Uncomfortable Care

Feeling through Ways of 'Being With' as a Doula-Ethnographer

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Abstract When doing research at the beginning and end of life, ethnographers often feel the urge to engage in the care of the people they are studying. In this paper, I reflect on my attempts to provide care as a volunteer doula, a non-medical birth support person, while conducting ethnographic fieldwork on childbirth in two midwifery clinics in Bali, Indonesia. Becoming a doula-ethnographer meant going beyond silent observation – what might be called 'being there' – to 'be with' women in labour. In this article, I explore this mode of being with, and show how it centres on witnessing, letting things happen, and not going in with an agenda. As my experiences show, caring in the mode of being with was also often uncomfortable and riddled with complex ethical considerations. In this paper, I stay with and reflect on this discomfort to show how the affective negotiations of my attempts to care for women in labour led me to crucial ethnographic insights.

Keywords childbirth – ethnography – doula – care – affect

Introduction

About a week after starting my doctoral research at a private maternity clinic in Bali, Indonesia, the midwives invited me to attend a birth. I was both excited and hesitant to accept their invitation because I was not sure what my role would be as an ethnographer during such an intimate and existential moment as childbirth. After receiving the birthing woman and her husband's approval, I decided to stand in the corner of the room and try not to get in anyone's way. As the daughter of a midwife, I had been present at a birth before. Despite this familiarity, the intensity of what I witnessed overwhelmed me. I was in awe of the raw and real strength of the woman in labour, and a tear rolled down my cheek when I heard the baby let out its first cry. However, my unclear position made me feel uncomfortable – taking notes in the corner felt disconnected and strange during such an emotional and intense event.

Over the course of my fieldwork, I gradually moved out of the corner of the birthing room. After completing a course at a second midwifery clinic on the island, I became more involved in the care of women during labour by volunteering as a doula, a non-medical birth support person. In this paper, I reflect on this journey and my experiences of combining research with the provision of care as what I call a doula-ethnographer. Engaging actively in the care of interlocutors is quite a common practice in medical anthropology. Examples are Angela Garcia (2010), who worked the graveyard shift as a detoxification attendant at the heroin detoxification clinic she was researching in New Mexico, and Lisa Stevenson (2014), who volunteered at a suicide hotline when studying youth suicide in Inuit communities in the Canadian Arctic. Furthermore, I am not the first anthropologist to train as a doula in order to gain access to and do research on childbirth (Ford 2020; Schiavenato 2020; Strong 2020). However, such a double role requires extensive reflection and ethical consideration. What challenges might we face as caring ethnographers? What does it mean to engage in care during research in such settings and, in particular, at the beginning of life?

Approaching those we study with care has been described as a key feminist research value (Ellingson 1998; Reinharz 1993). However, Rachelle Chadwick (2021: 557) argues that the values of empathy and care can gloss over the

hierarchies and power imbalances between researchers and interlocutors, thereby flattening and reinforcing differences between women (Chadwick 2021: 559, see also Hemmings 2012: 152). Drawing on her experiences conducting research on childbirth in South Africa, she contrasts care as a research method with what she calls "staying with discomfort" (Chadwick 2021: 559). As she argues, "acknowledging, and staying with, messy ambivalences, sticky discomforts, falterings, disconnections, epistemic uncertainty and the intense feelings often evoked in/through research interactions is critical to efforts to develop ethical and accountable feminist research" (Chadwick 2021: 559). I agree with the need to stay with discomfort, and in this article I do not shy away from the stickiness, messiness, and ambivalence of research – both in the role of a silent observer and as a doula-ethnographer. However, I also wish to challenge Chadwick's opposition between care and empathy on the one hand, and discomfort and ambivalence on the other. Instead, I argue, that engaging in care is often in and of itself messy, and attempts to care do not necessarily mean that interactions become smooth and devoid of discomfort or awkwardness.

In this paper, I show how doula work can provide an avenue for going beyond mere observation – or 'being there' – towards 'being with', a mode of engagement that is more in line with the aims of ethnography. As my experiences reveal, though, the ways in which I tried to be with as a doula-ethnographer were not straightforward nor easy. In order to highlight its inherent stickiness, to foreground the discomfort associated with it, and to point to the power asymmetries that underlie it, I refer to my care as a doula-ethnographer as uncomfortable care. Similar to Emily Yates-Doerr's concept of "antihero care" (2020), my focus on uncomfortable care aims to embrace the partiality and vulnerability of ethnographic fieldwork. Instead of aiming for a complete and holistic picture of the field, which is never truly obtainable, Yates-Doerr (2020: 241) argues that we should instead depart from a notion of interdependence and care, thereby foregrounding the importance of making good connections. As I will show, engaging in uncomfortable care as doula-ethnographer led to key research insights not because it gave me better research access or meant that I was present in more situations (more 'theres'). Rather, it was through the intimate and trusting relationships I built with the people I accompanied and my affective engagements with them that my research (and I myself as a person) benefited the most.

