

CHAPTER 4

EXPERIENCES OF HOSPITAL BIRTH

This chapter deals with women's experiences of birth in the institutional medical sector. In the main, this refers to birth within hospitals, run either by the state or by NGOs but excluding the private sector. The migrant women in Sucre included a few who had given birth in the hospital of the *Caja de Seguro*, the national insurance system which runs medical services for a minority of insured workers and their families. Across the study there were also a small number of births in medical posts. It was apparent from information given by the auxiliary nurses in Inka Katurapi and Tumaykurí that some home births in the rural areas are being attended by these biomedical personnel. However it did not prove possible to interview any women in depth who had experienced birth in this form. The main comparison within the study, therefore, remains that between home birth as described in the previous chapter, and institutional birth in a hospital or medical post.

The most detailed accounts of women's experiences of hospital birth were collected in Sucre, by the TCD-TIFAP team, and this work will be reviewed in section 4.1. The material presented in section 4.1 is taken from the same group of in-depth reproductive life-histories as were drawn on in section 3.5 of the previous chapter. It continues the style of reporting adopted there, and in some cases, continues the story from where it left off, as women move from home births to hospital births with age, parity, and migration.

Section 4.2 goes on to look at what can be learned from the quantitative study about hospital practices *as experienced by the women in the study*, drawing on the reports from individual project sites. Section 4.3 focuses on issues of language and ethnicity as they arose for women in the hospital situation. Although this chapter attempts to look at hospital birth from the point of view of the traditional culture, it does *not* include direct comparison of home and hospital birth care, which is reserved for Chapter 5.

4.1 QUALITATIVE ACCOUNTS OF HOSPITAL BIRTH FROM PERI-URBAN SUCRE

Within the group of nine women who told their reproductive life histories in the qualitative phase of the fieldwork in Sucre, there were five who had had all of their births to date in hospital. Three had six children, one four, and one eight. It became obvious

with time and a better knowledge of the whole group of women in the Mothers' Club, that this group who had had hospital births were all members of, or ex-members of, the Committee that ran the Club. This was linked to the fact that they were materially better off than many other club members: two ran small shops; two were not migrants but born in Sucre; three had had at least some of their births in the *Caja* hospital because their husbands had insurance; one had a complete secondary education; none had experienced the death of a child.

In these ways they were not typical of many of the Club members who had less economic resources, spoke less Spanish, and had migrated more recently. Nevertheless, this factor should not be exaggerated. We are talking about internal differences between Club members. All would have been living in poor economic conditions compared with people living in the centre of Sucre. The material benefits of the Club would not seem great to an outsider —100 grams of soya milk or yogurt for each child under five— and these women were all prepared to spend the daily and weekly time necessary to obtain this 'aid'.

None of these women had ever seriously considered giving birth at home. Those who were migrants had migrated young and worked in domestic service until they had children. Although they all had relatively recent roots in rural living and spoke Quechua, there was a presumption in favour of hospital birth. In part, it seems that this presumption went along with their economic status, particularly in cases where the husband had at some stage been in insured work. It would seem therefore that there is a factor of upward social mobility which brings women into institutional birth regardless of what kind of service is offered there.

On the other hand, there were two women in the group who had migrated to Sucre having already had several children at home in the country. Doña Emilia, whom we have already encountered, and Doña Alejandra, had both had one child at home in Sucre, and then had their last two births in hospital. The experience of this sub-group of women is particularly interesting to the project, since they are able to see hospital birth through the eyes of the traditional culture, having already had considerable experience of their own births and those of their mothers and sisters in the countryside.

4.1.1 Unattended births in hospital

The most striking fact about the four births that these two women migrants experienced in hospital, was that none had actually been attended by hospital staff. Three babies had been born in the hospital bed unattended, and one in the taxi on the way to the hospital.

One other woman had also had her first baby alone in hospital, making this an experience of three out of the seven women with hospital births in the group.

Both of Doña Emilia's hospital births took place in bed, unattended. It will be remembered that she had already given accounts of her unattended births in the country and at home in Sucre, and her account of hospital birth has much continuity with these. She prefaced the account of her fifth birth with a repetition of the joking claim that her children 'are born of their own accord', and described the typical pattern of labour pains that subside just before the birth. Even her description of her movements within hospital paralleled the movements she described in her rural births, as she walked to the toilet with the pressure to urinate, and then had difficulty getting back to the bed. However, her own intimate knowledge of her body, based on her experience of previous births, was not recognised by the hospital staff:

And he checked me and everything, the doctor, as soon as I arrived. He said that, "It's not time yet, it's not time yet, there's still some stages to go," he said. But it wasn't as if—! I knew all about it myself by then! I wasn't in for my first—, and so, mm, my body was trembling, my body was already beginning to tremble like it does, —peeing, peeing, peeing, all the time I was! I went into the toilet. And in the toilet I said to myself, "Oh dear! What'll I do now? My first time in hospital!" But the pain was coming to me, and I was telling the nurse, I was telling the doctor whenever they went by. So I went to the toilet, "Oh dear! I don't know! It feels like I'm going to have my, my daughter right here!" I said.

Then the nurse found her in the toilet:

"Whatever are you doing in there? Come back to bed! Lie down! It's not time yet!" she said. Back in bed they checked me again. They checked me, then the nurse and the doctor went away. But in the bed I got another pain, —I was *lying* down on my— "You have to lie on your *back*, just quietly now, and you should go to sleep," they said to me.

Doña Emilia suffers from chronic asthma as a result of tuberculosis, and cannot lie on her back normally, let alone when giving birth:

But I couldn't stay on my back with my breathing problem, let alone with this! So I turned over on my side, so I was, I was just lying on my side, when I GOT A PAIN, right there acro—, crosswise on the bed (.) NO WAY could I hold it back then, and so the baby was born right there in the bed.

The two other women in the ward called out to the doctor. Because of the shame she felt, Doña Emilia did not 'pick up' the baby, but simply reached down to clasp the baby with

her right hand, in order to prevent ‘the devil’ taking it. The placenta was born almost simultaneously with the baby. The doctor came in and lifted the baby by its feet, and gave it a smack to make it cry. He scolded Doña Emilia, implying that she had done something wrong:

“Oh, my dear lady! How on earth?”, he said.

Doña Emilia’s second hospital birth, although it took place in a different hospital, followed an almost identical pattern, with her giving birth alone in the bed. However, this pattern cannot be explained by individual characteristics of Doña Emilia. A very similar experience of giving birth alone was recounted by Doña Alejandra, when she first went to hospital after giving birth eight times at home. She described her shocked fear, when after arriving in hospital in labour, she was given an enema, went to the toilet, and the pains ceased completely. She waited silently on the hospital bed, wondering what had happened, and whether to go home again. Then that night, when the nurses had gone in to their office, and everyone was sleeping, she was woken by a pain. She went to the toilet, and had difficulty returning. Realizing the baby was about to be born, the other women told her to get onto the bed. She did so, and squatted on top of the plastic sheet to give birth. The other women called out to the nurses, who scolded her for not telling them in time, and took her to the labour ward to expel the placenta in the ‘gynaecological position’.

The third woman who had experienced unattended birth in hospital also gave a very similar account. Doña Honoria, like Doña Alejandra, gave the fact that she was living in rented accommodation with a landlady as her reason for going to hospital the first time. Her account has many similarities with those of Doña Emilia and Doña Alejandra. When she arrived in hospital, after spending the night pacing her room and going to a sister’s room at dawn, she was told she was not ready to give birth by the nurses. She gave birth alone in the bed, and once again, it was the other women in the ward who called the medical staff.

While these experiences were recounted with gentle humour, there is clear evidence in all of them of what must be called at best a failure of communication on the part of medical staff. It is also clear that, at least in the case of the two older women migrants, they saw the notion of giving birth in the ‘gynaecological position’ as impossible, and that their unattended births to that extent indicate a purposeful resistance of the standard hospital position.

