make us legal and repeal the laws concerning refugees in all of Germany and the European Union, refugees will always fight for their rights and organize demonstrations. They must think about how they treat refugees because refugees remain, of course, human beings. And all human beings deserve rights.★

Notes

1. *Residenzpflicht* (mandatory residence) is a legal requirement affecting applicants for refugee status or those who have been given a temporary stay of deportation (what the interviewers refer to as "*Duldung*"). Those affected are required to live within certain boundaries defined by the applicants' local foreigners' office. Foreigners who contravene this legislation can be imprisoned or face fines. The *Residenzpflicht* is unique to Germany. A 2007 complaint to the European Court of Human Rights regarding *Residenzpflicht* was dismissed.
2. For more info see: http://en.wikipedia.org/wiki/Dublin_Regulation
3. Hennigsdorf is a town 25 km northwest of Berlin.
4. The official German term is *Flüchtlingsheim*, ("refugee home"). The refugee movement refers to these facilities as "Lager", which invokes the historical use of the term *Konzentrationslager* or ("concentration camp").
5. For more info see: http://corasol.blogsport.de/ueber-uns/
6. Eisenhüttenstadt is a town located 120 km east of Berlin, near the border with Poland.

[[[ARTICLES]]]

Liberatory Midwifery: Towards People-Powered Health Care

Martha Roberts

Despite a history embedded in social movements, Registered Midwifery is now situated in petty bourgeois professionalism and biomedical practice. Following the medically-unattended home birth of my daughter in 1997, I became involved in the struggle for legalized and publicly-funded midwifery. I believed that the right to access state-funded midwifery was important, as was the protection of midwives from state persecution, court trials, jail sentences for practising medically-restricted acts,[1] and inquests resulting from babies born with birth injuries or who died during birth.[2] At that time, I was largely unaware of the trade-offs that state-sanctioned and funded midwifery would bring.

I am now a Registered Midwife working in a collective, community-based storefront clinic that I co-founded in the Downtown Eastside of Vancouver. My midwifery practice is in constant struggle with the bourgeois institutional and biomedical frameworks within which I function. At Strathcona Midwifery, we struggle to centre the needs and experiences of poor families, to respect working class perspectives on health and disease,

and to support families who decline routine medical care. A large proportion of the families we work with at the Strathcona Midwifery Collective have complex health and social needs; these families are marginalized and undermined by capitalist society due to being indigenous, migrant, transgendered, precariously employed, super-exploited,[3] socially-isolated, self-medicating with drugs or alcohol, struggling with mental illness, under- or un-housed, balanced on the margins of social acceptability,[4] and often viewed by the state as a potential risk to their children.[5]

I frequently feel angry that the systemic supports these families actually require to be healthy cannot be provided within the medical system. In fact, non-medical needs are disregarded in provincial maternity care guidelines.[6] I have endless discussions with women about medical tests that have little impact on long-term health or the experience of motherhood. I can spend an entire visit explaining the risks of and treatment for gestational diabetes to a pregnant woman who relies on the food bank to feed her family, is cut off from her cultural food traditions, and has very little control over what and when she eats, when what would make actual long-term differences are community control over food production, collective food purchasing and preparation, and support for familial and cultural traditions of food sharing.[7] My experience illustrates the major challenges that bourgeois professionalization and biomedical medicine pose to liberatory health practices that aim to be democratic, to challenge exploitative social relations, build community organization, expand our knowledge of health and disease, and centre care on the needs and experiences of marginalized communities.

I ask myself how we can work together as care providers and communities to address factors that really matter to good health: meaningful employment, job security, living wages, food security, housing, freedom from structural racism, homophobia, transphobia, and liberation from colonial domination. The history of Registered Midwifery in BC is an example of the limitations of bourgeois domination. What we need to fight for people's health is radical health organizing that challenges the myth of neutrality, encourages health care providers to stand in solidarity with liberation movements, and aims to build new forms of liberatory and democratic health practice that develop people power and new conceptions of health and disease based on the material realities of working class communities.

