

PART II
CHILDBIRTH PRACTICES IN BOLIVIA

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CHAPTER 2

THE FIELD STUDIES

Chapters 2 to 7 of the report¹ describe the field studies of childbirth practices in Bolivia, with an emphasis on the findings from the first, qualitative phase of the fieldwork. The starting-point is therefore women's experiences of home and hospital birth in the study areas, and the in-depth description of the traditional system of birth care in which these experiences are grounded (Chapters 3, 4, and 5). These experiences give rise to the view of birth care as divided between two medical systems —the 'traditional' and the 'biomedical'— and the relationship between these two systems is the subject of Chapter 6. Chapter 7 then draws conclusions from the fieldwork on ways in which the two systems can be better used and integrated in the cause of reducing maternal mortality.

The present chapter describes the aims, methodology, organisation, internal reporting, and public dissemination of the field studies.

2.1 AIMS AND OBJECTIVES

The study started out with the following objectives, which are here reproduced from the Work Programme of the project (Technical Annex to the project contract). There were three 'long-term objectives':

1. To identify appropriate technologies of birth for rural and migrant women in Bolivia, with a view to reducing the unacceptably high rate of maternal mortality;
2. To study the range of factors which prevent women from participating in formal health care services;
3. To study the relationship between women and their care providers from informal and formal health care systems.

and four 'specific objectives'

¹ I am grateful to Denise Arnold and Jo Murphy-Lawless for comments on an earlier draft of this Part of the report. I am particularly indebted to Susanna Rance for her very detailed comments on that draft, and for her continual support and help during the writing of this report, as well as throughout the project. I extend my warmest thanks to all the women who collaborated with the study in peri-urban Sucre, especially to Doña Emilia. And finally to my postmodern family, who followed me to Bolivia from Dublin, New York, and Donegal, my thanks for everything.

1. To produce baseline data on knowledges, attitudes, and practices of rural and migrant women in relation to pregnancy and birth.
2. To work with formal health care personnel at local level in developing and piloting new indicators to measure pregnancy and birth outcomes, which are informed by medical and anthropological knowledge.
3. To train women at local level in the work of recording indicators and disseminating results, thereby raising knowledge skills about the importance of maternal health issues.
4. To contribute to the more rapid and precise identification of resource needs and planning for pregnant women at local and regional levels.

At the first whole-team meeting, which took the form of a five-day seminar held in Sucre in October 1994, the objectives of the project were discussed in relation to research methodologies and to resources available. The objectives were broadly accepted by all teams, although doubts were expressed about the training objective, as set out in a three-strand programme in the Work Programme of the project.² Whilst it was agreed to provide training in data collection and analysis during the course of the research, both to researchers, and, where possible, to health personnel, the notion of ‘training’ local women in communication and networking skills was questioned. It was not clear what outsiders could add to existing cultural skills in these respects, and the notion of one-way training seemed paternalist. It was also decided that there was not sufficient provision of time or budgetary resources to run specific courses for local women.

2.1.1 Birth and death

There was considerable discussion at this first team meeting of the relative emphases of the project on birth and on death, particularly in relation to the prioritising of the issue of maternal death in the project’s title. The two issues were not felt to be wholly compatible as topics of research, especially in view of the emotional and cultural significance of death in Bolivian society, and of the shame and guilt associated with maternal death.

2.1.1.1 The CIES team’s encounter with death

These doubts were set out in the report presented at the October 1994 seminar by the team from CIES, based on the experience of a pilot project carried out in El Alto. Having

² See Paragraph 3.a of the Technical Annex to the Contract.

approached a group of women participating in a literacy project, they explained the present project to them as primarily about maternal death, and the role of birth practices in relation to it. It so happened that the group had, by an unhappy accident, just experienced a maternal death among its ranks, and CIES conducted an interview with the sister-in-law of the dead woman. The death had occurred in hospital during a blood transfusion, the woman having been transferred to hospital by her husband when an unexpected second twin appeared as a hand-presentation during a home birth.

The case showed rather starkly some of the cultural and economic aspects with which the project was confronted: the cultural fear of twins; a lack of confidence in the traditional midwife who was willing to attempt manual delivery of the hand-presentation; a wait of *seven hours* after transfer to hospital while the husband went to raise the money necessary for a Caesarian section. On top of all this, and the resultant death of both twins, (the first one having been left at home alone), the woman's death appears to have been caused by complications of the medical practice of transfusion, she herself having been recovering well after the Caesarian removal of her, by then, dead second twin.

However, having conducted this interview and one other with a relative of another woman who had died in childbirth, CIES found that there were negative repercussions among the group. Several of the women disapproved of talking about the dead, so disturbing the peace of their spirits, and provoking possible retribution.

2.1.1.2 The team decision to focus primarily on birth

The difficulties associated with talking about death influenced the team in taking the decision to focus primarily on the practices of birth. It was also felt that there was a gulf between the research aims of investigating the largely uncharted territory of childbirth practices in Bolivia, and that of reducing maternal mortality. The team did not have the resources, nor was it a project aim, to investigate in detail the causes of maternal mortality. In any case, important contributing factors to maternal deaths, such as unsafe abortion, lay outside the scope of the project. Rather, the team adopted the working assumption that the improvement of maternal chances in the foreseeable future would come about through greater knowledge and dialogue between the two systems of birth care, removing barriers of prejudice and fear, and encouraging formal medical services to adopt tried and tested cultural practices.

There were also doubts expressed about the ethics of introducing a framework of risk and death for looking at birth, since such a framework was possibly alien to the way in which

women conceptualise the reproductive process and the life-cycle in rural Bolivia. We return to this issue in Chapter 7 of this Report (section 7.1).

One way in which it was decided that the fieldwork could contribute more directly to discussions around maternal death was by focussing particularly around practices in relation to the third stage of labour. Since post-partum haemorrhage emerged as a major cause of death in all studies of maternal mortality, it seemed important to research practices in relation to the delivery of the placenta and to haemorrhage. This particular focus was adopted as part of the general focus on childbirth practices after discussion at the first seminar in Sucre.

2.1.1.3 The rejection of the ‘formal-informal’ dichotomy

On the basis of arguments adduced by ILCA in their preliminary report on Qaqachaka (see Chapter 2), the team agreed to abandon the notion of a simple dichotomy between ‘formal’ and ‘informal’ sectors of birth care, as had been proposed in the title of the project. The ILCA report had found that the ‘traditional’ system of birth care also contains ‘formal’ and ‘informal’ sectors, ranged along a continuum of practices. At one end of this continuum of formality/informality are those midwives, sometimes male, who are highly specialised. They deal primarily with cases of difficult birth, travel long distances, are skilled ritualists, and have younger midwives apprenticed to them. At the other end are those women and men, who may not even call themselves midwives, but who attend the births of their close and sometimes more distant kin. Both ends of the continuum draw on the same body of cultural knowledge about pregnancy and birth. Although this may be presented more formally by specialists, it is important to note that this knowledge is widely diffused. For instance, ILCA’s work among children in Qaqachaka showed an extraordinarily complex knowledge of local plants and their medicinal uses at a very early age.