The final unattended birth, that of Doña Alejandra in the taxi, also shows evidence of conflict, this time between herself and her husband. She herself explained that she did not want to go to hospital, and was in the process of giving birth at home, when she fainted, and her husband hailed a taxi on the main road near where they live. She came round in the taxi, fainted again, then came round as she gave birth while the taxi screeched to a halt at the doors of the hospital. She fainted again, and was woken by the pain of the doctor pressing on her abdomen to expel the placenta. After this experience, she was admitted to the hospital and was given a shower, which she described as cold. While it is possible that other cultures might see it as normal for a woman to wish to wash after birth, it should be emphasised that within Andean cultures, even warm water will be seen as 'cold', and therefore dangerous, even life-threatening, for the mother.

4.1.2 Expectations of 'care' and of 'help'

It came as a surprise to the researchers of the Sucre peri-urban team, that after recounting experiences which to us amounted to giving birth *without* care, Doña Emilia should pronounce her satisfaction with the care given in hospital. This was more than a comparison with her negative view of her husband's level of care in her home births. She on several occasions praised hospital birth care, and her reasons for this will be considered in more detail below (section 4.1.5). What becomes evident from analysis of the transcripts of this group of life histories, is that there is a linguistic distinction made between *atención*, which is used primarily for 'care' or 'attention' *after* the birth of the baby, and *ayuda*, which is used for 'help' during the birth of the baby.

Our own cultural bias as researchers schooled in 'Northern' approaches to childbirth is to expect the main focus of care to be on the birth of the baby. Modern pharmaceutical interventions ensure that the placenta is born very soon after the baby, meaning that care in this phase becomes assimilated in Northern thinking to the major focus on 'delivering' the baby. This cultural bias is evident, however, in our description of the three women's hospital births as 'unattended'. It is evident from Doña Emilia's account (though not from Doña Alejandra's) that she received the care she expected in hospital: that is, she received care *after* the birth of the baby. This may include care during the delivery of the placenta and the expression of blood from the uterus. It means having someone else to 'pick up' the baby, involving cutting the cord, as well as washing and clothing the baby. It also means being given nutritious food during the hours and days after birth: hence the importance that hospital food assumes in women's accounts of hospital care. Women also clearly appreciate the rest in a hospital bed which they receive in the two or three days after giving birth.

We argue, therefore, that for women with a relatively ‘traditional’ outlook, it is the experience of care *after* the birth of the baby that will colour their assessment of hospital birth. For women with a more ‘modern’ outlook, the notion of *ayuda*, or ‘help’ with giving birth to the baby, becomes more important in their accounts. Doña Juana, for instance, who had had seven of her eight children in the Social Security hospital, was proud of the fact that she had given birth to all of them vaginally, despite long and arduous labours:

But I always had terrible pains, each time. I’ve suffered a lot. But even so, they’ve never given me a Caesarean! I’ve always had them normally. Yes.

She also, however, expressed a tinge of resentment at the ‘help’ she perceived others as receiving in hospital.

J. But I was never given *anything*, not even a drip, nothing.

B. You were never once given a drip?

J. Nothing, not once anything to help me. Some of them are being given drips and injections as well to *hurry it up*, so that it will *help* them more, but me, nothing.

Such ‘help’, she believes, could have hurried up her labours, which she described as very long. While this notion of ‘help’ has continuity with the massage and herbal teas that are given in traditional birth care to help speed up labour, the expectation under hospital conditions is clearly that modern technology should be able to ‘help’ more efficiently than home technology. It is for this reason that the notion of ‘help’ seems to become more important in accounts of those who have experienced all their births in hospital.

These linguistic distinctions are important, not only because they indicate a shift from the focus on the birth of the placenta in traditional birth care, to that on the birth of the baby in the drama of hospital birth, but also because they show the shift from a concept of self-reliance in the traditional culture to that of female dependency in the modern one.

4.1.3 The practice of pressing on the abdomen

It has to be said that the stories of the hospital practice of pressing on the abdomen during the second stage of labour occasioned some unease among women researching on the project. This was particularly so for those of us to whom this practice was new, as we had not come across it in our experience in Europe and the United States. However, our outsiders’ views of this practice were countered by the negative views expressed by Bolivian women working on the project of ‘our’ practice of using forceps to extract the

baby. The use of forceps is seen in popular discourse as a major cause of mental handicap among children, and stories of severed limbs and heads abound. Medical personnel see forceps as used nowadays only by an 'old guard' of hospital doctors.

It is against this backdrop of a low use of forceps that the following accounts of abdominal pressure should be seen. The most detailed of these is that of Doña Bertha, when she went into hospital for the birth of her fifth child. She was seen first by a female gynaecologist who told her that the baby was dying because her waters had broken. The gynaecologist called the obstetrician, who said that he would have to do an emergency Caesarean, 'because the baby is huge, and is stuck'. Nevertheless, he decided to accelerate the labour with 'an injection and a drip', and to attempt vaginal delivery. But Doña Bertha says that although they were 'pouring' liquid into her through the drip, her pains stopped completely. So the doctor told her to buy another injection, 'a red one', and then they told her to push. When she said that she could not, the nurses took hold of her and pressed down on her belly to push out the baby:

And he says to me, "You have to push, and you have to -". "But Doctor, I can't any more." "You must push," he says. The nurses grabbed hold of me and said, "You have to push." Because they could see, which of course, I, I couldn't see. They were looking, right? And they said to me, "Push, now push!" They gave me the injection and the thing is that they pushed me here. ((indicating the abdominal area)) "This time the baby's going to come out. Two. Now. Now. Two pushes. On three, the baby's going to be born, otherwise we're going to give you a Caesarean." I::: got my baby out and then I don't remember anything, I don't remember anything, I didn't come round properly till they were sewing me up, and I was in a lot of pain, and I said to him, "And my baby, Doctor, what is it? a girl or, or, a boy?" I say. "It's a girl", he says, "but it's cost you," he says. The baby had torn me right inside, and just at that moment, she had done a poo-poo. Her hand came out first, and then the head.

The other woman who spoke of this practice in the qualitative interviews was Doña Juana, in the context of saying how *little* 'help' she had received in hospital (see above, 4.1.2) It seems from her account that the pressure on the abdomen appears to have been so routine that she hardly saw it as intervention.

During the quantitative questionnaire phase of the fieldwork, several women spoke spontaneously of the pain occasioned by this practice, especially those who were interviewed in hospital soon after giving birth. One woman, a rural migrant giving birth to her fourth child, had previous experiences of both home and hospital birth. She described the heavy manual pressure she had received as having caused her a lot of pain. She was surrounded by three male doctors (this was a training hospital), one of whom

pressed down on her stomach on one side, while another sat between her legs, and the third held her hand on the other side. She expressed her doubts about the safety of the practice:

That's why they make us burst open down there. People say that it's dangerous. And they don't give us anything to make us sleep, nor do they give us injections. That pressing with the hands is the only thing they do to us.

Another migrant woman, giving birth to her second child, in addition to describing the practice as very painful, also described it as 'helping' her. In this case, the doctor had told her that the baby was lying on its side, and would not get into a 'head-first' position, so that she was 'almost given a Caesarean'. The woman was thanking God that this had not happened, as she would not have been able to afford it, her husband having left her during the pregnancy. During the birth, she said, the doctor had sat between her legs, while two student doctors stood on either side of her pressing down on her stomach.

One question that arises is whether biomedical personnel see their practice as having continuity with the massage traditionally practised in the countryside. We did not find any direct evidence of this, and in general, urban doctors and nurses had no direct knowledge of traditional practices. Nevertheless, doctors believe that traditional midwives cause problems in birth, and sometimes attribute these to the use of rough manipulative practices. Nurses we spoke to explained their use of abdominal pressure in terms of a stereotype of the woman who 'will not try'. They spoke of cases in which the woman can in no way be persuaded to make the necessary effort to push the baby out, meaning that they have to take over from her and resort to heavy manual pressure to expel the baby. Nevertheless, the evidence from the quantitative phase of the project shows that this procedure is very widespread, and is not just reserved for the exceptional problem case.

4.1.4 Tears and episiotomies

The above account from Doña Bertha describes the internal vaginal tear she incurred with the hand-presentation of her fifth child (see section 4.1.3). Doña Demetria also gave a detailed description of her suffering from an episiotomy practised during the birth of her first child. She explained how she had experienced problems after coming out of hospital, because she had not looked after herself sufficiently, and 'air' had entered into her through the wound.

