

CHAPTER 5

THE COMPARATIVE EXPERIENCE OF HOME AND HOSPITAL BIRTH

This chapter looks at the study's findings on the comparison between home and hospital birth, as seen from the point of view of the traditional cultures. We look firstly at the terms in which traditional midwives draw up the comparison between hospital practices and their own, using data from the qualitative interviews (section 5.1). Secondly, we look at the quantification of *comparable* aspects of women's own experiences of home and hospital birth, using data from the quantitative questionnaires (section 5.2). Many hospital practices, such as the Caesarean section or episiotomy, clearly have no counterpart in home birth, and the data on women's experience of some of these was reviewed in Chapter 4. Here we look specifically at aspects of the birth experience which it makes sense to compare across home and hospital birth, such as fear, cold and birth position. Thirdly, in section 5.3, we discuss women's decisions to go into hospital or to stay at home to give birth, with particular reference to the peri-urban areas where women are, at least formally, presented with a choice between home and hospital birth. The data used here is from the quantitative questionnaire, including answers to an open-ended question on this topic. Finally, in section 5.4, we summarise the discussions on home and hospital birth that took place in two feedback sessions that were held in Mothers' Clubs that had contributed to the project.

5.1 TRADITIONAL MIDWIVES' VIEW OF HOSPITAL BIRTH

Traditional midwives' view of hospital birth practices is akin to a mirror image of the institutional medical sector's view of midwives. Both sides in this unequal rivalry between professions define their own practices in terms of stereotypical differences from those of the other side. What is particularly striking is the extent to which the same implicit terms of judgment are used of either side by the other. If biomedical personnel tend to see midwives as causing birth problems through dirty, dangerous and interfering practices, midwives themselves hold very similar views about hospital doctors' practices. Very strong feelings were expressed by midwives on two particular aspects of biomedical practice: doctors 'put their hand up' the woman, a practice that disgusts midwives from both a sexual and a hygienic point of view; and doctors 'cut' the woman, so endangering her life with the Caesarean section. These two axes of comparison are reviewed in the

following two sections (5.1.1 and 5.1.2). There are also a series of other cultural aspects which are important to the comparison, and which have been shown by ILCA to be intimately linked in to Andean religion and the cosmovision of which birth is part. These aspects are raised in section 5.1.3.

5.1.1 Operations versus massage

It has been pointed out that in the professional struggle between traditional midwives and doctors that is still being played out in some countries, midwives nowadays stake their claim to expertise on the grounds that they can deliver a woman from the Caesarean section (Good Maust, 1994: 11). This is an ironic reversal of the claims of doctors and obstetricians to be able to deliver a woman from the risks of childbirth. Midwives who collaborated with the present project told similar stories of having safely delivered women who had ‘escaped’ from hospital. Such claims were made, for instance, by midwives interviewed in Sucre and Ocurí. They were made also by the male midwife from rural Potosí with whom ILCA have worked, who has travelled widely and specialised in attending difficult births. Interestingly, Doña Lydia, the midwife in Sucre, raised the question of Caesareans in the context of an interviewer question as to whether she had ever seen a woman die, confirming the connection between Caesareans and death in traditional thinking:

M. But you’ve never let a woman die? or have you seen one die?

L. No no (...) I’ve never let a woman die. That’s, that’s what they are frightened of, that’s why they get out of hospital.

M. Yes

L. “They’re going to operate on me in hospital,” she says. “They’ve told me, ‘We’re going to do an operation on you’”. And so, I tell them, “Get her out and bring her to me. I know how to do it.”

M. Mm.

L. They go and get the woman out for me, and with my massage I help her to give birth here.

Of course, these stories and ideal-type differences cannot be taken to imply that in fact a Caesarean section is the most likely outcome for a migrant women giving birth in hospital. The data would suggest that women of this socio-economic status and cultural background are *less* likely to be sectioned than women from other social strata. We have already seen how the cultural fear of Caesareans influences women to negotiate ‘normal’ deliveries with hospital staff, even in difficult circumstances and even if this means submitting themselves to painful and possibly dangerous practices. The issue is to address these fears in their cultural terms. We argue that this will be more effective in

bringing down the actual death rate from Caesarean sections, than calling for more technology.

The same midwife gives more detail of the difference in practices between herself and the hospital when talking of difficult presentations. In the following passage she criticises not only hospitals, but also ‘ignorant men’:

- L. When the baby’s on one side, they suffer, but when it’s straight they just give birth, d’you see?
- M. Yes, I see.
- L. When it’s on one side, women who don’t understand try to force it out. Ignorant men too, they’ll try and make the woman force it out. But it’s as clear as daylight when it’s on one side! When the baby is lying diagonally, or kicking, it’s positioned like this, d’you see? I put it straight in those cases. But some babies put their little *hand* or foot out first. When they’ve put their hand or foot out, here in the hospital they operate right away, don’t they?
- M. Yes, yes
- L. They operate right away. My mother knew how to never let that happen!
- M. She’d never let that happen?
- L. She knew how to never let that happen. Its hand, she would wash her hand thoroughly, then she’d turn the baby around like this. My mother knew how to help a woman give birth by putting the baby in the right position.
- M. And you yourself, you can help them give birth too?
- L. I help women give birth, but I’ve never encountered a birth like that. I put the baby straight beforehand, that’s why.

