test...hmm, we should prescribe a fetal echocardiography later on.... no recent tetanus vaccination", she looked at me: " you should get vaccinated you know?"

I understood that she was talking to me through the mediation of the monitor: there was reported a virtual me, captured in the network of the hospital and consisting of an ensemble of values: Haemoglobin, thrombocytes, bi-parietal diameter, femur length and so on. I didn't even need to bring along my papers. Nor did I apparently really need to talk: this file, carrying my name, replaced me in the dialogue I was seeking with the doctor.

She asked me to lay down and started the morphology scan. The probe spied inside my belly to readily find a restless baby. Me and my companion had previously asked not to be told the sex. "How funny!" the doctor had answered. Then she forgot our request during the scan and

started talking happily about a baby girl and how big she was...

I noticed that she switched from a professional, technical grammar while watching the monitor, to a joking vocabulary with terms of endearment when referring to the baby and us as parents. Our "little princess" was growing fast, of course, she had a "big daddy and a big mum" she would be a "beautiful and tall treasure". I had the impression this was the language used to communicate what was considered irrelevant in medical terms.

When the scan was finished, she handed me the usual token picture of the face of the baby. I asked about the exam results and she said not to worry, everything was already in the hospital system.

Oh, yes, the virtual me circulating trough optic fibers...

As long as the figures were contained within a certain prefixed range, there was no need to say more. The only reason I noticed the P97 updated on my 'livro da grávida' among other values was because she had underlined it, as for attention.

So now the same virtual me had popped out of doctor P.'s monitor, and she was telling me that P97 represented the percentage that the size of my baby's femur occupied among all the femur scanned through the hospital's sonograms recently. It was at the ninety-seventh position in the list, where it should have been around the sixtieth or seventieth position to be suitable for a vaginal birth.

I counteracted that me and Nicola were both quite tall, and told her that in my family we had a history of quite big newborns, especially if compared to the average portuguese weight she was referring to. She was surprised when I told her that my weight was 4.5 kilos at birth, asking if my mother had had a vaginal delivery and, at my confirmation, looking at the apprentice with a shocked expression. I avoided telling her that my older brother was even bigger than me. Being a P97 scared me. I looked on internet for anybody having been through the same ordeal, but couldn't find any reassurance there. I didn't want a caesarian and I didn't want an epidural injection.

This I had decided since founding out I was pregnant, a conviction that had only been ingrained through the readings for my research on pregnancy. Even when, during the last sonogram, the sicilian doctor had told me anesthetic was a common protocol in Portugal, I answered that I wanted to know what it was like, to be able to be totally present and capable to give birth.

Even when she told me she couldn't understand why women wouldn't do it having the chance, I told her that I thought pain was part of the experience, if my mother and my grandmother had been able to sustain it, so could I. And, even when she insisted that she could not forget the 'animalistic cries' of women giving birth in a sicilian hospital she had worked in the past, I stood my ground.

I felt that that was a clear abuse of the power she had, in her position of 'counselor', to impress and guide the decisions of a first time pregnant woman just in one direction.

The P97 had been decreed as a risk in the prospect of a "natural" hospitalized birth. I was recommended to do a follow up sonogram earlier than the next trimester, to see if the growth of the baby was still so advanced.

I had to book a private examination in a different hospital, and searched on internet for any feedbacks on the doctor I was given the appointment with. She was apparently widely appreciated by soon-to-be mothers in Lisbon.

She confirmed that the baby was 'tall' - that's the adjective she used - but reached a lower position in the classification of the hospital we were doing the sonogram now: I wasn't a P97 anymore. She explained that the percentage was not an absolute value, but was relative to the pregnancies scanned in the specific hospital it was done. And she told us not to worry, it didn't mean it would necessarily have been a caesarian. We only had to find a different hospital where to give birth.

Of pregnancies at risk

"Disorder spoils pattern" (Douglas, 1966:1).

In technocratic reproduction, the pregnant body is constituted as a critical one: the uterus grows out of its boundaries, compressing and occupying the space of others organs. Endocrine system specializes in the production of few, targeted, hormones, creating a lack of others similarly important. The production of *relaxin* loosen the junctures: where it serves the enlarging of the pelvic bone to accommodate the growing baby, it threatens the stability of the general bones structure. [11]

Engaged in its inner transformation, the pregnant body suffers a lack of substances and balance.

"It also provides the materials of pattern" (*Idem*).

Auto-provision of vitamins is not sufficient: it has to be supplemented. There's a fall of immune defences: regular monitoring of urine values ward off the presence of vaginal infections.

A variable risk of foetal abnormal development can be checked through specific genetic controls.

"Danger lies in transitional states" - continues Mary Douglas in "Powers and Dangers" - "simply because transition is neither one state nor the next, it is undefinable".

It seems the same concept can be applied to the liminality that the pregnant body represents in biomedical culture.

The dialectic of danger and risk surrounds pregnancy in several classic ethnographic works (Douglas, 1966; Levi-Strauss, 1966). The expecting mother and the unborn child are, alternatively, a danger for others – thus they must be removed from proximity or go through rituals that normalize their presence in society – or at risk from others, so to seek protection and control.

In contemporary biomedical discourse the pregnant body emerges as a potential danger to itself. Conceived as a set of apparatuses (respiratory, cardiovascular, endocrine, to name a few) that undergo functional changes, its biological consistency appears as raw material that

11 Taken from "Physiological Changes in Pregnancy" Dr. Chloe Burton, Egton Medical Information Systems online: http://www.patient.co.uk/doctor/physiological-changes-in-pregnancy

could develop in unhealthy directions. Therefore, its management falls within the range of action of biomedicine: that of morbidity and cure.

