http://somatosphere.net/2018/05/antiinstitutional-menses.html

(Anti)Institutional Menses: Our Blood, Our Business

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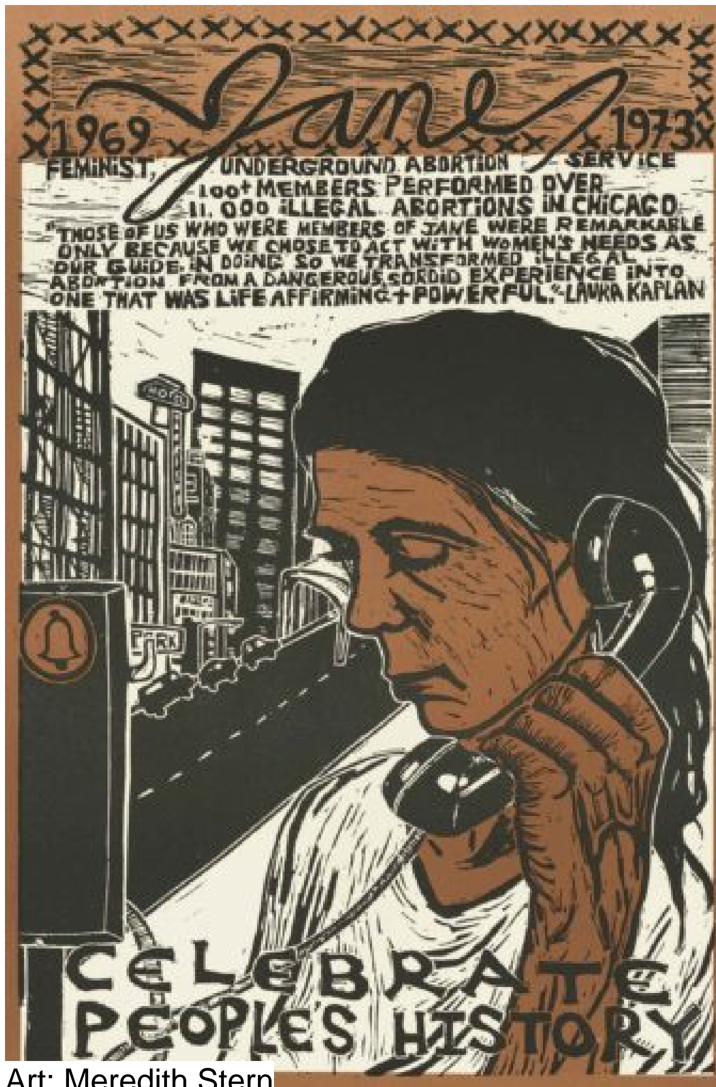
By Andrea Ford

Photo courtesy of "Jane"

Jane started us off by saying "I grew up in the US, so I could never count on having healthcare." Jane (for whom I'm using a pseudonym) is a midwife, dark hair pulled back in a low ponytail, with a warm look in her eyes. She's holding a device that looks like a weird experiment, some combustion between a school science fair project, piece of homesteading equipment, and steampunk accessory. Clear plastic aquarium tubing snakes around a mason jar fitted with a rubber stopper, accented by a syringe and a bouquet of wildflowers. Gathered around me on the living room floor are 15 other women who all provide reproductive health care in different capacities. One is part of the sex worker community. Another supports trans folks as a doula. One of the certified midwives is also a traditional *partera*. Some people work at a community health clinic that serves a lot of homeless people; others are trained in alternative healing. I introduce myself as a birth doula and anthropologist, a relative newcomer to the world of reproductive care. I'm there because I'm fascinated on intellectual, political, and personal levels by, as science historian Michelle Murphy aptly puts it, "seizing the means of reproduction;" the cover of her eponymous book depicts precisely this contraption.