It was also argued that the ‘modern’ system of birth care contained both a ‘formal’ sector, in hospital birth, including a range of modern techniques of intervention, and an ‘informal’ sector, in the practices of health promoters or auxiliary nurses attending home births in rural areas.

Of course, the ‘traditional-modern’ distinction is beset by as many problems as the formal-informal’ one which was intended to replace it. In the case of childbirth practices, a major problem with talking about a ‘traditional’ system is that this system is far from static. Over the years, theories and practices appear to have been adopted from western medicine, in a process that is still ongoing. The actual origins of different

practices are outside the scope of this project to trace, and are certainly irrelevant to the practitioners who have incorporated them into local reasoning and myth. As in the case of Andean religion or music, we are looking at a medical system that has been affected by the practice of *mestizaje*, —of the mixing of ethnicities and cultures that has been ongoing since the Spanish conquest. And as in these other areas, we may be continually struck by the vibrancy and the coherence of living systems that have taken on so much from outside, and yet maintain a high degree of cultural autonomy.

However, the project team did not come up with new terminology, and hence has had to make do with the circumspect use of old terms. Many internal reports avoided the use of the terms ‘formal’ and ‘informal’ altogether, as it was felt that they inevitably implied a hierarchy in favour of formal knowledge, seen as the property of the western, medical system.³ The term ‘biomedicine’ was felt to be useful in referring to the western, medical system based in the science of biology, and has been used in several of the project’s internal reports. This follows practice in recent medical anthropology (Bastien, 1992; Crandon-Malamud, 1991). The term ‘traditional’ has been used throughout this report to describe rural practices and those of rural migrants in peri-urban areas, though in the knowledge that, as a term, it does not adequately describe the dynamic and innovative nature of the systems of practices studied.

2.1.2 Birth practices and women’s experiences

The Project Proposal incorporated an aim that was both theoretical and methodological, which was that the research should start from women’s experiences in relation to birth. Paragraph 3.1.3 of the Project Proposal reads:

Subjects invited for interview will be first, women willing to narrate their reproductive histories, and thereafter those who have provided support during childbirth, whether from the informal support system (traditional birth attendants) or from the formal system (hospital staff).

The approach of the fieldwork was therefore to give priority to the experiences of women giving birth, and their experience of care within both traditional and biomedical systems. From there it would be possible to move out to the experiences and views of birth attendants in both systems.

³ This was in spite of the history of the use of the term ‘informal’, in relation to the *economy*, to demonstrate the greater vitality and inventiveness of this sector, as well as its organisational and systematising capabilities (Hart, 1973; de Soto, 1989). It has also been shown that the apparent dualism of ‘formal’ and ‘informal’ economic sectors masks a much more symbiotic relationship, whereby activities in the informal sector *sustain* others in the formal sector (Bromley, 1978). However, others have argued that this relationship is one of hidden exploitation, and that workers in the informal economy are linked in to a chain of profit-making by multinational enterprises (Birkbeck, 1978)

Theoretically, this way of deciding priorities relates to the feminist re-reading of Andean history and anthropology, which analyses Andean gender systems as based on concepts of parallelism and complementarity between the sexes. Colonial technologies of knowledge bring with them the practices and discourses of European patriarchy, in the form of legal systems, inheritance practices, religious beliefs, or indeed medical systems, all of which tend to devalue and occlude women's knowledges (Silverblatt, 1987; Harris, 1980; Arnold 1992). Methodologically, this approach gives priority to the voices of the 'subjects' of research referred to in the paragraph quoted above. It attempts ethically to place women as subjects of the research in the sense of subjects as active agents, rather than as subjects in the sense of those subjected by a new wave of colonial knowledges.

In practical terms, the research aimed to be 'empowering' for the women who took part in it. One of the medical personnel interviewed by CIES in El Alto complained that while women giving birth at home always say how they want their birth, in hospital they say nothing, and just do what the doctor says. 'Up till now we have never had a patient who says, "This is how I want it" ' (CIES, 1995a: 39). Since women had much to say in the privacy of their own homes on how they want to give birth in hospital, one of the things the project had to explain was why their voices could not be articulated or heard within the biomedical system. The project also took on a facilitating role, attempting to initiate and sustain dialogue between the different cultural systems of birth care current in the areas studied. In this way, it was hoped to put the voices of women and of members of indigenous cultures into the centre of debates on policy towards birth care in Bolivia.

2.2 METHODODOLOGY

The main fieldwork took place between October 1994 and July 1995, and was divided into two phases of data-gathering and internal reporting, followed by a shorter, third phase of dissemination and feedback. This section (2.2) outlines the methods followed in these three phases, while the following section (2.3) describes the different sites of study.

2.2.1 The two phases of the main fieldwork

The two phases of data-gathering and analysis were firstly, a qualitative phase (section 2.2.1.1), and secondly, a quantitative phase (section 2.2.1.2).

2.2.1.1 The qualitative phase

The fieldwork began with five months of in-depth, qualitative fieldwork in the different sites. The first aim of this phase was to research women's experiences of birth in rural and peri-urban settings, including experiences of both home and hospital birth. This aim, then, incorporated the two main comparative dimensions of the research into women's birth experiences: rural/peri-urban, and home/hospital. There was also a third comparative dimension, which attempted to compare 'traditional' rural communities with more 'modernising' ones, by means of the broad geographical division between the two rural areas where the team worked.

The second aim was to research the experience of birth attendants in both home and hospital sectors. In the traditional sector, this included both women and men, and family attendants as well as specialised midwives. In the biomedical sector, it included hospital doctors, nurses, and obstetricians, and in the rural areas, auxiliary nurses and trained traditional birth attendants who attend a small proportion of home births.

The methods followed were a combination of the traditional anthropological method of 'participant observation', and of the semi-structured interviewing favoured by qualitative sociologists. As already noted, emphasis had been placed in the project proposal on recording 'reproductive life histories' from women of childbearing age or older, and in-depth interviews with traditional midwives and other birth attendants. The first stage of this kind of in-depth work is that of negotiating access, meaning requesting and obtaining permission from relevant authorities, but also, in a fuller sense, gaining the confidence of those who it is hoped will collaborate with the study. For some teams this involved gaining access to new sites of study; for others, it involved returning to places where researchers had worked previously, but explaining and negotiating a new agenda. In almost all cases, the process entailed some combination of meeting with both non-governmental organisations (NGOs) working in the area, and with community leaders, or members of women's groups. In several cases, NGOs, many of them involved with women's health, provided introductions to rural communities, or to Mothers' Clubs and other women's groups in the peri-urban areas.