Constructed as such, every pregnant experience carries within it a degree of risk that (only) through biotechnological intervention can be revealed, measured and eventually corrected.

These stages correspond roughly to: 1) the practices of preventive medicine, with its genetic testing for inherited diseases and testing associated with health condition of the mother ; 2) continuous monitoring through pregnancy development, i.e. first trimester Down syndrome screen, triple marker or quad marker screen; amniocentesis, regular examinations to evaluate the pregnant subject general condition 3) intrauterine surgery, to correct foetal malformations.

Biopolitical intervention on reproduction bring along the weight of the eugenic turn of the XX century. Then, inspired by the idea of national fitness, body politics acted upon the capacity to procreate of "defective" categories of individuals.

In opposition with the past, as Rose observes, "contemporary molecular geneticists usually argue that their discipline, in common with the rest of medicine, has decisively rejected eugenics in favour of individualized, voluntary, informed, ethical, preventive medicine organized around the pursuit of health" (Rose, 2001:3).

The crucial differences from previous national genetic interventions directed toward the creation of perfected social body to the contemporary role of the state as facilitator in the direction of individual health lies on a discourse on responsibility: "every citizen must now become an active partner in the drive for health, accepting their responsibilities for securing their own well-being" (Rose, 2001:6).

This "democratized" genetic corresponds to the individualistic drift of biopolitics, where medical treatments are conceived as tailored around singularities. In this inwardly orientated societies, "selfhood", continue Rose "has become intrinsically somatic – ethical practices increasingly take the body as a key site for work on the self" (2001:18).

The "somatic selfhood" of pregnancy, I argue, is ambiguous and liminal: intervening on the unborn child, whose *soma* has yet to be externalized, requires passing through the mother's body and will. Vice versa, biomedical discourse often stresses how acting on a pregnant woman's body inevitably entails involving the unborn child, for which caution is advised. This conceptual separation evokes responsibilities toward invasive procedures such as amniocentesis and intrauterine surgeries.

In relation to reproduction, biomedical practices take the form of a highly technical and specialized "kit" with which people expecting a child have to familiarize with.

Analyzing dynamics of parturition, Davis-Floyd claims that the technocratic model of birth is a tacit dominant reality that, to be transmitted and rooted in the community, needs intensely elaborated rituals: "The cross-cultural ethnographic literature on childbirth yields nothing to compare with the number and intensity of symbolic interventions in the birth process developed by the physicians of Western society to enact and transmit its technocratic model" (Davis-Floyd,1993:298).

This discourse, I argue, can be taken a step back to pregnancy, where, as opposed to childbirth, it is made even more evident that the symbolic interventions performed by physicians and people involved in the health industry are less passively *sustained* and more actively *participated,* if not even sought, by the parents.

Self-technologies applied in pregnancy in fact satisfy both the need to ensure a healthy development, in conformity with biomedical set standards, that the desire to shape a new life in line with contemporary biopolitics.

Well before becoming parents, individuals are confronted with a number of new *commercialized* technologies in which to invest in the prospect of anticipating risk. In this key, I read the proliferation of companies offering kits for the collection of blood from the umbilical cord. When confronted with the promises of *potential* recovery from otherwise untreatable maladies, advertised under the resounding name of *stem cells*, prospective parents may as well be purchasing a magical artefact. In their advertisements, companies divulge no "exhaustive" scientific explanation about the workings of these kits, and there is no need to: as long as they leverage concepts of public domain - stem cells, genetic disorders - and are backed by scientific research, the interest (and market) is captured.

Obstetric ultrasound pictures and videos, too, constitute an imaginary that has been highly familiarized in biomedical societies, one that reverberates well beyond the sonogram rooms and of which parents often take possession.

I think it is interesting here to report the position of a doctor specialized in ultrasound that I encountered during my pregnancy. She was deeply engaged in raising awareness on the potential of obstetric ultrasound technologies through the organization of exhibitions in museum and cultural centers. She wanted to promote and divulge what she called a

"humanized use of medical technology" arguing that a childbirth starts from gestation, and that sonogram images help us to better perceive the reality and imminence of a pregnancy. Especially for the prospective father, "that lives an ideal and abstract experience of the pregnancy", the ultrasound would be a concrete support to realize the *facticity* of his child's existence.

In stark contrast with this "theory of ultrasound bonding", exploring how ultrasound images have been deployed in pro-life campaigns, Rosalind Petchesky notes how "from their beginning, such photographs have represented the foetus as primary and autonomous, the woman as absent or peripheral" (in Taylor 2008:27).

Following her lead, Hanson sustain that "pregnant women do not easily give up their own rights of interpretation over these images. Thus their response to a scan will depend on the clinical context and setting, but also more crucially on their social and ideological perspectives."

The rhetoric of "humanized use of medical technology" I argue, collapse when facing 'the other side of the coin' for which these technologies are recommended: in the presence of foetal abnormality. When confronted with the effective existence of the "abnormalities" it seeks to exclude, there is only one treatment biomedicine is able to offer: abortion. It is still within the parable of "risk management" that the prospective choice is consumed.

The background that informs and sustains the possibility of this interventions is framed by statistics and epidemiological studies, and is *pregnant* with the rhetoric of risk.

"Pregnant women are risk profiled by their doctor or midwife, and, if allocated to a high risk group for miscarriage, premature birth or associated difficulties, are subject to enhanced surveillance by midwives and gynaecologists" (Rose, 2001:8).