Stories of the ability to ‘turn’ difficult presentations are repeated over and over again with great confidence by midwives. The cultural confidence in this ability is shared both by midwives and by the women who avail of their skills. It is vital that health policy takes on board the need for further research into these skills.

We return to the issue of fear that underlies many of these stories. Traditional midwives in Inka Katurapi made it clear that their task is to make sure that ‘fear’ does not enter into the process of labour and obstruct it. They are thoughtfully critical of hospital practices which can ‘frighten’ a woman and hence slow up her labour. Such criticisms have also been voiced from within the institutional biomedical sector by professional midwives in other countries. Midwifery practice and thinking are largely absent from the current debate on childbirth practices in Bolivia, for institutional reasons that are considered elsewhere in this report. We argue that the introduction of this missing ingredient could

help to break down the diametrical opposition between traditional and biomedical practices as drawn up by both sides in the current debate.

5.1.2 Feeling the pulse versus manual penetration

In the following passage, the midwife Lydia explains how she takes the pulse during labour. This is then contrasted by the interviewer (M) with the hospital practice of ‘putting the hand up’ (the woman’s vagina to feel the cervix). This theme is taken up both by the midwife herself and by her 18-year-old daughter (D), who was pregnant at the time, with vehement expressions of disgust:

- L. ((indicating where she takes the pulse)) Here, on this side, just here, there is this little vein, and just here the vein peters out. When the woman is about to give birth, this vein goes “chikarababum”, and towards here it breathes: “taqq!”. ((pause)). ((half-singing:)) The herbal medicine comes surging *hot!* Hoohh, hoohh, hoohh, hoohh, hoohh ((half-blowing sound imitating the pulse in the vein)).
- M. When she’s about to give birth?
- L. “Right now she’s going to give birth,” we say. “It won’t be long now,” I say.
- M. Ah ya. But all this is very good, isn’t it, because in hospital, they are always putting their hand up.
- D. They *DON’T LOOK!* They don’t even look for *ONE* minute!
- L. They put *THEIR HAND UP*, don’t they! ((Angrily:)) HAAH!

In the above extract, the interviewer, who is an experienced professional nurse, makes clear her *own* awareness of the discomfort caused by the practice of manual penetration in hospital. She welcomes with enthusiasm the possibility of an alternative non-intrusive practice opened up by the midwife’s description of her skilled knowledge of the pulse. The midwife herself displays angry disdain for the medical practice of ‘putting the hand up’.

The continuation of the above extract shows how the very idea of manual penetration puts the young woman off going to ante-natal controls, despite pressure from the auxiliary nurse in the nearby medical post:

- D. I *DON’T LIKE* going for check-ups. That’s why I don’t, I can’t, d’you see? I never go, you see.
- M. You’ve never once, gone to hospital?
- D. No, no, I don’t like it. The nurse too in the, she said to me, “You’re going to come, aren’t you. You’re down for the check-up,” she says to me. I just say to her, “OK”. No! What for? “So

that I'll— ? What if I die when I'm there?" I say to myself. "So that they can put their *hand* up me and everything!. I *can't* do it!" ((low laugh)).

The evidence from experienced traditional midwives across the range of project sites all points to the fact that the hand is never *routinely* inserted into the woman's vagina, and that the routine practice of this in hospital is abhorrent to them. The above extracts demonstrate the disgust felt by women at the sexuality and sexual symbolism of this penetration of their bodies by a strange male. Midwives also express a more practical reasoning. They emphasise the need to avoid anything that could frighten a woman in labour; and they also use reasoning around hygiene, encapsulated in the phrase 'Our hand is poison' used by the midwife in Inka Katurapi.

However, several midwives, including Doña Lydia in the passage about her mother quoted above (section 5.1.1), and Doña Marcelina from Unkallamaya, told stories of other midwives having put their hand into the vagina in exceptional circumstances. In both of these cases the midwives spoke about their own mothers, from whom they had learned their skills. Such exceptional circumstances would be the case of hand presentation recounted above, or that of Doña Marcelina's, who once performed a manual removal of retained placenta. A case was also recounted to the Sucre peri-urban team of a woman's cousin who had been saved from a retained placenta by a midwife performing a manual removal of the placenta. In all these descriptions of traditional midwives inserting their hand, there is an elaborate account of the procedure of washing hands beforehand. Once again, we emphasise that midwives perceive a vast difference between the *exceptional* insertion of hands in emergency obstetric situations from that of the *routine* insertion of hands, often by more than one male doctor, in the course of a 'normal' hospital birth.

5.1.3 The culturo-religious critique of hospital birth

Midwives also articulate a range of other concerns about hospital birth. Among these are the practice of undressing the woman, the supine birth position, the relationship between the woman and the doctors, the use of loud voices around her, the non-ritual disposal of the placenta, and the failure to observe traditional religious practices of respect and giving thanks to the tutelary gods. ILCA¹ has shown how these concerns are rooted in cultural reasoning around birth which works through use of analogies. For instance, the clothing of the woman during birth is based not only in the practical reasoning that labour is encouraged by warmth, but also in the cultural analogy that sees the woman as like the

¹ The data used in this section is from ILCA, 1995a.

fields, that must be warmed by the sun. Her giving birth is like the harvest, with her skirt depicting the green of the vegetation, and her shawl the red of the earth.