Context and Positionality

I travelled to Bali to study two birthing clinics, each founded by an American midwife and staffed by Indonesian midwives. The founders of these clinics were strongly influenced by the natural childbirth movement, which emerged in Europe and North America in the 1960s and 1970s as a movement against the medicalisation of birth (Daviss 2001: 70). Based on the idea that a woman's body is made for childbirth, proponents of this movement argued that the birthing process is not eased through but rather disrupted by medical interventions. Proponents of natural birth criticize the language of risk that is central to modern obstetrics, and they argue that birth should not be seen as an illness to be cured with technology but rather as a natural process that is interrupted when it is moved to the hospital (Davis Floyd 1994). Therefore, they advocate for home birth or birth in non-medical clinics and promote the idea of natural pain relief using water, breathing techniques, movement, and massage. Drawing on a range of literature on natural birth and the careful negotiation and construction it requires (Annandale 1988; MacDonald 2006, 2007; Pasveer & Akrich 2001; Skeide 2020), the main focus of my research was to understand how these clinics drew on the natural birth movement in discourse and practice within the Indonesian context.

On the one hand, the discourse of natural childbirth posits birth in countries such as Indonesia as more "authentic", "traditional", and "close to nature" (MacDonald 2007: 56); on the other hand, rising C-section rates and the general medicalisation and hospitalisation of healthcare in these countries are seen as threats to women's autonomy and their self-determination regarding birth experiences. This means that such countries are attractive places for natural birthing clinics, which both aim to address the medi-

calisation of birth and draw on the 'naturalness' associated with these places. Bali is a prime example of this – an island that has long held a position in the Western imagination as "the 'enchanted isle', 'the last paradise', one of the world's great romantic dreams" (VICKERS 1989: 1). In recent decades, Bali has become a mecca for all things wellness, including yoga, alternative healing therapies, and clean eating. A well-established community of foreigners lives on the island, many of whom work in the wellness sector themselves, amongst whom the clinics were a popular place for perinatal care. There were also Indonesian women who travelled from other islands to give birth in these clinics and the occasional foreigner who travelled from abroad to Bali specifically to give birth.

The clinics biggest client group and main focus, however, were Indonesian women who lived in the area of the clinics, and were either Balinese or migrants from other Indonesian islands. With this main demographic of local working-class people in mind, the services at the clinics are made affordable through the support of aid organisations and local charities. At the smaller of the two clinics, women pay a small fee for services comparable to the prices at government clinics, while at the larger clinic, Indonesian women can access services on a pay-as-you-can basis. Foreigners who come to this clinic, however, are asked to pay around 1000 US dollars for their births, which is framed as a donation in order to keep the clinic running and free for locals.[1]

Before I embarked on my research, I learnt Indonesian for six months. By the time I was in the field, I was able to both conduct interviews and support women during birth in Indonesian. My research spanned several visits to Bali and Java for a total of nine months. Over this period, I attended fourteen births, the first six as an observer and the following eight as a volunteer doula. Apart from one woman from Switzerland and one woman from the US, all the women I saw give birth were Indonesian. These women were either from working-class or lower middle-class backgrounds, and while the low prices often played a role in their considerations for choosing the clinics, many of them were motivated by a wish to give birth vaginally and without medical interventions. Besides the midwives and the couple, I was not the only person present during these births. Almost all couples brought along several family members and sometimes friends, and there were often quite a few people walking in and out of the birthing room. When chatting with family members, I was often told that, in the village, it was an usual practice for the whole community to wait outside a woman's house when she was in labour. In this sense, labour and birth are deeply social events in Indonesia.

During the first few births I observed, I wondered whether my status as a young white woman meant that I was invited into the birthing room more easily and that my presence was less questioned. As the clinics had previously hosted foreign midwifery students observing births as part of an internship abroad, I seemed to slot rather seamlessly into that role. A common question I was asked was when I would finish my studies as a midwife. Although I made an effort of repeating that I was doing a PhD in Cultural Anthropology, not being a midwifery student made my role rather ambiguous. I did not fit into any of the existing roles in the clinic, as is often the case with ethnography in clinics and hospitals (WIND 2008).

My positionality as a young white woman also deserves further reflection, as the broader power imbalances and hierarchies that underlie my research contributed to my discomfort when observing births. I am a Dutch citizen (although I live in Switzerland and work for a Swiss university, which came with its own connotations of wealth and privilege) and was conducting research in a former Dutch colony. Making notes and attempting to remain removed from the interactions unfolding in front of me seemed to contribute to my status as supposedly objective outsider, a historically problematic status when it comes to colonialism and anthropology's role therein. In this way, I felt that my research, and, in particular, the way in which I stood in the corner of the birthing room taking notes, could be seen through the lens of ongoing asymmetrical knowledge production between former coloniser and colony.

