

From Pregnancy to Motherhood

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Abstract

Pregnancy, another state or gravidity, is the state of a woman who carries a new being. Pregnancy start with fertilization and ends with childbirth. Getting a baby is one thing, but be a mother is something else. As we all know, the pregnancy lasts for nine months, and when the baby is born, a great job begins. Childbirth means joy and happiness for mother, father, and other family members. The birth of a child means something more important: the beginning of the creation of a new human being.

Keywords: Pregnancy, Birth, Motherhood

1. INTRODUCTION

Given the historically held belief that all women are destined to be mothers, motherhood, as choice, is a relatively modern concept [1]. Today, most women consider motherhood as one option, with some opting for other paths of life. In fact, current statistics point to a substantial increase in childlessness in the USA, Canada, Europe, and New Zealand, with approximately 20% of women estimated to be childless around the turn of the century. While medical advances in the field of reproductive technology have resulted in more treatment options for infertile couples and in extending women's childbearing years, childlessness by choice is gaining more prominence.

This trend notwithstanding, the majority of women consider motherhood as a viable option, with most becoming mothers at some point in their lives. While motherhood is no longer prescribed for women in general, or proscribed for women who have disabilities, this group of women continues to face particular issues and challenges as they consider their reproductive options.

In consequence, anything that supports a traditional division of labor into male and female worlds is, broadly speaking, in the interests of pro-life women because that is where their resources lie [2]. Conversely, such a traditional division of labor, when strictly

enforced, is against the interests of pro-choice women because it limits their abilities to use the valuable "male" resources that they have in relative abundance. It is therefore apparent that attitudes toward abortion, even though rooted in childhood experiences, are also intimately related to present-day interests. Women who oppose abortion and seek to make it officially unavailable are declaring, both practically and symbolically, that women's reproductive roles should be given social primacy. Once an embryo is defined as a child and an abortion as the death of a person, almost everything else in a woman's life must "go on hold" during the course of her pregnancy: any attempt to gain "male" resources such as a job, an education, or other skills must be subordinated to her uniquely female responsibility of serving the needs of this newly conceived person. Thus, when personhood is bestowed on the embryo, women's non reproductive roles are made secondary to their reproductive roles. The act of conception therefore creates a pregnant woman rather than a woman who is pregnant; it creates a woman whose life, in cases where roles or values clash, is defined by the fact that she is—or may become—pregnant.

1.1. Health Care for a Woman who Wants to Get Pregnant

Women who are at increased risk of raised blood pressure should be advised to seek pre-

pregnancy care from their GP [3]. Women with chronic hypertension who take angiotensin-converting enzyme (ACE) inhibitors or angiotensin II receptor blockers (ARBs) should receive pre-pregnancy counselling on the increased risk of congenital abnormalities if these drugs are taken during pregnancy. The health professional responsible for managing their hypertension should switch them to other antihypertensive treatment (NCCWCH 2010).

The task of prevention and reducing the risk of raised blood pressure in pregnancy is complicated by the lack of precise aetiology. Pre-pregnancy advice may be beneficial for all women and in particular those with existing hypertension. In women with a body mass index over 35kg/m², weight reduction and regular exercise may help to reduce the fourfold increase in risk of pre-eclampsia. The role of maternal diet has received increased attention recently in a quest to understand the aetiology of pre-eclampsia. Studies on nutrients such as antioxidants, fatty acids and calcium and magnesium remain limited, which means that dietary advice to reduce raised blood pressure lacks an evidence base.

1.2. Pregnancy

There are an estimated 6.6 million pregnancies each year in the United States, and clinicians often see women who are pregnant for initial diagnosis or primary care [4]. Given that an estimated 51% of pregnancies are unplanned, women may not have considered pregnancy as a reason for fatigue, nausea, or amenorrhoea, and may seek care for these symptoms with a trusted clinician, regardless of specialization. A diagnosis of pregnancy can be surprising, and beginning care immediately with a trusted clinician can provide stability and increase the likelihood the woman will receive early prenatal care.

Pregnancy is a natural process for which medical intervention may be required, either throughout its duration or during labour [5]. A number of legal issues arise. Firstly, pregnant women are no less autonomous than non-pregnant women. Pain and distress do not necessarily make a labouring woman incompetent. However, a number of decisions in the late 1990s held that labouring women were incapable of making decisions whilst in labour, which allowed the courts to authorise Caesarian sections in the best interests of the mother. This alarmed a number of agencies, who saw that

health authorities and trusts were beginning to rely on the coercive threat of court intervention in order to achieve a successful delivery, despite legal assurance that competent women are allowed to refuse treatment even if this harms their foetus.

A woman's body undergoes significant changes in pregnancy, with the developing fetus making increasing demands [6]. Preparation for pregnancy should begin before conception, as fetal development begins from the third week after the last menstrual period. Damaging effects (e.g. exposure to drugs) may occur before the woman is even aware she is pregnant. Being as fit and healthy as possible before conception maximizes chances of a healthy pregnancy, but not all poor obstetric outcomes can be avoided. Pre-pregnancy counselling by a specialist team is recommended where specific risks and diseases are identified.