It is a menstrual extractor. To operate it, a sterile cannula, or thin rigid tube, is inserted into the cervix. It is attached via flexible tubing to the mason jar's stopper, where another piece of tubing comes out and is attached to a syringe. When the syringe is pulled, suction is created, and the uterine blood will drain through the cannula into the mason jar. This can be a quick, clean way to dispose of a period, for convenience or for those who don't appreciate its feminine connotations, including trans men. It can also be a way to remove any embryonic tissue embed-ded in the uterine lining, effectively aborting a pregnancy. The challenging part of using one is the cannula insertion, where there is the slim possibility of puncturing the uterus, or contaminating it via improper sterilization. Jane instructs us with great care about sterilization and proper technique, including how to use a speculum.

This knowledge-sharing gathering evokes dual genealogies in women's menstrual care, one of empowerment, and one of abandonment. The menstrual extractor is reminiscent of the "Our Bodies, Ourselves" movements of the 1970s, of house parties where women would teach each other to use speculums and mirrors to see their own cervixes. Some would use contraptions like this to regulate their periods (Murphy 2012). The topics under discussion also recall the suc-cessful intersectional rallying of the Jane Collective, an underground abortion referral service in Chicago from 1969-1973, started by a group of University of Chicago students in Hyde Park. It provided an estimated 12,000 abortions, and disbanded after Roe v. Wade (Horwitz 2017). I chose my pseudonym for Jane in reference to it. But such stories of competence are offset by stories of coat hangers or knitting needles, the tools of the desperate, tools taken into hands that were scared and incompetent, stories of gin baths, hemorrhage, sepsis, and death. Such stories constitute a potent cultural memory that highlights the risks of non-institutional care, marking it as a last resort for those whom medical and legal systems have abandoned.



Art: Meredith Stern

The twin dangers of illegality and lack of safety haunt present-day initiatives for non-institutional reproductive care. Yet there are serious problems with access to institutional care in Trump-era precarity, which play out on financial, legal, logistical, and emotional levels. Combined with racialized histories of gynecological abuse (Roberts 1997, Ross and Sollinger 2017), and a reputation of clinical care being inadequately responsive to the variety and complexity of reproductive experiences, these conditions make "DIY" or home care appealing for some. There is a growing decentralized network of underground home abortion providers in the US, recently estimated to include about 200 people (Presser 2018). The Our Bodies, Ourselves website includes a non-sensationalizing explanation of it, and UC Berkeley's Self-Induced Abortion (SIA) legal team is actively working on re-shaping the legal environment around non-institutional menstrual care. This movement echoes the movement for home birth, which has been and continues to be challenged on grounds of both legality and safety. Non-institutional care can be dangerous on these

fronts for both those receiving it and those providing it (indeed, abortion provision is dangerous even within institutional settings).

Getting behind non-institutional care requires a different appraisal of risk than that hegemonically asserted by many biomedical professionals and policed as epistemic authority via shaming and liability law. Some risks get highlighted and exaggerated, gathering fears around them, while others get brushed aside or dismissed, perhaps escaping notice altogether. For example, scholars have written about the primacy that risk to the fetus often has over risk to the mother (Bordo 2004), the ways maternal risks to black and brown women are not counted (Morton 2014), how in birth the liability risk of not intervening is greater than that of intervention, while the opposite is true for pregnancy (Lyerly et al 2009), and how some women prioritize "empowerment, embodied knowing, and relational connection" over biomedical conceptions of risk in their reproductive care (Chadwick and Foster 2013). Because risk is such a powerful hegemonic discourse, proliferating the ways one might legitimately negotiate it is a political initiative.

The gathering with Jane hints at how uterine care might be provided outside institutional settings. We discuss medication and herbs as ways to regulate menstruation. Medication is straightforward to use and relatively easy to obtain. The drug, misoprostol (often used in conjunction with mifepristone), is commonly prescribed for stomach ulcers, and clear guidelines for usage are available online, including a World Health Organization protocol and a guide to "Self-managed Abortion, Safe and Supported" (SASS) from the decentralized, international organization Women Help Women (WHW). This is by far the most commonly used method of restoring one's period. Emmenagogue herbs can induce menstruation by softening the cervix, contracting the uterus, and/or simulating estrogen. Though herbs can seem less connotatively disturbing than menstrual extraction — in my experience of white bourgeois America, herbalism evokes images of flowery hippies and Birkenstocks, something gentle and quaint — they are powerful and bleeding and cramping can be severe. The increasing use of the internet to spread information about herbal abortions lends itself to incomplete and decontextualized information, which can be dangerous particularly when coupled with the idea that herbs are "natural" and therefore safe.