I thus spent the first part of my research standing awkwardly in the corner, unsure of my role and aware of my (white) privilege, repeating that I was an anthropologist to people who were too busy to care, all the while wondering how to un-

derstand the bodily and affective processes of care that were unfolding in front of me.

Beyond Being There

In the introduction to this special issue, Julia Rehsmann & Veronika Siegl (2022) draw on a rich array of literature to illustrate the importance of studying processes of giving birth and dying. As their discussion shows, studying the beginning and end of life not only provides crucial insights into the very fundamentals of what it means to be human, but also raises many methodological questions, in particular regarding how to approach such experiences ethnographically. As Mira Menzfeld (this issue) argues in her contribution, understanding such non-delegable experiences as birthing and dying from an emic perspective is impossible. Researchers are unlikely to be dying themselves, and even if they have given birth, the acutely bodily experience of being in labour is different for everyone. Further, the beginning and end of life concern liminal and existential phases that often include intense pain and altered perception (Rehsmann & Siegl, this issue). This makes participant observation during such processes difficult, as busy medical staff often does not have time to interact, and the people experiencing labour and birth or dying are often unable to do so. The role of the ethnographer becomes unclear and potentially cumbersome for the research participants, as I experienced during the first births I observed.

Simply observing silently and taking notes when your research participants are going through intense pain and emotions can thus feel inappropriate and uncomfortable. In her book of personal essays, *The Vulnerable Observer* (1996), Ruth Behar constructs perhaps one of the most beautifully written critiques of observation without emotional engagement. As she asserts, "nothing is stranger than the business of humans observing other humans in order to write about them" (Behar 1996: 5). For her, this strangeness is mainly due to the fact that researchers are expected to conceal their own emotions when observing. This seems impossible to Behar, as emotions are key to anthropology. For her, anthropology is about

> loss, mourning, the longing for memory, the desire to enter into the world around you and having no idea how to do it, the fear of observing too coldly or too distractedly or too raggedly, the rage of cowardice, [...] a sense of utter uselessness of writing anything and yet the burning desire to write something (Behar 1996: 3)

This poignant description places the affective negotiations of ethnography and writing front and centre, revealing that pure observation perpetuates the myth that we can filter out our own emotions while doing research.

Behar's critique of only 'being there' highlights the need to develop an affective methodology, something that has long been key to a feminist approach to ethnography (Thajib et al. 2019: 15; Stoller 2019). For some authors, emotions play a role mainly in creating rapport and negotiating different situations during fieldwork (Bergman Blix & Wettergren 2015; Caroll 2012; Dickson-Swift et al. 2009; Holmes 2010). Other authors push further and argue that affects should play a central role not only in our methodological approach but also in our analysis. Similar to Chadwick, Julia Rehsmann (2019: 198) shows how taking discomfort seriously, as a starting point for emotional reflexivity, can greatly enrich the ethnographic endeavour of understanding the human condition. For sensitive topics and intimate, emotionally-charged situations, such as birth and death, an affective methodology is even more crucial (Dickson-Swift et al. 2009; Chadwick 2021; Oakley 1981; Sampson et al. 2008). Affect is often elusive and difficult to see as it moves between (human and non-human) bodies, is attached to spaces and objects, and is subjectively felt (Knudsen & Stage 2015: 5). This links back to the need to go beyond 'being there' towards bodily engagement. One way to engage bodily could be to take an active role in caring for people who are giving birth or dying.

The experiences of other ethnographers who study the beginning and end of life show how it can also become unethical *not* to engage. During her fieldwork in a public maternity ward in Tanzania, Adrienne Strong (2020) witnessed many infant and maternal deaths, thereby conducting fieldwork at both the beginning and end of life simultaneously. While she had not intended to

deliver babies, the dire situation of scarcity she encountered at the hospital led her to state that "simply scribbling away in my little black notebook had become untenable" (STRONG 2020: 18). After receiving a short training, she attended women who would otherwise have given birth alone, often on the floor of the delivery room or in the corridor of the ward because there were not enough beds (STRONG 2020: 18). She stresses, "to not engage in the ways in which I was invited to would have been a form of ethical violation when I was there and capable of doing so" (STRONG 2020: 19). STRONG's experiences show the strong urge ethnographers might feel to contribute, in some way, to the care of interlocutors in pain. However, Strong's experiences of fieldwork are very different to mine. The clinics in Bali were not places of scarcity and abandonment, and no babies or mothers died in their birthing rooms. As for me, I did not deliver any babies. Instead, half-way through my fieldwork, I trained as a doula – a non-medical birth support person.