In my pregnant experience as much as those of the other participants to this research, risk was a ghost that hovered in our meetings with doctors as much as during our discussions. The condition of risk was a dynamic one, that could be detected and then backed down depending on the stage of the pregnancy and the results of other medical controls we would do.

V.'s pregnancy had been considered at risk due to blood loss she had experienced in the first trimester. When time passed, she was out of peril and started working again, but was nonetheless treated as a "case" at risk because of the hardening of the womb she would often feel.

K.'s appointments with her obstetrician fell every two weeks due to her nausea, for which she was hospitalized and subsequently treated with medication. Hers too was considered a pregnancy at risk, and she was given several tests during its course.

T.'s high risk pregnancy was detected in her own physiology: she had what is clinically defined an *incompetent* cervix, one that was not closed enough and high enough to ensure the protection of the uterus. She should have avoided working at all and should have rested for the full length of her childbearing.

My risk was as well due to physiological features, but of a corporeality *in fieri*: the baby was growing at a higher rate than average for the hospital standards, so it was set to be a surgical birth. Being classified as a P97 weighted heavily on my capacity to make choices regarding the trajectory of my experience. Any previous claim that I had, to try to do a natural birth, was sorely tested by this decree.[12]

While the course of a normal pregnancy was carried out under the supervision of doctors in the *Centro de Saúde*, risk pertained to the obstetric ward of the hospital of reference. Women followed in these departments usually undergo, in relation to their risk, more tests than the average.

"Diagnosis" - stresses Ilana Lowy - "homogenizes medical practices" (2011:301).

Diagnosis, I would add, doesn't necessarily apply only to classified diseases' manifestations, but, under the semantic of risk, to the general possibility of developing a troublesome condition.

At some point, we were all under the common denominator of *pregnancy at risk*, though for very different causes.

Lowy's work (2011) interestingly juxtaposes the different forces at work in the development of medical classifications: historically developing clinical observation, management procedures, medical technologies and social and political interests. Taxonomies have as well a performative role that "may define causality and responsibility, shape inter- and intra-professional authority and medical division of labour, redistribute responsibility for health and sickness, mould patients' experience and trajectories" (Lowy 2011:301).

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12 With the benefit of hindsight, I wish to point out that all our pregnancies had a successful ending and none was affected by the risks described by doctors during gestation. T. *did* gave birth some weeks prior to her due date, but not enough to be considered a premature birth, and the delivery occurred without problems.

This last feature, following Hacking's treatise on *human kinds,* falls within the "looping effect" that arises from the categorizing order of "industrialized bureaucracies" (Hacking,1995:351).

Kinds regarding living persons are characterized by a circular movement: they "create", by definition, types of people and are embraced by the same beings classified within them. Against the claim of nominalistic theories that focus on the socially constructed nature of categories, thus subtracting them from a dialectical character, Hacking stress the instability, the interactivity of human kinds' classifications, opposing factuality to relativeness. Furthermore, he underlines that general categories existing in nature are human kinds only in a specific social context.

Bringing his discourse back to clinical management of expecting women, risk kind is defined by "fluid diagnoses that change easily as patients are processed through the protocols" (Lowy 2011:309), therefore rendering that of risk an unstable category, liable to change with the development of the pregnancy.

Nonetheless, risk is labelled through the observation of what are considered in biomedical terms potentially problematic conditions, it is founded on existing traits.

K.'s nausea, V.'s contractions, T.'s *incompetent cervix* and the *P97* of my developing child, all the "symptoms" that made us a group at risk were effectively there: still I question if they would have made us pregnancies at risk outside the biomedical knowledge.

The most important aspect, though, with which I wish to conclude, is the "intrinsic moral value" of human kinds that informs their interactive quality.

Under the definition of pregnancy at risk, a woman is put under special vigilance and testing: where in part it serves the shared ethical value of *protection* toward the pregnant woman and the unborn child – a trait that I will discuss in the next chapter – it also shapes the *patient* understanding and management of her own pregnancy, charging it with increased pressure and responsibilities.

Facing the unknown with a possibility of the pregnancy diverting for the worst, each of us reacted by sizing what we took as datum point in our pregnancy.

Where V. was over zealous in her complying to the obstetrician warning, perceiving with alarm every sign she read as a threat and *embodying* risk by rushing to the hospital several times and living her pregnancy with an anxious disposition, K. was just cautious, but lived her

being considered at risk with fear, a trait that came out at every encounter of ours.
As for me and T., “the known may overpower the knowers” (Hacking 1995:360).
We surely absorbed our risk classification, but decided to look for different interpretations of our conditions: T. found it in her Austrian midwife's management of pregnancy – she had to be careful with her movements, but didn't need *absolute rest* – and I looked and found, still in Portugal, still where I had decided to live, an alternative biomedical way of addressing pregnancy and childbirth: the “humanized model” of birth (Davis-Floyd, 1993).

VII

Apparently I was fine, the problem that had so alarmed the general practitioner at the Centro de Saúde was a nonsense. When I had told him what I had felt "down there", he had widened his eyes and declared that my pregnancy was no more one he could follow: mine was a hospital case.

I felt so relieved now about knowing everything was fine that, even though I was still lying with legs apart wide open for the hospital's gynaecologist perusal, in a small room that counted as well the presence of my companion and two apprentices, I excitedly exclaimed: so I can have a natural birth! Even a water birth!

To my surprise, the doctor stood up, took off his gloves, looked at me with a sceptical expression and brought his united fingers several time against his forehead – in a gesture signifying "you're crazy" that appeared to me so stereotypically Italian I nearly burst in laugh in front of him...if only he hadn't commented:

"Oh menina! ter um bebê não é como brincar com bonecas!"

