Shannon Pawson's Presentation to the Women's Empowered Health Workshop

It used to be that a birthing woman was surrounded by the women of her community and birthed in her own home. Midwives were called to support the family during the birth of the baby. Birth was a joyous fact of life – work to be accomplished to benefit the family and the community. It used to be that Mama and baby were then tucked into bed for several weeks following the birth and were nurtured by the women of her community. Neighbors knew each other, a lot of times depended on each other and communities relied on the land to sustain them.

Today – neighbors might know each other, but they don't depend on each other. Communities are not what they once were – we tend to rely on the retail stores to sustain us, not the land. Family members pass each other during their busy days, each going to their own job to make money to pay for the things they need or just want.

Birth has become a business too. It has been moved into hospitals and has become a procedure preformed BY doctors ON women. It is no longer an accomplishment that a woman achieves with the support of others. We hear so much negativity about birth these days that it sometimes gets lost in the shuffle that women are divinely designed to birth babies. This is a miracle, but it is also totally normal and a simple bodily function. Women have literally for 1000's of years been doing this and surviving. The proof is that we are all HERE. Medical doctors stepped into birth only about 100 years ago, and yet people were breeding successfully all that time before. We in the West have over time become convinced that altering natural processes makes them better – more predictable, more controllable and therefore safer. Mother Nature is constantly proving that false.

According to anthropologist Robbie Davis-Floyd – despite its claim to scientific validity, the Western medical system is less grounded in science that in its wider cultural context; like all health care systems, it embodies the biases and beliefs of the society that created it. Western society's core value system is strongly oriented towards science, high technology, economic profit and patriarchal governed institutions.

Along with technology, we also prize information. In pregnancy and birth, becoming informed is equated with being responsible, both of which are strongly encouraged culturally, yet there is also a price to pay. We may have all of the information in the world, but we cannot predict our experiences in birth. And we diminish our own authority in birthing and in mothering – we disempowered ourselves – when we put more faith in information from the outside (tests, scans, others' opinions) than we do in our own internal knowing of our bodies and our babies. In fact from the very beginning, when we first suspect we might be pregnant – we could use this ancient system of knowledge and allow our bodies to show us, instead we pee on a stick and have the pregnancy test inform or 'confirm' for us. Given time – pregnancy will unfold gradually which allows space to learn and adapt at our pace – and that gives us opportunities for reflection, dreaming and time to imagine what could be.

To those not involved with birth it may seem that American women have all the choice in the world of where and how to birth. We do have many choices – these choices are a result of real struggles by activists, from contemporary middle-class women seeking to bring humanism to technocratic birth, back in time to the Boston upper-crust ladies who worked hard in the 1920's to bring scopolamine (twilight sleep) from Germany to the US and to convince doctors to use it. Choices like these were denied to the American poor and underserved (who were "supposed to suffer"), so then *those* women turned around to demand all the technology they could get as soon as they had access to it. Because the privileged women had it, so they 'knew' it was best. Now that knowledge blankets the planet, convincing women they should WANT medical birth and justifying using all that technology even on the women who don't want it has been a US marketing success story. What is choice and privilege in one setting becomes an

almost invisible coercion in another. What obstetricians “know” is that women are choosing drugs and technology – so forcing drugs and technology on women who don’t choose them can be easily coded as ‘giving women what they want’ and ‘respecting women’s choice’.

We live in a society where the victimization of women is very common. In childbirth, one of the most graphic demonstrations of the power of ‘doctor’s choice’ is the lithotomy position (flat on your back with your legs up in stirrups on an elevated table) so popular with doctors not because its physiologically sound, but because it enables them to attend birth standing up, with a clear field for maneuvering. We know very well that this position complicates childbirth, but the many good physiological reasons to allow women to give birth in upright positions (which include increased blood and oxygen supply to the baby, more effective pushing, and wider pelvic outlets) are far less important to most physicians that their own comfort, convenience, and status. In the West, ‘up’ is good and ‘down’ is bad. The person who is ‘on top’ has the status and the power and rarely gives it up for the good of the laboring woman and child.