Becoming a Doula

After several months of research and attending several births as an observer in the smaller of the two clinics, I decided to extend my research to a second, larger natural birth clinic on the island. The midwife who started this clinic knew that I had observed births and said that I could also be present at births in her clinic. However, she wanted me to volunteer as a doula rather than to stand in the corner taking notes. She suggested I join the yearly doula retreat that she organised together with a well-known American doula. I took her up on this suggestion because I was eager to step out of the corner of the birthing room. I was aware that that volunteering as a doula, as a way to conduct research on birth, would come with its own ethical considerations. At the same time, I thought that if I was there during births, I might as well try to contribute something through my presence.

The doula retreat was two weeks and took place in Bali. It was attended by women from all over the world – including the US, Australia, Germany, France, and South Africa. In addition, three Indonesian women participated with a scholarship offered by the clinic. This scholarship was the only way in which it was feasible for these Indonesian women to join the course, as attendance cost upwards of 2000 dollars (including food and lodgings). The women who joined the course were mostly from white, middle-class backgrounds. While some had given birth several times and attended dozens of births, others did not have children of their own and had never been present at a birth. What was striking was that almost all of the women were practicing a profession that they wanted to combine with being doula, such as teaching (prenatal) yoga, massage therapy, or practicing traditional Chinese medicine. Doula work was thus situated within a larger economy of wellness and alternative medicine and was seen by most women as an additional skill that they wanted to add to their repertoire. In and of itself, this course was a fascinating space for understanding the role that Bali plays within the global natural childbirth movement, of which doulas are often a part. These women saw Bali as both a centre for wellness and alternative medicine and a place that is implicitly associated with 'the natural', and therefore as the ideal place to learn how to be a doula.

The word "doula" comes from ancient Greek and means "a woman who serves". The term was first used in its current meaning in 1969 by the American anthropologist Dana Raphael – a protégée of Margaret Mead. A doula is someone who provides continuous physical, emotional, and informational support to a woman and her partner before, during, and just after birth. The fact that doulas have no medical responsibility, nor familial relationship to the birthing woman, is crucial to their role, as this means that they can provide constant support while maintaining some distance and without having to make difficult decisions. Doulas have become quite popular in the United States, where they work in both hospital and home birth settings, and their popularity in Europe is now steadily increasing (FORD 2020; MARXER 2022; NIEUWSUUR 2020). In Indonesia, there are only a handful of women practicing under this term, most of them located in Jakarta.[2] However, traditional birth attendants, or *dukun bayi*, have been providing similar support before and after birth for centuries, and have occasionally fulfilled a similar role during birth

alongside a government midwife, or *bidan* (Ambaretnani 2012; Newland 2002; Niehof 2014).

A broad range of research has been conducted on the benefits of doulas during birth, which shows that, amongst other outcomes, labours attended by doulas are generally shorter and with fewer complications (Bohren et al. 2017; Gruber et al. 2013; Kozhimannil et al. 2016). However, in the media, doulas have sometimes been pitted against midwives, and the necessity of their role has been questioned (Fitzpatrick 2020; Hofman et al. 2020; Nieuwsuur 2020). Furthermore, there has been discussion about the professionalisation of doulas and whether they should be regulated (Meyerson 2019). The doulas I know mostly prefer not to be regulated as they feel this gives them more freedom to practice as they wish. However, this raises the question of what the role of the doula entails and where the boundaries of their scope of practice and responsibilities lie. In the doula course, we practiced different massage techniques, learnt how to help women move into different positions that improve foetal positioning, and had sessions on birth trauma, breastfeeding, and belly binding. However, what doulas actually do during birth varies and often they do not do very much at all.

Instead, the support a doula provides is often about being a constant and reassuring presence. Indeed, there is a common joke amongst doulas that they should call themselves 'belas', as their role is more about 'be'-ing (with) rather than 'do'-ing. You cannot give birth for someone, and while 'natural' pain relief, such as massage and water, can be beneficial for certain women in labour, it is not possible to take pain away completely without medical interventions. Furthermore, some women do not like to be touched at all, and longer verbal exchanges are often not possible due to the hormonally induced altered state women enter during labour. So in most cases, being a doula simply means 'being with' women and their partners throughout the journey of birth.

In this sense, and as I will show, it does not differ much from accompanying people as an ethnographer. For me, however, becoming a doula did mean taking on a certain responsibility for the women and partners who allowed me to accompany them. Once I had committed to being someone's doula, I felt a responsibility to contribute something to the woman's birth experience through my presence. This feeling of responsibility sometimes came into conflict with my role as a researcher. Before I get into those tensions, however, I will first elaborate on the idea of being with, a mode of care often employed in both midwifery and palliative care.