Then kept murmuring to himself, but loud enough for me and the apprentices to hear: "Esta é uma locura....ter um filho não é brincar...esta não é uma brincadeira"[13] *while closing the tent to give me privacy to get dressed and going behind his desk.*

First I felt shocked and mortified; I think I became red in the face, because I suddenly felt hot. Then I redress so quickly that I felt a cramp grasping my leg, but couldn't wait to put the shoes on before answering him: "I certainly am not playing, I am talking about the water birth practiced at the Hospital of Setúbal by your colleagues - I underlined the last word trying to get a reaction out of him– not of my house bathtub!".

It didn't work, he filled some papers, dismissing me fairly soon with a "Good luck!".

I didn't really want to argue anymore and listened to my partner advise - it was useless confronting a doctor like this. But it spoiled my relief for the good outcome of the gynaecological examination.

I kept thinking that, even manifesting his contrary opinion, if he had addressed me more seriously instead of practically treating me like a incompetent, I would have gladly heard his

13 "Ehi girl, having a child is not like playing with dolls!", "This is madness...having a baby is not playing...this is no joke" .

motivations.

I had found through the internet a public hospital in Setúbal where it was possible to give birth the water. I had been fascinated before about this practice, when I thought I would have never had a child. I feel comfortable in the water, it's an element that I've always looked for when choosing a place to live. Wanting to know more, I had visited the hospital at the fourth month of my pregnancy.

I wasn't really expecting anything. I didn't 'know' anything about all these prenatal care and practices before, I was just discovering it in the making.

This was an important point throughout my pregnancy, one that at time seemed taken for granted by the health operators I met. I didn't know what any examination, test, visit entailed until it was finished, and, more importantly, I didn't have a clue what giving birth would have been like.

What I felt I may have wanted – to feel as comfortable as I could, to try have an experience I would have remembered with joy – was just a general idea that didn't correspond to any actual practice.

Akrich and Pasveer observe that "the embodied know-how of both doctors and patients allows certain gestures required by an examination to be made, when outside these particular circumstances they could be experienced as attacks on the integrity, honour or dignity of the person" (Akrich and Pasveer, 2004: 64).

While it was true that I knew that I had to undress when I was prescribed a Pap test, the "embodied know-how" was not sufficient to give me an idea – and the consequent feeling of awareness – with regards to the general picture of the course of pregnancy and delivery.

I often felt lost for not being told why I was being examined, or what would have happened afterwards.

When we visited the obstetric ward in Setúbal, the nurse administrator guided us through a tour that marked the different stages of a childbirth: the check-in in the emergency, the labour ward, where I could walk, take a shower, relax on a fitness ball, the room with the devices to evaluate the progress of labour and check the baby's hearth and contractions, then finally the delivery ward with the childbirth room, small and cozy (as much as a hospital room can be cozy) with an inflatable pool, an audio system to help relax with music, nice colors on the walls... His discourse was directed toward us: "This will be your experience. It will unite the

two of you like nothing else. So you take it in the direction you want to take it, and we'll help”.
For the sake of knowledge – and chance, we didn't know how long it would have taken for us to go to the hospital when the labour started – we later went to the prenatal class of the hospital in Lisbon where I was being followed for routine check-ups, too.
The delivery room was big, accessible from two opposite sides by two swinging doors equipped with windows. Inside it was bright white, with a central birthing stool and two lateral beds, surrounded by medical machineries and big light lamps – it looked like an operating room. Nurses and physicians entered and exited one or the other door while the nurse was saying: “you will have many people here, telling you what to do, but remember to listen to your instinct. If the anesthetist is telling you to push, but you don't feel like pushing, don't rush. Of course you have to collaborate with the obstetric...”.
I looked at Nicola and was glad to see that he too had already made up his mind: we would have rather spent a month in Setúbal waiting for the child to decide it was time to come out, than risk to transform our first experience of childbirth in a surgical operation.

Giving birth in Portugal

During my pregnant fieldwork - pregnant in more than one sense, with all the new experiences, knowledge, accounts and emotions it brought – I had the luck to spend time with some women anthropologists engaged in the field of health, maternity and birth.

Apart from the valuable advices on bibliography and research lines, the most important contribution they gave was sharing their personal childbirth narratives and help me form an idea of what meant, in terms of personal agency, to give birth being able to make choices, as opposed to the medicalized technocratic birth model (Davis-Floyd, 2001).

I had the privilege to read Elizabeth Challinor's autoethnography of the childbirth of her third child in Portugal (Challinor, 2012). It was her first hospitalized delivery after having given birth to her two older daughters at home, back in England. Written in the form of a diary, it gave me a vivid impression of her vicissitudes in dealing with health operators in a highly medicalized setting – like the one I was just living through. More than this, it provided me with a "vocabulary" of what alternatives I could look for to render the experience more subjective, to have an "active" birth.

Being a first pregnancy, I didn't know what I was going to go through and, though feeling that a lot of medical practices of routine were invasive and unnecessary, I didn't have any valid alternative from which to draw.

My resistances and fears came from my family, friends and other women's narratives, both in Italy and in Portugal: stories about being shaved hurriedly and dry to rush to the delivery room, the anesthetic not having full effect while "being cut", lying during labour on the hospital bed not being able to move for the drip connected to her arms, feeling like pushing and being answered that the machine did't detect the contraction...

Much of what happens in a delivery ward was kept clouded from nurses and physician during my monthly visits at the hospital. When I approached the eightieth month and we were advised to undergo a prenatal course, the nurses talked about breathing technics, epidural anesthetic, episiotomy, following the obstetric physician direction and *collaborate* through the expulsion phase.