However, Doña Bertha also told us that she had had episiotomies or suturations in *each* of her six births. This repeated trauma had left her with continual pain, and difficulty with movement. It emerged during the qualitative phase that Doña Bertha was not the only woman in the group to have experienced repeated episiotomies. Doña Juana distinguished between tears, episiotomies, and tears which had been enlarged by cutting before suturing. Between these variants, she had undergone suturation on four out of eight births. And Doña Felicia also spoke of the episiotomies she had undergone in hospital. In fact, the only women of the group who had given birth in hospital who did *not* speak of episiotomies or suturing were the three who had given birth alone in the bed.

It is to be noted that a quantitative study such as was carried out in the second phase of this project will not generally show up repetitive practices like this, if it asks, as this one did, only about the woman's last birth. However, several women spoke spontaneously of repeated episiotomies, and this information was sometimes registered in a comment on the questionnaire. In this way, two other cases of repeated episiotomies were recorded: one woman had experienced four, and another five episiotomies.

The association of tears with manual pressure on the abdomen is evident from the in-depth accounts of Bertha and Juana. As all of these women gave birth in the 'gynaecological position', it is interesting that ILCA report a low rate of tears in Inka Katurapi, where women give birth mainly in the 'all fours' position. However, it was felt that the quantitative data across the project on episiotomies and tears was probably an underestimate, due to the embarrassment experienced by interviewers in talking about this topic, so that is difficult to pursue these associations across the wider sample.

4.1.5 The birth of the placenta and the 'cleansing'

From accounts given in both the qualitative and quantitative stages, it would appear that manual pressure on the abdomen is common also in the third stage of labour. We have already cited Doña Alejandra's experience in being woken from a 'faint' by the doctor pressing on her stomach to remove the placenta. In Doña Emilia's first hospital birth, the placenta was born right after the baby and before the doctor and nurses arrived. Nevertheless, Doña Emilia experienced manual pressure *after* the placenta had been born, in the practice known as *la limpieza*, the 'cleansing' or 'cleaning-out'.

Doña Emilia welcomed and approved of the practice of 'cleansing', despite the fact that she described it as very painful. In this she was not alone. Several other women in the group expressed similar approval of the practice (see section 5.4.4). Her own narrative makes sense of her approval of the practice through her general fear of blood loss. This

fear was derived in part from traditional beliefs about the decline of blood over a woman's life-cycle, and partly from her particular history of miscarriage, tuberculosis and repeated births. Her account of her experience of 'cleansing' was given in the context of a general question from the interviewer about whether she prefers to give birth at home or in hospital:

- B. And why did you decide to go to hospital, when you had had all the others at home?
- E. The doctor made me go. "You have to go, because in your house you're going to be, —what's the word?— *damp*, damp. In hospital it's not like that," he said. That's right, Barbara, in my house I'd be bleeding for a week or even more, no?
- B. Yeah?
- E. In hospital it doesn't last long, not even a night
- B. Yeah?
- E. The, the placenta comes out and then ((coughing)) the nurse begins to rub your stomach little by little by little by little, no?

It is important to note that Doña Emilia emphasised the length of time that bleeding lasts in explaining her preference for hospital birth. However, we are left in no doubt that the practice is painful:

- E. That time she did it to me, the nurse rubbed my stomach little by little, then more, more, more
- B. Aha
- E. She made me want to scream with the pain.
- B. Oh, it hurt?
- E. It hurt

A division of labour between doctors and nurses is observed in the practice, with doctors exerting the heaviest pressure:

- E. Then they called, "Doctor! Could you take over now please, doctor?" , and the doctor came over, and then I started to say, "Oowww!" . The doctor came over and like *this*, he squeezed it *all* out with his two hands, and they caught it all in a little tray.

Doña Emilia finishes recounting this incident by returning to the theme of blood flow with two metaphors:

- E. And the amount of blood that goes into that tray! It's like when we're bleed- , killing a sheep.
- B. Yeah?
- E. *Every* little drop, yes
- B. In the hospital?

- E. In the hospital, like as if they were, (...) ummm, collecting it, getting it together, no? They get every drop out there, *every* drop, (squeezing) it downwards like a wet cloth.

This description shows how hospital practices may be interpreted in different ways by those viewing them from a different cultural perspective. The pain of the practice is not an issue for Doña Emilia, provided her blood flow is established, cleansing the womb of any clots that have accumulated there during pregnancy. The fact that she lays such stress on this blood flow being finished quickly is also reminiscent of the data from Tumaykuri indicating an ‘appropriate’ brief, length of menstruation. This idea of ‘appropriate’ length of blood flow after birth was confirmed by the interpretation of a question about this blood flow on the second-phase questionnaire. Generally, women interpreted the notion of ‘much’ or ‘dangerous’ blood flow in terms of the length of *time* after birth that their blood flow lasted, rather than the quantity of blood. In other words, if the flow went on too *long*, it was considered dangerous. This also confirmed ILCA’s contention that to ask about blood flow in a sequence of ‘little—much—dangerous’ was non-sensical in terms of traditional thinking, which sees strong blood flow as healthy (ILCA, 1995c: 5-6).

The notion that the blood flow after birth is ‘cleansing’, in the sense that it washes away any clots or remains of the placenta, is shared both by rural migrant women and by nurses working in the institutional medical sector. Indeed, this is a commonly held notion among Bolivian women in general, and manual pressure to remove the blood seems to be a very widespread hospital experience. However, it should be said that Doña Emilia was the only woman in the study who gave the practice of ‘cleansing’ as her reason for preferring hospital birth.

During the quantitative phase, women who were interviewed in hospital soon after giving birth talked more about the *pain* of manual pressure during the third stage of labour. One woman who was in a lot of pain after a tear and suturation two nights previously, spoke of having been rubbed first gently and then with great force to get the placenta out. This was followed by the excruciatingly painful operation of manual removal of the placenta ‘piece by piece’. She was then put on a drip and given an injection to stop her haemorrhaging. This was not an isolated case: another woman who had given birth the night after her in the same hospital had experienced a similar pattern of procedures. Forceful rubbing was followed by manual extraction, since:

- (the placenta) did not come out all in one piece. It had broken up, and they took it out of me bit by bit with their hands.

These women were not exceptional cases within a larger group, but were the only two women to have given birth on the public ward during the two days in question. The pattern of forceful rubbing and pressure leading to partial retention of the placenta and the necessity for a painful manual removal is not an experience that will encourage women to have confidence in hospital birth.

A further factor here that is distressing to women is that the placenta is not returned to them in hospital so that it can be ritually buried. The only reported case in which a placenta had been returned in peri-urban Sucre was after one birth in a medical post attended by a doctor who had worked previously in the rural hospital in Ocurí. The study of women's birth experiences in Ocurí did show that it is general practice there to return the placenta to the mother for ritual disposal. It was also found that in some cases in El Alto the placenta had been returned to women by the institutions where they had given birth. From the cultural point of view, these are extremely important and pioneering initiatives by the institutional health services. They have emerged from the dialogue between migrant women and hospital staff, and represent the removal of one major cultural barrier to migrant women's acceptance of hospital birth. As such, these initiatives deserve wider recognition and imitation in other public institutions.

4.1.6 The 'gynaecological position'

It is clear from women's descriptions of giving birth in hospital that the 'gynaecological position' is very generally used, and entails lying on one's back on a narrow bed, with one's legs parted and 'bound' in stirrups. A doctor generally sits between the woman's legs, on a chair, facing her genitals.

When Doña Alejandra was asked whether she preferred to give birth at home or in hospital, the first thing she said, laughing, was that in hospital they give birth on their backs, which was something she could not do. Her overall answer to this question was more complex and brought in other positive factors, such as 'cleanliness'. Nevertheless, we have seen how in fact when she was in hospital, she managed to avoid giving birth in the 'gynaecological position', by squatting on the bed on her own.

Doña Emilia, similarly, talked of how lying on her back was impossible for her. The special circumstances of her asthma made this difficult at the best of times, but the labour pains made it completely impracticable. She, too, avoided the 'gynaecological position' by giving birth on her own in the bed, lying on her side, and lifting one leg slightly. But we should note that this was not her preferred position when giving birth at home, which has always been in a squatting position, supporting herself on the side of the bed.

