Normal birth as a cultural phenomenon - background to the proceedings

JOANNA WHITE & MARIA JOHANNA SCHOUTEN
Centre for Research in Anthropology, Instituto Universitário, Lisboa (CRIA-IUL); University of Beira Interior and CICS/University of Minho

The seminar

This document recounts what took place at the seminar "Normal Birth: Experiences from Portugal and Beyond", which was held in Lisbon on 28 February 2013. The general aim of this event was to enable those with a professional, academic or personal interest in normal birth, and childbirth practices more generally, to share and discuss experiences. The seminar included invited international guests, and while the overwhelming majority of participants were from Portugal there was also representation from the United Kingdom, Brazil, Holland, Italy, Denmark and the Czech Republic.

The title of the seminar was deliberately suggestive. The term normal birth, as we understand it, indicates birth with no medical or technological intervention or interference in the physiological process - the concept, by implication, not only relates to the moment of birth but to an outcome which can only emerge following certain approaches to pregnancy and early stages of labour. The term normal birth can also perhaps be conflated with "natural birth", in the sense that the process is physiologically unaided. However, from our experience, the term is unstable; there is not yet international consensus concerning the definition of normal birth, and the concept has been co-opted to mean different things (Davis-Floyd, 2008). The term can, for example, be used to describe normative or typical birth, in other words, what is most "normal" in a particular institutional or cultural setting. By implication this means that even caesarian birth could be considered "normal" in some contexts, which underlines the ambiguity of the term and how it can be appropriated in different settings.

A more specific objective of the seminar was to facilitate reflection upon the Portuguese situation in terms of how childbirth is defined and practiced, and to draw on other country perspectives in order to shed new light on future prospects and possibilities

for maternal health practices in Portugal. As organisers we hoped the event could act as a catalyst in relation to the many, often quite distinct, "conversations" taking place about childbirth in Portugal, thereby enabling a range of experiences and views to be shared and discussed. In addition to the invited speakers, a wide range of individuals with an interest in childbirth - mothers, obstetricians, midwives, doulas[1], anthropologists and sociologists - were all present in the audience and a number of them posed questions and contributed to the plenary debate. The Lisbon event was unique in that it provided an open platform for these quite dispersed groups.

Role of the COST Action project in the seminar

The seminar benefitted enormously from the presence of Professor Soo Downe, who is Chair of the network project: "Childbirth Cultures, Concerns and Consequences: creating a dynamic EU framework for optimal maternity care", or, what is officially known as "COST Action IS0907". The objective of this Action is to advance scientific knowledge about childbirth and maternity care drawing on the synergy of experts from 26 countries (23 of which are in Europe). Expertise within the Action ranges from midwifery to obstetrics, psychology, paediatrics, sociology, and anthropology, and members of the Action are working together to develop new analyses, systematic reviews and research related to diverse themes, such as maternity care among migrant women and the prevalence of vaginal birth amongst women who previously underwent a caesarean section.

We are both on the Portugal Management Committee of the COST Action and the fact that Lisbon was the venue for the 2013 spring meeting of the Action prompted us to organise a follow-on event which could benefit from the presence of international COST members. We tried to organise an event which would interest a wide range of people and would stimulate debate about the situation in Portugal. We were not disappointed. In some senses, by highlighting the variety of perspectives and ways of approaching childbirth, the event even provided "data" for our own continuing academic work.

Joanna is a British anthropologist based in Lisbon, who has a longstanding interest in gender, the body, beliefs and practices related to reproduction, and the culture of institutions. For many years she worked in the field of applied medical anthropology in Cambodia and Vietnam. This included studying maternal health practices amongst drug-dependent and HIV-positive pregnant women as well as long-term ethnographic fieldwork which explored traditional practices related to pregnancy and childbirth amongst ethnic minority highland communities, and interactions between these minority groups and government health services. She has given birth twice in the United Kingdom: the first time in a normal birth centre[2] within a hospital, which was amazing, the second time in a small

[1] The word doula comes from Greek, meaning "she who serves" and refers to a trained and experienced professional who provides physical, emotional and informational support to the mother before, during and/or just after birth.