At that stage though, I already had an idea of how I wanted my childbirth to be like.

V. was at her second pregnancy; even though the first had taken place more than twelve years

before, she still had an idea of what it was like to give birth. She was happier to deliver in Portugal than in Brazil, as her first time. She felt reassured about being followed assiduously by physicians and thought that if it was going to be a caesarian, it would have been better done than the previous she had had. The way she lived her pregnancy, with the same wonder and expectancy that I felt, made it seem like this was her first too. I understood that every pregnant experience must carry with it a certain level of anticipation and mystery about the outcome. Still, she was more used to those medical terms with respect to which I felt a sort of aversion.

K., on the other hand, was as new as me to this journey, and had some resistances when it came to caesarian rates in Portugal and Brazil. The preoccupation that her pregnancy could go wrong was strong, so she often told me that she would have followed the obstetric guide, despite she may not have liked them, for the sake of the child. Knowing the experiences of her sisters and her mother, she was happier to be giving birth in Portugal rather than in Brazil, where, she claimed, medical assistance was poor and recourse to over-medicalization was high.

T., as I have argued before, was a different story. She had a very clear idea of where she wanted this pregnancy to go, even if it was her first one, too. She had sought this child, she had talked to many friends in Portugal before choosing and, with the support of the medical members of her family, had decided to give birth in Austria. She told me she had the impression that in Portugal childbirths were as medicalized as it was in Austria fifty years ago. She was fairly specific about her “dos and don'ts”: she didn't want to be shaved, didn't want to give birth lying on her back, she wanted to be able to move during labour and bring a personal midwife with her.

These practices are usually addressed as the “humanized birth”, an hospital adaptation of the “holistic midwifery birth model”, and they're often joined to the “Baby-Friendly Hospital Initiative” for the promotion of early breastfeeding supported by the World Health Organization (Davis-Floyd, 2001).

I had found them in the Public Hospital of Setúbal, forty minutes by train from Lisbon.

So why had the gynecologist of the hospital I was being followed monthly reacted with such indignation at the prospect of a water birth?

In Portugal, maternal and children health is condensed into a narrative that, I found, is widespread and socialized among citizens as much as health professional.
It portrays the health history of a country that in fifty years has passed from one of the highest to the lowest infant and maternal mortality rate in the european continent, and one of the lowest in the world nowadays.[14]
Infantile mortality rate decreased from 77,5% in 1960 to 3,4 % in 2005.
It is estimated that between 1960 and 1998 the total decrease was calculated at 92%.
Maternal mortality in the year 2000 was situated around 2,5%, the third lowest in Europe, while the percentage of unassisted births the same year was measured at 0,15%.
I'll follow Almeida (2005) in her reconstruction of the development of health services in Portugal in the past sixty years. The drop in mortality rates from the mid 1950s to recent times has ensue from the development of private maternity services such as the *Istituto Maternal* (Maternal Institute) during the 40s, in line with the already established french *Goutte de Lait* and *Consultation de Nourrissons*.
The services included prenatal and gynecological consultations, pediatric assistance and puericulture. Structures were initially developed in Lisbon and only later diffused to the rest of the country.
Other developments that are recalled with a causal relation to the drop in infant mortality rates are the improvement of the health conditions of the population, with the implementation of prophylactic and therapeutic means (like antibiotics), the national vaccination scheme, launched in 1965, improved infrastructures, as water and sewage systems, better housing conditions.
In 1978 the International Declaration of Alma-Ata stated health as a fundamental human right and one of the most important social goal at world-wide level; it was followed in Portugal by the birth of the National Health System (1979), extending the right to health to all Portuguese citizens. Already, in 1975, the development of the Primary Care System had seen the diffusion of Local Health Centres (Centros de Saúde) on the national territory, in line with other European countries. New health policies identified the priority of prevention and health promotion, especially with regards to maternal and child health.

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14 Datas are collected online from: www.ine.pt (Instituto National de Estatística) and from "Os Desafios da Saúde Materno-Infantil portuguesa nos Inícios do Século XXI" , Almeida Remoaldo, 2005

It was recognized that improvement in health conditions was strictly connected with higher schooling rate, objective that was reached especially in the last two decades of the XX century.

With the development of Neonatal Intensive Care Units in the 1980s neonatal mortality rate saw as well a strong decrease, and when, in the year 2000, the WHO World Health Report was issued, Portugal classified twelfth in the performance of health systems world-wide.

It is not difficult to imagine how this tremendous drop in infant mortality rates in Portugal, that has characterized maternal health in the last sixty years, represents reason of pride among portuguese health practitioners. It is not hard to understand, also, how it has feed the popularity of clinical biomedical practices among citizens.

Shared narratives of risk prevention and emergency care in relation to hospitalized birth are as strong among portuguese citizens as they are in other populations around the world.

Still, it is within the same biomedical system that other, less medicalized models of childbirth have been tested, developed and have become routine.

The article from which I have drawn the datas reported above concludes with considerations on the challenges that Maternal and Child Care in Portugal faces in the XXI century. (Almeida, 2005).

Besides an implementation of preventive practices and a wider program of sexual education in schools, an *omen* to a less technical and a more humanized model of cure is made, with a reference to a classic notion of medical practice as *art* and *humanities*.

In this direction, it invites health professionals to pay more attention to “traditions and believes, rooted in the population, that condition health behaviours” like prenatal screen and alcohol consumption during pregnancy (Almeida, 2005:560).[15]

I suggest to reformulate and broaden the range of this advice.

