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# Trends and consequences of the technocratic paradigm of childbirth in Portugal: A population-based analysis of birth conditions and social characteristics of parents

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ABSTRACT

*Objective:* The aim of this paper is to analyse the evolution of birth conditions in Portugal and to establish a correspondence between maternity care and the socio-economic characteristics of new mothers.
*Methods:* A multivariate quantitative analysis (Multiple Correspondence Analysis and Cluster Analysis) was used, based on official quantitative data from different surveys.
*Results:* There is a consistent trend to a technocratic model of birth in the Portuguese context, where socio-economic characteristics appear to influence fertility rates and birth conditions.

*Results:* The evolution of birth conditions in Portugal reveal the institutionalisation of birth, with a strong presence of doctors, a higher frequency of births on certain weekdays, an increase in the proportion of births in private hospitals and an increase in the frequency of caesarean sections. There is an association between higher social status and more medicalised forms of assistance in childbirth. Women with higher levels of education, aged between 30 and 39 years and who were married tended to be distinguished from the population of Portuguese women as a whole by three factors: birth in a hospital, the standardisation of pregnancy duration and the presence of a doctor at the birth. Women's educational and professional status also appears to influence their adoption of alternative models of birth, however, such as home birth.
*Discussion:* Limiting the study of childbirth to its medical aspects leaves important dimensions out of the analysis: women's perception of birth-related risks associated with the medicalised offer of maternity care, and the implications of this childbirth paradigm for health outcomes and for future care.
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## Introduction

In the twenty-first century, human birth involves risks, as it ever did. However, factors associated with modernity have helped to change and made more complex the knowledge, assessment and management of risks concerning childbirth [1]. In the wider context of the medicalisation of society [2,3], the reconceptualisation of *risk* and *birth* – which has come to be defined as a risk process – has legitimised a transition from a social to a medical approach to childbirth [4]. This was supported throughout the twentieth century by population changes [5,6], advances in obstetrics, and the development of technology to accompany pregnancy and childbirth. Thus, the possibility of establishing new risk controls for the different events around birth has revolutionised the traditional model of assistance at birth.

The medicalised and institutionalised model of birth care, with medical assistance provided in accordance with a technocratic model [7], is defined by a new personal and social relationship with the body, mediated by the doctor and the use of technology. This process is presented as conforming to social norms and, simultaneously, as a reflexive process based on the availability and management of risk information, relationships built on trust, and the integration of pregnancy and birth into identity construction – elements that contribute to decision-making [8–10]. It is described as a normalised process in the sense that women and indeed parents do not associate technological and medical interventions with the notion of an unnatural procedure [11].

Nevertheless, the consolidation of obstetrics as a medical specialty has not reflected a linear, standard and medicalised model of childbirth in the Western world [12], as is illustrated by Floyd by means of a typology that defines three paradigms of birth

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– technocratic, humanistic and holistic – as a function of the conceptualisation of the human body and of the relationship between mind and body [7].

Furthermore, the specific characteristics of a country or region – its social, demographic, historical, cultural, political and geographical dimensions – and the individual characteristics of new mothers (or parents more generally) have been seen as important elements to differentiate national profiles of assistance and preferences at birth, as well as outcomes in infant and maternal health [13–17]. Indeed, the social profile of individuals is considered, across different research results, to be the most important factor in the preference for birth place (which involves preferences for other aspects, such as the availability of professional care and technological resources) and in specific fertility patterns [18]. In that sense, social and individual characteristics facilitate or mediate access to information and empower different forms of social behaviours and social relations [19,20].

The association between birth characteristics and the mother's profile has not been studied sufficiently [11], although a few studies have considered the link between birth characteristics and the mother's or parents' social profile [19,20]. The aim of this paper therefore is to relate the characteristics of mothers to the maternity care they receive, in the Portuguese context. Portugal has undergone profound demographic and social change in recent decades, including a large reduction in fertility levels.