[2] Midwifery units or "birth centres" are small units which are staffed and, in most cases, run by midwives. They offer a homely and comfortable, rather than a clinical environment. In the UK, an "adjacent midwifery unit" (AWA) is attached to a hospital where obstetric, neonatal and anaesthetic care are available should they be needed in the same building or on a separate building on the

hospital in the countryside which resulted in an episiotomy and was not such a pleasant experience. Her discussions with Portuguese family and friends when visiting Portugal during her pregnancies (the father of her children is Portuguese) prompted an interest in cultural notions about pain and the management of pain in labour which informed the design of her present research; she is currently a Marie Curie Fellow at the Centre for Research in Anthropology (CRIA-IUL) in Lisbon and is managing a study on cultural processes pertaining to pregnancy and childbirth in Portugal and England.

Maria is also an anthropologist and for her PhD research she lived in a remote village in Indonesia, sharing the experiences of the inhabitants and observing crucial events such as birth and death. On a more personal note, her first own childbirth experiences were in the Netherlands, where a few decades ago homebirth was the obvious option. Her move to Portugal, where she also gave birth and thus confronted the Portuguese system of maternity care, increased her interest in the anthropology of reproduction, while the areas in which she has come to specialize through her professional work - gender studies, sociology of the family, and the sociology and anthropology of health - have provided points of convergence and contextualisation in relation to this interest. The humanization and the "de-medicalization" of health care, including maternity care, are currently important topics within the Anthropology and Sociology module of the Medical course at the University of Beira Interior (UBI), which she coordinates.

Relevance of childbirth to social science and vice versa

While we both have a particular interest in the anthropology of childbirth, to date, relatively little academic work has been conducted and published in these spheres within our academic milieux of anthropology and sociology in Portugal. There is significant potential for more research in this area. Childbirth, and reproductive processes more generally, provide a rich vein of study for social scientists, through which they can build on and further existing, and even seminal, work in their particular disciplines. The study and critical examination of childbirth can, for example, illuminate the following (not exclusive) areas:

- conception and treatment of the body in society (Foucault, 1975; Bourdieu, 1977; B. Turner, 1987); embodiment (Merleau-Ponty, 1962; Laqueur, 1990; B. Turner, 1996; Shilling, 2003);
- conception and treatment of the female body (Douglas, 1966; Ortner, 1974; K.A. Martin, 1993; Davis, 1997; E. Martin, 2001; Young, 2005); gender, embodiment and identity in childbirth (K.A. Martin, 1993; Akrich and Pasveer, 2004; Lupton and Schmied, 2013);
- critical transitional events in the human life cycle (rites of passage) and the importance of ritual within broader society (Van Gennep, 1960; V. Turner, 1967);

same site. A freestanding midwifery unit (FMU) is usually where a unit is on a separate site or some distance away from a hospital without immediate obstetric, neonatal and anaesthetic care. To find out more see www.nhs.uk/conditions/pregnancy-and-baby/pages/where-can-i-give-birth.aspx#close

pregnancy and birth as ritual processes (Balin, 1988; Davis-Floyd, 1992; McCallum and dos Reis, 2005); childbirth as a liminal phase in terms of personal identity and social structures and rituals (Van Gennep, 1960; V. Turner, 1967; Cete-Arsenault, Brody and Dombeck, 2009);

- the rise of biomedical knowledge and associated institutions as forms of social and political control, including the penetration of biomedicine into the personal sphere (Foucault, 1975, 1989; Illich, 1974; Nunes, 2006; Alves, 2011); historical medicalization processes and authoritative knowledge pertaining to childbirth (Arney, 1982; Davis-Floyd and Sargant, 1997);

- the concept of "total institutions" (Goffman, 1961); hospitals as institutions with defined structures, rules and a dominant "culture" (Carapinheiro, 1993); the structural, spatial and temporal management of institutions (Zerubavel, 1979); the management of time in institutions where delivery takes place (McCallum and Dos Reis 2005; McCourt, 2009);

- hospitals as "non-places" (Augé, 1992) where people find themselves "in transit", without a sense of belonging (Prescott, 2009);

– cultural representations of risk (Beck, 1992; Adam, Beck and Van Loon, 2000); risk discourse in care and management of pregnancy and childbirth (Bryers and van Teijlingen, 2010).

Cutting across all these areas, feminist scrutiny of childbirth has brought new and fruitful insight, including fresh examination of the historical appropriation of human birth – and the work of traditional midwives – by the medical profession (Green, 2008), the "disciplining" of women´s bodies (E. Martin, 2001) and women´s agency and complex experiences as parturients (K.A. Martin 1993; Fox and Worts, 1999; Beckett, 2005; Akrich and Pasveer, 2004).