The contrast between the warmth of home and the cold of hospital occurs again and again when country people talk about hospital birth. A woman from Inka Katurapi who had once given birth in hospital in La Paz speaks of the cold she still feels in her body from that time:

The doctors come along and take everything off us! And our blood stops moving. And one of them presses us and pushes the baby out. And they let the cold get into us. I still feel it in my foot. We've good reason to be frightened, but we put up with all this, we put up with it without saying a word. The cold gets into us. It doesn't matter to them you see. They even take our shawls off us! Our blood even congeals, because they even make us walk with only a thin shirt on!

(ILCA, 1995a: 75)

This is contrasted with the clothing that a woman who gives birth in the country must wear both during and giving birth. To make the point, the midwife's daughter talked of cases where the woman is so well wrapped up round her neck, that someone else has to feed her.

Likewise, the responsibility of the husband towards the woman giving birth is seen by analogy with the responsibility of the cultivator towards the fields. He must look after her, including the duty nowadays of buying some of her clothes. The doctor has no such relationship with the woman giving birth. Hence rural people do not see him as likely to give the same level of care.

Similarly, the traditional, upright birth positions, as well as giving a woman more strength to labour, also return the blood and amniotic fluids to the earth. The *Pachamama* deity, the Mother Earth of Andean religion, is extremely important to midwives in the acquisition of their knowledge, and must always be ritually thanked with libations during attending a birth. In hospital, midwives note that the blood is collected in a metal container, and disposed of in non-sanctioned ways. They also fear and deplore the hospital practices of either 'throwing away' the placenta in an unknown place, or else burning it, rather than returning it to the earth. These practices are potentially dangerous for the health and well-being of the mother, and can cause the baby to 'turn black', just as rotten products of the harvest turn black.

Traditional midwives respect the sexual privacy of the woman giving birth. They do not uncover her, or lift up her skirt to look. They see this respect as broken by practices such

as washing the genitals of the woman with water, and the manual penetration that we have already analysed. More generally, they see the relationship established between the woman and a doctor as at best formal and cold. At its worst, they see rural people as treated 'like dogs' in hospital. They deplore the use of loud voices, and the entry of unknown people into the room where a woman is giving birth. And rural people often speak of the 'disrespectfulness' shown by doctors when they come into the presence of a woman giving birth without asking permission or thanking God, and without pouring libations to the earth. Midwives themselves speak only with *cariño*, 'love' or 'kindness', to the woman, keeping their voices 'soft and low'.

Finally, in traditional cultures, it is customary to give ritual thanks for the survival of the mother after the birth. This is done by chewing coca and pouring libations to the spirits of the house and of the surrounding mountains when both baby and placenta have been safely delivered. People speak of this relationship between themselves and the surrounding landscape at such times as being 'as if we were a family come together, like a complete weaving'. Institutional birth separates the mother from her family and her surroundings not just in a literal, but also in a spiritual sense.

5.2 COMPARISONS FROM THE QUESTIONNAIRE STUDY

This section deals briefly with the questionnaire findings on some of the most salient comparisons in the experience of home and hospital birth, using reports produced by the individual institutions and sub-teams on their work during the quantitative phase. It does not draw on the analysis of the amalgamated data set across the different project sites, which is written up in Chapter 13 of this report. This section continues on from section 4.2 in the previous chapter, which looked at the quantitative findings on some aspects of hospital birth which do not have home equivalents. The main reports drawn on here are those from El Alto and from peri-urban Sucre, since both of these contained samples of home and hospital births. Where relevant, figures from the rural sites are also drawn into the comparison. A summary table is presented in section 5.2.6.

It has already been pointed out that, in order to fulfil the assigned quota of home and hospital births, the teams in Sucre and El Alto, while starting with the groups where they had worked in the qualitative phase, had then to branch out to new sites. It was not possible, therefore, to guarantee the stability of a number of background socio-economic and cultural variables across these different sites. As a disproportionate quota sample, the two groups are not necessarily internally homogeneous in all other respects except that of the place where they gave birth.

This problem with the construction of the sample can be rephrased as a finding: namely, that hospital birth is linked to higher socio-economic status, educational attainment, and years of migration. It was the experience of teams in both peri-urban studies that in order to find home births, it was necessary to interview women in neighbourhoods of more recent migrants, where women were more likely to be primarily native-language speakers and have less formal education. Conversely, in neighbourhoods of longer established first or second generation migrants, who spoke more Spanish and had more formal education, there were more hospital births. Both teams found that it was not possible to fill their quote of hospital births by working through neighbourhood links in peri-urban migrant areas, and had to work directly through hospital settings. The questionnaire and its analysis do not allow us to make this point statistically. Nevertheless, the dynamics of sample construction in the two areas point to important underlying social patternings, whereby a hospital birth becomes one of a number of cultural symbols of having 'arrived' and acculturated to urban lifestyles.