1.3. Prenatal Care

There are several key components to prenatal care including the establishment of an accurate gestational age and estimated date of delivery, the initial assessment of maternal risk factors for the development of complications, the ongoing assessment of maternal and fetal health and well-being, and patient education [7]. Pregnant women receive 13–15 office visits for a typical low-risk pregnancy when care begins in the first trimester. After her initial visit a woman will see her provider every 4 weeks until 28 weeks' gestation, and then every 2 weeks until 36 weeks' gestation, followed by weekly visits until delivery. Women at higher risk for complications, or those who develop complications in pregnancy, may be seen more frequently. Despite a general acceptance and widespread adoption of prenatal care, there is little evidence that demonstrates proven effectiveness in reducing maternal and fetal morbidity and mortality. Observational studies comparing women who receive prenatal care and those who do not are confounded by selection bias regarding socioeconomic status, maternal education, substance abuse and other factors that affect health and risk status.

1.4. Childbirth

Childbirth can be an unpredictable process [8]. Midwives and obstetricians sometimes have to respond swiftly to an unforeseen emergency. The woman may be in acute pain, perhaps a little panicky, or significantly affected by doses

of painkilling drugs which cause some mental confusion. Doubts may surface about her decision-making capability, and/or time to seek consent may truly be limited. The Court of Appeal has suggested that if the woman is temporarily incompetent to make decisions for herself, health professionals may do whatever is required in her best interests. Defining the borderline between capacity and mental incapacity in such cases is tricky. It is too easy to assume women are incompetent. 'Birth plans' offer a partial solution to such dilemmas. Women, ideally in consultation with their midwives outline how they wish to be treated if certain emergencies materialise. 'Advance decisions' should have just as great force and authority at childbirth as in the life-threatening circumstances in which they are more usually invoked. The controversy over whether the law should compel medical attendance in childbirth would be much less substantial if the woman's rights in hospital were fully protected.

1.5. Parent Obligations

The obligation of parents to provide certain material needs to their children is the least controversial type of parental obligation [9]. Having these needs met is crucial to human well-being, and so receiving basic care is included among the fundamental interests of children. Certain things are required for human life, such as food, shelter, clothing, physical safety, and basic medical care. Of course, not all parents are able to provide these things for their children. This is sometimes the case due to a personal failing of the parent. Other influences more outside of the control of parents also hinder their ability to meet these obligations. There are sometimes political, social, and economic hindrances and even barriers that prevent some parents from providing for their children in this manner. So, on a case-by-case basis, the level of blameworthiness of a parent who is falling short in this area will certainly differ. Some may be unable to obtain or keep a job, and their immediate obligation might be to obtain the requisite professional training or psychological counseling so that they are in a position to be gainfully employed. A parent in such a situation who refuses to change is seriously failing in his or her obligations as a parent. A parent who is making a good faith effort to provide for their children but due to political, social, and economic hindrances is unable to do so is certainly much less blameworthy and possibly not blameworthy at

all. Rather, those who are responsible for the presence of these hindrances bear the moral responsibility.

1.6. Motherhood

The contexts in which women live their lives as mothers are, then, socially constructed, historically specific and culturally varied [10]. Motherhood is often considered to be a universal experience and yet becoming a mother is everywhere socially and culturally marked and shaped. Becoming a mother, then, is always more than a biological event. The ways in which 'a society' score values and organisational principles' structure reproductive behaviours and practices has been noted in recent years by anthropologists and sociologists. Women's expectations and experiences around reproduction and childbirth are produced through interactions with others, and shaped by reference to dominant forms of 'authoritative knowledge'. As a result, there may be little 'cultural space' available for alternative ways of thinking or knowing about reproduction and childbirth.

The mother of a child is the woman who gives birth to the child [11]. This is so even where there is assisted reproduction and the woman who carries and gives birth to the child is not genetically related to the child.

The woman, who is carrying or has carried a child as a result of the placing in her of an embryo or of sperm and eggs, and no other woman, is to be treated as the mother of the child.

This indicates that, in relation to motherhood, it is the gestational rather than the genetic link which is crucial. In fact the genetic link is irrelevant in establishing legal motherhood. This could be explained in any one of three ways. The most convincing argument is that the pain and effort of childbirth and the closeness of the bond which develops through pregnancy and birth justifies the status of motherhood. The gestational mother has given more of herself to the child than the genetic mother. In other words the law emphasises the social aspect of parenting over the genetic link. Secondly, the law could be justified on the basis of certainty. It is far easier to discover who gave birth to the child than to ascertain who (if anyone) donated the egg. Thirdly, the law might be seen as a way of encouraging egg donation. Egg donors may be deterred from donating if they were to be regarded as the parents of the child.

2. CONCLUSION

Pregnancy is one of the happiest periods in a woman's life if it is planned and desired. Pregnancy is a period that begins with fertilization and ends with the birth of a child. It takes nine months or 40 weeks, or 280 days. When a child comes to the world, there is no one happier than his parents. Motherhood is not simple, but it makes sense because the child ultimately becomes a man. Creating a healthy, normal man has no price.

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