As well as childbirth providing a wealth of material for social scientists, conversely, academic analysis can further understanding of how choices and experiences related to birth and the ways in which these are perceived are shaped by a complex meshing of wider processes, systems and discourses. For those seeking to improve or even transform existing practices, such knowledge is essential. To give an example particularly pertinent to the Lisbon seminar, which is revealed within the proceedings which follow this Introduction, the contemporary option of "natural birth" in Portugal is in reality founded on a particular philosophy and approach and grounded within a specific discourse (often related to homebirth). This can be understood as a position which emerged in reaction or opposition to the dominance of biomedical and technological interventions prevailing within available maternity services and institutions for giving birth (Santos, 2012; Nunes, Roriz and Filipe, 2012). Similarly, the rejection of certain delivery positions and options by some medical professionals in Portugal as "savage" (see for example Challinor, 2012: 148) underlines the social construction of birth within the biomedical paradigm, and a prevailing discourse that a controlled birth within a medical institution is part of a civilizing process.

This is just a brief overview, but we believe that the decomposition or deconstruction of the various elements influencing and constructing beliefs, choices, ritual practices and other behaviour around childbirth provide enormous insight into culture and society. Moreover, most studies of childbirth to date have examined one country or social group, and we consider that comparative analyses as well as the exchange of experiences across borders and networks can be a fruitful enterprise, increasing awareness of cross-cultural and cross-national (even intra-national) diversity (Jordan, 1997; Christiaens, Nieuwenhuijze and De Vries, 2012) and how particular cultural values can shape the way care during pregnancy and birth is organized (Van Teylingen *et al*., 2009).

Existing scholarship examines the institutionalization of cultural categories of evaluation (Lamont and Thévenot, 2000) and the "national repertoires" available for understanding and evaluating experience (Gimlin, 2012). Such theoretical approaches offer great potential for the study of childbirth across different settings, revealing the importance of the local context in defining and appraising what are ostensibly neutral categories. Already, the study of civil society movements focused on childbirth across different countries have revealed important differences in the discourses and national "narratives" presented within campaigns to improve childbirth for women, for example (CES, 2011; Akrich, Leane, Roberts and Nunes, 2012; Nunes, Roriz and Filipe, 2012).

Varying levels of medical intervention in childbirth across European countries, with no clear correlation to outcome, have prompted questions as to how these relate to specific national health systems (Euro-Peristat, 2004), and the potential for learning from the cultural and organizational models of childbirth amongst countries which exhibit differing rates of intervention has been highlighted (Elmir, Schmied, Wilkes and Jackson, 2010). It is therefore also important to remember that social science research can equally contribute to practical and policy interventions as well as theoretical concerns.

Overview of proceedings

To open the seminar Joanna White provided a broad historical overview of the evolution of childbirth in Portugal, from the predominance of homebirth up until the 1970s to the present situation, where birth now largely takes place in hospital. Perinatal mortality rates have improved dramatically over recent decades, yet over the same period childbirth has become increasingly medicalized and the country now ranks amongst the highest in Europe in terms not only of levels of instrumentalized vaginal birth (forceps and ventouse) but the percentage of caesarians performed. Current movements are underway to promote normal birth, both amongst social activists and certain health professionals. At the time of the seminar the Ministry of Health was taking active measures to try and reduce caesarian rates.

Soo Downe then made the keynote presentation which drew on her wealth of experience of working to promote normal birth. She began with a definition of normal birth which focused on physiological transition and highlighted how an increase in the rate of medical intervention in birth is an international phenomenon which can be related to the

philosophy of caregivers; research in the UK has shown extreme variability in intervention rates between hospitals under 100 kilometres apart, which can have nothing to do with women´s physiology, for example. The wide-ranging presentation reviewed recent research on the impacts of caesarian section, including the risks it can pose to mother and baby when carried out with no medical indication. She also discussed the importance of women´s choice, the costs of various forms of delivery and intervention and the moral and ethical issues associated with this, and the proven value of trying to do things differently in close co-operation with women. The presentation ended with a screening of "Hannah´s Story", a video showing an active normal birth which took place at home with the support of midwives. Following the presentation there was a lively discussion about homebirth in Portugal and associated reporting systems, and the influence of different delivery settings on women and their newborns.

The second guest speaker was Rita Correia from the Portuguese Association for the Humanization of Childbirth (Associação Portuguesa pela Humanização do Parto; HumPar). She outlined the history of HumPar and the broader campaign for the "humanization" of birth in Portugal, as well as the logistic details of securing a homebirth in Portugal. At the end of Rita´s presentation Mary Zwart-Werkhoven, a Dutch midwife and childbirth activist resident in Portugal for over fifteen years, made a short intervention in celebration of homebirth.