Ways of Being With

The idea of being with appears in many popular and academic writings on midwifery and is often seen as a characteristic of midwifery care that distinguishes it from obstetric care (Bradfield et al. 2018; Hunter 2002; Dickson 1996; Kaufman 1993). Indeed, the very term 'midwife' means 'with woman', a fact often mentioned when describing the woman-led approach that is typical of midwifery (Hunter 2002: 651). Annekatrin Skeide argues that the mode of being with is enacted in midwifery through witnessing, which she defines as "embodied interrelatedness in a particular environment" (2018: 192). Skeide (2018: 195) invokes the stereotype of the knitting midwife to illustrate how the midwife employs witnessing as active-passive care: she seems to just sit and knit without doing much, but actually, she is watching, listening, and feeling. The passive-active care provided by the knitting midwife enables women to trust their own bodies during birth, as the fact that she sits silently and observes reassures women that what they are going through is normal and does not require action (Skeide 2018).

This is something I also often saw in Bali. The midwives remained quite passive during early labour, often not staying in the birthing room and only checking in every hour or so. As Sandra, the founder of one of the two clinics, described it: "For me, the best birth means a natural – I don't know if 'untouched' is a better word – birth. You know, just quietly observing. Letting it happen." Sandra describes the key to midwifery care in these clinics as a *not doing* rather than a doing. The care of the midwife becomes implicated in the construction of a 'natural' birth.[3] However, quietly observing and letting birth happen was only one aspect of care in these in clinics – both midwives and birthing women repeatedly stressed that care "from the heart" (*dengan hati*)

was also key to creating a natural birth. Caring for women from the heart required emotional labour from the midwives, as it meant being warm and loving but also attending to the birthing women's emotions. Being with women as a midwife in these clinics thus had both a passive (letting birth happen) and active (emotional labour) element.

When it comes to care at the end of life, the importance of witnessing people's suffering and being with people who are dying is often described as the key to good palliative care (Driessen et al. 2021). As Annelieke Driessen et al. found during research with palliative carers in the UK, being with is established not by saying or doing something, but "through not saying something or entering the conversation with an agenda, and not doing something" (Driessen et al. 2021: 17). In his contribution to this issue, Marcos Andrade Neves (2022) gives a beautiful description of how being with someone who is dying might look like in practice. Therein, the intimate bond he has with his dying friend and interlocutor Margot is enacted through his mode of being with as he holds her hand during her last breaths. In Lisa Stevenson's work on the suicide epidemic amongst Inuit youth, her understanding of care evokes very similar notions as what Driessen et al. and Andrade Neves refer to as being with. Writing against Annemarie Mol and her colleagues' notion of care as an always active doing – what they call 'tinkering' (Mol et al. 2010) – Stevenson argues that care can also consist of waiting and "allowing situations – and people's lives – to unfold" (Stevenson 2014: 177).

Witnessing, letting things happen, allowing situations to unfold, and not going in with an agenda thus constitute key characteristics of being with. This mode of care seems to be particularly common to care at the beginning and end of life, perhaps because of the existential nature and singularity of these experiences (Menzfeld, this issue; Rehsmann & Siegl, this issue). Yet, while medical professionals, like midwives, bear a significant medical responsibility and therefore have to put down their proverbial knitting and act when necessary, doulas are not allowed or trained to provide medical care or make any medical decisions. For doulas, being with is the main gift they have to offer. For this reason, it is even more important that doulas do not have an agenda and are not guided by their own expectations of a good birth. In the doula course, we were repeatedly told that we should not speak for the birthing person but rather learn how to amplify their voice. Therein, witnessing in the sense of listening to the others' hopes and fears and acknowledging them without jumping into action is essential to doula care.

The idea of witnessing also connects doula work with ethnography. Before leaving for her ethnographic fieldwork in Tanzania, Strong (2020) had also trained as a doula. As she writes, her main goal in training as a doula was to serve as a witness to the woman's labour, whether it was a good or a bad experience. She argues that "witnessing is often the most valuable tool a doula has to offer and is not terribly different from the similar gift an adept ethnographer can provide through interviews and presence" (Strong 2020: 18). In return for being welcomed into their interlocutors' lives, good ethnographers can give their interlocutors the 'gift' of witnessing: they make participation in their research worthwhile by listening to interlocutors' stories with empathy and trying to truly understand their experiences. In this sense, being with is both a mode of caring and a mode of exploration and engagement that ethnographers employ in the field.

In my experience, I found that the role of the doula both complements and extends the role of the ethnographer. While both are interested in accompanying someone on their journey and witnessing their experience, being a doula extends the intention of the feminist ethnographer to care for and about the people she researches and makes that care more tangible and physical. Whereas the hands of the ethnographer are mostly scribbling notes, the hands of the doula reach out to squeeze hands, rest on shoulders, and press on lower backs. As a doula, I was almost constantly in either physical contact with birthing women or maintaining eye contact with them throughout the many hours of labour (see also Schiavenato 2020). This physicality and bodily engagement, the active element of the passive-active care of being with, made me aware of different things than when I was standing in the corner taking notes. However, the responsibility I felt to

contribute something to the birthing experience of the women I accompanied also led to challenging situations, as I will now show.