Colonial and Capitalist Expansion & the Medicalization of Midwifery

Before modern medicine, when women gave birth, midwives helped.[8] Before colonial contact, the practices of indigenous birth attendants were holistic and grounded in spirituality, community connectedness, and the centrality of birth as a cultural rite of passage and sacred ceremony. Despite great cultural variation, historical knowledge suggests that midwives shared commonalities of practicing community-based reciprocity and mutual aid, keeping community history, administering spiritual birth and death rites, acting as healers and advisors, and building a culture and "knowledge fund" of birth.[9]

European colonialism brought the capitalist mode of production, exploitative social relations, and budding political and ideological institutions of social organization and control, including the Western medical profession and their supposedly "scientific" practices. Integral to the growth of Western medicine were hospitals that centralized and institutionalized patient care. In British Columbia, a rapid movement of birth from home to hospital occurred between the First and Second World War and, by 1940, 84.4 percent of births occurred in hospital.[10] Yet, hospital care was not necessarily the driving force in reducing maternal mortality; improvements in sanitation, living conditions, nutrition, transportation, and working conditions were also significant.[11] If and how medicalization contributed to reducing mortality are unclear, but one fact is certain: the broad-scale application of a medical model and the outright exclusion of midwives were also harmful. In particular, maternal outcomes were worse in indigenous communities following the hospitalization of birth.[12]

Medicalization of childbirth transferred knowledge of and control over birth to the growing medical profession. Birthing women were a huge pool of patients who bolstered the reputation and expertise of the medical profession, a profession that eagerly applied surgical and pharmacological interventions to deliveries.[13] Universal application of interventions such as episiotomies that cut into the muscles of a woman's vagina – while rarely medically necessary and extremely painful – created a myth that medical techniques were necessary for the safety of mother and baby.[14] The patriarchal structures of medical education and practice kept nurses ignorant of the physiologic mechanics of childbirth and forbade nurses from attending to labouring women unsupervised.[15]

Excluding nurses effectively excluded women as skilled attendants and disregarded women's lived experiences of childbirth as a legitimate form of knowledge. In an outrageous display of bourgeois arrogance, the 1979 Medical Practitioners Act gave exclusive jurisdiction of practicing midwifery (conducting childbirth and related skills such as vaginal examinations) to members of the College of Physicians and Surgeons of BC: unless you were a doctor, practicing midwifery was now a criminal offence.[16]

Through interconnected processes of capitalist expansion, colonization of Indigenous land, and colonization of women's bodies by western medical science, birth came to be viewed predominantly as a medical event, controlled and protected from lay providers by professional legislation restricting medical practice,[17] which in turn criminalized birthing practices outside of this paradigm. Bourgeois medical practitioners viewed women's rich and incredibly diverse traditional birth knowledge and culture as unscientific, thereby claiming women's bodies, birth, and infant care (including infant feeding practices) for the domain of medical science.[18] Care for women during pregnancy and childbirth is a good example of how the bourgeois medical system creates a demand for highly questionable, technically sophisticated, and very profitable interventions.

Registered Midwifery: A Liberal Feminist Response

Registered Midwifery is an interesting case study in feminist attempts to subvert patriarchal and racist medical institutions. Starting in the late 1960's with the women's health movement, organized resistance to medical domination was born out of growing dissatisfaction with the treatment of women within the medical system.[19] The home-birth and midwifery movement campaigned to have the state recognize midwifery as a health care profession and publicly fund midwives. Legislating and funding midwifery had the potential to provide midwifery to women who had previously not been able to access lay midwives due to cost. By 1994 in Ontario and 1998 in British Columbia, Registered Midwifery was included as a protected title in the Health Professions Act and covered by public health insurance.[20]

While midwifery care is a vast improvement for childbearing women who are able to access a limited number of midwives, the process of legislating Registered Midwifery was contentious. The

lay midwives of the women's health movement were predominantly white, middle-class women with the financial resources to study and attend births without guaranteed remuneration. For the "midwifery project to achieve broad-based political support, the midwife needed to be reconfigured in the public imagination as respectable: i.e., knowledgeable, modern, educated, and Canadian/white."[21] Although British Columbia followed Ontario's lead and included an Aboriginal exemption clause for indigenous midwives, who were required to demonstrate they were practicing prior to the passing of the Midwifery Act,[22] many question the justice of white professionals writing law to govern practices on unceded Indigenous territory. Indeed, some Registered Midwives acknowledge that"[in] pursuing the goals of legalizing midwifery and access to midwifery care [in B.C.], neither the Midwives Association of British Columbia nor the Midwifery Task Force addressed the wishes of Aboriginal peoples. There had been no attempts, within these organizations, to identify Aboriginal midwives."[23] The exemption clause fell grossly short of its mark, and no midwives applied for exemption to practice.[24] The professionalization of midwifery was an extension of class and white privilege that in many ways replicated the historical process of medical appropriation.