4.1.7 From the fear of hospital to the voicing of complaints

In the rural areas studied, fear of hospital and fear of the Caesarean is not only widespread, but has been incorporated into local myths. One of these is that of the *q'ara uñas*, the aborted fetuses, or unburied placentas, which take revenge by killing people, and of which pregnant women must take particular care. Another is that of the fat-stealer, which has been noted widely across the Andean area. The fat-stealer, generally known in Bolivia as the *likichiri*, is a malignant being who steals a person's body fat, causing them to waste away and die. Since colonial times, the fat-stealer has been particularly linked with powerful white men, and sometimes explicitly with white doctors.¹ These myths are nowadays being elaborated to express rural people's fear of hospital birth. This fear has many aspects, but two of the most salient are the fear of being cut open, which is equated with death, and the fear of the revenge of an unburied placenta.

One recent account, which comes from a Bolivian gynaecologist who made a study of reproductive practices in another area of the highlands, shows how these two fears are linked in beliefs about the placenta.² If properly treated, the placenta can protect both against the devils that snatch children's souls away, and against the white doctor/fat-stealer (AYUFAM, 1993: 24). In the present project, a similar complex of fears was encountered by Primo Nina of TIFAP, in his visits to the project site of Phichichua. During the first team visit there, in November 1994, a young child had died very suddenly, hours after the appearance of a whirlwind where the child was sitting in good health. By July 1995, the community was in a state of near trauma, shutting themselves in their houses during the period around sundown, while adult people would suddenly strip naked to frighten away the *q'ara uñas*. There was much talk of young girls who had aborted fetuses in the community, of hospitals and doctors, and of the knives used on women in hospital birth (Primo Nina: personal communication).

In the peri-urban areas in Sucre, these fears were perhaps less extreme, there being a fairly widespread acceptance of hospital birth. Nevertheless, fear was present among the

¹ The link with doctors is made in the AYUFAM account of the grease-stealer (1994: 24). More usually, the fat-stealer was said to be a priest figure (see Crandon-Malamud, 1991: 120).

² The following is a translation of the account of these beliefs recorded by this anonymous gynaecologist:

The [dried] placenta is also said to serve as a 'preventive weapon', capable of protecting children from the 'devils that can take away their soul'. Finally, it also serves as prevention against the 'Kari Kari'. This last is a regional pathology which consists in a devil [the Spanish doctor] who extracts the fat from the kidneys of a sleeping person. According to the people, this is always fatal. The 'Kari Kari' is also a disparaging term for a non-Andean doctor (AYUFAM, 1993: 24).

women interviewed. Doña Emilia, the first time she was going to hospital for a birth, describes how she nervously tidied and washed around the house all day, and made up the clothes that were required for the baby in hospital from old clothes. Hoping that her husband would return from his work nearby and accompany her to hospital, she sent her oldest son to look for him. Neither he nor his father returned, and eventually she had to go on alone. She describes her feelings as she left:

I'd made a whole bag of little clothes, and, I was carrying it as I left. I padlocked the doors of the house. As I left I was even crying here, "Will I return or not?" I said. As they had told me that the baby was turned round backwards, perhaps I'd have to have an operation, they said.

Doña Emilia's fears are perhaps understandable as those of a rural migrant who was going to hospital for the first time for a birth, and therefore did not know what to expect. However, another woman who voiced her fears of hospital to us was Doña Honoria, who had migrated to Sucre as a teenager and had had all her children in hospital. At the beginning of the following interview extract she is talking of the lack of a traditional midwife in the barrio where she lives, and saying how helpful it would be to have one:

- H. Often, ((a midwife)) is very necessary of course, because often we don't want to go. Myself, for example, mm (...) mm I'm, you see, I'm *afraid* (...)
- B. What of?
- H. They have to force me to go there, my husband
- B. Of what? Of the hospital?
- H. Yes, of the hospital
- B. You're afraid?
- H. Yes. "I'll just have it here," I say. "Why should I go to hospital? What will they do to me there?" I say. That's what I *say*, but all the same, no, no, NO, they take no notice of me till they get me to the hospital. (?) always in hospital.
- B. (.) But your husband makes you go, are you saying?
- H. Yes, he takes me you see. (?) He goes to call the ambulance without telling me.
- B.,M. Ah
- H. (.) But he's the one who's more frightened!
- All. ((laughter))
- H. "What would I be doing here?" he must think, "Nothing!"
- M. "Yes, of course! What could he do?"

The above extract shows the nature of women's fear as residing in what will be 'done to them' in hospital. It also shows the intermediary role of the husband in getting women to go to hospital, a role that was found also in other in-depth interviews. This role is shown

to be linked to the *loss* of the traditional role for husbands of helping the woman in labour and birth. The fact that he will have no role in the hospital (husbands were not allowed to accompany their wives in labour in any of the Sucre hospitals) is compensated by his active role in seeking transport to take his wife there.

It is also noteworthy that the relations between husband and wife in this account appear to have become the ‘modern’ ones where the wife must defer to her husband’s wishes. This is in strong contrast to the accounts that Doña Honoria gives of her own mother’s birth, where the husband deferred to what his wife wanted. Her mother used to shut herself in a room on her own until the baby had been born, and wanted no one with her. Doña Honoria would help her father in the kitchen, and as soon as they heard the baby cry, they would go in and help cut the cord, and be ready with hot herbal teas and food for the mother.

This contrast between herself and her mother is made even more forceful by Doña Honoria’s account of her own mother’s death. She did not witness this, as she herself was living in Sucre already, and knew nothing at the time. Her mother had suffered a haemorrhage a week before the birth of her twelfth child, at the age of 42. She refused all attempts to take her to hospital, including that of a bus-driver, who brought his small bus up the track to the house and tried to take her. Doña Honoria explained her mother’s reasoning in terms of fear of ‘what the doctors would do to her’, and preferring ‘to get better at home’. The baby was born dead, and she herself died the day after the birth.

Finerman reports a similar case of a 43-year-old woman in the southern highlands of Ecuador, who refused the advice of ‘friends, relatives, and nurses’ to go to hospital for her haemorrhaging after a miscarriage at 7 months. She stated that she would rather die at home, a sentiment echoed by other members of her community (Finerman, 1989: 37). It is of course possible that these stories represent attempts to cover up the shame of relatives at deaths which might have been avoided. However, the similarity of the two stories suggests rather that they represent the extension of the cultural logic of respecting the woman’s wishes about her body.³ The clash between this traditional autonomy of women and the modern mode of deference to the husband’s wishes is well illustrated by Doña Honoria’s statement that she and her sisters blamed their father for their mother’s death. The implication was that her husband should have brought her to Sucre regardless of her wishes, just as Doña Honoria portrays her own husband as bringing her to hospital for childbirth when she would rather stay at home.

³ See also the account of Doña Rufina’s death in childbirth which opens Catherine Allen’s book (1988).

There is some continuity between the rural fears of hospital, expressed in myths, and the fears expressed by women in the peri-urban study, quoted in this section. These women did not invoke supernatural elements to express their fear, which showed itself rather as a fear of obstetric intervention, particularly of the Caesarean operation, and more generally, as a fear of the routine treatments in maternity hospitals. But fear was not the only element in these women's discourse. At other times they came closer to the position of 'complainers' that is thought of as the typical discursive position for citizens of the modern 'consumer society'. So, in the accounts of birth in hospital, we find a generalised dislike expressed for routine non-obstetric practices such as cold showers, enemas, undressing and shaving. We can also find complaints about the pain and danger of manual pressure on the abdomen, both before and after the birth of the baby, as well as about the pain and damage caused by repeated episiotomy and suturing. And we can find a refusal, expressed both verbally and practically, of the routine obstetric practice of the supine, lithotomy birth position.

These remarks must be understood against the backdrop that these seven women had, in some sense, 'chosen' to go to hospital for their births. Their reasoning is often complex and contradictory, and at least two of them said that it was their husbands' choice rather than their own that brought them to hospital. Yet most will cite the greater safety of hospital birth for themselves as a reason for going. The two other women in the group, who chose not to go to hospital (see section 3.5.6), were both comparatively young, and if they continue bearing children for another fifteen years, are likely themselves to eventually go to hospital.