Yossy Arefi, Queen Anne's Lace.
https://food52.com/recipes/30698-queen-anne-s-lace-cognac-cocktail

Herbal uterine care doesn't align neatly with event-oriented categories such as abortion, contraception, birth, PMS, etc. Jane explains that as a teenager who "geeked out" on reproductive medical history and femme lore, as well as being a born researcher and experimenter, she learned how to use Queen Anne's Lace as a contraceptive. It is a lacy wildflower related to the carrot, a weed that grows rampant in rubbly abandoned lots across the US and therefore can be easily wild-harvested, costing no money (though Jane suggests ways to thank the plant or the earth when collecting it). The flowers and the seeds, when brewed into teas or tinctures, or even chewed and swallowed, are "nature's morning after pill." They make the uterine lining slippery, dissuading implantation of any zygotes that might be meandering out of the fallopian tubes. I wonder, is this contraception or abortion? Herbs that cause uterine contractions are also useful postpartum to expel the placenta — this is a property of juniper, for example, which is responsible for the link between gin and abortion, and which is also an important part of Navajo birthing rituals (Begay 2004). A parsley suppository softens the cervix and could bring on a delayed period or induce labor. Red raspberry leaf is used for toning the uterus in situations as varied as excessive bleeding to lack of bleeding to preparation for childbirth. Having multiple indications can also be true for pharmaceuticals, particularly when considering the flexibility with which some outcomes are coded as primary while others are "side effects" (Sanabria 2016, Masco 2015). This fluidity of purpose is more obvious with herbs, though, as they lack the authoritative framework of the medical industry, and so using herbal medicine might reinforce a conceptual fluidity

between various reproductive experiences.

I want to offer two provocations, which both rework contemporary hegemonic discourses about reproductive healthcare by expanding what is thinkable. The first provocation is about the exclusive desirability of institutional care. Adding questions of qualities and decentralized politics to questions of access proliferates legitimate models for care. Racist medical history and present racism in hospitals and clinics, classist assumptions and judgments along with financial obstacles, lack of appropriate care for trans and queer folks, and moralizing restrictions on options for female bodies all contribute to hostile institutional environments. Emotional and spiritual aspects of care, particularly around pregnancy terminations, are largely absent from institutional experiences, as is non-emergency follow-up care. Following a logic similar to that advocating for abortion and birth doulas (and even death doulas and "home death"), care that is integrated with one's community, daily life, and emotional, spiritual, and political needs offers specific and important benefits.

The second provocation is about terminology and reframing. Speaking about menstruating people and people with uteruses disaggregates things that are collapsed into one another and naturalized as a unit, breaking up the rhetorical weight of "woman," for example. This is not only in support of trans politics (not all people who menstruate/conceive/have uteruses are women), but also because not all women menstruate/conceive/have uteruses. I acknowledge that gender-neutral usage erases the particular categorical oppressions women have faced (Pollitt 2015), but there are ways in which de-reifying the category itself might loosen some of this categorical op-pression. Speaking about menstrual care and menstrual management evokes ongoingness and the quotidian nature of healthcare and reproductive embodiment, bypassing the event-hood of "abortion" and the "moment of conception," and their charged politics of fetal life and death. Blurring boundaries and proliferating ways of approaching reproductive issues is a political project that loosens hegemonic epistemologies and institutional justifications, opening up possibilities for greater self-determination on a number of fronts, including gender, sex, sexuality, motherhood, parenthood, and the lived experience of health.

Art: Bridget Nielsen

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