Bourgeois Institutions of Medical Domination

A clear analysis of the ways in which bourgeois and biomedical domination are created and recreated through health care practice is essential for those of us who truly seek to build liberatory community health practices and projects that do not imitate the very oppressive structures and institutions we seek to transform. We need to start talking honestly about the class orientation of health care professionals, who directly benefit from exploitative social relations, exert tremendous economic and political power, and often unwittingly replicate unequal relationships with their patients. Registered Midwifery continues to be rightly criticized for being Eurocentric and petty bourgeois in orientation.[25]

Self-regulating health care professionals who work in an autonomous medical practice, such as doctors, dentists, and midwives, have tremendous institutional control and access to wealth. Vicente Navarro accurately describes health care professionals as "lieutenants of the bourgeoisie" due to the high level of class privilege and control they have in the capitalist economy.[26] In fact, 14.3 percent of the 1 percent in Canada are employed in the

health sector.[27] Doctors decide what types of health care are needed by individuals and communities: they write clinical care guidelines and set standards of care, their professional associations have remarkable control over the price of care, and providers bill the state (or patients) directly for the care provided. The doctor tells us what to do, when to do it, and how much to pay for it; and we do pay – over $3.8 billion in BC in 2013.[28] Doctors' fees have increased 22 percent in the last decade. The service model of remuneration means health care professionals occupy an economically powerful position. Registered Midwives are no exception. Many midwives in B.C. own lucrative private practices that are profit-oriented, provide a highly privileged lifestyle for their owners and are not accountable to the community.[29] Maternity care providers in Canada – Obstetricians, Family Doctors, and Registered Midwives – are an extremely rich and powerful group with vested interests in existing institutions of bourgeois control.

Health care professionals participate in exploitative social relations under capitalism. In their own practices, doctors and midwives either directly exploit employees, such as administrative staff, childcare workers, and cleaning staff, or work in an institutional environment, such as a hospital, in which they heavily rely on exploited labour power.[30] Exploitative social relations also frame clinical encounters between care provider and patient. Our petty bourgeois class position contributes to misunderstandings and challenges in providing care for working class families. Relationships with pregnant patients are undermined by economic inequities and structural racism within the medical system and by class bias and interpersonal racism during clinical encounters. Women report that maternity care providers do not understand lived experiences of homelessness or precarious housing, un- and under-employment, poverty, and hunger, and subsequently do not understand the context framing individual health behaviour. Poor and marginalized women feel they do not have the choice to reduce stress, prevent workplace injuries, improve nutrition, increase physical fitness and exercise, or rest more. Many women report feeling hyper-medicalized and even traumatized within and by the medical system.[31] These reports may explain why the number of pregnant women abstaining from the recommended number of prenatal visits is rising in BC.[32]

Biomedical Dominance of Midwifery Practice

Organizers who struggled within monolithic medical and political structures to legalize and fund Registered Midwifery in British Columbia recognized and acknowledged to varying degrees that the move involved threats to a woman and family-centered model of care. Some argued that legalization would result in Registered Midwives "bring[ing] a number of invisible partners to their relationships with women – insurers, legislators, physicians, other providers and regulators."[33] This occurred in BC, where Registered Midwives are integrated into the medical system, required to hold Medical Staff Privileges at hospitals, and follow provincial medical standards. Professional regulation distances midwives from communities they serve because midwives are often compelled to be more accountable to the medical system in which they operate.

The core tenets of the midwifery model of care enshrined in B.C. Provincial legislation – informed choice, choice of birth setting, and continuity of care – were intended to bring balance to the biomedical framework and facilitate meaningful relationships between care providers and patients. But these regulations exist within a broader biomedical milieu, which compromises their realization. Informed choice was meant to honour pregnant families' expertise and input into their care. The College of Midwives of BC recognizes women as primary decision makers and states decision-making should be a shared responsibility. However, we must recognize the barriers to the application of this policy. Four years of baccalaureate education enculturates midwives into the medical profession: scientific studies, professional guidelines, and hospital policies shape the information we provide and how we frame women's choices in prenatal care.[34] We may know the theory of the social and structural determinants of health, but when faced with women's decisions, we often view them through lenses of institutional norms and medical risk.

Choice of birth setting is also compromised because health care professionals are trained to see women and the concept of risk through a biomedical lens. Consider the case of a woman coping with depression by taking an SSRI (selective serotonin reuptake inhibitors, a commonly prescribed antidepressant) who decides to give birth at home. She views the risk of being hyper-medicalized, judged, and controlled by medical staff at the hospital during her birth as greater than the extremely small risk of her baby needing intubation from SSRI-induced respiratory depression. But the

Canadian Pediatric Society recommends 48-hours of medical surveillance for all neonates born to mothers taking SSRIs despite the fact that needing immediate assistance with breathing at birth is "an extremely rare consequence of fetal exposure."[35] A woman taking SSRIs and choosing home birth must be willing to go against the recommendations of the Canadian Pediatric Society, and this situation often makes Registered Midwives who attend labouring women very uncomfortable: some midwives refuse to provide home births for these women. The very fact that I chart "declined" on a woman's chart repeatedly throughout the course of care – "declined continuous fetal monitoring, declined IV antibiotics, declined vaginal examination" – fails to capture the gross unequitable social contexts that limit women's supposed choices, gives the appearance of equality among women, and diverts our attention from deep-rooted problems within biomedical institutions.

