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Maternal Transition

A North-South Politics of Pregnancy and Childbirth

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"This unique study comparing women from the global north and south transcends the binary model that says the medicalization of birth is either oppressive or liberating. Through cross-cultural, in-depth interviews with women from Cuba, Honduras, Canada, and the United States Johnson skillfully demonstrates how women's preferences for health care during pregnancy and childbirth are shaped by their race, class, and gender positions."

—Iris Lopez, *CUNY-City College, author of* Matters of Choice: Puerto Rican Women's Struggle for Reproductive Freedom

"Through thoughtful and sensitive interviews, Candace Johnson enables women to tell their own stories about health, reproductive decision-making and bodily agency. Incorporating feminist theories and research methods, *Maternal Transition* analyzes these narratives within the contexts of local history, culture and politics. Dr. Johnson examines the background assumptions in maternal health care and healthy women programs which structure the decisions women make during pregnancies and childbirths. She also documents the silences in healthy women programs regarding charged choices such as terminating a pregnancy safely and legally. *Maternal Transitions* should be required reading for public health, women's studies, and global politics scholars and practitioners."

—Laura Woliver, *University of South Carolina*

Maternal Transition

What are the political dimensions that are revealed in women's preferences for health care during pregnancy and childbirth? The answers to this question vary from one community to the next, and often from one woman to the next, although the trends in the Global North and South are strikingly different.

Employing three conceptual frames: medicalization, the public/private distinction and intersectionality, Candace Johnson examines these differences through the narratives of women in Canada, the United States, Cuba, and Honduras. In Canada and the United States, women from privileged and marginalized social groups demonstrate the differences across the North-South divide, and women in Cuba and Honduras speak to the realities of severely constrained decision-making in developing countries. Each case study includes narratives drawn from in-depth interviews with women who were pregnant or who had recently had children. Johnson argues that women's expressed preferences in different contexts reveal important details about the inequality that they experience in that context, in addition to various elements of identity. Both inequality and identity are affected by the ways in which women experience the division between public and private lives—the life of the community and the life of the home and family—as well as the consequences of intersectionality—the combinations of various sources of disadvantage and women's reactions to these, either in the form of resistance or compliance.

The rigorous and highly original cross cultural and comparative research on health, gender, poverty, and social context makes *Maternal Transition* an excellent contribution to global maternal health policy debates.

Candace Johnson is Associate Professor of Political Science at Guelph University, Canada. Prior to joining the University of Guelph in 2003, Professor Johnson taught at Brock University in St. Catharine's Ontario and at the American University in Washington, DC. Professor Johnson has published in the areas of health care and social policy, the philosophical and political dimensions of rights and citizenship, Latin American politics and society, women and politics, and feminist theory. She has published in the *Canadian Journal of Political Science,* the *Journal of Health Politics, Policy and Law, Polity,* the *Journal of Latin American and Caribbean Studies, Global Public Health* and *Canadian Woman Studies.* She was the recipient of the 2009 Jill Vickers Prize, awarded by the *Canadian Political Science Association* for her work on gender and politics.

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Candace Johnson

To Miranda and Max,
The children who inspired the questions,
And to all of the women who helped to provide answers

Acknowledgments

One of the final tasks that I was charged with completing for my publisher, Routledge, was a marketing survey for the final version of this book. I sat at my computer and began to explain the niche into which I think this book fits, somewhere between women's/gender studies and political science (my disciplinary home), with stops along the way in medical anthropology, public health, and philosophy. I wrote that the niche would (should?) be of wider appeal to a non-academic audience, in particular women who are interested in stories about pregnancy and childbirth in different cultural and political contexts. But I had definitely framed this book as a work that lies outside of the mainstream, beyond the realm of questions of central importance to political scientists. However, this book, and so many other books in this "niche" that have gone before it, should also be recognized for addressing the politics of the reproduction of the human species. It is hard to think of this topic as a mere niche, yet somehow discussion of the maternal, academic and otherwise, gets presented this way, even by its own proponents. So, let my first acknowledgement be the topic itself: the politics of reproduction of the human species, a topic so fundamental, so central to all other matters, that it should require no justification, no marketing strategy at all. And my second acknowledgement is that for centuries now, countless women, as writers and activists, have been trying to make this point resonate and stick.