People's “traditions and superstitions” is a rhetoric often used in biomedicine to mark a separation between the rational, healing-orientated behavior of doctors versus the irrational, vices driven impulses of patients.

It is a discourse that integrates a vision of human beings as composed of flesh seasoned by

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15 “Por seu turno, os profissionais de saúde devem ter na sua prática clínica, uma maior atenção às tradições e crenças enraizadas na população, que condicionam vários comportamentos em termos de saúde.” (Almeida, 2005)

believes.

The risks and effects that this way of conceiving and constructing *otherness* – in this instance patients – bring, have been expressed in terms of *musealization* or *epistemicide* of different forms of knowledge (Matos *et al.,* 2010).

Starting from collocating on the same level the two subjects of the equation, thus deleting the differentiation based on rational/irrational attitude means recognizing both participants of the healing process as bearers and producers of values and visions – often shared.

At least in the biomedical setting, doctors and patients are living in the same cultural landscape. This doesn't mean that distances are shortened and differences attenuated, and it is by virtue of this differentiation that cure devices need to be formulated as a ground of negotiation.

Analyzing how clinical work is characterized by the dynamic encounter of observation and classification, Löwy states that "the interactions of numerous ways of knowing is well exemplified in medical work, where complexity and 'impurity' are the rule, and intervention (therapeutics) is always intimately entangled with representation (diagnosis and classification)" (Löwy 2010: 299-300).

I would add that this complexity is reflected as well outside the biomedical system, where local practices in clinical settings overcome and affect the homologating effects of its protocol-based backbone.

In this sense, it is rather correct to talk about *biomedicines* in the plural, as a system of peripheral systems that integrate practices often very different from each other (Pizza, 2005).

Practices are, at least, practiced by people, and this presupposes a margin of unpredictability that, despite it is difficult to encounter - from the point of view of a just-been pregnant *patient* – can make of biomedicine an *ars medicinae.*

Picture 3

Social imaginaries: the sexy, alluring nature of pregnancy

CHAPTER THREE
"A FLESH EMBUED WITH SOCIALITY"[16]

On feminism and choice

When italian singer Gianna Nannini – a usually reserved and low profile artist - announced her pregnancy, in the summer of 2010, by showing off her round belly on Vanity Fair wearing a t-shirt with the inscription "God is a Woman", the news received much public attention, when not outright indignation. She was single, homosexual, and 54 years old.
The cover's picture seemed to tease famous expecting women's images we've been used to see on popular magazines.
Since Demi Moore appeared naked and pregnant on the same periodic more than twenty years ago, a long succession of *celebrities* had some magazines uncovering their winking pregnant sensuality. From lumpish and asexual, the pregnant body has become in recent decades a privileged ground on which female sexuality is played. It is a sexuality though that is far from the women liberating project Iris Young had foresaw in the 1986 first special edition on motherhood and sexuality of Hypatia (Oliver, 2010).
Young envisioned the overcoming of patriarchal social control as lying on the separation between motherhood and sexuality: "Patriarchy is founded on the border between motherhood and sexuality. Freedom for women involves dissolving this separation."
As long as pregnancy was separated by sexuality, women wouldn't have been able to claim a role as subjects of pregnancy and motherhood.
As Oliver argues it is noticeable instead, today, at what expenses the sexualization of the pregnant body has brought the social representation of motherhood. Far from liberating itself from the *otherness* to which the patriarchal gaze confines it, the objectification of that gaze has been extended to the pregnant body, producing the imaginary of a sexy, alluring nature of pregnancy. It is on the problematic of choice that Gianna Nannini, too, addressed her answers to the polemics that followed the magazine issue, claiming the freedom to choose what to do and how to do it. Hers was clearly a provocative gesture: she could as well have been the

16 Rosemary Betterton "Maternal Bodies in Visual culture"
Online: http://www.mamsie.bbk.ac.uk/back_issues/issue_one/

epitome of contemporary "reproductive species". At the center of the controversy lies what is perceived by many as the intrinsic decline that in-vitro fertilization and genetic engineering carry with them. The scenario against which these criticisms are raised consists of the indefiniteness that technologized procreation store for the future, like the possibility to create beings born from biogenetic experimentations. Basically, as Kelly Oliver points out, "new technologies bring new anxieties about both men and women becoming irrelevant for reproduction" (Oliver, 2010:770).

Conversely, high-tech reproductive devices are supported by a popular imaginary that sees women freed from the race against their "biological clocks". Contemporary women can postpone the project of having a baby while dedicating time to pursue their career, sperm banks give the possibility to conceive without the necessity of a sexual act, broadening the choice to create a family to same-sex couples. Customers can choose the donor profile, seduced by the weight of biotech engineering in an age of genetic promises of "perfectibility". Oliver observes that with these new perspectives in biotechnologies "the language of choice becomes the fantasy of planning, controlling, and eliminating chance from reproduction".

The question of motherhood as women's choice is one that has often engaged feminist scholars' interest. Setting the stage had been Simone de Beauvoir rejection of motherhood in *The Second Sex*, where she declared: "the conflict between species and individual, which sometimes assumes dramatic force at childbirth, endows the feminine body with a disturbing frailty . . . and it is true that they [women] have within them a hostile element—it is the species gnawing at their vitals" (in Oliver, 2010:762).

Though assuming a radical stance, Beauvoir amends her drastic position by suggesting that women can eventually go beyond patriarchal stereotypes as long as they make motherhood their own project, and not a burden biologically determined. This version of motherhood as an active creative choice, has been sustained, in different argumentations, by Julia Kristeva.