A Balancing Act

I met Selena, a 37-year-old woman from the French speaking part of Switzerland, during a prenatal yoga class at one of the two clinics. She explained that she had come to Bali to give birth because of her complicated relationship with the baby's father, who did not want to be involved in the child's life. To escape the situation, she had decided to fly to Bali – which she called "the land of my heart" – to give birth. She had heard about the clinic during a previous trip to the island and dreamt of having a natural birth. Selena was very happy when I offered to volunteer as a doula during her labour. Though her friend from Switzerland, Emilie, would also be with her, she wanted all the support she could get.

When Selena's labour started, one of the first things she asked me was "am I almost there?" Unfortunately, her cervix was only 1 cm dilated, with still 9 cm to go. After twelve hours of labour with no progress, Selena requested to go to hospital so she could get an epidural for the pain. Emilie and I accompanied Selena and, together with two clinic midwives who were there to facilitate the transfer, we all piled into the small clinic ambulance. Upon arrival at the hospital, the clinic midwives left and the hospital midwives took over. Selena told me later that she found the hospital midwives brisk and unfriendly, and that the vaginal check one of them conducted was extremely painful. The midwife conducting the check refused to speak directly to Selena and instead told me in Indonesian that Selena's cervical dilation was still only 2 cm.[4]

After about an hour, when Emilie had shortly left the room to get some food, an obstetrician finally arrived. Despite her perfect English, she too turned her attention to me and explained that it was against their protocol to give an epidural before 5 cm dilation. I asked what other options there were for pain management and the doctor just shrugged and said, "All we can do is a C-section". I looked over to Selena, who looked up at me with pain and despair in her eyes. When I looked back at the doctor, I realised that they both expected me to decide what to do. However, as both a doula and an ethnographer, I was neither willing nor able to make such a decision for Selena. Out of sheer desperation, the only thing I could think of was to leave the room. I excused myself to go to the toilet as I felt the tears welling up inside me. After quickly pulling myself together, I returned to the delivery room, where, fortunately, the doctor had decided to do another vaginal exam and found that Selena's cervical dilation had progressed to 6 cm.[5] With an obvious sigh of relief, Selena exclaimed that with a dilation of 6 cm, she could make it to 10 cm without pain medication. A little over three hours later, she pushed out a healthy baby girl.

Supporting women through such a life-changing yet uncertain and volatile process as a doula, I was taught to not let my own emotions or expectations play a role in the care I provided. Yet, what I experienced moved me emotionally. Trying to care for Selena and to advocate for her care with the hospital midwives and obstetrician was so frustrating and overwhelming that I could no longer hold back my tears – although I made sure to hide them from Selena, who needed me to be a calm and reassuring presence. When I think about how Selena went from utter desperation to being convinced once again that she would be able to give birth without pain medication, it still fills me with awe and admiration. Furthermore, my own frustration in trying to care for Selena helped me to understand better how much perseverance it must have taken for her to keep going. Though I could never truly understand how Selena must have felt, I was better able to grasp the complex exchange between Selena and the doctor because I was a part of it.

My own feelings of frustration and despair thus made me aware of the way women can be treated in the hospital when they are transferred from one of the midwifery clinics. As women in Indonesia told me repeatedly, care in the hospital was a lot less affective, responsive, and personalised than in the midwifery clinics I studied. Based on this experience, I had to agree with them. Feeling my way through the care in the hospital also helped me to understand how much the births in the clinics are overshadowed by a potential transfer. A transfer breaks the midwives' moral promise to care for women and negates

the natural childbirth movement's ideal that all women can and should give birth without medical intervention. For this reason, birthing women, birth partners, and midwives worked hard to avoid a transfer. I referred to this as co-anticipative care work in my dissertation to illustrate the affective, future oriented, and collaborative nature of such negotiations (Fitzpatrick 2022).

Accompanying Selena in the hospital was by far the most challenging situation I faced as a doula-ethnographer. It illustrates how taking on the role of a doula-ethnographer can be a balancing act between passive and active care, between doing nothing and doing something, between witnessing and interfering. While in many instances I managed this balancing act successfully, in this moment it became too much for me. Being with women as a doula means being a continuous presence and not leaving a woman's side until after her child is born. Being with as an ethnographer also relies on continuity and physical presence, and I missed a crucial bit of observation during this birth when the obstetrician conducted an additional vaginal check. However, in that moment, staying within the boundaries of my role and not making or contributing to any medical decisions was more important to my mode of being with as a doula-ethnographer than physical presence. In this instance, and rather paradoxically, being with meant for me not being there at all.