In the rural areas, all teams undertook phases of living in the community, which was essential to placing the research topic in its social, economic and cultural context. In some cases members were able to combine informal talk about pregnancy and birth with daily living; but on the whole, and particularly where the researchers were visiting communities where they had worked previously, participant observation tended to be aimed at setting up interviews on the topic. Arranging interviews can be a lengthy

process, where communities are geographically dispersed and where the pressures of economic life mean that people are away from their principal houses much of the time.

In the peri-urban areas, observation took the form of attending meetings of groupings of women already brought together by various NGOs. Interviews were arranged in diverse settings: some were conducted in meeting times, either with individuals or small groups in a space separate from the main group; others were offered by group members in their own homes, in response to a request from the researchers. In all settings the ‘snowball’ process was followed, whereby women who were interviewed made suggestions as to others who would be willing to give an interview. In one setting, the researchers deliberately followed this snowball process with the aim of including women outside the organised group, in order to avoid any possible bias introduced by belonging to such a group.

The preoccupations and priorities raised in the discussion of aims and objectives above (section 2.1) are set out in the set of ‘study questions’ for this phase of the fieldwork, that had been set out in the Project Proposal. These questions formed the basis for more detailed interview guides or sets of questions that were drawn up by individual teams before embarking on the fieldwork. They are quoted here, and have been re-grouped and annotated in italics, so as to provide a guide to the reader of this Report in interpreting the findings of the qualitative phase, presented in subsequent chapters.

- How does traditional birth care deal with normal birth, and how does it identify and describe complications of pregnancy and birth? (*See Chapter 3*)
- How is the physiology of childbirth described in indigenous languages, and how does this differ from descriptions in medical textbooks? (*See Chapter 3*)
- What is the role of husbands in attending births in Andean societies (ritual, practical, or both)? (*See Chapter 3*)
- How do women describe their experiences of childbirth under both these systems? (*See Chapters 3, 4 and 5*)
- How do health professionals perceive indigenous childbirth practices? (*See Chapter 5*)
- How do traditional cultures perceive hospitalised childbirth? what are the sources of possible cultural fears, and how are they formulated in myth? (*See Chapter 5*)
- Are there differential perceptions of the birth process on the part of women and of men? (*Data lacking, but see Section 6.2.5*)
- How do health professionals perceive husbands’ role in traditional childbirth? (*Data lacking, but implicit in views of indigenous childbirth practices, see Chapter 5*)
- How extensive are the provision and take-up of formal systems of ante-natal and birth care? (*See Chapter 6*)

- To what extent are formal and informal systems integrated? (*See Chapters 6 and 7*)
- How is death in and around childbirth understood within traditional cultures? (*See Chapter 7*)

In both rural and peri-urban settings, the interviews were tape-recorded and a certain number of them transcribed. Where possible, recording was done in the native languages of the areas studied, Aymara and Quechua, and transcriptions were set out in parallel text with the Spanish translation. It was agreed to circulate a minimum number of such transcriptions among the whole team. In practice, transcription and translation proved to be the area of project work where there was the most obvious deficit both of time and the necessary skills. Nevertheless, all teams did succeed in circulating at least some transcribed (and, where relevant, translated) material to the other teams.

Internal reports were produced by all the teams, in Spanish, on their qualitative fieldwork. These were circulated to the other teams and were discussed at the second all-team seminar, held in Sucre in March 1995, where the process of planning the quantitative fieldwork was undertaken.

2.2.1.2 The quantitative phase

The qualitative phase had been conceived as providing the basic research material of the project, but also as providing the inputs to the preparation of a questionnaire to be administered in the second, quantitative phase of the main fieldwork. The purpose of this questionnaire was to compare experiences of home and hospital birth across a broader sample of women in the different field sites, using concepts and issues that had emerged as important in the first phase. A draft of the main points to be covered in the questionnaire was prepared through group work at the seminar in March 1995. This was then worked on by sub-committees in the following weeks, and versions were faxed between Sucre and La Paz until a basic agreement was reached among the teams. The final version of the questionnaire then had to be translated into Quechua and Aymara. Some questions were added by the CIES and ILCA teams to the basic agreed version. Procedures and time-tabling were put in place for the completion of the questionnaires.

The construction of a sample population for the questionnaire was a complex process, bearing in mind the number and characteristics of the different sites (see below, section 2.3), and the need to sample similar numbers of women with home and hospital births. A form of disproportionate quota sampling was therefore adopted, with each individual team being given specific quotas of home and hospital births to fill. It is important to note that these quotas were not intended to be proportional to the rates of home and hospital birth either in the individual areas worked in, or over the whole population

covered by the survey. The sampling was purposively ‘disproportionate’ in its intent to cover the two groups —home and hospital births— in equal numbers. Therefore, *generalisations across the two groups in the total sample cannot be taken as representative of the wider population outside the sample.*

An example of this disproportionate sampling is shown by the way the hospital sample was constructed. In the first phase of the fieldwork, virtually no experiences of hospital birth had been encountered in the rural field sites, while in some peri-urban sites, less than half of the women had experienced hospital birth. It was necessary, therefore, to move outside the field sites where relationships had been developed in the first phase, into hospital sites, where interviewing was conducted on maternity wards and in post-natal clinics. Here the relationships established with the women interviewed were of a more transitory nature than those established with a community or group in the first phase. However, hospital work brought the advantage of closer contact with medical staff, and the opportunity to observe on the wards, in waiting-rooms, and, on one occasion, in an ante-natal clinic.

The completed questionnaires were coded and analysed by each of the teams from the different sites, and each team then produced a report on this phase. These internal reports were circulated to the other teams and were discussed at the final seminar of the whole team in La Paz in July 1995.

2.2.2 Other project work

2.2.2.1 ILCA’s preliminary work on Qaqachaka

The team from ILCA undertook to produce a report *before* the start of the main fieldwork in Bolivia, based on recordings made by them in previous years in Qaqachaka, a rural, Aymara-speaking community in Oruro Department. This report was submitted to DGXII of the European Commission in English in July 1994. It contained a very thorough presentation of the knowledge systems and practices around fertility, conception, pregnancy, birth and early childcare, and argued for the recognition of traditional midwifery specialists as part of a ‘formal’ sector of traditional care. It also contained much linguistic documentation of Aymara terms. This report was then translated into Spanish and circulated to the other project teams prior to the first whole-team seminar in Sucre in October 1994. Its findings and the questions it raised formed a basis for the planning of the project work at that seminar and have continued to inform discussion among team members.