In *Stabat Mater* theorizing the *female genius,* she argues that motherhood may be our only hope of creativity, the last human bastion against the automation of life. Where cultural constructions reduce mothers to fetal containers, they are instead the potential carrier of the continuation of the species. But women's experiences and choices have to be valued in their inner ambiguity: "Like childbirth, analysis (and writing, art, and mysticism) can bring a time of new beginnings and rebirths and a certain serenity'' (in Oliver, 2010:775).

VIII

"Are you waiting?"

I was asked, in a strong Southern Italy accent, from a woman we were renting a room from.

It had been Nicola's idea to escape for a couple of days to a little island not too distant from our hometowns and enjoy the last summer days before going back to Portugal.

"Yes, my partner is taking the suitcase inside, he'll be out in a minute". She laughed.

"No, I meant you're waiting, you're caressing your womb, so you are waiting right?". There and then I remembered from unspecified memories (my father's family? Some movies?) that that was the Neapolitan way to express "expecting" as in waiting for a child to grow and be born.

I had not noticed I was touching my belly, but apparently I did that a lot lately. It had only been a few weeks I had discovered to be pregnant and already I was visibly embodying it.

The woman had a knowing look on her face, and I discovered my posture and attitude reflected in her gaze: my hand was caressing the womb, not just touching the belly.

I was unconsciously cradling the little being that was growing inside of me.

More or less a month later I was waiting for a bus in a busy junction in central Lisbon.

Again, a young woman gestured for me to take her place on the bench, it was a silent invitation delivered while shifting her gaze from my face to my belly.

I wondered if my condition was already that visible, but realized it wasn't. At that stage, the roundness could have been easily mistaken as body fat. It was my stance that give it away to who had eyes to see.

I soon discovered that my new body was a field of socialization: women neighbors I never talked to before, now stopped me every time we had a chance to meet outside my doorstep to ask about the developments of my pregnancy: how are you doing? Do you have morning sickness? Is it a girl or a boy?

This last point was an approaching means used especially from unknown women I would meet on the bus, a question that triggered the sharing of their pregnant memories, and I often detected a hint of nostalgia in their tones. I wondered if I would have missed being pregnant in the future.

The bigger my belly became, the more casual interactions I had with women around the city.

When it grew over any misunderstandable size, pregnancy was everywhere in my day.

There were seats dedicated just to me in public transportation. They were marked by a stylized drawing depicting a big belly woman, in the company of a person supported by a crutch and another woman carrying a child in her arms.

When in the crowd of the peak time I could barely enter the bus and stand there, now I would always find an advocate ready to claim my priority to sit in those seats.

I was given precedency when waiting for the bus, in line at the supermarket, when paying the bills. When I declined, normally they took it as a out of politeness rather than expressing my will to stand. I often felt embarrassed when someone insisted.

I was looked with approval: it felt like occupying a place of high regard in social classification. People concerns, expressions and demeanors when dealing with me, or just crossing me in the street revealed acceptance in a positive, liking way.

I wonder what they were approving: maybe a woman keeping up with her role? Was it a combination as well of my stance, my features, the color of my skin, my dress?

Was it the same for other women?

I wasn't alone: I met pregnant bellies everywhere, waiting in line at the citizen's bureau, sitting on the metro, crossing the street with child in hand, behind the counter of the supermarket, jogging on the Tejo bank on sundays.

Pregnancies were bold points in my social landscape.

Sharing Pregnancies

I would usually meet V. in her busy hair salon just out of Lisbon; she talked to me between serving a customer and another.

It was a place frequented almost exclusively by women, and I guess it was a funny show for them, when entering the shop, to see the two of us sharing news and commenting on our belly developments. It often became a collective chat and, when it was time for me to say goodbye, I would go home with a bundle of good wishes and advices based on others' experiences.

R., V.'s husband, was helping with the shop administration in those months, so he was a discreet spectator and pleasant commentator when it was time to indulge in some jokes on gravid exuberance.

V's had mostly regular customers, the salon had that familiar atmosphere of an habitual meeting place. She had established good relationships there, and when she got pregnant, many of them had lent or given her their children's clothes, sheets, cribs.

She was very proud of this, often enthusiastically showing me new things she was offered. We determined that, if one had a good net of support around her, having a baby was not necessarily as expensive as it's said to be.

When I visited V. at her house, K. would join as well: they were friends, con-nationals, neighbors and moreover, they told me, they supported each other like family members would have done. When K. was back from hospital the first time, it had been V. that stayed with her during the mornings, while her husband was working.

They helped each other in daily chores, and replaced the other when one was working; K. would look after V.'s son when he was out of school, V. would run errands for her while she was in bed. They had another Brazilian friend helping them on a daily basis. They kept contact everyday with their families in Brazil, and planned to have the help of their respective mothers toward the end of the pregnancy. V.'s mother came to Portugal with her sister long before time - it had been V.'s idea and it had backfired somehow. When she gave birth, she was alone with her husband and son. But apparently she didn't have to worry, the support of her friends was as good as her family.

K. too had her mother coming to Portugal early, when she got very sick the first months. I met her the first time with her mother, a nice woman who seemed to be the one doing the research

between the two of us: she was always interested in my pregnancy, how I was dealing and if I felt good. She spent a couple of months in Portugal before going back to Brazil, much earlier than K.'s delivery. She eventually came back again a few weeks before though. Their house was always very busy: the three of them, their friend, V. and her family.

When V. organized her "Chá de Fraldas"17, the brazilian equivalent of the "Baby Shower" where presents consists exclusively in diapers, it felt like being in Brazil: there were many friends of her, most of them Brazilian, and I really had an idea of the net of support she and K. shared.