4.1.8 Negotiating birth

To conclude this section on the reproductive life histories recounted by women in Sucre, we look at the case of Doña Demetria's sixth birth. Doña Demetria was another second generation migrant in the Mothers' Club, who spoke Quechua by preference and wore the *pollera* skirt used by rural migrants (and increasingly by women in the rural areas themselves). Her account of her sixth birth followed on a discussion of her general difficulties during pregnancy (she was pregnant at the time), which she experienced as a time of vomiting, swelling, and sickness. By contrast, she said, all her actual births had been easy. Then she qualified this by saying that all her girls had been born easily, but that she had suffered greatly with her boy baby. The account of the birth of her boy, then, illustrated this difficulty. At the end of the account, she again emphasised that all her births had been 'normal', except this one.

Doña Demetria experienced swelling during this sixth pregnancy, had much vomiting and difficulty in eating, and was taken into hospital. She explained that the baby was 'undernourished', and that even though the pregnancy went to ten or eleven months, there was no strength to push the baby out. She described labour pains that started, but which disappeared when the doctors or nurses entered the room. She had a 'motor' strapped to her stomach and her nose blocked with something to give oxygen to the baby. She had been in hospital one month, and was still in much pain and was being threatened with a Caesarean.

So I just had to suffer, eee, then after I had been there a month, there was a, a *señorita*, eee, she was helping out there, I think there were two of them, they were white people (gringuitos), specialists, where were they from? they told me, "Señora, don't worry, we're going to help you tonight," they told me. And when they said that, I said, "Yes, Doctor, please. I can't hold out any longer, my legs, look at them, they're swollen," I said. "We know. Don't worry. Right now we're going to put you on the drip; we have the drip; we have injections so that we can help you", they told me like that. And I said to the *señoritas*, "Please, help me, I can't stand this pain any longer. I want to free myself (of the baby), even if the baby dies. Right away." That's what I said. But they had already told me I was going to the operation. But I would not be operated on. "I want it out right away, even if it's dead," I said. It was the only way. I just did not want to be operated on,

As Doña Demetria continued her story, it became evident that this negotiation of an outcome for her suffering was being done behind the back of the Director of the hospital:

And at 8 o'clock they put it in me. The head doctor had gone somewhere, and when he had left, they put the drip in here ((indicating her elbow joint)). It didn't hurt. "Now go on, have it! Tomorrow you're going to say to the Director: 'I was having *very* strong pains,' you're going to tell him. That way you're not going to be lying," they said. And then I said. "OK," and as soon as they put the drip in me, the pains started to come right away willy-nilly. The pains came right away, when the drip had only gone down a little way. So the pains were coming, and then, —I was on the trolley, and I just couldn't hold it back, and right there on the trolley, er, when I was just getting to the labour ward, there it was! the baby came out. Right on the trolley. It almost fell to the ground.

The doctors congratulated her on her baby boy, and dressed it in clothing they provided.

So the next morning at eight o'clock, the Director came round on his visit. That nurse winked at me, and I was lying back happily in bed, and then they whispered to me, "You're not going to say anything, you're not to talk about it," they said, "you're to say, 'I had a normal birth.'" They were

whispering like that, and I was saying, “Yes, the pain was very strong, so I went into labour, I got these very strong pains down below and then I had my baby.” That’s what I was saying. But he said, “This baby shouldn’t have been born yet, this baby wasn’t ready.” Because the baby was all hairy, and tiny, it was very small.

The baby was in an incubator for two weeks.

We reproduce this story here not to pass retrospective judgment on the hospital, where there were evidently clashes of medical opinion involved. Rather, our aim is to demonstrate the woman’s agency in negotiating with the medical staff for the treatment she wanted. She was clearly desperate to have the baby, having endured a pregnancy of ten or eleven months by her own reckoning, and being aware that her inability to eat or keep food down was damaging the foetus. She was also clearly very keen to avoid a Caesarean, which was why she accepted to be complicit in the deception practised by the two foreigners. The details of her account make it clear that she was aware of the risk that the procedure might cause to the baby, but she was prepared to accept that risk.

We emphasise that Doña Demetria was motivated to approach the foreign medical personnel and accept this risk not just because of the pain that she was in, but because she was aware that she might have to have a Caesarean. We argue that this perceived ‘threat’ of the Caesarean is something that women from migrant backgrounds are reckoning with and negotiating with inside hospital. In other cases it was seen how women accept the ‘help’ of manual pressure, and expect the kind of ‘help’ in the form of oxytocic drips and injections that Doña Demetria was eventually successful in obtaining for herself. In fact, this group of women experienced a remarkably low rate of Caesareans: none was reported among the 54 births of the nine women who recounted their life histories in the first stage of field work; and only one was reported out of 39 women from Mother’s Clubs who were interviewed during the quantitative stage. (See section 4.2.1.2 for further discussion and comparisons.)

It is possible that the low rate of Caesareans experienced by the women in this group is a result of negotiation going on between women and medical personnel. The negotiation may not always be as explicit as it was in Doña Demetria’s case. Perhaps more usually it is embodied in a series of unspoken assumptions about the appropriate treatment for women from rural migrant backgrounds. However, we argue that a close reading of the transcripts of these life stories reveals that women are not simply passively accepting hospital technology. They are often active in negotiating the kinds of hospital birth for themselves that in some respects, if not all, comply with their cultural needs and understandings.

4.2 THE QUESTIONNAIRE STUDY OF WOMEN'S HOSPITAL EXPERIENCES

This section attempts to see how far the findings from the qualitative interviews in relation to experiences of hospital birth were born out in the second, quantitative phase of the fieldwork. It deals firstly with experiences of biomedical intervention in birth which are not directly comparable with home practices (section 4.2.1). Secondly, it deals with 'medical pluralism' in relation to hospital birth: in other words, the use of traditional practices before, during and after a hospital birth. Other important experiential factors, such as 'fear', 'cold' and birth position, are better dealt with in the context of the *comparison between* home and hospital birth, and are therefore left until Chapter 5.

It will be remembered that the sample constructed for the administration of the questionnaire was a disproportionate quota sample, involving instructions to each team to sample a certain number of home births or of hospital births, and in some cases, of both. This section draws on the individual reports compiled by each team on the analysis of their questionnaire data. No attempt is made here to analyse the data as one study across different sites, as is done in Chapter 13 of this report; and the data on hospital births is here isolated from the *comparison* with home birth, which is undertaken in Chapter 5. The main reports drawn on here will therefore be the reports on questionnaires carried out by CIES in El Alto, by TCD/TIFAP in Sucre, by TCD in the rural hospital of Ocurí, and by ILCA in hospitals in La Paz and Viacha. Of these, the two largest studies were that in El Alto, where questionnaires were administered to 40 women who had given birth in hospitals or medical posts, and that in Sucre, where 65 women with hospital births were interviewed.

Given that the aim of this particular section is to see how far the findings of the qualitative phase in relation to hospital birth were born out in the quantitative phase, it should be noted that the sample population of the quantitative phase in the peri-urban areas was inevitably slightly broader than the small samples interviewed in-depth in the first phase. In Sucre, the sample for the questionnaire survey was constructed on the basis of the Mothers' Club and another woman's group that had been worked with in the first phase. It proved necessary to branch out to a Mothers' Club and a nursery in two neighbouring communities, in order to fulfil the sample quota for home births. The rest of the quota for hospital births in Sucre was then filled by approaching women in hospital wards and ascertaining whether they were migrants or not. These strategies probably brought in women from a wider variety of socio-economic, cultural and regional backgrounds than were sought out in the first phase. Similarly, CIES found its larger sample of hospital births in the questionnaire phase by working through post-natal clinics

in maternity units in El Alto. It is likely, again, that this probably brought in a wider socio-economic grouping than had been encountered in the first phase. It is also likely to be the case that working through post-natal clinics would pick up on more cases of problem births and obstetric intervention than would have been encountered in a non-clinic-based sample.

4.2.1 Experiences of intervention

This section looks at the quantitative data on the experiences of intervention that emerged as important in the qualitative interviews. Of the five major categories reviewed in section 4.2.1.1, —induction/acceleration of labour, the Caesarean operation, abdominal pressure in second stage, episiotomies, and abdominal pressure in third stage— only the first two are categories of intervention recorded in hospital statistics. We also include the hospital category of instrumental delivery, mainly conspicuous by its absence in the results of our study. Apart from the Caesarean operation, and to some extent episiotomy, the categories correspond to women’s own terminology of ‘help’ and ‘care’ in childbirth, as they arose in the qualitative interviews. The Caesarean operation figured highly in the analysis of women’s *fear* of hospital birth, even though no experience of actual Caesarean section was reported in the qualitative phase. A wider discussion of Caesarean rates is included in section 4.2.1.2, since it is against this backdrop of fear of the Caesarean that we believe that the experience of other practices must be viewed.