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important and innovative community organizations in Canada, the United States, and Honduras. I am grateful to Roya Rabbani, Executive Director of Immigrant Services, for her generosity, time, and insight. Similarly, I am indebted to an incredible team at the Canadian Red Cross (International Operations): Dr. Salim Sohani, Richard McCabe, and Elaine Hernandez (who has become a great friend). Thanks also to the Red Cross staff who assisted me "in the field," especially Dr. Luis Amendola. Their work is as humbling as it is inspiring, and I thank them for including me in their project in Honduras. My research partner in Texas, the International Valley Health Institute, deserves recognition for the difficult and important work that it does on border health issues. Director Isidore Flores, and *promotores* Ester S. Carbajal and Irma P. Santos are committed to making a difference in the lives of everyone living in the Río Grande Valley community, and I thank them for sharing their time and expertise with me. Special thanks are owed to Ann V. Millard, Associate Professor at the Texas A&M School of Rural Public Health, for reading and commenting on a draft of Chapter 7. Also, Heather Swanson, Clinical Director of Holy Family Services and Certified Nurse Midwife, and all-around smart and delightful woman, further facilitated my research efforts in Texas.

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A debt of gratitude is owed to my amazing children, Miranda and Max, who have to bear all of the eccentricities of an academic mother—absences during research trips and writing sequestrations, and endless piles of paper that they were not allowed to touch.

Finally, to everyone unnamed, for various reasons, especially the Cuban assistants, who will not get the credit that they deserve.

Contents

1 Introduction

> I just kind of felt like, you know, it is a mother's right to be able to have her child and women all over the world are doing it without epidurals, like why can't we?
>
> Participant TX10, McAllen, Texas

> Back home . . . they all dream of hospitals.
>
> Participant M2, Guelph, Ontario (originally from Laos)

> The discourses of both feminism and bioscience are fraught with polarized reductions in which scientists are too frequently represented as either heroes or villains, and women are represented as their victims or resisters. Images of pregnancy "as if" it were located exclusively in the domain of either technical medicine or timeless maternal identity both exhibit similar rhetorical errors. The seeming universality of pregnancy is continuously undermined by its concrete historical and local embeddedness.
>
> Rapp 2000: 49

The decisions that women make concerning the type of care that they will receive during pregnancy and childbirth are often complex and sometimes contradictory. The choice between care provided by an obstetrician or a midwife, or a birth in hospital or in the home, may be fraught with materialist and moralistic dilemmas, and the consequences of choosing one provider or venue over another can have significant tangible and symbolic consequences. Yet in many instances, there is no choice to be made, as the realities of insurance coverage, cultural traditions, or poverty structure (or preclude) decisions for women and their families. In any case, such decisions, whether severely limited by structural constraints or seemingly boundless, require the navigation of technological and personal terrains, as well as the calculation of "risk" to both physical well-being and the boundaries of identity and selfhood. These complexities exist in the context of ongoing global debates, which are aimed at reducing confusion and risk, particularly in the developing world.

The Millennium Development Goals (MDGs), the most evolved iteration of development objectives, reach maturity in 2015. The expectation is that

all eight goals will be achieved through various combinations of social, political, and economic adjustments. Goal number five, the reduction of maternal mortality ratios (MMRs) by three-quarters, draws particular attention because MMRs are much more than health indicators; they are considered to reveal important details about complex inequality in all societies. MMRs tend to be highest in countries with the most marked gender inequality, where civil, political, social, and reproductive rights for women are severely curtailed or nonexistent. Within societies, MMRs are often higher among indigenous women or racial minorities, which can be attributed to problems with access to important social goods, and enduring legacies of colonialism and racism. Efforts to reduce MMRs and improve maternal health predate the MDGs by several decades, but overall little progress has been made toward global reductions. Hopes are high that the MDGs have inspired new approaches and have created new political momentum, so that avenues for measurable progress are opened and, ultimately, fewer women die from childbirth related complications.

Like so many other problems endemic to developing countries, the causes of maternal death are well understood, and the solutions relatively simple. Amartya Sen refers to these as "remediable injustices": unfair outcomes that could be easily fixed with favorable political will and modest resources (2009: vii). Recent court cases in India and Uganda have determined that there is a right to maternal health, to childbirth that is free of preventable harms (Johnson and Das forthcoming; FIGO 2013), and that governments are responsible for ensuring that this right is protected. However, these cases, like the MDG commitments, have done little to ensure the conditions necessary for safer childbirth, meaning reduced risk of death for mothers and infants. Risk of maternal death is associated with maternal age, number of previous births, and access to skilled providers at time of delivery. Reduction of MMRs requires access to education, means of family planning, medical clinics, and emergency care. While these are taken for granted in developed countries, women in developing countries only "dream of hospitals," or pray that all will turn out okay in the absence of more concrete, less metaphysical options for care.