Uncomfortable Care

As Chadwick (2021: 557) argued, the affects circulating in research encounters, such as feelings of frustration, desperation, and discomfort, should be understood as "the products of intertwining relational, material, embodied, discursive, intersubjective and sociomaterial dynamics". These affects are crucial for understanding, interpreting, and representing the research field, as they can turn us "on" and "off" to particular lines of thinking (Chadwick 2021: 557). As a doula-ethnographer I shared not only in the frustration and desperation when labour became complicated or took much longer than expected, but also in the joy and elation when babies finally made their appearance after hours and hours of their mother's hard work. Being present at such a crucial and intimate moment in someone's life often meant that I created strong intimate bonds with the people I accompanied during birth. Despite the relationships it facilitated, however, being with as a doula-ethnographer did not smooth over the feelings of discomfort I described at the beginning of this paper. The underlying power asymmetries did not disappear just because I was no longer simply observing but was now engaging in care. If anything, my affective engagements made it even more pertinent to reflect on the power dynamics and ethics of my relationships and interactions in the field.

Selena and I grew close during the weeks that followed her birth, and she came to visit me in Zurich after my fieldwork ended.[6] I also stayed in contact with many of the other women I supported, and I visited them in their homes across the island. My relationships with people in the field thereby changed and evolved with time, as did the ethics of these relationships. Before leaving for Bali, I obtained ethical approval for my research from the medical faculty at Udayana University (this was required for my research visa), and I printed out informed consent forms, which I had my interlocutors sign when I first asked them to be part of my research. But as my role in the field and my relationship with interlocutors evolved and changed, so did the ethical considerations of my research. This necessitated a relational approach to ethics (Ellis 2007; Halse & Honey 2005; Canella & Lincoln 2007), meaning that I had to consider repeatedly what the ethical repercussions of my attempts to provide care as an ethnographer were. Let me give some examples of how my interactions with people changed when I became a doula-ethnographer.

First of all, being a doula changed the way in which I moved through the space of clinic. I spent many more hours continuously in the clinic, walked in and out of rooms quickly and with purpose, and ate meals at the table just in front of the kitchen with the midwives and other staff. This meant that, even more than before, people assumed that I had medical knowledge and expertise, and I was associated strongly with the clinics. It was common for women and their partners to walk up to me to ask (medical) questions. On several occasions, couples asked me to second guess the midwives when they had been referred

to the hospital due to a pre-existing condition or indication that came up during pregnancy. These couples saw me as representing the values of the natural birth discourse that had attracted them to the clinic.[7] Being put in this situation by couples made me feel uncomfortable, and I always tried to deflect such questions and make sure that the couples understood that I did not have any medical expertise or authority.

Secondly, as a doula-ethnographer, I had to negotiate with many different actors and the power dynamics of these interactions were sometimes quite complex. This is illustrated by my experience supporting Cindy, a woman originally from West Papua who I met and interviewed while she waited for a prenatal check-up. When she went into labour several weeks later, she called me and asked if I could come to the clinic to support her as a doula. When I arrived, however, her mother, who was also there for support, questioned the fact that I was supporting women in labour while I had not given birth myself. She then asked to see a doctor, and when I told her there were no doctors on staff, she became angry with me and stormed out the room. While my interactions with Cindy's mother made me feel uneasy and inadequate, I stayed and supported Cindy because I thought that she wanted me there.

Such complicated and uncomfortable power dynamics are compounded during childbirth due to its existential, emotional, and intimate nature. Women who are in labour often find it difficult to talk or answer questions, and this meant that I sometimes had to assume what they wanted in order to care for them. For example, I accompanied a woman from Sumbawa named Bayu who had come to the clinic with her Australian husband because they both wanted their child to be born naturally, without medical interventions. Throughout the harder parts of her labour, however, Bayu begged me and her husband for pain medication, repeating the phrase "help me" over and over again. As I could see that she was progressing and that full dilation was imminent, I decided to gently remind her that she had chosen this clinic for a reason and that she was strong and capable of giving birth without pain medication. While Bayu later told me that she appreciated my encouraging words, as an ethnographer whose aim was to deconstruct discourses of natural birth, I felt uncomfortable reproducing and contributing to them instead.

As my experiences accompanying women like Selena, Cindy, and Bayu show, it was never possible to fully comprehend the effects that my engagements as a doula-ethnographer had, and whether I made the right decisions in my attempts at care. Due to the responsibility I felt and was perceived to have for the care of women in labour when I became a doula, I sometimes came to represent or reproduce the structures and discourses I was aiming to study. In this way, caring for women during the emotional and existential process of labour and birth was unavoidably riddled with complex ethical considerations and uncomfortable convergences. The act of care itself was thereby neither a way to smooth over unequal or awkward relations nor a way to make discomfort go away. Rather, while acknowledging and embracing the partiality and vulnerability of this mode of research, engaging in uncomfortable care helped me to better understand the complex and intricate webs of affect and care that were spun in the birthing room and beyond.

