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PH226: Multidisciplinary Perspectives on Maternal and Reproductive Health

Birth Narrative: Bio-Social Differences in Childbirth

Taylor Parks

Agnes Scott College

Maternal mortality is a worldwide occurrence that has affected millions of lives across many developing and developed countries. Maternal mortality is a health outcome that stems from numerous causes and health disparities that affect the life of a mother antepartum or postpartum. For many of the cases, maternal mortality occurs as a result of delays in healthcare, inability to seek healthcare, or inadequate healthcare, which are all heavily influenced by an individual's socioeconomic status. For this reason, one would expect that the bulk of maternal deaths occur in developing countries. Despite the fact that maternal deaths are especially prevalent in developing countries, there are also a large number that occur in developed countries even in the presence of adequate resources and seemingly up-to-date healthcare practices; however, the maternal deaths are not evenly distributed within the developing and developed countries, which prompts researchers and healthcare professionals to assess specific determinants and causes and find ways to overcome them. This is seen in how the United States has a maternal mortality ratio that soars over other developed countries. For this reason, it is important to examine the biosocial aspects of birth in the United States compared to other developed countries in order to reach a consensus on how the United States's culture of medicalization has contributed to its soaring maternal mortality ratio. In this paper, Brigitte Jordan's bio-social model of birth will be applied to an interviewee's births in the United States and the United Kingdom to demonstrate ways that the United States's healthcare providers can foster a more positive birthing experience and environment for pregnant individuals.

According to a group of collaborators from *The Lancet*, the United States's 2015 maternal mortality ratio (MMR) was 26.9 maternal deaths per 100,000 live births while the

United Kingdom, with the second highest MMR among the developed countries, had a 2015 MMR of 9.2 maternal deaths per 100,000 live births (Kassebaum et al.). The collaborators of *The Lancet* also determined that abortion, hemorrhage, and hypertension are among the leading causes of maternal mortality worldwide. Kassebaum et al. also mention that "since the 1980s, the global health community has focused on reducing maternal mortality through a sequence of initiatives, beginning with the Safe Motherhood movement in 1987, to the creation of the Partnership for Maternal, Newborn and Child Health in 2005." Such strategies have fostered improvements across many other countries and even caused the global MMR to decline; however, the United States maternal mortality ratio has increased since 1990. It is also important to note that within the United States there is an uneven distribution of maternal deaths across the different racial and ethnic groups. According to Mary Ann Leiser of *Midwifery Today,* "African American women are three to four times as likely to die during pregnancy, birth, or postpartum as other women in the United States." Each of the developed countries have an abundance of skilled attendants, such as doctors, nurses, and midwives, to perform deliveries; however, there are differences in the United States's perception of birth that result in such a large MMR along with the uneven MMR distribution across the different racial/ethnic groups. From here, it is imperative to examine the United States and other developing countries with the same scope.

In her book, titled *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States,* Brigitte Jordan uses a biosocial model of childbirth to compare practices across different countries. Jordan's model is immensely applicable between the United States and the United Kingdom because it allows one to examine

the various dynamics that contribute to a mother's birthing experience and health outcomes. According to Jordan, the biosocial aspects of the birth event that summarize the model are: "the local conceptualization of pregnancy and birth, preparation for birth, attendants and support systems, birth territory, the use of medication, the technology of birth, and the locus of decision-making power" (Jordan, 1988, p. 48). From here, the local conceptualization of pregnancy, preparation of birth, birth territory, and use of medication will be used to compare the interviewee's birthing experiences in the United States and the United Kingdom.

According to Jordan, pregnancy is heavily conceptualized as a medical procedure in the United States (p. 48). This revelation is exemplified in the interviewee's birth narrative, where she explicitly mentioned that she felt like she was more of a "patient" in the United States while she felt like she was more in charge of her birth in the United Kingdom, which will be exemplified in other aspects of the biosocial model. Concerning the 'preparation of birth' aspect of Jordan's biosocial model, the interviewee mentions how much more satisfied she was with the prenatal care in the United Kingdom. According to the interviewee, she was impressed with her prenatal care in the United Kingdom because she was required to bring a "red folder" with her to all of her obstetric appointments, which served as a birth plan for her and a method of organization for healthcare providers. Also, it is notable that the United Kingdom has free healthcare for permanent residents, which also influenced the interviewee's positive prenatal experience. Although the interviewee did not give much detail about her prenatal care experience in the United States, it is possible that her experience, along with that of other mothers in the United States, aligns with Jordan's findings revealed in *Birth in Four Cultures*. Jordan describes

the level of prenatal care in the United States as highly variable, and expands on this idea by mentioning how women of lower socioeconomic status often have no prenatal care (Jordan, 1988). If the United States implements a system similar to that of the United Kingdom, a pregnant mother would be able to obtain free prenatal care while being able to keep an organized record throughout their pregnancy.

Furthermore, the 'birth territory' and 'use of medications' aspects of Jordan's model, the interviewee mentions how she was much more satisfied with her birth experience in the United Kingdom due to the fact that she could make more decisions concerning her birth territory. According to Jordan, "American obstetric wards have traditionally been designed with a view to organizational efficiency and central availability of the resources of medical technology (Jordan, 1988, p.69). Jordan expands on this idea by mentioning that In the United States, the woman is completely immobilized and unable to get comfortable with her surroundings. This idea is seen in how the interviewee mentions that she was not given a walking epidural for her birth in the United States. Instead, the interviewee was told that the epidurals were already pre-mixed and that she would have to be completely anesthetized or not have an epidural at all. Also, the traditional delivery environment in the United States consists of a woman with her feet in stirrups so that the birth is made more convenient for the doctor. In contrast to the United States, the interviewee mentions that the hospital in the United Kingdom was much less medicalized and had a whole floor of the maternity ward staffed with midwives and equipped with birthing pools and non-medical birthing accessories. Also, the interviewee was given a walking epidural for her pain for the birth that took place in the United Kingdom. After reviewing these comparisons, it is

conclusive that the approach to childbirth in the United Kingdom is much less medicalized than that in the United states. This means that in the United Kingdom, pregnancies are treated less as a medical procedure that should be treated with medical interventions. This idea is perpetuated by Jordan, who argues that the United States "has no institutionalized mechanism for separating normal from complicated births," which causes medical professionals to speed up labor through the use of episiotomies and the administration of pitocin (Jordan, 1988, p.69).

In final analysis, Brigitte Jordan's bio-social model of childbirth demonstrates that there is a critical need for the United States to adopt a healthcare system along with healthcare practices that align with those of the United Kingdom and other developed countries. Jordan's perspectives are also aided by the opinions of the interviewee, who experienced birth in both countries and was much more pleased with her delivery in the United Kingdom. In order for the United States to lower its MMR, healthcare professionals must agree to change their perspectives on childbirth while demedicalizing maternity wards. Also, United States healthcare professionals must gravitate towards finding a line of demarcation between normal and complicated births.

References

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