Further complicating the relationships among risk, resources, and maternal health are the cultural contexts for pregnant and parturient women. Pregnancy and childbirth *mean* different things in different countries and communities, and this meaning reveals underlying social and political dynamics. For example, in the United States, there is a growing demand among American-born women for midwifery care, and some women explicitly reject medicalized childbirth as the commodification of a woman's physical and emotional domains. Women of Mexican origin who have settled in the South Texas border region, however, seek medical care for pregnancy and childbirth as a way of reducing the risks that are all too familiar for Mexican women: lack of access to doctors, births attended by unskilled midwives, and an even harsher economic reality. Fewer women have the means

to pay for any medical care, and installment payments are not an option, as hospitals and doctors require payment in full before care is provided. Similarly, for many Canadian-born women, choices made concerning providers and care throughout pregnancy and childbirth confirm autonomy, independence, and reproduction as a natural, woman-centered series of events. Yet for many immigrant women in Canada, choice of provider and type of care indicate relative privilege and abatement of risk; in their countries of origin, women make every effort to access the most advanced medical care available, which affirms not their autonomy but their status. In Honduras, women in poor, remote regions regard pregnancy as high risk events over which they have little to no control. As such, the events of pregnancy and childbirth have little ascribed meaning. In Cuba, access to medical care for pregnancy and childbirth is highly politicized. Although in theory all women have access to the same high level of publicly provided medical care, the consequences of inequality mean that some women have better access than others, and without money or gifts for obstetricians, the socialist promise of equality cannot be fulfilled. Therefore, the transition to motherhood can harbor multiple complex meanings, or can reflect relatively simple realities. Mapping and understanding these meanings, it is argued throughout this book, are essential in addressing the causes of, and developing solutions to improve, global maternal health.

There is also an important transition underway in interpreting and understanding maternal health. The ongoing debates about safe motherhood, and the implications of prioritizing maternal, neonatal, and child health (MNCH), make clear that maternal health is a highly politicized domain. The dimensions of this political character are global, and require transnational research and comparison. This transition progresses *from* addressing the effects of maternal risk (death and morbidity) *to* addressing the complex causes of maternal risk (gender inequality, racism, and enduring patterns of colonialism). This book focuses on the latter, and interrogates the various contexts—social, political, global, North-South—that create meaning and identities through pregnancy and childbirth, and engender or mitigate inequality. One of the most significant findings of the research, which is exemplified by the quotes presented at the beginning of this introductory chapter, is that women of the Global North—the relatively privileged women of the United States and Canada—tend to romanticize and desire the sorts of experiences that are typical of the Global South, such as natural births in home or community settings with little or no medical intervention. Women of the Global South, however, would prefer full access to the advancements of medical science as a way to eliminate the risk and stigma associated with birthing in the developing world. This dual trend is itself a transition that moves some women closer to nature and others closer to technology in response to the complex dynamics of inequality, identity, scientific versus emotional literacy, and the shifting meaning and significance of the maternal imaginary. Such a finding confirms Rayna Rapp's admonition that

pregnancy is not a universal experience and cannot be fitted into the exclusive domain of either advanced medicine or the traditional female identity.

GLOBAL MATERNAL HEALTH POLICY: TWO WORLDS

In *The Business of Being Born* (a documentary film that was mentioned by some of the women in the U.S. research site), narrator and producer Ricki Lake provides an evidentiary account of the need to return to more natural, woman-centered childbirth as a means to empower women. The return to nature entails more midwifery care, home births, and less medical intervention, obstetrical care, and hospital births. The historical problem is one that is well known and well documented (see for instance Rich 1976), namely that doctors in the nineteenth century discredited midwifery and began to attend births as a way to increase their scope of practice, and hence their power and authority. At the time of this takeover (to be discussed in greater detail in Chapter 5), success rates for medical doctors were much worse than they had been for the midwives, largely as a result of infections transmitted by the doctors themselves as they went from the operating room to the bedsides of parturient women. Over the next several decades, and once the causes of infection were discovered and addressed, maternal and infant mortality rates declined, but the negative impact of medicine on women's childbirth experiences endured. During the first half of the twentieth century, women were sedated and bound as they labored, and the effects of "twilight sleep" eliminated the experience and memory of the birth event. Further, the routine use of medications in the United States such as cytotec and thalidomide, which were later discovered to have permanently damaging and sometimes fatal consequences, called into question both the efficacy and intentions of medicine in the realm of childbirth.

