ON BIRTH

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Until recently in human history, birth has been exclusively the work of the work of women as they labor and bear down with their uterine muscles to push their babies from the private inner world of their wombs into the larger world of society and culture. Yet today increasing numbers of women around the world have their babies pulled through the vaginal canal with forceps or vacuum extractors, or cut from their wombs via cesarean section. The medical definition of birth is the emergence of a baby from a womb—a definition that ignores all issues of women's involvement and agency. This definition and its implications encode the challenges faced by social scientists who study childbirth.

The history of the anthropology of birth has been chronicled by Robbie Davis-Floyd and Carolyn Sargent in their introduction to the edited volume Childbirth and Authoritative Knowledge. Anthropologists have consistently shown that, although childbirth is a universal fact of human physiology, the social nature of birth and its importance for survival ensure that this biological and intensely personal process will carry a heavy cultural overlay, resulting in wide and culturally-determined variation in childbirth practices: where, how, with whom, and even when a woman gives birth are increasingly culturally determined.

Brigitte Jordan's comparative study of birthing systems in Holland, Sweden, the United States, and Mexico's Yucatan, originally published in 1978, was the first to comprehensively document the wide cultural variations in birth. Her biocultural approach utilized the cultural definition of birth, the place of birth, birth attendants, artifacts utilized to facilitate or control birth, and differences in knowledge systems about birth as foci for cross-cultural comparison.

Among these, place of birth has emerged as most salient for how birth happens. In home settings across cultures, from huts to large houses, childbirth flows according to the natural rhythms of labor and women's social routines. In early labor, women move about at will, stopping their activities during the 45 seconds or so per contraction, and continuing their activities (which may include doing chores, chatting, walking, eating, singing, dancing etc.). Such activities subside as they begin to concentrate more on the work of birthing, often aided in this labor by massage and emotional support from their labor companions, who are usually midwives. Many cultures have rich traditions about who should be present (sometimes the father, sometimes only women, sometimes the whole family and/or friends), how labor support should be provided, what rituals should be performed to invoke the help of ancestors or spirits, and what herbs and hand maneuvers may be helpful to assist a birth or stop a postpartum hemorrhage. When birth is imminent, women at home usually take upright positions, squatting, sitting, standing, or on hands and knees, often pulling on a rope or pole or on the necks or arms of their companions, and work hard to give birth, rewarded by the baby in their arms. Postpartum practices vary widely: some cultures encourage early breastfeeding, some code colustrum as harmful and feed the baby other fluids until the breastmilk comes in. Steam and herbal baths, and periods of postpartum confinement are often culturally prescribed, varying in length from a few to forty days.

Where freestanding birth centers exist, whether staffed by traditional or professional midwives, the experience of birth is resonant with the experience of birthing at home—a free flow. There are no absolute rules for how long birth should take. As long as mother's vital signs are good and the baby's heartbeat is relatively stable, trained attendants allow birth to proceed at its own pace.

Birth in the hospital is an entirely different experience. The biomedical model dominant in hospitals demands that birth follow a certain pattern, including cervical dilation of one centimeter per

hour—an arbitrary rule unsupported by science but consistent with industrial patterns of production. Ensuring the mechanical consistency of labor requires frequent manual checking of cervical dilation, which, if determined to be proceeding too slowly, will be augmented by breaking the amniotic sac and intravenous administration of the synthetic hormone pitocin (syntocinon) to speed labor. Women are often not allowed to eat or drink, and thus are routinely hydrated through intravenous lines, which also facilitate the administration of pitocin and other drugs. Electronic fetal monitoring to record the strength of the mother's contractions and the baby's heartbeat is pervasive in Western-style hospitals, in spite of the fact that its routine use does not improve most birth outcomes but does significantly raise the cesarean rate. Episiotomies to widen the vaginal outlet at the moment of birth are also common, although scientifically demonstrated to be unnecessary in 90% of births. Such routine obstetric procedures have been interpreted by Davis-Floyd as rituals that symbolically enact and display the core values of the technocracy, which center around an ethos of progress through the development and application of ever-higher technologies to every aspect of human life, including reproduction.