2.2.2.2. Coordination work

The work of coordination was carried out jointly by Dr. Barbara Bradby as overall Project Coordinator, and Susanna Rance, as Bolivian Coordinator, involving two half-time commitments. The job of Bolivia Coordinator was set up as a half-time one, while Barbara Bradby devoted half of her time to research, and the other half to coordination. The work of coordination involved international, national, regional and local-level work.

International work entailed financial and administrative coordination, with the European institutions and with Brussels. Six-monthly reports were submitted to Brussels by the Project Coordinator, including short reports and evaluations commissioned from the individual teams in Bolivia.

National work involved firstly the work of coordinating the teams in the different areas, through the three whole-team meetings, and through written, telephone and e-mail contacts in between times. It also involved liaison between the project and the National Health Secretariat⁴ in La Paz. A series of meetings was held throughout the year between the Coordinators and National Health Secretariat officials, involving discussion and circulation of internal project reports. These achieved the result of a formal Agreement, signed with the National Health Secretariat in February 1995, which enabled the joint dissemination of project findings with the National Health Secretariat in July 1995. National coordination also involved liaising with other NGOs and internationally-financed projects working in the area of childbirth.

Liaison at the regional level with the Regional Health Secretariats⁵ and NGOs providing health services was undertaken both by the Coordinators, and by the individual teams as they negotiated access to the different sites. Finally, coordination was necessary between the different institutional teams at local level, in the two project 'bases' of La Paz and Sucre.

⁴ The National Health Secretariat (*Secretaría Nacional de Salud*) was the title of the equivalent of a Ministry of Health in Bolivia during the period in which the project was working there. The Health Secretariat was a sub-division of the Ministry of Human Development (*Ministerio de Desarrollo Humano*).

⁵ The regional divisions of the National Health Secretariat are called Regional Health Secretariats. There are twelve of them, nine with the names of the Bolivian Departments, and three others, of which El Alto is one.

2.2.2.3 The Agreement with the National Health Secretariat

The Agreement⁶ signed in the form of a *Carta de Intenciones* (literally, 'letter of intent') with the National Health Secretariat at national level included the following points:

- The objectives of the project were concordant with the framework of the government's national plan for the reduction of maternal mortality, the *Plan for Life*;
- The work of the project would support the efforts of *Plan for Life* by providing new ethnographic data that would improve understanding of traditional practices;
- The Ministry had already written to the Regional Authorities requesting collaboration, and agreed to provide data on hospital births for the quantitative phase of the project;
- The Project agreed to provide copies of internal and final reports to the Ministry;
- The Ministry agreed to take the findings and recommendations of the project into account in its own ongoing planning and implementation of policy in the area of perinatal care, both at regional and national level.

This latter point was elaborated in further coordination meetings throughout the year into a commitment to *joint dissemination* of the project findings. (See below, section 2.2.2.5, and sections 7.4.2 and 7.4.3).

2.2.2.4 The Meeting of Traditional Midwives organised by CIES

The first public event of the project was the *Encuentro de Parteras*⁷ (Midwives' Encounter), held in El Alto of La Paz in February 1995. This event was organised by the

⁶ A copy of the Agreement (*Carta de Intenciones*) is included in Annex 1 to this report.

⁷ The word *partera* translates literally as 'midwife'. However, in practice in Bolivian society, the word has evolved to denote only those practising outside the institutional medical sector. Professional midwives such as those who attend 'normal' births in Europe have not existed as a profession in Bolivia since the mid-1970s, when the specialised training of obstetric nurses was discontinued under pressure from doctors and obstetricians. But the popular term for such nurses who attended births in hospital and in urban homes had meanwhile become *matrona*, with *partera* being largely reserved for rural and native-language contexts. However, even the association of the *partera* with the traditional context has been blurred in recent years with the introduction of schemes to 'train' *parteras* by the institutional medical sector. Hence the *parteras* who attended this meeting were not all 'traditional midwives', since in fact many of them had learned to reject traditional practices, after attending short courses in 'midwife training' organised by the Ministry of Health or by NGOs. In official terminology these are known as 'trained midwives' (*parteras capacitadas*). Midwives who follow traditional practices, on the other hand, are known as 'empirical midwives' (*parteras empíricas*), a term which has passed into popular urban usage. This opposition between 'empirical' and 'trained' implies that traditional midwives receive no training, and shows a lack of awareness of the conceptual and practical training provided by apprenticeships, sometimes of twenty years, in the traditional sector. It also, curiously, demeans the empiricist foundation of modern science and biomedicine.

CIES team in conjunction with the Regional Health Authority, building on previous institutional contacts. It attracted over forty traditional midwives, far more than had been expected, and was attended also by members of ILCA and the two Project Coordinators. It was written up in the national press,⁸ and the National Health Secretariat made a video of the day. The event and the debates it generated are further described below, in section 6.2.3 of this Report.

2.2.2.5 Dissemination in conjunction with the National Health Secretariat

The project work plan included two months for dissemination and feedback in June and July of 1995. In practice, this time was cut down to one month because of an overrun of time on the qualitative and quantitative phases. Most teams were able to undertake some feedback activities with the communities in which they had worked during this time, including visits to the rural communities by ILCA and TIFAP, and *sociodrama*⁹ sessions organised by TCD in Sucre. (See below, section 5.4) The CIES team demonstrated its commitment to the project by extending its activities into August, when it held a dissemination event jointly with the Regional Health Authority in El Alto. TIFAP intended to carry on dissemination through articles in a Quechua-language newspaper after the formal end of the project fieldwork.

However, in the month of July it was decided to place a major focus on the organisation of a Dissemination Meeting at national level, which was held on 25th July 1995. The National Health Secretariat co-sponsored the event together with the five institutions on the project team. Invitations¹⁰ were prepared and sent out by the National Coordinator to a wide variety of official and NGO representatives. It was felt to be very important to produce a short document of conclusions and recommendations for dissemination at this event, which could be approved by the whole project team. To this end, a process was set in motion whereby the individual teams passed brief documents of their conclusions after both phases to the Coordinators, who met and drafted the document together. This was then passed for approval to the Team Seminar held in La Paz on 24th July, and after discussion, was approved by all those present.

⁸ A copy of the article that appeared in *Equidad*, a weekly supplement on women and gender to a national daily newspaper, is included in Annex 1 to this Report.

⁹ The word *sociodrama* can be translated as English as 'role-play', but this loses the sense of the social meaning of an enactment of an interaction which is there in the Spanish phrase. We have therefore left the original Spanish and italicised the term throughout.

¹⁰ A copy of the invitation to this event is included in Annex 1 to this Report.

The Dissemination event was attended by over a hundred representatives of the Ministry and NGOs, as well as by several journalists. It is described below, in section 7.4.2 of this Report. The Dissemination event held by CIES in El Alto in August in conjunction with the Regional Health Authority carried on this work of dialogue that has been central to the project's methodology. It is described below, in section 7.4.3 of this Report.