In addition to medicine's questionable history in pregnancy and childbirth, current U.S. statistics concerning maternal mortality and c-section rates are alarming. The MMR for the United States is 21 per 100,000 live births, a rate that has almost doubled since 1990. The trend, unfortunately, is the same in Canada, where MMRs went from 6 in 1990 to 12 in 2010. By way of contrast, in Honduras, one of the poorest countries in the hemisphere, the MMR improved substantially, from 220 in 1990 to 100 in 2010 (WHO 2010). Why are MMRs rising in developing countries in the region and falling in developed countries? Part of the answer is that there are higher rates of multiple births and more babies born to older mothers in the United States and Canada, factors that increase risk of mortality and morbidity. It is also likely the case that other medical conditions, such as Type 2 diabetes and hypertension, increase the chance of negative outcomes. But the fact remains that mortality rates are getting worse as medical technology advances and medical interventions in childbirth increase. One interventionist trend that has caused great concern in recent years is the growing popularity of the

cesarean section. In the United States, rates of c-sections have risen from approximately 22% of all births in 1990 to 32.3% in 2009; in Canada this rate has also increased, from approximately 18% in 1990 to 26.6% in 2009 (OECD 2011: table 4.9.2). This trend might serve as evidence of the increase in high risk births (and consequent need for more surgical interventions), or might constitute a separate and significant risk, as a c-section, as routine as the procedure has become in most OECD countries, is a major abdominal surgery that carries the potential for complications and mortality.

The solution to the problems of increasing c-section rates and MMRs, according to many contributors to the documentary, is a return to natural childbirth, whereby women can labor and birth in a comfortable (preferably home) environment without the medications and procedures that are standard in the hospital. The goal of natural birth is the empowerment of women through independence and endurance, and evidence-based medical practice is thoroughly denounced (the contributors do allow for exceptions, although the cost of these seems to be high, as the claim is made that women who have c-sections or normal vaginal births with epidurals are unable to feel love for their babies due to the inhibition of critical bonding hormones). Women are pressured into medicalized childbirths with unnecessary interventions by doctors who are pressured by insurance companies. Hospital protocols are responsive to insurance provisions, both for health coverage for patients and for malpractice indemnity for doctors and institutions, and do not deviate from these to accommodate women's preferences or needs. Further, anecdotal evidence that c-section rates increase immediately before long weekends and holidays creates the suspicion that obstetricians opt for performing a c-section over waiting out a long, laborious normal birth in order to keep their own familial or social commitments. One midwife who was featured in the documentary concludes, quite simply, that there is virtually no risk of adverse outcomes in childbirth for women who are in good health. While this might be true among affluent women in New York City or on midwifery guru Ina May Gaskin's farm, evidence from the Global South tells a very different story.

Global maternal mortality ratios are incredibly high and resistant to improvement. In 2005, the MMR for Sierra Leone was 2,100 (maternal deaths for every 100,000 live births) (WHO 2007: Appendix 5: 33). The average for Africa was 900; for South East Asia 650; the Americas 130; and Europe 39) (WHO 2007: Appendix 7: 34). Ireland has the lowest MMR at 1 per 100,000 live births (WHO 2007: Appendix 1: 29). This is the indicator that reveals the greatest inequities between North and South, developed and developing countries. There is international public health consensus concerning the reasons for the disparities and the pathways that expose women in all parts of the world to the risks of maternal death. There is also consensus concerning what is needed in order to reduce those risks. Moreover, there is longstanding international political commitment to addressing the incidence of maternal death, particularly in those countries and regions

where MMRs are extremely high. Momentum for Safe Motherhood, (introduced as a collaborative effort of several international agencies in 1987 as a means to achieve the goal of reducing maternal death), was recreated with the appointment of reduction of MMRs as one of the Millennium Development Goals (MDGs). It would appear that the confluence of political and public health dynamics were ideal in creating a context for action, and that positive results were imminent. However, the political complexities of a relatively simple public health problem have effectively halted progress on this front (see Berger 2007; Fernandez 1999; Maine and Rosenfield 1999; Shiffman and Smith 2007; and Weil 1999). In the words of Shiffman and Smith,