Finally, the continuity of care component of the midwifery model was intended to support women who seek midwifery care to build relationships with a small group of no more than four midwives so that the mother can get to know the midwives who will be attending her birth. This principle acknowledges that building relationships takes time and effort; however, it fails to account for the fact that midwives not only have responsibilities to the families for whom they care – they are also professionally and personally accountable to the medical institutions in which they operate, including the hospitals at which midwives hold medical staff privileges. As Jordan describes, although "midwives as professionals may hope to affect standard desensitizing birth practices, they themselves are affected by joining professional bodies that are subject to dominant beliefs with attending legal and political obligations."[36] Agonizing fears of professional disciplinary action, litigation, and losing the licence to practice hang over Registered Midwives who step out of the bounds of professional standards to provide woman-and-family-centred care to those who opt out of medical norms. Ultimately, the invisible partners of bourgeois social structures and the biomedical system shape the care we provide.

Democratic, Co-operative, and Community-based Health Care

What does resisting bourgeois and biomedical domination mean for health care professionals and for Registered Midwives? First,

we can take inspiration from Doctors for the 99 Percent, who insist that "[w]e no longer agree to passively participate in the medical-industrial complex. We take back the art and science of our profession from the distortions and the profits, and place it in the service of the people."[37] In order to take such a brave leap, health care workers and professionals must support and challenge each other through the formation of a national alliance of progressive health workers for social and economic justice. We must find our collective voice, for to remain silent is to side with the oppressor; there is no such thing as medical neutrality! We must speak out about the brutality of the bourgeois medical system and demand accountability in our respective institutions, in public forums, and in our much-needed progressive organizations of health workers. Sorting out the good and the bad in medicine is a major challenge, as the history of bourgeois medicine is fraught with contradictions between healing and harming.[38] Medicine has been and continues to be a weapon in the arsenal of imperialist power, as can be seen in the evacuation of Indigenous women from their traditional territories to give birth and the importing of Western medicine as a measure of social control in neo-colonies across the globe.[39]

But speaking out is not enough; class exploitation and national oppression are the root of health inequities under capitalism, and only by addressing exploitative social relations can we hope to make a significant contribution towards health for all. The next step towards liberatory health practices is to start to tackle the exploitative and inequitable social relations in health care, and to challenge biomedical frameworks of health and disease that perpetuate a narrow and individualistic interpretation of health care. We can take the lead from numerous examples of health care by and for the people. There are inspiring examples of communities taking charge of their health care, such as Barrio Adentro in Venezuela and the Community-Based Health Programs in the Philippines. These examples illustrate how health care can and must be democratically controlled by exploited and oppressed communities for it to be truly responsive to the needs of the people. For instance, the Bolivarian Misión Barrio Adentro not only provides acute medical care, but also vital food sharing programs, social gatherings, fitness classes, and a myriad of ways for people to participate actively in their own health care and that of their entire community.[40]

Che Guevara, who was trained as a medical doctor, once said, "Medicine should only intervene in cases of extreme urgency,

to perform surgery or something else which lies outside the skills of the people of the new society we are creating."[41] We must start to actively challenge the bourgeois domination of health knowledge. The bulk of what we do in health care, particularly in midwifery and in preventative health, could and should be provided by lay community health workers chosen by community members themselves, and within a social and structural framework of health and disease. Evidence shows that many aspects of health, particularly maternal-youth-child health, are extremely amenable to being controlled directly by the community and run by lay practitioners. All revolutionary movements have incorporated popular health projects into the core of their work,[42] and we have much to learn from their examples. An important goal for progressive health workers is the formation of sustainable and autonomous community-based health centers. Democratically-controlled health clinics run by community health workers, with health care professionals such as doctors or midwives acting in a consultative role, would be a leap forwards in shifting exploitative social relations to relations of reciprocal collaboration and breaking the stranglehold of bourgeois professionalism. Having medical staff be hired (and fired) by community members and paid on an equitable salary holds physicians, midwives, and other professionals accountable to the communities they purport to serve and removes the motive to over-medicalize for financial gain.