Table 4.1 collates the numbers of women who reported experiencing different kinds of intervention in their hospital births in the different regions studied.

TABLE 4.1 PROPORTIONS OF WOMEN EXPERIENCING DIFFERENT KINDS OF HOSPITAL INTERVENTION, BY STUDY SITE					
Practice:	Study site:	Sucre (n=59)	Ocurí (n=10)	El Alto (n=40)	La Paz (n=14)
Caesarean section		9%	10%	32.5%	21%
Induction/acceleration		30%	40%	48%	50%
Abdominal pressure in second stage		39%	30%	20%	0%
Episiotomy		34%	0%	28%	18%
Abdominal pressure in third stage		43%	0%	2.5%	0%

Sources: CIES, 1995b; ILCA, 1995c; TCD, 1995c; TCD/TIFAP, 1995; TIFAP, 1995c.

It is important to note first of all that the much higher rates of Caesarean section in El Alto and La Paz than in Sucre and Ocurí are probably explained by characteristics of the sample in the two areas, rather than representing a real difference in hospital practices. The El Alto sample of hospital births was constructed in post-natal clinics of maternity hospitals. Women who have had Caesarean sections are far more likely to attend such a hospital clinic than women who have had unproblematic births. The Sucre sample, which combined home-based interviewing with interviewing women after birth in hospital, probably obtained a more representative sample of all births.

The La Paz/Viacha study used a different sampling criterion from that used in the other three areas. For the peri-urban studies of hospital birth, the general criterion was that migrant women should have resided ten years or less in the urban area. However, the La Paz/Viacha study was not part of a peri-urban study, but rather an extension of a rural one. Hence, it aimed to interview only rural women who had arrived at an urban hospital in La Paz or Viacha. The women interviewed were therefore either rural residents who had been transferred into hospital in difficult circumstances, or women of less than one year's residence in La Paz. This may account for the higher rates of intervention than among the more settled group of peri-urban residents in Sucre.

Having said this, the data do seem to bear out the idea that abdominal pressure and episiotomy are seen as an alternative to the Caesarean, with lower rates of Caesarean section and induction being associated with higher rates of abdominal pressure and episiotomy. Only one case of the use of forceps was found in El Alto and none in the other study areas. Again, this confirms the cultural preference for manual pressure over instrumental delivery that was discussed in section 4.1.3.

The table shows a much higher use of abdominal pressure in the delivery of the placenta in Sucre than in other sites. It is possible that this reflects the fact that the Sucre maternity hospital is a training hospital, which figured in women's accounts of the practice there. It is also possible that it reflects different interviewer interpretations of the alternatives offered on the questionnaire.

The figures on episiotomy are likely to be underestimates, as explained above (section 3.1.4). The nil reporting in Ocurí, in particular, is probably unreliable. Nevertheless, the figures broadly confirm the routine nature of episiotomy reported by women in the qualitative phase.

4.2.1.1 Caesarean rates and socio-economic status

The study data on Caesarean rates need firstly to be set within the broader national context, where it is clear that these rates vary widely with socio-economic status. For instance, the main Maternity Hospital in Sucre collects statistics divided by public patients and private patients, from which Caesarean rates can be derived, as shown in Figure 4.2:

TABLE 4.2 CAESAREAN RATES BY SOCIO-ECONOMIC GROUP OF PATIENT, SUCRE MATERNITY HOSPITAL, 1994	
Socio-economic group of patient	Caesarean rate
Public	7%
Private	30%
TOTAL PATIENTS	11%
<i>Source:</i> Compiled from 'Informe anual de ingresos por causa y grupo de edad del servicio de obstetricia correspondiente a los meses enero - diciembre, 1994', Hospital de la Mujer, Sucre (Annual report on entries to obstetric services by cause and age group, January - December 1994', Maternity Hospital, Sucre).	

Another source shows a wide variation in Caesarean rates across maternity hospitals in different cities of Bolivia, with the lowest of those sampled being in a clinic in El Alto, in an area which had grown up recently with a largely migrant population (Camacho and Murillo, 1992: *passim*). This same report shows a similar pattern (though higher overall levels) in Santa Cruz to that found in Sucre. The main maternity hospital in Santa Cruz had a Caesarean rate of 28% in 1990, and was made up of a rate of 26% among public patients, and 56% among private patients (*ibid*: 7).

In any study of Caesarean rates in a situation where a substantial percentage of births are taking place outside the institutional sector, the problem arises as to what should be the population over which the rate is calculated: whether that of all births, or whether only of hospital births. Our study also faces this dilemma. Table 4.3 presents some different measures of Caesarean rates as they emerge from the study data from peri-urban areas in Sucre and El Alto.

TABLE 4.3 MEASURES OF CAESAREAN RATES FROM THE SUCRE PERI-URBAN STUDY DATA, ACCORDING TO DIFFERENT DENOMINATORS OF POPULATION AND BY SOCIO-ECONOMIC INDICATORS		
	Socio-economic group:	
	All women in the sample (n=106)	Women in receipt of food aid (n=39)
Denominator of population: Caesareans as a proportion of:		
all births	5.7%	2.5%
hospital births	9%	4.5%

Sources: TCD, 1995c; TCD/TIFAP, 1995.

In Table 4.3, membership of the Mothers' Club, and therefore being in receipt of food aid, is used as a proxy for economic poverty. The rate of Caesareans among this group is about half that of all women in the sample, whether measured over all births, or over hospital births only. The rate of Caesareans for hospital births as a proportion of all births in the sample, at 9%, is slightly below the 11% recorded among public patients in the Sucre Maternity Hospital. The rate among the poorer socio-economic group is, however, less than half that figure, at 4.5%. These data confirm the general picture of the connection between Caesarean rates and socio-economic status taken from the Sucre hospital figures and the national study of Camacho and Murillo (1992). However, they also indicate that the variations in Caesarean rates according to socio-economic status occur *within* the 'public' socio-economic grouping, as well as between it and the 'private' grouping.⁴

⁴ The situation in the El Alto study undertaken by CIES was very different, with an overall rate of 32.5% Caesareans among the hospital births in the questionnaire. This is extremely high by any standards for public patients, and it is probable that a factor here was that the interviews for the quantitative phase were administered through post-natal clinics in hospitals. It is likely that a far greater proportion of women who have undergone Caesarean operations will present for post-natal check-ups than those who have given birth vaginally. However, as CIES do not give details of the sample population and how it was constructed in their report, it is not possible to explain here why their figure is so high (CIES, 1995b).

ILCA also found a very high rate of Caesareans in their small study of hospital births in La Paz and Viacha, where there were 3 out of 14 cases, a rate of 21%. This also would be out of line with the reported general Caesarean rates in public hospitals in La Paz. One large maternity hospital there reports a general rate of 18%, and the rate for public patients would be a figure slightly lower than that [Camacho and Murillo, 1992: 12]. A factor here is that a different sampling criterion was applied by the team from that used in Sucre and El Alto: the questionnaire was administered only to women with less than one year's residence in the urban area. This seems to have meant that the sample mainly picked up women who had been transferred to hospital from rural areas in emergency conditions. It is therefore not strictly comparable with the sample of more established urban migrants who were interviewed in Sucre, which does not detract from the validity of the ILCA findings in their own right.

In order to be comparable with the hospital figures, the relevant figure in Table 4.3 is obviously the one for hospital births only. However, we would argue that in a situation such as that of the peri-urban study, where women can be described as having a choice between home and hospital birth, the 'real' rate is that measured over all births. In practice, women use the length of their labour as a criterion for going into hospital or not. If the labour is very short, they do not have time to get to hospital, particularly during the night, when there is no transport. On the other hand, if labour goes on for what a woman judges to be a long time, she will decide to go to hospital, even if she had not originally planned to do so.