At a statistical level, it is important that the findings of this study are not misinterpreted as if the two groups (home and hospital births) had been randomly sampled from an overall population. The study worked by filling approximately equal *quotas* of each group, which do not correspond to the proportions of home and hospital births in the population as a whole that was being studied. The study population was defined as 'rural and migrant women', with 'migrant' being defined as resident for 10 years or less in the peri-urban area. There are published data for the rural population at national level which show that approximately 80% of rural women give birth at home, and 20% in hospital or a medical post (INE, 1994: Table 8.3). These figures include small towns in rural areas, and the proportion of home births was undoubtedly higher in the sorts of rural communities where the project teams were working. For urban areas at national level, the proportions are 60% giving birth in hospital, and 40% in the home (*ibid.*). No figures are available for peri-urban neighbourhoods, or for migrant women, at this level. In the peri-urban neighbourhoods where CIES worked in El Alto, it was found that almost all women gave birth at home, perhaps 90%. In the areas in Sucre where the TCD/TIFAP team worked, a rough estimate would be that about half of women were giving birth at home, and the other half in hospital.

Overall, then, an estimate of home and hospital births within the study population as a whole would be in the order of 75% home and 25% hospital. We emphasise that this is only a subjective estimate, as the study was not built around any form of representative sampling of the population as a whole. Rather, the objective was to study the two groups of home and hospital births in equal numbers, so creating a sample which is *disproportionate* to their representation in the study population as a whole. In general

this means that findings should always be presented as findings about two distinct groups. Any amalgamation of the data from the two groups needs, therefore, to be interpreted with great care.²

5.2.1 Birth position

There is no doubt that in hospital the main birth position being used is the one known as the 'gynaecological position' in Bolivia, that is, the supine dorsal position with feet in stirrups. Where exceptions show up on the questionnaires, it is usually because the birth was unattended.

In home births, positions are more varied. In the Sucre peri-urban study, the favoured positions were all vertical ones, which together amounted to 82% of home births (18 out of 22 cases). These were divided between 14 cases of squatting, 3 of kneeling, and 1 'on all fours'. This left 18% of home births (4 out of 22 cases) which took place 'lying down'.

In the home births surveyed in El Alto, rather more women appear to have adopted a lying-down position for birth, at 31% (11 out of 36 cases). The most favoured upright positions were there 'kneeling' (9 cases) and 'semi-seated' (7 cases).

The higher rate of giving birth lying down in home births in El Alto than in Sucre, suggests that the sample in El Alto was undergoing more acculturation to urban life than that in Sucre, since the lying position is very rare for birth in the rural areas from which these women had migrated.

In the rural areas, positions adopted are overwhelmingly upright ones or on all fours. These positions have been discussed in relation to the expulsion of the placenta in Chapter 3, and are discussed further in Chapter 13.

5.2.2 Feeling cold

Only the study of peri-urban Sucre presents comparable data on feeling cold during birth broken down by home and hospital births. Here 90% of women who had given birth in

² It was a failing of the training aspect of the project that this point was not successfully communicated to all the individual teams working on the quantitative phase. Hence, some of the individual reports were written up with no distinction being made between home and hospital births, and with the data being amalgamated across the two different groups. This limited their usefulness from the point of view of analysis.

hospital reported feeling cold (25 out of 28 cases). The comparable figure for women who had given birth at home was still high, at 60% (13 out of 22 cases). CIES presents a composite figure of 49% of women feeling cold in both home and hospital births in El Alto (37 out of 76 cases).

Clearly, then, feeling cold during birth is a very general birth experience, and is not confined to hospital birth. Nevertheless, the very high numbers of women reporting cold in hospital means that this is a problem that needs to be seriously addressed if hospital birth is to become more comfortable, as well as more culturally acceptable.

The figures for feeling cold from the rural sites are strikingly, much lower. In the Quechua-speaking rural areas, 29% of women reported cold as a problem during birth (12 out of 42 cases). In the Aymara-speaking rural areas, 23% reported experiencing cold (11 out of 48 cases). It is notable that both these figures are substantially lower than those for home (and hospital) births in both urban areas.

5.2.3 Fear

The report from peri-urban Sucre shows that women were more likely to experience fear when giving birth in hospital than when giving birth at home. The Spanish word used in the questionnaire was *susto*, a concept implying fear or fright of a degree to cause illness.³ In peri-urban Sucre, 52% of those with hospital births had felt such fear (29 out of 56 cases), while only 27% of those with home births reported feeling fear (6 out of 22 cases). An even higher incidence of reports of fear came from the small study in the rural hospital of Ocurí, where 90% of the women interviewed had felt fear (9 out of 10 cases). Given that fear is a widespread emotion on giving birth, one would expect to find it being reported across different contexts. However, the fact that fear is being reported *more* frequently in hospital seems to confirm numerically the findings of the qualitative phase in relation to hospital practices.

However, the CIES report on El Alto reports a different pattern of findings. There, more women with home births reported feeling fear than those who had given birth in hospital. 50% of those who with home births reported fear (18 out of 36 cases), compared with 28% of those with hospital births (11 out of 40 cases). This latter figure is in line with

³ *Susto* has been much written about as a folk concept of illness that is widespread in Latin America and has puzzled biomedical practitioners (e.g. Uzzell, 1977). In Bolivia, it has a specific meaning within traditional cultures of a dangerous, and usually mortal illness involving loss of soul. However, the word is also used in everyday discourse to mean the equivalent of 'a fright' in everyday English, as in '*Me dió un susto*' — 'It gave me a fright'. It was a failing of the questionnaire that it was not sufficiently clear on which of these meanings was intended.

the frequency of reports of fear from ILCA's study of hospitals in La Paz and Viacha, which also stands at 28% (4 out of 14 cases). Both CIES and ILCA were studying hospital births of migrants from Aymara-speaking areas. In general, then, it seems that fear of hospital birth is greater in the Quechua-speaking urban areas than in the Aymara-speaking ones.