I made some friends since living in Lisbon, which hadn't been for long when I discovered I was pregnant. But I found a lot of support and help too. My friend L. was very attentive since the beginning: she wouldn't let me sleep alone in my house when Nicola was out of town and thought of me when there were offers on "healthy food" at the market. She wanted us to meet her family - her parents were from Mozambique and had four daughters - they made it their responsibility to look after us as a surrogated family. And I started receiving newborn's *necessaire* even before learning what they were for – pram, stroller, baby carrier, "kangaroo" – from friends with grown up children. These strange objects were given with personal stories as instruction leaflets - on how useful they had been, or how "damn difficult" to close, or that time when the baby fell off the chair and they caught him just in time...

At the end, and contrary to what my mother thought, being pregnant and "alone" in Lisbon wasn't difficult at all. It meant participating in new dynamics, meeting friends' friends and friends' families, a sort of concocted net of relationships that grew spontaneously around us, supporting in many aspects.

Through internet, I talked to my friends and family often, as K., V. and T. did, and updated them on the growth of my belly regularly through pictures or funny drawings that made the distance less melancholic.

I would have liked to have them near - my female friends from adolescence, my mother, my grandmother, the many women of my family back in Italy - to share with me the wonder of this transformation I was going through, to see my belly catapult from one side to the other, to confide to when I had doubts and fears.

This distance that separated me from what I felt familiar, however, made me open to

17 Literally "Diapers Tea"

alternatives, that I found in the many women that would approach me telling their pregnancy narratives in the most disparate situations.

I think that this will to share their pregnancies' memories had a double function: to recall a time and an experience that is special – either good or difficult had it been – in the sense that is a unique modality of embodiment, often perceived as a *capacity* of the self; and find complicity in somebody that, being actually pregnant, was perceived as peer, and could grasp their experiences from within.

These stories were lived reconstruction of experiences that – now I know – were inseparable from their body: a memory that was shared through words and flesh. In my pregnant body, and in what in entailed, they reflected what had once been their own pregnant *being-in-the-world* – and I incarnated them all, as possibilities.

CONCLUSIONS

I have argued before that the pregnant embodiment can be understood in terms of *dividuality*, turning over its original semantic and directing it inwardly, to express a sense of openness and fluidity in relation to an internal *other*, felt at once as owned and different.

The same term could be revalued, in part, to designate the "outer" effects that a pregnant *figure* triggers. I linger on the suggestion of the pregnant image as a visually socialized imaginary.

The unequivocally protruding belly is a powerful symbol that initiates social relationships, and brings about distinct practices and interactions.

Probably – and paradoxically - the only rival the pregnant figure has in terms of symbolic investment is the image of the un-born child socialized through the diffusion of sonograms pictures (Taylor, 2008).

Where *dividuality* can be defined as relational personhood, by virtue of its image a pregnant woman becomes relational, in the sense that her presence brings forth a social acknowledging configured in terms of approval and protection – towards the fetus, the woman-carrier, towards the means of reproduction that guarantees social continuity.

Iris Young emphasizes this aspect as "stolen" subjectivity in the experience of pregnancy:

"Pregnancy does not belong to the woman herself. It is a state of the developing fetus, for which the woman is a container; or it is an objective, observable process coming under scientific scrutiny; or it becomes objectified by the woman herself as a "condition" in which she must "take care of herself."(Young, 2005:46).

I agree with Young in considering that pregnancy is socially managed as such: a public endeavor to guarantee preservation and a formal care, that the pregnant woman has to reciprocate through a disciplined self-management and conformation.

"Children are God's blessing" has been the casual approach of numerous women during my pregnancy. The possibility of an unwanted pregnancy is an aberrance that, as a tabu, doesn't find space in social mundane narratives.

A pregnant woman's choices, could be argued, are still individual and there's still a level of auto-determinacy. But *choice* is an ambiguous category, that mistifies agency with a rhetorical denotation of freedom. The social pressures that work to shape the behavior and

ethics of a pregnant woman are undeniable.

Concurrently with biomedical rhetoric of risk, pregnancy is socially designed with frailty and need, underestimating the empowering experience it can be for some women.

Conversely childbearing is lived by most women as a vulnerable condition, embodying a social discourse whose ultimate aim is compliance.

Referring to the incapacity of women to live their experience of pregnancy in synergy with other women, Emily Martin writes "Just as in the case of the worker in capitalism, women are separated from other persons around them: they are isolated from other mothers, at least in the middle class, by insular nuclear families." (Martin, 1987:19).

Based on my experience and research, though, I argue that in the immediacies of everyday life the picture is more complex and blur: pregnancy is produced by a fluid interaction where embodied social compulsions live space to forms of personal resistances, where biomedical prescriptions are filtered through idiosyncratic performances, often sought through other women's advises and support.

Pregnancy is not only an experience solely of women – this I know personally and understood better throughout the research.

But it is a *gendered* experience that belongs to the specific configuration of women embodiments.

Oliver (2010) suggests that pregnancy is an empowering experience for women because "the maternal body with its other-within not only challenges traditional theories of personal identity, but also can be taken up as the beginning of a new ethics of difference." (Oliver, 2010:763).

I suggest that the pregnant embodiment is a compelling instrument to rethink modalities of existence in cultural anthropology.

A lived experience of pregnancy is, in its core, a rupture of dualisms: it splits subjectivity, crossing the borders of flesh; it puts into question the distinction between individual and social, being both at once without solution of continuity. It threathens as well the construction individuality as historically developed in western understandings.

Like the protruding pregnant womb, it is at once within and outside. In the end, it carries the creative potential of liminality.

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