The growing worldwide supervaluation of Western high technologies has induced many developing countries to destroy viable indigenous birthing systems and import the Western model even when it is ill suited to the local situation. Western-style hospitals built in the Third World may lack the most basic supplies but still be stocked with high-tech equipment. Hospital staff often have little understanding of or respect for local birth traditions and values, with the result that local women often avoid such hospitals whenever possible. From Northern India to Papua New Guinea to Mexico, indigenous women echo each other's concerns about biomedical hospitals and clinics in both rural and urban areas: "They expose you," "they shave you," "they cut you," "they leave you alone and ignore you, but won't let your family come in," "they give you nothing to eat or drink," and "they yell at you and sometimes slap you if you do not do what they say." Ironically, none of the rules and procedures these women find so alarming are essential to good obstetric care; rather, they reflect the importation of the culturally insensitive technocratic model.

The transglobal imposition of this model on childbirth, sold to goverments as "modern health care" and to women as "managing risk" and "increasing safety in birth," has resulted in an explosion of technological interventions in birth unprecedented in human history, including cesarean sections. Despite the World Health Organization (WHO)'s demonstration that nowhere should cesarean rates be above 15%, cesarean rates for Taiwan and China are at 50%, for Puerto Rico at 48%, for Mexico, Chile, and Brazil at around 40%, for the US at 27.6%, for Canada and the UK, 22%. Physician convenience and economic gain, combined with deeply ingrained medical beliefs that birth is a pathological process that works best when technologically controlled, are other factors in the recent rise of cesareans. The WHO standard is met in the Netherlands, with its cesarean rate of 12%, and is reinforced by the excellence of birth outcomes in that country. This success is entirely cultural: Jordan and Raymond DeVries, among others, have found that the definition of birth as a normal physiological process in the Netherlands, in combination with Dutch cultural values on family, midwifery care, and careful attention to scientific evidence, have led to the minimal interventions in hospital birth and the high home birth rate (30%) in that country. In contrast, in most of the developed world home birth rates hover around 1%, despite its demonstrated efficacy and safety.

The massive disparity between the scientific evidence in favor of less intervention in birth and the increasing interventions of actual practice reflect widespread acceptance of the Western technocratic model of medicine as <u>the</u> model on which to base developing health care systems, the political and economic benefits to physicians and technocrats from the imposition of this model, the forces of globalization and their concurrent trends toward increasing technologization, and women's concomitant faith in this model as the safest practice for birth. Nevertheless, the hegemony of this model is heavily contested. In addition to the thousands of local birthing systems, three primary

paradigms for contemporary childbirth exist throughout the world: the technocratic, humanistic, and holistic models. The technocratic ideology of biomedicine metaphorizes the body as a machine and encourages aggressive intervention in the mechanistic proces of birth. The reform effort located in the humanistic model stresses that the birthing body is an organism influenced by stress and emotion and calls for relationship-centered care, respect for women's needs and desires, and a physiological, evidence-based approach to birth. The more radical holistic model defines the body as an energy system and stresses spiritual and intuitive approaches to birth. In dozens of countries, humanistic and holistic practitioners and consumer members of growing birth activist movements are utilizing scientific evidence and anthropological research to challenge the technocratic model of birth. They seek to combine the best of indigenous and professional knowledge systems to create healthier, safer, and more widely cost-effective systems of birth care.

Yet, from an anthropological point of view, all three paradigms are limited by their focus on the care of the individual. For example, mortality resulting from birth is widely recognized as a massive global problem. Biomedicine identifies conditions such as hemorrhage and toxemia as major causes of maternal death, and advises investment in doctors, hospitals, and rural clinics to provide prenatal care to prevent toxemia, and active intervention immediately after birth (administration of pitocin, cord traction for rapid removal of the placenta) to prevent hemorrhage. This biomedical approach makes it appear that problems inhere in individuals and should be treated on an individual basis, patient by patient, hospital by hospital. In contrast, anthropological research in countries with the highest maternal mortality rates highlights the general poor health of women, who suffer from overwork, exhaustion, anemia, malnutrition, and a variety of diseases resulting from polluted water, showing that the most important interventions required for improving women's health and for increasing safety in birth are clean water, adequate nutrition, and improved economic opportunities for women.

Further Readings and References

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