We can compare these findings from the peri-urban areas with the frequency of reports of fear in the rural sites. Generally, it seems the case that reports of fear in peri-urban settings are much more frequent than those reported from rural sites. In the Quechua-speaking rural areas, which were part of the Sucre study for comparative purposes, fear was reported in 10% of cases (4 out of 41 cases). It is notable that the frequency of reports in the Quechua rural sites is lower than that reported for *both* home and hospital births in the peri-urban areas of Sucre.

In the Aymara-speaking rural areas, we find that fear is more frequently reported than in the Quechua-speaking rural areas. In the Aymara-speaking areas studied by the ILCA teams, fear was reported in 38% of rural home births (18 out of 48 cases). If we compare these figures from the Aymara-speaking rural sites with the corresponding Aymara-speaking peri-urban sites studied in El Alto, we find that the rural frequencies are *higher* than those reported for *hospital* births in the urban areas, but *lower* than those reported from *home* births there.

Three interesting differences emerge from this complex picture:

- In both linguistic areas, fear in childbirth is more frequently experienced in home births in the peri-urban areas than in home births in the countryside.
- In the Quechua-speaking areas, fear in childbirth is more frequently experienced during hospital births than in either rural or peri-urban home births.
- In the peri-urban areas, fear in hospital childbirth is more frequently experienced in the Quechua-speaking sites of Sucre than in the Aymara-speaking sites of El Alto.

The data does not allow us to do more than speculate on the reasons for these patterns. It may be that one effect of health education in the peri-urban areas is to make women more aware of risks, and so more frightened of birth than they are in the countryside. Alternatively, it may be the experience of migrant women that they are dislocated from the family system of care and emotional support which prevails in the countryside. As we have seen, many young women live in rented accommodation on their own, and

women's partners or husbands are generally not able to attend them due either to disinclination or to employers' lack of understanding. Such social factors presumably combine to make birth a more frightening experience in the town than in the country, and would explain why some women go home to their mothers in the country to give birth.

The finding that, in Sucre, fear is more frequent in hospital than in home birth, may be related to the fact that two of the maternity hospitals there are used as training hospitals for medical students, and is discussed further in Chapter 14. This finding needs to be set against the finding from El Alto, where hospital birth is less frequently a source of fear than is a home birth in either a rural or peri-urban setting. Without more information on the composition of the hospital sample in El Alto, it is difficult to speculate on why this might be so.

5.2.4 Manual pressure on the abdomen

With regard to manual pressure on the abdomen in the second stage of labour, there is a small difference between the findings in Sucre and those in El Alto. If we exclude cases of Caesarean section from the figures, 41% of hospital births in peri-urban Sucre reported the application of manual pressure on the abdomen by medical staff, (11 out of 27 cases). This compares with 27% of home births in the Sucre study (6 out of 22 cases). Perhaps more importantly, the verbal reports of this procedure being extremely heavy and painful all came from hospital rather than home births. In El Alto, manual pressure on the abdomen had been experienced by 30% of those who had given birth in hospital vaginally (8 out of 27 cases), and by 33% of women who had given birth at home (13 out of 36 cases). The practice was therefore reported slightly more frequently in home births.

Turning to manual pressure on the abdomen in the third stage of labour, that is, during the expulsion of the placenta, only the report from peri-urban Sucre has data on this broken down by home and hospital birth. There, 44% of hospital births reported receiving 'strong rubbing' during delivery of the placenta (12 out of 27 cases). This figure confirms that the reports of this practice from the qualitative phase were not isolated cases. No case of 'strong rubbing' was reported in home births, although 18% said that they had been given 'gentle massage' (4 out of 22 cases).

The data from rural areas suggests that strong manual pressure is used rarely during the birth of the baby, and that no form of massage is used during the birth of the placenta. The only case where massage was used to aid the birth of the placenta was one in which the woman had spent time in towns, and was interpreted by the researcher as an imitation of urban practices (TIFAP, 1995d).

5.2.5 The use of traditional practices

Comparative data on the use of traditional practices in relation to both home and hospital births is also available from the Sucre peri-urban study. The data on the use of traditional practices in conjunction with hospital birth has already been reviewed in section 4.2.2, and has shown that such practices are frequently used in pregnancy and in labour before going into hospital. As would be expected, the comparison with home births shows that these same traditional practices are used more frequently in home birth than when the woman goes to hospital.

The data for the sample of 22 home births from peri-urban Sucre show that 91% used herbal teas; 50% used the *manteo*; while 59% used massage. These figures show a strong survival of traditional practices in the peri-urban areas, especially when taken together with the numbers of women who use traditional practices before going to hospital for a birth (see section 4.2.2).

A comparison with the rural sites in the study shows that there is an *increase* in the frequency of reported use of traditional practices in the peri-urban areas. For instance, in the sample of 40 home births in Quechua-speaking rural communities, only 53% reported taking herbal teas during labour; 38% had used the *manteo*; while 25% had used massage. Since these communities are in the cultural area from which many of the women in the peri-urban sample in Sucre have migrated, it is an important finding that there is increased, rather than decreased, reported use of traditional practices in the towns. We emphasise that this is *reported* use, since the issue of medical disapproval was thought by several of the researchers to have discouraged women from giving positive answers to these questions. It is possible that the figures may simply reflect differential investment by interviewers in giving women the confidence to declare practices known to incur disapproval.