If we consider the possible reasons for the lower rate of Caesareans among the poorer socio-economic groups, as found in Sucre and in the hospital statistics at national level, we should mention first that popular discourse tends to argue that doctors make money out of performing Caesareans. This, we understand from the two doctors who worked on the team, is not in fact the case in public hospitals. A different line of explanation is that suggested above, in section 4.1.8. Women from the poorer economic groups are generally also those from rural migrant backgrounds, who have a strong cultural fear of the Caesarean, as well as a strong need to avoid paying the cost of the operation. They therefore negotiate in more or less open ways with medical staff to avoid the Caesarean, being prepared to endure painful forms of manual intervention or painfully long labour in what they see as recompense for their wishes being respected. Negotiation was strikingly involved in Doña Demetria's story of the underhand application of the oxytocic drip, (see section 4.1.8). And we could recall also the stories of difficult presentations or long labours that were delivered normally, recounted by Doña Bertha and Doña Juana, where these women indicated their preference for a difficult, 'normal' birth over a Caesarean operation, and that this preference was respected (see sections 4.1.2 and 4.1.3). We should also recall Doña Emilia's fear of death by Caesarean when she went into hospital for the first time, which she solved for herself by avoiding the medical staff altogether while giving birth (see section 4.1.1).

The cultural 'fear' of the Caesarean has two components: one component regards the operation itself as equivalent to death;⁵ the other regards the woman's body after a

⁵ While we have analysed these fears as cultural, this does not mean they are without basis in fact. In the most detailed study of maternal mortality in hospital birth in Bolivia, the Germán Urquidi Maternity Hospital in Cochabamba recorded a rate of 283 deaths per 100,000 live births, over the ten year period from 1979-88 (Terán, 1990: Table 3, page 17). Of the 143 deaths recorded, 27% were of women who underwent Caesarean operations. (ibid: Table 19, page 37).

Caesarean as worthless, presuming that she can no longer do heavy work, lift weights or give birth normally. Although the project interviews with doctors and nurses do not provide any direct evidence of this, the experiential accounts from women imply that hospital staff are attuned to this very strong fear of the Caesarean among migrant socio-economic groupings, leading them to collaborate with the women's strong desire to give birth vaginally. The women's narratives that we have examined in the previous section illustrate, over and over again, the pride evinced by the women in having endured the pain of a difficult presentation or a difficult labour, often compounded with the pain of contractions artificially strengthened by oxytocic infusion, of manual pressure on the abdomen, and of episiotomy followed by suturing. This pride must be understood in relation to the cultural fear of Caesareans, a fear that we argue is tackled actively in the 'modern' case by negotiation between women and hospital staff as to what kind of birth they will have, and in the 'traditional' case, by giving birth unattended. The converse of this is that the Caesarean is seen by these women as an *implicit* threat underlying all hospital procedures. The fact that they end up with below average rates of Caesareans indicates the success of their agency and negotiation over the kinds of births they want in the hospital setting.

4.2.2 Medical pluralism in relation to hospital birth

It was already evident in the qualitative phase that women were making use of traditional methods of birth care along with biomedical check-ups during pregnancy. During the questionnaire phase, the extent to which women were making use of traditional methods as a conscious adjunct to hospital birth became much more evident. We have called this strategy 'medical pluralism' (see, for instance, Landy, 1978; Crandon-Malamud, 1991). This was particularly pronounced just before going into hospital, where traditional care appeared often to be seen as 'safeguarding' the woman from the dangers of hospital.

This was not an easy area for interviewers. Women were often reticent to talk about their use of traditional methods, as these are strongly disapproved of by institutional medical personnel. One woman who had been given an unexpected Caesarean on her sixth birth in hospital, an experience that had left her very 'frightened', said that the doctor had told her that the baby was in the wrong position, and that this must have been due to the performance of the *manteo*. It is highly unlikely that the doctor would have known about the *manteo* in any detail, and this case seems rather to illustrate the general scapegoating of traditional practices. In general, the longer interviewers were working with the questionnaire, the more data started to come out on this topic, and we are left with the impression that there is scope for further research here.

The data in Table 4.4 refer only to the studies of hospital birth conducted in peri-urban Sucre and the rural hospital of Ocurí, since the El Alto data was not broken down by home and hospital births in the report.

TABLE 4.4 PROPORTIONS OF WOMEN WITH HOSPITAL BIRTHS USING TRADITIONAL PRACTICES DURING PREGNANCY AND LABOUR (3 SITES)						
Practice:	During pregnancy			During labour (before leaving for hospital)		
	Sucre	Ocurí	La Paz	Sucre	Ocurí	La Paz
Herbal teas	48%	20%	36%	46%	70%	29%
<i>Manteo</i>	18%	30%	29%	14%	40%	7%
Massage	25%	30%	43%	21%	30%	36%
Walking	n.a.	n.a.	n.a.	64%	70%	29%

Sources: ILCA, 1995c; TCD, 1995c; TCD/TIFAP, 1995; TIFAP, 1995c.

It is interesting to note from this table that Ocurí, which is the closest to a rural environment of the three sites, shows a pattern of greater use of herbal teas during labour than in pregnancy. By contrast, the urban centres of Sucre and La Paz show a lesser use of herbal teas before setting out to hospital, but a greater use of them during pregnancy. However, in general the findings collated in the table amply demonstrate the importance of medical pluralism in the continued use of traditional practices in and around hospital birth. The findings presented here have somewhat simplified the picture, as they have not attempted to account for the use of traditional practices in the period after birth, i.e. after the woman has been discharged from hospital. Patterns here varied across the different regions, but included the use of herbal teas to 'cleanse' the blood, periods of rest varying from days to weeks, and the use of special diets, revolving centrally around the consumption of lamb.

4.3 LANGUAGE, CULTURE AND ETHNICITY

The data in this section draw on the study done in the rural town of Ocurí during the quantitative phase of the project (TCD, 1995c: Part II). In all, 11 interviews were conducted on the basis of the questionnaire, with women who were migrants into Ocurí. The intention was to collect data on women's experiences of hospital birth there. One interview turned out to be about a home birth, giving data on 10 hospital births in all.

Unlike Sucre, where Quechua speakers are used to negotiating with Spanish speakers in the urban environment, Ocurí is a small rural settlement where there is much less Spanish spoken, so that to be monolingual Quechua is more common. In addition, several medical personnel we met in Sucre spoke or understood Quechua, having themselves migrated in from surrounding areas. Paradoxically, in Ocurí, the staff currently in the hospital were mainly themselves from non-Quechua-speaking backgrounds, making the hospital and the IPTK training centre the main spaces where Spanish is spoken in the little town.

4.3.1 The experience of monolingual native-language speakers in hospital

One case, in particular, of the ten hospital births that formed part of the study in Ocurí, suggests that language spoken is an important factor in hospital communication. The woman in question was 25 years of age, and a relatively recent migrant into Ocurí from the surrounding rural area, having lived there for 4 years. She had had 7 births, out of which only 3 children remained alive. During her last pregnancy, she went into labour after seven months (eight months by western calculations), and at one point in the interview characterised the birth as a *malparto* or miscarriage. This labour lasted two days, and at some point, she went into hospital, sensing that something was wrong, as she had never been to hospital before. We do not know from the questionnaire how long she had been in hospital when she gave birth, but in her own words, they

threw her on one side, and left her alone when the baby was about to be born, and she had to call out to the washerwoman, and then her baby died after half an hour [from interviewer notes taken during the interview]

She spread her wool shawl on the floor and gave birth squatting over it. It seems that after the birth she called to the washerwoman, who in turn called the nurse.

We have no information as to why the baby died, other than that the birth was premature, or even a miscarriage, and the death may have had nothing to do with the lack of medical attention. Nevertheless, it is clear that the woman herself had come into hospital in the realization that she had a problem, expecting help and care. Later in the interview she gave this opinion of hospital attention:

They don't even attend us properly in hospital if we go. They don't know to give us anything; instead, they cause us pain with their rubbing. [from interviewer notes taken during the interview]

In the context of the rural hospital, the washerwoman therefore acted as a bilingual mediator between the woman giving birth and the nurse. We consider the policy implications of this in the following section.