Obstetrician’s medical training focuses on detecting and treating the pathological problems of pregnancy, labor and birth. They are surgical specialists who are performing an increasing number of cesarean sections each year. And even though we may want to have less technology in ‘normal hospital birth’ as Dr. Sara Buckley said in 2002 – We live in a culture that prizes and puts its faith in technology. We reward those, such as doctors, who are masters of technology and indeed we are fortunate to have their skills available to use when we need them. Although medical personnel do have the power to give orders to patients and establish institutional policies and procedures, they can be and often are held accountable for deaths and outcomes that no mortal could prevent. We are witnessing more and more law suits against obstetricians – almost all of which blames them for not using **enough** technology. This proliferation of lawsuits against obstetricians over the past two decades is testimony to the way citizens have turned this tenet of the technocratic model against its proponents. Even those who **want** to practice differently just can’t win in our current system. One way hospitals are attempting to appease families who want more natural options – is by putting up curtains and hiding the medical equipment behind wooden cupboards to give a hospital room a more home-like look. They are missing the point.

Our current mainstream birthing options are very concerning. The majority of US women without question accept they will have an obstetrician to provide care during pregnancy and childbirth and because of that they receive some of the lowest quality of care in the world. Appointments are rushed, nurturing is limited and women are often forced by their care providers into a state of fear about their abilities to grow a baby and their impending birth. Many women end up with unnecessary interventions beginning with induction and ending with cesarean surgery. In truth 90% of births require NO assistance. 9% of births require minor assistance. Only 1% of births require significant assistance. The Obstetrical Model of Care treats ALL women like they are the 1% - to the detriment of the other 99% of birthing women, and the detriment to our economy.

Those who are attempting to move birth from a medical procedure have mountains of scientific data on their side, but all that data hasn’t made much difference in the practice of birth. Routine electronic fetal monitoring remains pervasive, even though it does not improve outcomes - but does raise the incidence of unnecessary cesarean surgeries. Induction of labor increases prematurity rates and labor complications; its use has skyrocketed in the past decade to over 53% of all US births. Epidurals can slow labor, generate fevers and increase the need for further interventions for both momma and baby (who will end up in the NICU if the mother develops a fever). It’s very common for a hospital to report a 90% epidural rate. Cesareans generate higher rates of infection and other complications (including death) than vaginal birth, but the cesarean rate in the US is at an all time high and growing.

Did you know that the US, with all its technology and hospitals, is FAR from the safest place on this planet to give birth? In 2006 the US ranked 33rd in infant mortality rates in the world. That means 32 other countries have lower infant mortality rates than the US, even though we supposedly have the best medical health care in the world. You have to consider the differences in our maternity care and countries like Iceland, Sweden or Norway (who are in the top five lowest infant mortality rates in the world). Are all the inductions, constant fetal monitoring, ultrasounds, epidurals, vacuum delivery and cesarean sections helping to increase the number of live births? Is intervening frequently in the birth process and trying to medically manage birth resulting in better birth outcomes? NOPE

With 99% of MATERNAL deaths occurring in developing countries, it is too often assumed that maternal mortality is not a problem in wealthier countries. BUT – statistics released in September of 2010 by the United Nations place the United States 50th in the world for maternal mortality – our maternal mortality ratios are higher than almost all European countries, as well as several countries in Asia and the Middle East.

Even more troubling, the United Nations data show that between 1990 and 2008 – while the vast majority of countries reduced their maternal mortality ratios for a global decrease of 34% - maternal mortality nearly doubled in the United States. For a country that spends more than any other country on the planet in health care and more on childbirth related care than any other area of hospitalization (US $86 billion a year) this is a shockingly poor return on investment. Western medical care is not cheap and it does not work.