However, the finding that traditional practices are more frequently used in towns than in the countryside meshes well with the national statistic that home births are more likely to be attended by a traditional midwife in an urban area than they are in a rural area (see section 6.1.1.2). The factor here may be increased access to skilled care in an urban concentration, as opposed to the dispersed conditions of the countryside.

5.2.6 Summary of questionnaire findings on the home-hospital birth comparison

Table 5.1 summarises the data from the foregoing sections:

TABLE 5.1 COMPARATIVE DATA ON EXPERIENCES AND PRACTICES IN HOME AND HOSPITAL BIRTHS: 2 PERI-URBAN AND 2 RURAL STUDIES (all figures in percentages)						
	Peri-urban studies				Rural studies	
	Sucre		El Alto		Quechua	Aymara
Category:	Home	Hosp	Home	Hosp	Home	Home
Upright birth position	82	0	69	0	93	77
Cold	60	90	(49)		29	23
Fear	27	52	50	28	10	38
Abdominal pressure in second stage	27	41	33	30	15	10
Abdominal pressure in third stage	0	44	11	4	0	0
Herbal teas	91	46	(57)		53	92
<i>Manteo</i>	50	18*	(18)		38	67*
Massege	59	25*	(20)		25	65*
* The figures marked with an asterisk include uses of these practices during pregnancy						
<i>Sources:</i> CIES, 1995b; ILCA, 1995c; TCD, 1995c; TIFAP, 1995c & 1995d; U. of St. A./TIFAP, 1995b						

This section has compared some of the aspects of birth care in hospital which emerged as prominent in the analysis of women's experiences, with measures of similar aspects of care as experienced in home births. It has found that fear, or fright, in birth is experienced more often in the peri-urban settings than in the countryside, and was most frequent in the hospital settings in Sucre. In these latter settings, fear was closely associated with cold, making hospital birth an uncomfortable experience, both physically and culturally. Discomfort is also caused by the lithotomy position, which is almost universally used in hospital for delivery both of the baby and the placenta. In the home, upright positions are the norm for the birth of the baby, though it is common to adopt a comfortable position lying in bed for the delivery of the placenta. The accounts of manual pressure on the abdomen in both the second and third stages of labour which are a fairly normal part of hospital practice in Sucre, were not found to be part of home birth practices there. However, in El Alto, manual pressure was found to have been applied in the home in a number of cases in second stage, and rather more frequently than in

hospital. Finally, traditional practices around birth, which had been found to be relatively common before and after going to hospital for birth, were found to be more frequently used in home births.

This section has not attempted to deal with other important aspects of birth care, in particular those relating to women's nutrition, rest, and ritual washing in the post-partum period. This is in part because there was a conceptual problem in the questionnaire design, which did not distinguish between food, rest and washing received in hospital, and practices and experiences of attention after the woman had returned home. This makes it difficult to compare what was in any case a very wide variety of answers, several of them to open-ended questions, across the two groups. (But see Chapter 13 for a summary of findings on these points.)

It is relevant to record here the opinion of older women in Sucre that the previous strict observance of post-partum rest and other practices was now very much a thing of the past. It was said by the nurse working on the project team in Sucre that a generation ago, women in the countryside rested for a whole month after giving birth; but this is clearly not the case among migrant peri-urban women today, where often the only rest a woman gets is her three days in hospital for the birth.

5.3 WOMEN'S PREFERENCES FOR HOME OR HOSPITAL BIRTH

The choice between home and hospital birth only really arises in the peri-urban areas of this study, and is even there clearly constrained by economic circumstances and by the availability of transport. In both Sucre and El Alto, a *minority* of women who had given birth in hospital stated that they would prefer to have given birth at home, in answer to the question, 'Where would you like to have given birth?'. The figure is comparatively low in Sucre, where only 15% of women with hospital births would have preferred a home birth. In El Alto, 25% said they would have preferred to give birth at home; while in the rural hospital of Ocurí, 20% said they would have preferred to have stayed at home.

The verbal comments recorded on the questionnaires show that these are frequently cases where a woman came into hospital because her labour had lasted longer than she judged appropriate. How long that is depends very much on the individual woman, her experience of previous births, and on the time of day and availability of transport. It is important to note that in such cases there is no clear-cut prior preference for home or hospital birth. Rather, decision-making is a process which may have different outcomes. A short labour which comes in the night relieves a woman of having to make the decision. It was found in Sucre that economic reasoning was not usually used in isolation

from other factors in women's explanations of preferences for their place of birth. Nevertheless it does figure as part of a widely shared process of decision-making, whereby women hope for a short labour so as to avoid the expense of going into hospital, and conversely, regret having spent money on coming into hospital in cases where they gave birth soon after they got there.

Another factor that commonly enters into women's explanations of where they prefer to give birth is their husband's availability to attend them in the home. Generally in the peri-urban areas, women's partners or husbands were working as labourers in the construction industry. These employment patterns did not apparently permit of taking time off to attend to a wife's birth without losing earnings and, most probably, the job. Usually women gave the lack of someone to attend them in the the home as a reason to back up an expressed preference for *hospital* birth. That is to say, they answered this question not as a desire detached from their material social circumstances, but very much from within their actual possibilities.