Conclusion

Being with is a mode of engagement that is central to both the way in which I cared for women as a doula and the way I related to my interlocutors as an ethnographer. Despite this commonality, I found that being with as a doula-ethnographer was often uncomfortable, difficult, and messy, and it brought up many ethical questions as my role evolved over time. This underlines that, as researchers, our engagement with ethics should not cease as soon as we have obtained ethical approval or after our informed consent forms have been signed – it should be an ongoing engagement without end. Following Chadwick (2021), part of my commitment to an ethical and accountable feminist research practice has been to acknowledge and reflect on my feelings of discomfort in the field and the power asymmetries that underlie them. Therein, the commitment to care need not be at odds with the aim of staying with discomfort and acknowledging the stickiness of unequal relationships in the field. Instead, I argue that uncomfortable care can be a way through which to create and sustain intimate

and affective relationships with people across such differences.

My experiences reveal an underlying tension when it comes to the affective dimension of being with as a doula-ethnographer. As I was taught in the doula course, I always tried to bracket my own emotions when being with women as a doula. In a paradoxical way, however, this forced me to recognise my feelings and deal with them, so as not to let them take up space in my care. Feelings, such as frustration and despair but also joy and elation, welled up inside me as I negotiated with different actors. I grappled with these emotions by writing about them in my journal and field notes and reflecting on them extensively. In the end, these reflections pointed me to the central role of affect in the natural birth movement in Indonesia, leading to key insights for my research. As I balanced active and passive care, witnessing and interfering, I was able to see how natural birth in this context relied on a balancing act from the midwives between letting birth happen and caring from the heart.

Another balancing act for me was between deconstructing and representing/reproducing the discourse I was aiming to study. There too, embodying the discourse through my engagements as a doula-ethnographer showed me how it is enacted in practice in the clinic and beyond. The bodily engagement of being with women in labour, including the sometimes uncomfortable negotiations this active-passive care required, thus became a crucial heuristic for understanding the way in which natural birth was perceived and practiced in this context.

Notes

1 During the time of my research, around four or five women gave birth in the smaller clinic on a weekly basis. At the larger clinic, there were ten or more births a week. Both clinics also attracted dozens of women a week for prenatal check-ups, and the larger of the two clinics also offered free prenatal yoga classes. It also had a general practitioner and traditional Chinese medicine practitioner on staff, who also treated (Indonesian) patients who did not come for perinatal care for free.

2 I got this information from a small group of doulas I met in Jakarta, when I visited a doula I had met at the course and stayed with her for a week.

3 I use quotation marks around the word natural here to stress that, while supposedly natural and based on the innate capabilities of women's bodies, 'natural birth' does not just happen by itself. As other ethnographers have also shown, constituting birth as natural requires rhetorical work (MacDonald 2007: 6), bodily negotiation (Skeide 2020), and technological mediation (Pasveer and Akrich 2001).

4 There was quite a mix of different languages spoken in the hospital. Selena only spoke a few words of Indonesian, while both Emilie and I were fluent enough to conduct conversations with the hospital midwives. While I communicated with Selena and Emilie in English, the midwives only spoke a little English. Emilie and Selena communicated with each other in French. Although I can understand some French, I cannot speak it.

5 Either the hospital midwife who had examined Selena earlier had been wrong about her cervical dilation, or the dilation had progressed extremely quickly in the last hour. It could also be that because Selena found the vaginal examination that the midwife had performed rather painful, she had contracted her muscles, making it difficult to examine her accurately.

6 Our socio-economic circumstances were quite similar, as we both lived in Switzerland and have stable jobs (Selena works as a special needs teacher in a school) with average incomes for Swiss standards. This and the fact that we were both foreigners in Bali surely facilitated our relationship. However, the similarities between us end there. Selena is almost ten years older than me and comes from an immigrant, working-class background. While my parents are also immigrants, they are white and middle-class. Our communication was also not always smooth, as Selena is fluent in French and Spanish (two languages I do not speak), but often had trouble expressing herself in English. This did not matter so much when it came to supporting her during birth and spending time with her and her newborn Maya, but when I tried to interview her more formally about her birth experience, I ended up asking her to talk in French and later had the recorded interview transcribed and translated.

7 While I do not know for sure, this might also be because of my appearance as a young white woman and the fact that the natural birth movement has been imported in its current form from Western Europe and the US to Indonesia – meaning that it was possible that the couples associated me implicitly with this discourse and its approach to birth because I am European and white.

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