2.3 THE FIELD SITES AND TEAMS

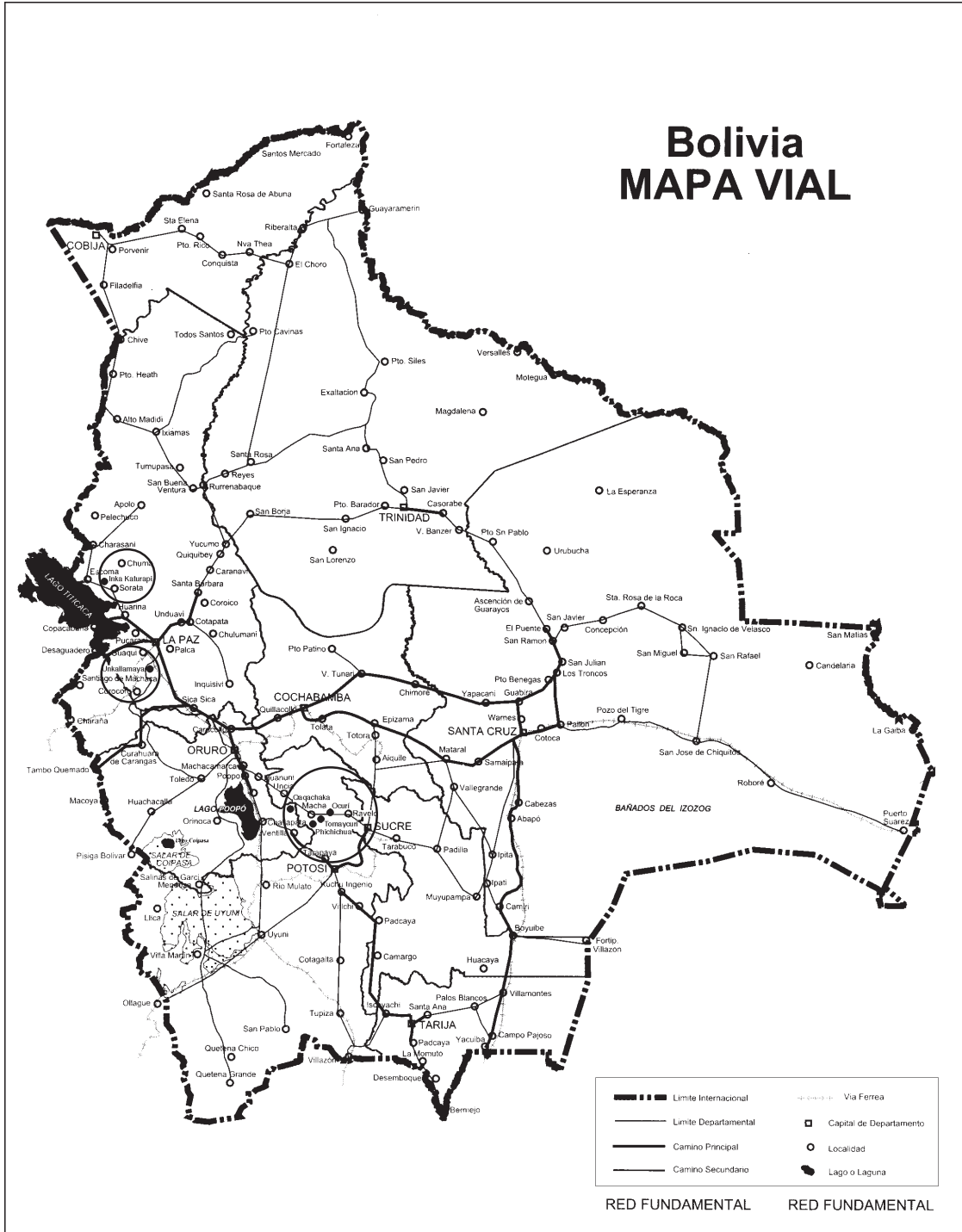
For the sake of simplicity the project field sites have been divided into two main areas, La Paz and Sucre, indicating the two urban centres where project researchers were based, and where team meetings took place. In fact, the project's field sites were spread over a much wider geographical area, as Map 1 indicates, and as we explain in the following sections (2.3.1 and 2.3.2).

2.3.1 The La Paz area

2.3.1.1 The teams based in the La Paz area

The teams working in the La Paz area were from the following institutions:

- *CIES (Centro de Investigación, Educación y Servicios)*. The Centre for Education, Research and Services is an NGO specialising in women's health. Based in La Paz, it has in recent years opened regional offices in three other urban centres in Bolivia, and is in the forefront of education and provision of family planning services. In the year before the fieldwork, CIES had opened its own clinic in El Alto, which, among other services, provides a few maternity beds. CIES employed two social scientists and one medical doctor as researchers on the team, all as half-time posts.
- *ILCA (Instituto de Lengua y Cultura Aymara)*. The Institute of Aymara Language and Culture is an NGO engaged in research and promotion of Aymara language and culture. Its personnel had much past experience in documenting and analysing the place of women in Aymara culture, including reproductive issues. They include Juan de Dios Yapita, the Aymara linguist and scholar, whose expertise was invaluable to the linguistic work of the project. ILCA's research team encompassed two anthropologists (one full-time and one half-time) a linguist, a medical nurse, and an Aymara-speaking *promotora*, or community worker.



Map 1 Field Sites

2.3.1.2 The sites around the La Paz area

- CIES based its fieldwork in two Health Districts of El Alto, a city adjacent to La Paz that has grown very rapidly as the result of rural-urban migration in the last ten to twenty years, mainly from Aymara-speaking areas. It now has over 400,000 inhabitants and is more than half the size of the city of La Paz, but lacks many of the basic facilities and services of a large city.

The first group contacted was a *Núcleo de Educación Femenina* ('Female Education Centre') in Senkata, an area of informal housing within Health District II on the periphery of El Alto. Most of the inhabitants of Senkata are displaced miners and rural migrants who arrived in the years following massive mine closures in 1986. There is no running water or electricity, and no health centre or medical attention. The Educational Centre was established by CDA, the 'Centre for Self-managing Development', which is an NGO that promotes literacy and productive initiatives without recourse to 'aid' in the form of donated foodstuffs.

The second group was sought for comparison because women in Senkata had had so little contact with institutional medical services. A group of women was located with the help of another NGO, in a more established zone called Alto Lima, under Health District I of El Alto. Contacts were also made with medical personnel in various health centres in this District.