5.4 REFLECTIONS FROM TWO MOTHERS' CLUBS

During the dissemination period, sessions of *sociodrama*, or role play, were organised in Sucre with the two Mothers' Clubs who had cooperated with the study. In each case, the researchers had previously given short talks to the groups about the results and recommendation of the study. In a different session, members then acted out short improvised dramas of hospital and home birth followed by a discussion of the issues raised. This section attempts to convey some of the comparisons and the suggestions made by the women who had collaborated with the project's research.

5.4.1 Treatment and maltreatment

Both groups told stories of maltreatment by hospital staff, although they were careful to say that this does not happen all the time, and that only some medical staff are 'nasty'. But the issue of racism came up in these stories, with ill treatment being reserved especially for women from the country, and women who wear the *pollera*, the skirt worn by migrant women. One woman told of having seen a country woman hit in hospital. And nurses are said to scold women in labour, saying 'You're screaming now, but why didn't you scream like that when you were with your husband?'

Food came up repeatedly as an issue in discussing the differences between treatment in different hospitals. It seems that some hospitals do not provide food to women on public

wards, who must arrange for relatives to bring it in. At other times, hospital food is seen as inadequate for a woman's needs after giving birth.

Women who had given birth at home were somewhat disconcerted by these stories of maltreatment, and tried to put into actions and words what for them was the normality of the care and warmth they had received in the home.

5.4.2 Preparation for episiotomy

One group discussed episiotomy, many women having experienced it. Several women who were more urbanised in their appearance argued that doctors were helping them by performing this surgery, because it shortened their length of labour. Then one woman asked, 'Why don't they explain about it to us in the ante-natal check-ups, if they want us to go to so many of them?' This seemed an extremely important point about the provision of information in ante-natal care.

5.4.3 Medical students and being on display

Both groups brought up the issue of student doctors, who receive training in two of the three public maternity hospitals in Sucre. In one of them, a woman complained:

there are loads of student doctors all around us, and we have to lie there in front of them with our legs open wide. Some young girls arrive there and don't know anything about it, and just don't want to open their legs. But they say, "Open your legs!", and force them apart. Those of us who are older already know about it.

This was contrasted with the case of the third hospital, where there are no medical students, just doctors, who are 'kind'.

In the other group, two women told stories of repeated manual vaginal examinations by student doctors which had been 'resisted' by the women involved:

Those students, every one of them puts their hand up. They did it to one lady on the ward. Every single one of them handled her. And afterwards she couldn't even walk. They made her scream with the pain. We other women on the ward all got together to tell them that they shouldn't put their hand up one after the other like that.

The second woman told her own story:

I was in the Maternity Hospital and there were lots of medical students, and they were putting their hands up me a lot, and I said, “Don’t be handling me like that. I’m a person too. Do I look like I’m a peasant woman for you to be handling me like that?”

Unfortunately this woman, herself a rural migrant, had to invoke her own stigmatising stereotype of the country woman (*campesina*) to make her point to the medical staff.

5.4.4 Abdominal pressure and ‘the cleansing’

Once again, the theme of painful abdominal pressure was raised in these discussions. Several women spoke of the pain this causes, and one specifically recommended that the practice should be stopped as it is so painful. Others talked about it in relation to the expulsion of blood after the birth, in terms that were approving:

It’s all right for them to press us. With that they help us to expel those lumps of blood, and then our belly doesn’t hurt any more.

Interestingly, one interchange between two women (A and B below) attributed the same cultural logic of cleansing the blood to the doctor:

- A. I was saying, “Ow, Doctor, please don’t hurt me so much,” and the doctor: “You’ll have to put up with it.”
- B. “You’ll have to put up with it.”
- A. And the doctor, “You have to get out all that dirt inside.”

When Doña Celestina talked rather shyly about her home birth after this discussion, she chose to open by saying, ‘In my home, no one causes me pain,’ once again pointing up for us that there is a difference between the pressure being exerted in hospital and the massage that is applied in the home.

5.4.5 Traditional practices

The performance of the *manteo* in one of the groups’ role play elicited a discussion about the circumstances in which a woman should have this practice performed. While some women argued that it should only be done when the baby is in the wrong position, others argued that it was important to do it just before the birth, or just before setting out for hospital. As this was a group in which many of the members were not migrant women, wore urban clothes, and had their babies in hospital, the researchers were surprised by the apparently widespread practice of doing the *manteo* before going to hospital.

Likewise with discussion of herbal medicine. Most women in the groups said they take herbal drinks, some of native herbs, but often of parsley, oregano, or the traditional drink made with three seeds each of wheat, orange and pumpkin. However, several women repeated the biomedical view that ‘herbal teas can do harm to us or the baby’. This medical disapproval of traditional practices produces a cultural split in many women, who adhere to traditional practices, but must keep them hidden from the doctors.

5.4.6 Home births

It was notable that in both groups there was much more reticence towards participating in the *sociodrama* about home birth than about hospital birth. It will be evident also from this summary that the discussion also centred much more around hospital birth. In the session with the Mothers’ Club in Yanachaki, it was particularly ironic that after a long pause for volunteers to come forward to enact home birth, the white-coated doctor of the medical post walked into the room and crossed it, looking for something, just when the participant was enacting labour and getting near to giving birth. His entry stopped the enactment in its tracks, in a striking mirroring of the entry of strangers into the room where a woman is labouring.