In the light of this case, we returned to the interviews done in Sucre in the quantitative phase. A revision of the questionnaires of the peri-urban study showed that of 9 completely monolingual (Quechua) women from the total of 52 interviewed, 7 had had their babies at home. Three of these women gave economic reasons for not wishing to go to hospital, and three gave 'fear', expressed in the strong terms of 'I take fright'. One woman also mentioned 'shame', and fear of being operated on. Another gave the following reasoning for preferring to stay at home:

Some doctors come in one after the other, and some of them hit the women. That is why I wouldn't go to hospital.

We stress that this is the expression of a woman who has not actually been to hospital herself. We quote it to demonstrate the way in which monolingual Quechua-speaking women have a particularly negative view of the hospital experience.

4.3.2 The resource of bilingualism among migrant women

Against this background, the role of the washerwoman in the case outlined needs to be taken seriously. Migrant women who straddle both rural and urban cultures are also commonly fluent speakers of at least two languages. They represent a resource of potential bilingual mediators for monolingual native-language speakers entering hospital for whatever reason. In the context of hospital childbirth, the general cultural fears are particularly pronounced in the rural areas, and among monolingual migrant women. Bilingual migrant women, we argue, could well be employed by the institutional biomedical sector as a way of improving the hospital experiences and outcomes of native-language speakers in childbirth.

Precedents exist for this sort of strategy in other countries. In Britain, various schemes have been in existence since the early 1980s which use bilingual speakers to act as link-workers with non-English-speaking women from ethnic minorities. These initiatives were taken partly in response to the observable worse outcomes in maternity care for women of certain ethnic backgrounds (Parsons, et al., 1993). Evaluations of the 'Asian Mother and Baby Campaign' found that while its health education drive had little impact, 'the link-worker schemes were successful and highly valued by Asian women and most professionals' (ibid: 72).

A different approach was adopted in the Mothers' Hospital in Hackney, London, where the 'Multi-ethnic Women's Health Project' has been in existence since 1980. Women working for the project are called 'health advocates', and do more than just interpret. Their aim is to mediate between women and health professionals, so that non-English-speaking women are offered an informed choice of care. They negotiate solutions to cultural problems as they arise between women and health care professionals, 'although ultimately they see themselves as advocates for women' (Parsons, et al., 1993: 73). A retrospective study was commissioned of the impact of the introduction of women's health advocates on obstetric outcomes, using another hospital with no advocates as the control. Significant differences were found between groups of non-English-speaking women in the two hospitals in various areas: length of antenatal stay, induction rates, and method of delivery (*ibid.*). Caesarean rates actually fell in the group in the Mothers' Hospital from 11% to 8.5%, while in the control hospital they had risen from 11% to 17% over the same period (1979 and 1986). These figures were statistically significant, and while the change cannot be definitively attributed to the presence of health advocates, the evaluation concluded that better communication had influenced clinical practice (*ibid.*).

A key factor in the greater success of the 'advocacy' scheme over that of 'link-workers' is attributed by Parsons and her co-authors to the fact that health advocates were autonomous from the health institutions where they were representing women. This was illustrated when the project's funding was taken over by the central health authorities in 1989, and the role of the advocates became merely that of link-workers. The scheme would have collapsed had it not been taken back into funding by the 'Community Health Council' in 1991 (Parsons, et al., 1993: 74).

While the conditions and structure of health funding are very different in Bolivia than in contemporary Britain, it would seem that such a scheme could well be pioneered by an NGO in cooperation with the National Health Secretariat there. Such conditions would provide the kind of autonomy for women's health advocates recommended by the evaluations of the British schemes. Parsons and her co-authors conclude their argument by remarking that language is not the only barrier to inter-cultural communication:

the cultural 'problems' of how to provide appropriate care will not disappear once the majority of women using the services can speak English. In fact the need to provide for cultural diversity and raised expectations may well become more pressing (Parsons et al., 1993: 74).

This conclusion has many resonances with our own project. Language is a crucially important issue in the experience of monolingual native-language speakers giving birth in

Bolivia, and we would like to see the development of a scheme of health advocates for such women. However, language is only one component, if a central one, of cultural difference, and cultural differences survive in bilingual urban conditions. Ultimately, therefore, health advocacy must be about both linguistic and cultural differences, if it is to provide a successful mediation service between the different cultural traditions in Bolivia today.

4.4 SUMMARY OF WOMEN'S EXPERIENCES OF HOSPITAL BIRTH

The study methodology allowed hospital birth to be approached from the point of view of traditional birth practices. Again, detailed analysis of women's reproductive life histories shows how the reality of their experiences of hospital birth differs from the norms of hospital procedures. Women who are migrants from rural areas enter hospital birth with a series of expectations. These expectations derive partly from their assimilation of biomedical claims for the greater safety for hospital birth. But they are also structured by a strong fear of the Caesarean operation, which derives from traditional beliefs. A figure in the form of a Spanish doctor or monk has been credited for centuries with the power to extract the grease from a sleeping person's kidneys, so causing a fatal illness which is much feared across the Andes. This fear combines with the general fear that sickness enters the body during birth because it is 'open', which is countered in traditional practices by the clothing of the body parts where 'air' can enter. In practical terms, the body of a woman who has undergone a Caesarean is seen as worthless, unable to work or to bear children.

These fears around the Caesarean operation structure the behaviour of rural migrant women in hospital. Far from being passive recipients of hospital routines, these women follow active strategies through hospital care which lead to vaginal births rather than Caesareans. In a small group of seven women in receipt of food aid who gave detailed accounts of hospital births, three had given birth alone in hospital, one of them on two occasions. Where these women had given birth many times previously in the countryside, their accounts show how they replicate the practices of home birth within the hospital context, evidently preferring to give birth alone and in positions other than the 'gynaecological' one. The other women in this group receiving food aid had not experienced home birth themselves, having had all their babies in hospital. For these women, the strategy of avoiding the Caesarean was through direct and indirect negotiations with hospital staff to ensure a vaginal birth. This commonly involved the acceptance of painful obstetric interventions, such as oxytocic infusions, manual pressure on the abdomen, and episiotomy, to avert the 'threat' of the Caesarean. In one case, a woman who had been in hospital for a month with a problem pregnancy, actively

negotiated the application of an oxytocic drip to induce her labour, without the knowledge of the consultant in the hospital. It is not clear how far hospital personnel have themselves adapted to the concerns of rural migrant women, and actually facilitate them in obtaining the kinds of birth care that they seek. In relation to another important cultural concern, that of the return of the placenta for ritual disposal at home, hospitals in some areas have consciously adapted to cultural needs, so allaying one important factor in cultural anxiety around hospital birth.

These findings from the qualitative phase were by and large born out by the results of the quantitative questionnaire across a broader sample. Other Bolivian sources show that Caesarean rates increase dramatically with socio-economic status, as between public and private patients. Our research at the *lower* end of the socio-economic scale shows that women in receipt of food aid received far fewer Caesareans than the average for public patients, so confirming the success of the women's strategies that emerged in the qualitative phase. In relation to the delivery of the placenta, women in both phases of the project reported the use of manual pressure on the abdomen, both to expel the placenta and to 'cleans' them of blood afterwards. Despite reports of the extreme pain of this procedure, some women welcomed it, because it is seen as effectively 'cleansing' the blood, and because they then bleed for a shorter time after the birth. This understanding of hospital practices fits with traditional views of the importance of attention during and after the birth of the placenta. Women who are seen to adopt more 'modern' concerns look more for 'help' during the birth of the baby, and are sometimes mildly resentful when they do not receive intervention.

The results of both phases show 'medical pluralism' in the beliefs and practices of migrant women in relation to hospital birth. Traditional theories are used to explain modern problems, such as the entry of 'air' into the body being used to explain sickness after an episiotomy, or the decline of blood in the mother's body being seen as leading to excessively long pregnancies and low birth-weight babies. Traditional practices, such as the use of herbal teas and massage, are observed in pregnancy and before going to hospital by many migrant women. In relation to the expectations and fears set out above, these practices are seen as safeguarding the 'normality' of the hospital birth, and avoiding the Caesarean. Women who are monolingual speakers of native languages tend to face particular problems in hospital birth, since most medical personnel are not speakers of these languages. A case where one such woman had called out to the hospital washerwoman to help her, who was bilingual in Quechua and Spanish, points to the possibility for piloting schemes of employment of bilingual 'health advocates' for monolingual rural and migrant women going into hospital birth.