- ILCA's personnel divided into two teams and approached two Aymara-speaking rural communities with differing characteristics. The first was Inka Katurapi, in Omasuyos Province, Department of La Paz, a community formed out of an estate after the Land Reform in the 1950s, at 6 hours' journey from La Paz city, and 2 hours from Ancoraimes. The introduction to the community was through the NGO *Consejo de Salud Rural Andino* (Council for Andean Rural Health), which runs a small hospital in Ancoraimes and had in 1994 constructed a brand new medical post in Inka Katurapi, staffed by an auxiliary nurse. The community can be considered to be 'modernising' in that there is a weekly market attended by agricultural buyers from La Paz, and there is considerable out-migration.

ILCA's second team approached the community of Unkallamaya, in the Province of Aroma, also in the Department of La Paz. Unkallamaya is close (half an hour by road) to the urban centre of Viacha, which itself is only two hours distant from La Paz. In Viacha there is a state-run hospital and a medical centre run by an evangelical organisation, and Unkallamaya is also within walking distance of three other medical centres in

neighbouring communities. Therefore, in comparison with Inka Katurapi, Unkallamaya had more long-standing access to institutional medical facilities. It also had a slightly different linguistic make-up, there being much bilingualism with Spanish. In general, its proximity to Viacha and to La Paz means that it can be categorised as a ‘modernising’ community.

- During the second, quantitative phase, both CIES and ILCA broadened their areas to include more cases of hospital births. CIES worked through a post-natal clinic in a maternity hospital in El Alto; and ILCA conducted some interviews with women on the wards in various maternity units in La Paz and Viacha.

2.3.2 The Sucre area

2.3.2.1 The teams based in the Sucre area

The teams working in the Sucre area were from the following three institutions:

- TIFAP (*Taller de Investigación y Formación Académica y Popular*). The Centre for Academic and Popular Research and Training is an NGO based in Sucre and working on socio-economic and cultural issues, with a specialised focus on the Quechua language and culture. TIFAP contracted two full-time researchers for the project, an anthropologist and a linguist, who is also an Andean medical specialist. TIFAP also provided other research assistance and back-up to the project through its Secretary and Director.
- The University of St. Andrew’s, Scotland. The participation of St. Andrew’s was through its Institute for Amerindian Studies, which provided an anthropologist for the year in Bolivia, who in turn contracted a local community educator as a research assistant.
- Trinity College, Dublin, Ireland. This university was the ‘leader institution’ in the project, through its Department of Sociology and the Centre for Women’s Studies. It provided the Project Coordinator, who was also a sociological researcher, for the whole year in Bolivia, and it provided a medical sociologist specialised in childbirth, for the latter seven months of the fieldwork. The Project Coordinator contracted a local nurse as research assistant.

Two teams were formed out of these three institutions, to undertake study in the rural and peri-urban areas respectively. The rural team divided into two sub-teams, composed of TIFAP on the one hand, and TIFAP–St. Andrew’s on the other, studying two different

sites in the rural area of North Potosí. The peri-urban team was made up of personnel from TCD and TIFAP.

2.3.2.2 The sites around the Sucre area

The sites where these teams worked were chosen so as to include a rural, Quechua-speaking area on the one hand, and a peri-urban area of Sucre with a substantial number of migrants from the rural area in question. The two rural communities studied were in the north of Potosí Department, which is connected by road to Sucre, which itself lies in the neighbouring Department of Chuquisaca.

- The first of these, Tumaykuri, is a community of pastoralists, where kin groups live in dispersed units with their herds of llamas and sheep, above the level of cultivation. In recent years, a nucleated village has been mapped out and has started to grow along the road that passes through the lower level of the community. This new settlement pattern and the concomitant diversification of economic activities into more agriculture and handicrafts, have been greatly encouraged by the building of a medical post on the road by the *Instituto Politécnico Tomás Katari* (IPTK). The Tomás Katari Polytechnical Institute is an NGO which has offices in the cities of Potosí and Sucre, and which runs a rural hospital and training centre in the small town of Ocurí, at one hour's journey by road from the medical post in Tumaykuri. It staffs the medical post with an auxiliary nurse.

The second community studied, Phichichua, lies a little further east from Sucre, bordering the road from Potosí to the small town of Macha, and is of mixed agricultural and pastoral activities. The nearest medical post is in Macha staffed by a doctor from IPTK, but there are smaller posts staffed by auxiliary nurses within the area that was covered by the fieldwork. One of these, which lay within Phichichua itself, has been staffed only very recently by a female nurse from the other side of Ocurí, and people from Phichichua still tend to go to the post in neighbouring Castilla Uma, which has been staffed for a longer period by a male auxiliary nurse. The nearest hospitals are in Colquechaca and in Ocurí. During the second, quantitative phase of the fieldwork, the area of fieldwork was widened so as to include interviews with women from neighbouring communities.

In both these communities the principal language spoken is Quechua, although a certain number of members have acquired Spanish to differing degrees, mainly as a result of temporary or circular migration.

- There has been widespread migration into Sucre over the last decade from all the surrounding areas, but that from North Potosí has been particularly heavy owing to the combination of mine closures, and the drought which intensified in 1983. In order to obtain a comparison with birth practices in the rural area being studied, the peri-urban team therefore concentrated its research in the first phase of the project in a neighbourhood of Sucre with a high proportion of migrants from North Potosí, which has been given the pseudonym of ‘Yanachaki’. This neighbourhood is equipped with a medical post, also run by IPTK, and staffed by a doctor and auxiliary nurse. Access was given to the team by IPTK to the ‘Women’s Centre’, still popularly known as the ‘Mothers’ Club’, through which it distributes dairy products to children under five in the neighbourhood. The main daily language of the neighbourhood is Quechua, although most of the women have some knowledge of Spanish, and some of them are highly competent speakers in both languages. Levels of formal education are low, although some women have basic literacy and some primary schooling.

During the second, quantitative phase of the fieldwork, the field site was widened to include four peri-urban neighbourhoods, and the three maternity hospitals in Sucre. This was in order to obtain sufficient numbers overall for the questionnaire in the short time available. In the neighbourhoods, the base was also widened so as to operate through the network of women’s organisations, so avoiding the impersonality of door-to-door work. This was also necessary so as to obtain a sufficient proportion of home births, as it was found that in Sucre, a high proportion of births to migrant women living in the peri-urban neighbourhoods were taking place in hospital. Although it is Bolivia’s official capital and is the seat of the Supreme Court, the National Archive, and the oldest University in Bolivia, Sucre is a medium-sized town rather than a city: its total population is about 100,000. Nevertheless, it is equipped with three maternity hospitals, a network of medical posts, and a good public transport system. So, in order to find home births for the sample, it was necessary to move into more peripheral neighbourhoods, and ones to which the inhabitants had migrated more recently.

In this second phase also, questionnaires were administered to women who had recently given birth in all three maternity hospitals. The peri-urban team also undertook a small study of births in the rural hospital of Ocurí, as part of the larger questionnaire study, in order to include this mid-point of comparison between urban and rural birth experiences. Finally, in-depth interviews were conducted with medical personnel in the hospitals in Sucre and Ocurí, as a complement to both phases of the project.