> Safe Motherhood advocates have made concerted efforts to develop frames for the issue that might resonate. They have emphasized the severity of the issue, made rights-based arguments, connected the issue to economic outcomes, and noted the effects on children. Despite these efforts, no frame has convinced many political leaders, which is a situation that continues to puzzle several members of the policy community. (2007: 1375)

One of the reasons offered by the authors for the neglect of an issue that seems to meet all criteria for making it a priority agenda item is that it is indicative of a more widespread problem of general disregard for women's health issues by (mostly male) political decision-makers. In addition, the fact that many feminists disliked the term "Safe Motherhood," meant that there was little pressure from feminist and women's organizations for political action to focus on this particular policy issue. The problem, for many, was that "Safe Motherhood" generated conservative discourse by equating women's health with maternal health and ignoring the broader dimensions of sexual and reproductive health (Rance 1997: 12).

The pronatalist implications of Safe Motherhood are potentially damaging not only because they sideline other women's health concerns, but because they limit rather than expand women's scope of autonomy (Meyers 2001: 737). In other words, the objections extend beyond concerns about women's health issues that are hidden by Safe Motherhood programs (such as access to family planning and abortion services), or concerns about general access to health care (patterns of entitlement, ability to access available services, and availability of antibiotics), to concerns about the "discursive environment" and its effect on women's ability to make choices (Meyers 2001: 737).

For example, in Mexico, beginning in the 1970s, the feminist movement responded to a "hostile discursive environment" (Meyers 2001: 737) for women's sexual and reproductive health by reframing reproductive rights and abortion politics in the language of "voluntary motherhood" (Lamas 1997: 58). It might be the case that in Mexico, as in other Latin American countries, the role of the mother (in both practical and symbolic terms) is

more empowering than limiting, and therefore was mobilized as a feminist strategy (whereas it might be denounced as a discursive hindrance in Canada or the United States). The strong maternalist tradition in Latin America might be thoroughly conservative on one level, as it declares the role of mother to be essential for women, but on other levels it has provided avenues for agency and resistance. However, the limiting vector in this analysis is not "motherhood," but its discursive disconnection from critical political debates. More recently, Mexican feminists working within GIRE, the leading national reproductive rights organization, have worked to develop more widely resonating frames that make reproductive choice a matter for quality of democracy (Lamas 1997: 65). According to Marta Lamas, a founding member of GIRE, "we felt it was necessary to transform the profoundly subversive concept of women's repossession of their own bodies into arguments that are more closely bound to democratic concerns" (Lamas 1997: 61). The strategy of liberating reproductive choice from the relatively obscure feminist discourse of agency, autonomy and subjectivity and connecting it to key sociopolitical values such as democracy, tolerance, and diversity, without abandoning the language of "voluntary motherhood" was perhaps well conceived and well calculated, as access to abortion was expanded in two Mexican states and in the federal district (Mexico City) in 2007.

However, the discourses of motherhood or maternity and the consequences for autonomy require further exploration. Diana Tietjens Meyers describes motherhood and pronatalist discourse as constructing a "transfixing" discursive regime, which is dangerous because "it defeats autonomy by harnessing highly directive enculturation to unconscious processes that are codified and consecrated in a standard-issue self-portrait and self-narrative" (2001: 762; 758). Meyers is concerned with individual autonomy and the discursive attacks on that autonomy, although her analysis applies to societal-level initiatives such as Safe Motherhood. Conferences, documents, agreements, and policies at global, national, and local levels enable "enculturation to unconscious processes" because they present a goal (reducing maternal deaths) that seems to be unquestionably positive. Yet the repeated structuring of women's sexual and reproductive health as maternal health might undermine the very autonomy that is considered to be crucial for family planning and prenatal education, and, ultimately, better maternal survival rates.

Therefore, frames are important and discourses are powerful because they have the potential to script and shape ideas, preferences, and behavior. Recent UNFPA documents have transformed safe motherhood discourse with reference to Mothers and Others with Midwifery Skills (MOMS) rather than skilled birth attendants. The term "skilled birth attendant" had been used in previous reports (of various UN agencies) to indicate the importance of the possession of particular skills in attending pregnant and parturient women. For example, the 2004 World Health Organization (WHO), International Confederation of Midwives (ICM), and the International Federation