### *The Portuguese context*

Since 1982 (i.e. for over three decades), Portugal has had a fertility rate below the replacement level. Since 2012 and to the present, Portugal has had the lowest total fertility rate in the European Union (28 countries) – 1.28 live births per woman in 2012 and 1.31 in 2015 – and one of the highest mean ages for women giving birth – 30.2 years in 2012 and 30.9 in 2015 [21].

Different social science authors have contextualised these results against a broader background of social, family, economic and political transformations [22–24]. Easy and widespread access to modern contraception for women in Portugal has combined with a redefinition of family values, based on the recognition of new aspects of womanhood, especially in relation to education and work. In addition to more options for women there has also been a shift in the ideal parenting model, which has seen a repositioning of the place of children, with heavy investment in them.

Furthermore, in recent years, the financial crisis has made fertility a critical issue in various countries [25], including Portugal, where fertility is now very much on the political and government agenda, leading, for example, to the creation of a commission promoting policies for the 'removal of obstacles for desired fertility' [26].

Demographic and sociological analysis has centred on fertility trends, family and social frameworks, but not on the conditions and characteristics of birth [27,28]. The latter type of research, though, by extending the dimensions considered in the explanation of practices and models of birth, has the potential to improve knowledge about birth conditions, as well as about infant and maternal health.

While it is undeniable that without modern obstetric, medical and institutional procedures we could not attain the very low levels of maternal mortality achieved in Portugal (where no more than 7 or 8 cases a year are registered), some characteristics of the technocratic model of birth may nevertheless have adverse effects on maternal (and infant) health. For instance, Portugal has seen a marked growth in the use of caesarean section, particularly in private hospitals, where the rate is more than double that in public hospitals. A lack of data in Portugal prevents an analysis of the effect of this trend on mothers' health outcomes, but studies covering other countries have found that there is a higher risk with caesarean birth (elective or after labour) or instrumental vaginal birth than with spontaneous vaginal births, which is reflected in an increase in maternal mortality [13,14,29–35].

Previous studies in Portugal have focused on the effects of the social framework on fertility. Here, we examine the childbirth conditions and the profile of women who have children, in order to understand who gives birth and under what conditions of care; the analysis will consider each aspect separately, as well as the relation between them. Thus, we expect to provide a better understanding of the development in Portugal of the evolution of the conditions of childbirth and of the sociological and demographic characteristics of new mothers.

## Methods

### *Sources and period of analysis*

We collected data from three different official sources: newborn surveys (1988–2011) and hospital surveys (1985–2010), and national censuses (1991, 2001 and 2011).

#### *Newborn survey*

The newborn survey provides information about births in Portugal in each year (122,121 cases in 1988, falling to 96,993 cases in 2011) and is the result of cooperation between the official services where live births are registered (Civil Registry) and the National Institute of Statistics (INE, Portugal), which is responsible for the statistical treatment of the data. The data are made available to researchers in the form of databases.

This is the most complete quantitative source with information on births, newborn infants and parents; it is an official source with a generally exhaustive coverage of events in the whole country, given the obligatory registration of all newborns. This contributed to the strength and quality of the data and the analysis of the results.

We have analysed three groups of characteristics from this source: baby (sex, weight, nature of birth, date of birth); birth characteristics and conditions (pregnancy duration, place of birth, assistance provided); and parents (birth dates, place of residence, level of education, employment status, and profession).

#### *Hospital survey*

We considered data from hospital surveys over the period 1985–2010. This source provided information about the 'type of birth' and 'institutional nature of hospital (public or private)'.

#### *Censuses*

Data from the last three Portuguese national censuses (1991, 2001 and 2011) on women's educational level nationally were compared with data specifically on new mothers, drawn from the newborn survey (above).

#### *Critical analysis of the data sources*

In order to improve the analyses, namely through the integration of more variables and their relation with others concerning different aspects of birth, it would have been desirable for the newborn survey to have included a few questions available in the hospital survey, such as 'type of birth' and 'institutional nature of hospital (public or private)'. As this was not the case, we have considered the data separately in the analysis.

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