2.4 INTERNAL PROJECT REPORTS

It is important to list here the main internal reports produced and circulated internally by the project team in this Final Report, not only to give credit to the work done by individual project teams, but also because many of these reports have already been circulated to the Bolivian National Health Secretariat, in accordance with the Agreement signed with the authorities. Others have been delivered to the relevant NGOs providing health services in sites where the project worked. Therefore, these reports and their circulation form part of the overall methodology of the project with respect to the initiation and support of dialogue between the two medical systems operating in Bolivia in relation to birth. In furtherance of these aims, authors and addresses of the institutions that produced the reports are listed, so as to enable other interested parties to request copies of this documentation.

2.4.1 Reports produced by CIES

Address: Centro de Investigación, Educación y Servicios, Casilla 9935, La Paz, Bolivia.

Fax no: 00-591-2-2491571

2.4.1.1 Qualitative phase

- *'Hacia la reducción de la mortalidad materna en Bolivia: informe de la fase cualitativa'* ('Reducing maternal mortality in Bolivia: report on the qualitative phase'), CIES, 1995. (44pp; Spanish language text)

2.4.1.2 Quantitative phase

- *'Hacia la reducción de la mortalidad materna en Bolivia: informe preliminar de la fase cuantitativa'* ('Reducing maternal mortality in Bolivia: preliminary report on the quantitative phase'), CIES, 1995. (21pp. + tables; Spanish language text)

2.4.1.3 Summary final report

- *'Hacia la reducción de la mortalidad materna en Bolivia: prácticas apropiadas de atención perinatal en los sistemas biomédico y tradicional'*, ('Reducing maternal mortality in Bolivia: appropriate practices of perinatal care in the biomedical and traditional systems'), CIES, August 1995. (12 pp.; Spanish language text)

2.4.1.4 Midwives' workshop

- *'Encuentro de parteras de la Ciudad de El Alto: informe parcial del equipo organizador'* ('Workshop for midwives of El Alto city: preliminary report of the organising team'), prepared by Susanna Rance, for CIES, April 1995 (21pp.; Spanish language text)

2.4.2 Reports produced by ILCA

Address: Instituto de Lengua y Cultura Aymara, Casilla 2681, La Paz, Bolivia

Fax no: 00-591-2 2396815

2.4.2.1 Preliminary phase

- 'Traditional Maternity in Qaqachaka, Oruro: an outline summary of the existing health care facilities, practices and beliefs surrounding childbirth in one Andean *ayllu*', by Denise Arnold and Juan de Dios Yapita, ILCA, July 1994. (66 pp., including glossaries of Aymara terms; English language text submitted to the EC; Spanish language translation, *'Maternidad tradicional en Qaqachaka'*, circulated to the team in Bolivia in October 1994)

2.4.2.2 Qualitative phase

- *'Maternidad tradicional en el altiplano boliviano: las prácticas del parto en algunas comunidades aymaras'* ('Traditional maternity in the Bolivian highlands: birth practices of some Aymara communities'), by Denise Arnold, Juan de Dios Yapita, Mauricio Mamani, Cipriana Apaza, Margarita Tito, Marcelo Villena, y Yolanda Payano, ILCA, March 1995. (83pp.; Spanish language text; Annexes include table of 'Traditional Medicine used in birth', 23pp, and transcription/translation of interview in Aymara with a male traditional midwife, 55pp)
- *'Informe borrador de la comunidad de Unkallamaya'* ('Preliminary report on the community of Unkallamaya'), by Mauricio Mamani, Denise Arnold, and Yolanda Payano, ILCA, April 1995. (41 pp.; Spanish language text; accompanied by transcription/translation of interview in Aymara with a traditional midwife, 68pp.)

2.4.2.3 Quantitative phase

- *'Informe borrador, fase cuantitativa: Maternidad tradicional en el altiplano boliviano: las prácticas del parto en algunas comunidades aymaras'* ('Preliminary report, quantitative phase: Traditional maternity in the Bolivian highlands: practices of birth in

some Aymara communities'), by Denise Arnold and Juan de Dios Yapita, with the ILCA team and statistical consultants, ILCA, June 1995. (114pp.; Spanish language text and tables)

2.4.2.4 Summary final report

- *'Informe Final. Proyecto para la reducción de la mortalidad materna: prácticas apropiadas del parto'* ('Final Report. Project on the reduction of maternal mortality: appropriate birth practices'), Denise Arnold and Juan de Dios Yapita, ILCA, July 1995. (8pp.; Spanish language text)

2.4.3 Reports produced by TCD

Addresses: Barbara Bradby, Dept. of Sociology, Trinity College, Dublin 2, Ireland. Fax: 00-353-6771300. Jo Murphy-Lawless, Centre for Women's Studies, Trinity College, Dublin 2, Ireland.

2.4.3.1. Qualitative phase

- *'Partos domiciliario y hospitalario en un barrio peri-urbano de Sucre: experiencias relatadas por mujeres'* ('Home and hospital births in a peri-urban neighbourhood of Sucre: women recount their experiences'), by Mary Aguilar and Barbara Bradby, Dept. of Sociology, TCD, with support of Primo Nina and Teresa Ramos, TIFAP. Dublin. March 1996. (124pp.; Spanish language text)

2.4.3.2. Quantitative phase

- *'Informe parcial de la fase de investigación cuantitativa'* ('Preliminary report on the quantitative research phase'), by Jo Murphy-Lawless and Teresa Ramos, TCD/TIFAP (12pp.; English and Spanish language versions extant)
- *'Informe interpretativo de los datos de la fase cuantitativa'*, ('Analytical report on the data from the quantitative phase'), by Mary Aguilar and Barbara Bradby, TCD: Parts I and II on the peri-urban study, July 1995; Part III on the Ocurí study, November 1995. (42pp.; Spanish language text)
- 'Summary quantitative report for Sucre' (*'Informe sumario cuantitativo del estudio Sucre'*), by Jo Murphy-Lawless, Centre for Women's Studies, TCD, July 1995. (47pp. + tables; English language text. Introduction, 13pp. also available in Spanish)

2.4.3.3 Obstetric practices

- *‘Políticas y prácticas biomédicas para las mujeres en trabajo de parto en Sucre’* (‘Bio-medical policies and practices for women in labour in Sucre’), by Jo Murphy-Lawless, Centre for Women’s Studies, TCD, 1995. (16pp.; English and Spanish language versions extant)

2.4.4 Reports produced by TIFAP

Address: Taller de Investigación y Formación Académica y Popular, Casilla 447, Sucre, Bolivia