This is how Celestina described home birth to the group:

In my home no one causes me pain. The midwife attends me. They give me herbal teas to drink. When I’ve drunk the teas, then I have my baby. They wrap my head up. Nobody presses me on my stomach.

The simplicity of her description does not need to be over-romanticised as an always calm and peaceful home birth. Rather, her words reflect the perception of ordinariness that cultural customs have for the cultural insider. Strikingly, her discourse twice reflects what she has heard the other women saying about the pain caused by abdominal pressure in hospital, as she begins to contrast their experience with hers.

The impression that the researchers took away was that there was a strong social *stigma* attached in that setting to home birth. For the women who were relatively acculturated into peri-urban life, such as the group of women around the Committee of the Mothers’ Club in Yanachaki, home birth was associated with ‘backwardness’, with poverty, with rural life, and with the cultural difference of the native-language cultures that are looked down on by the dominant creole population. By contrast, hospital birth signified upward social mobility and acculturation into mestizo urban life.

However, this dichotomous representation should not be exaggerated. We need to keep in mind that use made of modern hospital services is embedded within 'traditional' practices both before and after birth. In particular, we need to remember that these particular groups of women experienced low rates of the Caesarean operation that they so dread. Despite some complaints about the pain of abdominal pressure, this method of giving birth was preferred to what was sometimes presented as the alternative of the Caesarean. As well as the concrete examples presented in these discussions where women spoke of having stood up to doctors over the issue of repeated manual penetration, the researchers found that women are in many ways accepting and using the institutional and medical system on their own cultural terms. Indeed, there was evidence that hospital staff share some of these cultural values.

5.5 SUMMARY OF FINDINGS ON THE COMPARATIVE EXPERIENCE

Traditional midwives' view of hospital birth mirrors the conventional biomedical critique of themselves as using dirty and dangerous practices. Midwives generally deplore the use of Caesarean sections and episiotomy in hospitals, seeing their own manual techniques of massage as superior. They also deplore the biomedical practice of inserting the hand up the woman's vagina, which is seen as sexually intrusive as well as unhygienic and laying the woman open to infection. Although midwives are often accused by doctors of using this practice, their own accounts make clear that it is never used routinely, and by some midwives never at all. Actual examples of inserting the hand by midwives which were recounted to the project were exceptional ones, and were limited to cases of hand presentations and of retained placenta. The traditional critique of hospital birth also has social and religious dimensions. Hospital practices are seen as flaunting religious codes of respect to the 'mother earth' which are observed in traditional birth through libations and the chewing of coca-leaf. These traditional observances translate into an atmosphere of calm and respect around the woman giving birth, and the prioritising of her wishes.

The traditional critique incorporates ideals in respect of home birth, which may not always be fulfilled. The questionnaire study gave an opportunity to compare some experiential aspects of home and hospital birth, such as 'fear' and 'cold', as well as practical aspects such as birth position and the use of manual pressure on the abdomen. The questionnaire data need to be understood in the light of two factors. Firstly, this was a disproportionate quota sample, seeking equal numbers of home and hospital births, which are not, however, equally distributed across the population of rural and migrant women as a whole. Secondly, there is the factor of non-comparability of the two groups in a series of background socio-economic characteristics, which is almost inevitable given

the correlation of hospital birth with higher socio-economic and educational status, and with acculturation into urban mestizo society.

While fear and cold were experienced by a proportion of women across all the sites, they were in general far more frequently experienced in both home and hospital births in peri-urban areas than in rural births. In some hospital contexts, very high proportions of women reported feeling fright and cold. Birth positions were almost universally the 'gynaecological' position in hospital, while in home births a variety of upright positions were the commonest ones, including squatting, kneeling and 'on all fours'. Abdominal pressure during the birth of the baby was much more commonly used in hospital births than in rural births, though in one area, peri-urban home births reported a higher rate of use than in hospital. Abdominal pressure during the birth of the placenta was not reported at all from the rural areas, while in some hospitals, rates were high, and a few cases were reported from home births in one peri-urban area. With relation to the use of traditional practices, it was found in the Sucre-based study that, not surprisingly, their use is higher in peri-urban home births than in relation to hospital births. However, it was less expected to find that their use in peri-urban home births is also higher than it is in rural births in the areas studied from Sucre.

All in all, the data indicate a general increase in anxiety around birth in urban as opposed to rural areas. There are also some indications that hospital practices, such as the use of the lithotomy position and of abdominal pressure, are beginning to be adopted in home births in some peri-urban areas. However, the data also suggest that in areas where traditional practices may be declining in rural areas due to the emigration and non-replacement of midwives, these practices are being reconstituted by migrants in urban areas. Feedback from sessions with women in two Mothers' Clubs in Sucre indicated very strong negative feelings around the manual penetration regularly practised on them by male doctors, particularly in training hospitals. There was also much comment about the maltreatment of lower-class and especially country women in hospitals, although social treatment was also said to vary between different hospitals. The view was forcefully expressed that if 'help' is to be routinely offered in the form of episiotomy, women should be prepared for this through ante-natal education. In general, it was difficult for women who had home births to articulate their preference clearly in a mixed group of women with home and hospital births. This reflects the socio-economic and cultural status accorded to hospital birth in urban lifestyles, which may in the end be the major factor in increasing hospitalisation of births in Bolivia.