Now to trump even those statistics that show where you live influence our chances of living through birth – race in the US is a huge factor on outcome. For the last 50 years, black women who give birth in the US are approximately four times as likely to die as white women. The greater risk of death for black women does not simply reflect a greater risk of an underlying complication occurring; in a national study of five medical conditions that are most common causes of maternal death and injury (preeclampsia, eclampsia, obstetric hemorrhage, abruption and placenta previa), black women in the study were two to three times more likely to die than the white women who had the same complication. Likewise, a study comparing maternal outcomes for Mexican born women and white non-Latina women in California found that while Mexican born women were less likely to suffer complications overall, they did face a greater risk of particular obstetric complications such as postpartum hemorrhage, major postpartum infections and third and fourth degree lacerations, suggesting that the in labor care they received may have been poorer quality.

There are no acceptable excuses when we consider the fact that we lab behind most developed countries and when numerous developing countries, such as Vietnam and Albania, with much fewer resources than the US, are making strides towards meeting their goals of reducing preventable maternal deaths, while the US is backsliding. In every country that has a lower maternal mortality that the US, midwives – not obstetricians – work with normal pregnancy and birth. The US and Canada are the only highly industrialized countries in the world where normal, low-risk births are primarily attended by obstetricians. In Great Britain, all Scandinavian counties, Germany, Ireland and many other countries, 75% of all births are assisted by trained midwives. Obstetricians in these countries serve as specialists who provide assistance for that small percentage of births in which there are serious complications. US women demanding better will help force a change.

Our health care system is in reality an ‘illness care system’ – with insurance and HMO’s dictating what is prescribed for whom and when – our medical model of care is more about economics rather than wellness. If you are here – I’ll assume this isn’t a surprise to you.

The chances of having a natural birth or medical birth depend greatly on your care provider's philosophy of care. Some providers believe pregnancy is a dangerous condition and should be closely monitored by a medical professional. And I just explained how well that thought process is working out. Others believe pregnancy and birth are normal events that benefit from loving and skilled observation and occasional intervention if need arises.

I practice the Midwifery Model of Care. This model of care is sustainable, using far fewer resources, costing less money for everyone involved and improved outcomes. The Midwifery Model of Care puts the sense of responsibility and the sense of accomplishment back to the birthing woman and her family. The relationship between the midwife and the birthing family is collaborative in nature. Putting the woman giving birth in the center and in control so that she, not the doctors or anyone else, makes the decisions about what will happen. Putting the focus of maternity services as community based (out of hospital) primary care, not hospital based (specialist) care. As midwives, we believe the practice of midwifery is very different than the practice of medicine. Midwifery is a discipline pertaining to a normal cycle of life. Pregnancy and birth are fundamentally healthy processes. Each woman is unique and her care should be tailored to meet her individual needs. Midwives will attend to the emotional and spiritual components of childbearing for being as important as appropriate pregnancy, labor and postpartum physical care.

Studies have shown that planned homebirth with a trained attendant is actually safer than hospital delivery. If that fact were more widely known, perhaps homebirth would be more broadly practiced in the US, where it now is less than 2% of the total births. So when a family does choose natural birthing, or homebirth – they are going against what is the 'norm' in our country. Finding support for decisions that are not in line with what are perceived to be normal are difficult, especially for first time parents who are just beginning to find their 'parenting legs'.

A good midwife can remind us by her presence that we carry genetically the birthing successes of all our foremothers, and that we know already how to give birth. Empowering a mother – empowers her ability to mother. This is better for her, better for her children, better for the community and ultimately better for the world. If we chose to support a return to a model of care from our past, a model of care that many nations who spend less and have better outcomes than we do use, a model of care that respects women as capable, intelligent people – we can once again enjoy a system where birth is a family thing, work accomplished by women, supported by midwives and benefiting the entire community. In healing birth we are also healing ourselves, our babies and the earth.

Birth is the life experience most able to heal or hurt a woman and her baby. The effects last a lifetime for both. One day everyone will wake up and realize that being born IS important!