2.4.4.1 Qualitative phase

- *‘Los tabues y la tecnología del parto en una comunidad de pastores de puna’* (‘Taboos and technology of birth in a highland pastoral community’), by Cassandra Torrico, TIFAP, 1995. (55pp.; Spanish language text)

2.4.4.2 Quantitative phase

- *‘A reading of the statistics’* (*‘Una lectura de las cifras’*), by Cassandra Torrico, Tumaykuri rural team, TIFAP, 1995. (approx. 20 pp.: English and Spanish language versions extant)
- *‘Informe parcial de la fase de investigación cuantitativa’*, (‘Preliminary report on the quantitative research phase’), by Primo Nina, Azari peri-urban team, TIFAP, June 1995. (7pp.; Spanish language text)

2.4.4.3 Vocabularies

- *‘Vocabularios acerca del parto’* (‘Vocabularies of birth’), TIFAP (42 pp; Quechua vocabularies of birth from interviews, with Spanish translations)

2.4.4.4 Final summary reports

- *‘Resumen parte cualitativa y cuantitativa: area rural y urbana —Liq’uni, Phichichua y Azari’*, (‘Summary of the qualitative and quantitative phases: rural and urban areas—Liq’uni, Phichichua and Azari), by Primo Nina, TIFAP, July 1995. (10 pp.; Spanish language text)

- *'Resumen parte cualitativa y cuantitativa: Tumaykuri'*, ('Summary of the qualitative and quantitative phases: Tumaykuri'), by Cassandra Torrico, TIFAP, July 1995. (10 pp.; Spanish language text)

2.4.5 Reports produced by the University of St. Andrew's

(Address: Institute of Amerindian Studies, University of St. Andrew's, St. Andrew's, Fife, Scotland, U.K.)

2.4.5.1 Qualitative phase

- *'Prácticas tradicionales del parto entre quechua-hablantes en el Norte de Potosí: análisis preliminar. Proyecto CE'* ('Traditional birth practices among North Potosí Quechua-speakers: preliminary analysis. EC Project'), by Tristan Platt on the qualitative work of the Phichichua rural team (Balbina Arancibia, Primo Nina and Tristan Platt). (Contains section I, 'Sources of the study' and section II, 'Periodisation of pregnancy'.) University of St. Andrew's, March 1995. (23pp. Spanish language text)

2.4.5.2. Quantitative phase

- *'Informe sobre la encuesta cuantitativa de madres campesinas'*, ('Report on the questionnaire survey of rural mothers'), by Balbina Arancibia and Tristan Platt, University of St. Andrew's, with the support of Primo Nina, TIFAP, June 1995. (22pp.; Spanish language text)

2.4.6. Transcriptions of interviews

In addition to the above reports, which, where indicated, contained transcriptions as appendices, a number of other transcriptions were circulated internally to the teams. Since permission has not been sought for wider circulation of these interviews, the following list is for information purposes only and the narrators are listed anonymously:

- *'Entrevista con Don D.'* ('Interview with Don D. '), transcription in Aymara and parallel Spanish translation of interview in Aymara with a male traditional midwifery specialist, Denise Arnold and Juan de Dios Yapita, ILCA, 1995. (55pp.)
- *'Entrevista con Doña R.'* ('Interview with Doña R. '), transcription in Aymara and parallel Spanish translation of interview in Aymara with a traditional midwife, Cipriana Apaza and Mauricio Mamani, ILCA, 1995. (68 pp.)

- *‘Entrevista no.8: Doña D.’* (‘Interview no. 8: Doña D.’), transcribed in Quechua with parallel Spanish translation by Balbina Arancibia, Primo Nina and Tristan Platt, Phichichua rural team, Sucre, 1995. (86pp.; including vocabulary)
- *‘Entrevista de la Partera L.’* (‘Interview with Midwife L.’), transcribed in Quechua with parallel Spanish translation by Mary Aguilar, Jacinta Andrade, Barbara Bradby, and Primo Nina, Peri-urban team, Sucre, 1995. (50 pp. including glossary)
- *‘Entrevista de Doña E.’* (‘Interview with Doña E.’), transcribed in dialect Spanish, by Mary Aguilar, Barbara Bradby, and Teresa Ramos, Peri-urban team, Sucre, 1995. (40 pp.)

2.5 PUBLIC DISSEMINATION AND DOCUMENTATION

The document produced with inputs from individual teams by the Coordinators is entitled:

- *‘Hacia la Reducción de la Mortalidad Materna en Bolivia: Presentación de Resultados Preliminares’*, (‘Reducing Maternal Mortality in Bolivia: Presentation of Preliminary Results’), La Paz, 26 July 1995. (4 pp.)

The document was printed on notepaper containing the logo of the Bolivian National Health Secretariat (*Secretaría Nacional de Salud*), as well as the logo of each participating team.¹¹

2.6 SUMMARY DESCRIPTION OF THE FIELD STUDIES

The study set out to identify appropriate birth practices for rural and migrant women in Bolivia, and to look at the factors which prevent women from taking up biomedical care where available. The main fieldwork took place between October 1994 and July 1995 in two areas of Bolivia, with bases in La Paz and in Sucre. Research teams were composed from three Bolivian non-governmental organisations (CIES, ILCA and TIFAP), and two European institutions (TCD and the University of St. Andrew’s). As a whole, the team incorporated an inter-disciplinary mix of anthropologists, linguists, sociologists, and women’s health specialists. Medical personnel recruited to the team included two nurses, one doctor, and a traditional medical practitioner.

¹¹ A copy of this document is included in Annex 1 to this Report.

In each area, studies were undertaken both in rural and in peri-urban settings. The study was divided into two phases of data collection, a qualitative and a quantitative phase. Methods used in the first phase were participant observation and in-depth semi-structured interviewing. Interviews were conducted with women about their birth experiences and reproductive life histories, and with their care providers in both the biomedical and traditional spheres. Preliminary project work had shown that traditional birth care has both a 'formal' sector of specialised midwives, and an 'informal' sector of family care provided by husbands and female relatives. Interviews were tape-recorded and where possible, transcribed fully. Those that were recorded in Quechua or Aymara were transcribed in the native language with a parallel translation into Spanish. Each team then analysed their work and produced an internal report for circulation to the whole team.

The second phase of fieldwork used a questionnaire that was administered to two groups of women across the field sites, aiming to cover equal numbers of women with home births and women with hospital births. The questionnaire was designed by the whole team on the basis of the work of the qualitative phase, and was translated into native languages. Quotas were assigned to each of the individual teams in each of the categories. Each team conducted their own analysis of results and produced internal reports on the second phase which were circulated to the whole project team.

A final phase of dissemination built on the formal Agreement that had been signed earlier in the year with the National Health Secretariat, and events were organised at both national and regional level. Despite the run over of time from the first two phases, some teams also undertook feedback with women and other participants at local level.