Cristina Teixeira presented the findings of her recent research on the determinants of obstetric intervention which aimed to investigate the high caesarean rates in Portugal. The study identified an inter-play between country of origin, the context of hospital practice, and institutional protocols influencing the prevalence of caesarean section. A wide variety in both induction and caesarean rates was identified amongst the five hospitals studied. Of the Portuguese, "other European", African and Brazilian women included in the cohort of women studied, Brazilian women were statistically more likely to have a caesarean, which appeared to demonstrate an important relationship between the cultural views of women regarding childbirth, the obstetrician or the hospital responsible for their delivery, and birth outcome. Following the presentations by Rita Correia and Cristina Teixeira the discussion focused on the possibility of vaginal birth after caesarean (VBAC) in the Portuguese context, the role of prenatal care in changing approaches to delivery, the importance of a referral system linked to homebirth and the possibility of direct entry midwifery in Portugal[3].

Issues for reflection

A whole range of theoretical and practical perspectives, opinions, data and experiences were shared at the event. The nature of the dialogue between speakers and the audience often highlighted contrasting significance attached to childbirth amongst health professionals, activists and other members of society. Even the tensions which surfaced

[3] As opposed to the current system which requires a nursing degree and a minimum of two years of professional experience as a nurse, followed by two years of specialised training.

were, to us, positive, in that they exposed quite vividly the nature of the challenges to be overcome on the road to an optimal maternity care situation in Portugal founded on cooperation and a common vision.

Over the course of the seminar, during both the presentations and the plenary debate, a couple of issues surfaced which we feel deserve further reflection and/or action:

- Firstly the differences in medical intervention during childbirth as revealed in the data presented, not just between countries but also within the same country, depending on hospital or region, were stark. These variations evidently are not related to female physiology but to other factors, such as the social and cultural contexts, the organization of health services and the management and staff behaviour within specific institutions. The interaction between women and health staff, as well as the personal biography of individual parturients, may also help to explain the higher or lower degree of medical intervention in each case. Further qualitative and quantitative studies can enhance current understanding of these differences.

- Rates of caesarean section are often rightly taken as a "benchmark" of overall levels of medicalization, and are increasing internationally. Although necessary, advisable and even life-saving under certain conditions, recent studies reveal that caesarian section can, at the same time, pose a significant risk for the health of mother and child, particularly, according to several studies, when undertaken without medical indication. Yet current medical discourse often emphasizes risk in terms of the dangers of not intervening. In situations of no medical indication the provision of a wide range of options for childbirth is advisable and better and more complete information should be made available to women concerning these options, through a comprehensive system of antenatal care.

- The need for change in standard approaches to childbirth service provision was expressed in a number of the papers presented, as well as during the discussion. It became clear that in several countries well-intended health professionals, especially midwives, are not always given the opportunity to provide the more holistic or woman-focused support they would like. (It should, however, be noted that no obstetricians present at the seminar spoke up so we cannot make any decisive statement about their position. Indeed the frank perspective of doctors involved in delivery would have enriched the debate in the seminar).

- Internationally, dissatisfaction and doubts about the medicalization of childbirth, as well as the spread of more information, has resulted in movements which promote demedicalization and "humanization", movements which have been initiated and supported by professionals, civil society and mothers, fathers and families. Nascent movements have emerged in Portugal, where normal birth (meaning physiological childbirth, including waterbirth), homebirth, doula support during pregnancy and delivery, are all gaining popularity. For the majority of the population, however, these alternative options are beyond their reach. Few government hospitals promote normal birth, for example, and the state

health system does not support homebirth, so midwives and doulas are hired privately. The current situation whereby some women circumvent existing services is telling and raises fundamental questions about the current role and responsiveness of the state in the provision of adequate support to women and their families through childbirth.

While this document is only being published some months after the seminar, the content and issues outlined above remain as relevant as ever. We hope that these proceedings not only inform, serving as a faithful record of what occurred, but provide new insight, prompting readers to reflect upon their own positions regarding pregnancy and childbirth, in the Portuguese context and beyond.

Note on presentation of the proceedings:
In this document the seminar presentations have been transcribed in full, together with relevant PowerPoint slides; no formal written papers were requested from the invited speakers. We have been careful to include the references cited during presentations in full as well as the websites of the organisations and other entities referred to, to enable readers to follow up areas which interest them.
The proceedings in English are in the first half of the document, followed by a full translation in Portuguese.
All relevant slides from the presentations are included as "figures".