I work with the Alliance for Peoples' Health, an organization of progressive health care workers and community health organizers, who have been attempting to put elements of these models into practice.[43] Our popular health work focuses on generating new knowledge of health and disease from a working class perspective with solid grounding in the social determinants of health. We aim to challenge a limited biomedical understanding of the most common health issues facing our communities, from mental health to chronic diseases such as diabetes; we seek to weave preventative and curative health together, and break from the bourgeois control of the knowledge and practice of health and healing.[44] Oppressed and exploited people often know that their health issues have social, as well as biological, roots: that diabetes is a disease deeply connected to colonialism,[45] and that many mental health issues are underscored and exacerbated by capitalism. Grouping members of our communities together for collective health analysis and problem solving, as well as sharing practical tips, tools, and mutual support, is a step towards healing. Health

is an incredibly powerful organizing tool, and community health workers are natural community organizers.

At the Strathcona Midwifery Collective, our work towards creating a community-based health care centre openly acknowledges exploitative social relations and challenges the grip of bio-medicine on the provision of maternity care. A community board of directors owns the practice and midwives do their best to incorporate knowledge on the structural and social determinants of health into our care in concrete ways – as advocates and as midwives working in partnership with women. As such, we have high home birth rates and many women decline routine care. The biggest improvement we could make to midwifery would be to have families and communities re-design care. There is little good evidence to support the model we use, according to which health care professionals see women very frequently to screen for complications such as hypertension and diabetes.[46] It would be incredible to have women themselves run centres focused on building social networks of mutual aid, and have the bulk of prenatal care done by community health workers.

Solidarity with Liberation Movements

It is impossible to have liberatory health practices without liberation movements[47] for "it takes a collective movement, an uprising, and a fresh process to help us find the courage to face the system whose roar we no longer hear."[48] The greatest achievements in health have their origins in political struggle and economic re-distribution,[49] including workplace rights and safety, environmental regulations, public sanitation, significant improvements in housing, the social safety net, and guaranteed income (welfare/EI).[50] On the flip side, we know that being working class, being exploited, and are being oppressed bad for our health.[51] True public health solutions lie in supporting working class struggles for social and economic transformation[52] and struggles for national liberation from (neo) colonialism.[53] The Registered Midwives who actively campaigned to repeal the Interim Federal Health Cuts and the physicians campaigning to have welfare recipients receive the maximum available food allowance from welfare are inspiring examples of health care professionals taking action for equity and justice.[54] But we must extend this solidarity outside of clinical confines.

Liberatory health practices are grounded in movements for social and economic transformation.[55] Arable land, nutritious

food, and economic justice are antidotes to disease.[56] It's time for progressive health workers to take a public political stand to defend the gains of revolutionary movements, to openly support the Maoist/Adivasi armed revolutionary forces in India, the Zapatistas, the National Democratic Front of the Philippines, and the Bolivarian revolution.[57] In 2010, when 43 community health care workers were arrested by the Armed Forces of the Philippines and illegally detained for 10 months on suspicion of being armed combatants, international pressure, including solidarity efforts by Canadian health care workers and supporters, contributed to their release.[58] It is critical now more than ever to defend the gains of the Bolivarian revolution and the successes of the Bolivarian Misións, such as Barrio Adentro. Publicizing health care professionals' support for genuine liberation struggles through online and print media, open letters to consulates and government officials, public education campaigns, and rallies sways public opinion and helps ensure the safety and liberty of our comrades in the movement. When called upon to share our skills and access to material and economic resources, we must take action and respond. Closer to home, we well-remunerated health care workers and professionals have the means to provide substantial financial support through direct cash donations to struggles such as the Mi'kmaq Warriors and the Unist'ot'en Camp, who are defending traditional territories and, through their efforts, ultimately defending human health and this planet we share from the nefarious encroachment of environmental and cultural destruction. If called upon to provide medical and technical aid, we should and must respond.

Each step towards realizing liberatory health practices is a collective step realized by my political comrades working in health projects across the globe, my fellow health workers at the Alliance for Peoples' Health and the Strathcona Midwifery Collective, and the marginalized, oppressed, and exploited families and communities we work with. Creating spaces for collective re-learning, as well as a dreaming of new liberatory models of health education and community-based practice, requires our concerted effort. I believe it is time to form a nationwide organization of revolutionary health workers and start pooling our collective knowledge towards a revolutionary model of health care against the one institutionalized and enforced within the settler capitalist Canadian state.★

Notes

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13. Ibid.

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