

CHAPTER 6

RELATIONS BETWEEN THE TWO SYSTEMS OF BIRTH CARE

This chapter looks at the existing relationship between the two systems of birth care in Bolivia. Section 6.1 sets the context by looking at the structure of the professions involved in birth care, and at national planning for traditional birth care. Section 6.2 reports on the project's findings on the availability of services and on the relationship between systems at local level.

6.1 THE NATIONAL CONTEXT: THE ‘VIEW FROM ABOVE’

6.1.1 The structure of the professions involved in birth care

This section looks at the overall provision and social distribution of doctors, nurses and midwives as professions attending birth in Bolivia.

6.1.1.1 The biomedical professions: international comparisons

By international standards, the number of doctors per head of population in Bolivia is relatively good, but the number of nurses is very low.¹ Another way of putting this is that there is an unusually high proportion of doctors to nurses. *Plan Vida*, the government’s five-year plan for the reduction of maternal mortality, quotes a figure of one doctor per 1,530 inhabitants, and of 0.6 nurses for every one doctor (SNS, 1994: Anexo 1). However, these figures on their own are misleading. The low ratio of qualified nurses to doctors is supplemented by the existence of a body of ‘auxiliary nurses’, who do much of the routine work in hospitals and medical posts. *Plan Vida* gives statistics for the ratio of doctors and nurses in the public sector, citing one doctor for every 0.5 nurses, and one doctor for every 1.6 auxiliary nurses (SNS, 1994: 11). It

¹ According to World Bank economic classifications, Bolivia ranks near the bottom of the group known as ‘lower-middle-income economies’. However, in terms of doctors per head of population, Bolivia has nearly twice as many as the average for this group of economies, which was 1 doctor per 2,850 people in 1990. However, in terms of nurses, Bolivia does badly. The latest year for which comparative figures are available is 1970. The average for the lower-middle-income economies was then one nurse per 1,300 population. Bolivia had less than half this average, at one nurse for every 3,070 people (World Bank, 1995: Table 27). See also World Bank, 1993: Table 28. A more recent figure for Bolivia is contained in *Plan Vida*, which quotes a figure of one nurse for every 2,470 people in the period 1984-9 (SNS, 1994: Annex 1).

also states that the ratios are similar in the Social Security sector, although no figures are available for the private and NGO sectors. Including both nurses and auxiliary nurses, then, there are approximately 2.1 nurses for every one doctor in Bolivia.

Bolivia's position vis-a-vis other countries can be seen in the international tables compiled by the World Bank in their *World Development Reports*. Although the latest full comparison available is for 1970, it is there clear that the Latin American countries exhibit a structure of the medical professions that is quite unlike that of most of the rest of the world (World Bank, 1995: Table 27). While most other countries have more nurses than doctors,² Latin America and the Caribbean have more doctors than nurses. In 1970, the continental average was one doctor for every 0.77 nurses. Brazil and Argentina exhibited this structure very markedly, each having approximately 2 doctors for every one nurse.³ Bolivia appears in the 1970 comparison as close to the Latin American average, with one doctor for every 0.66 nurses. By comparison, in the 'high-income countries' the balance is the other way around, with, on average, 3.22 nurses for every one doctor. Ireland had one of the highest ratios of nurses to doctors among the high-income countries, at 6.1 nurses for every one doctor.⁴ Since the Bolivian figures are explained as including auxiliary nurses,⁵ it can be seen that there has been a marked improvement in the ratio of all nurses to doctors by the mid 1990s, when, as noted, there were 2.1 nurses for every one doctor.

6.1.1.2 Regional distribution of biomedical personnel

In the Bolivian context, a further factor is that the relatively good numbers of doctors per head of population must be taken in conjunction with the opportunities for employment within the profession. There are 8,700 members of the *Colegio Médico de Bolivia* (the Bolivian Medical College), the doctors' professional organisation.⁶ But of these, only

² The major exceptions to this 'normal' pattern in the rest of the world are Bangladesh, China and Pakistan, which all have considerably more doctors than nurses according to the latest figures available (World Bank, 1995: Table 27).

³ Among the Latin American countries, Chile, Ecuador and Venezuela exhibit the more typical modern structure, having more nurses than doctors. (World Bank, 1995: Table 27).

⁴ It is interesting that many of the low-income countries of Africa also have high ratios of nurses to doctors. Tanzania had 6.7 nurses per doctor in 1970; Malawi had 25 nurses per doctor in 1990 (World Bank, 1995: Table 27).

⁵ See World Development Report, 1995: 240. The Explanatory Note to Table 27 there states, 'Nursing persons include auxiliary nurses, as well as paraprofessional personnel such as traditional birth attendants. The inclusion of auxiliary and paraprofessional personnel provides more realistic estimates of available nursing care.'

⁶ The figures in this paragraph are taken from an article in the daily newspaper, *La Razón*, of 2nd October, 1995, entitled, 'The Public Health Sector has only 1,938 Doctors' (*La Razón*, 1995b). This article included a table from *Dossier Estadístico, Secretaría Nacional de Planificación, Ministerio de Desarrollo Sostenible y Medio Ambiente* (Statistical Dossier, National Planning Secretariat, Ministry of Sustainable Development and the Environment), June, 1995.

1,970, or 22%, have jobs in the public health services. Of the rest, 1,200, or 14%, are employed in the Social Security sector, and the rest, 5,530, or 64%, are in private practice. Since the Social Security and private sectors are located almost exclusively in urban areas, it is only the public health services that serve rural areas at all.⁷ The 64% of doctors in the private sector is likely to include, therefore, doctors who are unemployed or underemployed in urban areas. It is an observable fact that qualified doctors compete with each other for employment and clients in the larger towns and cities. Hospital and other public service posts are often dependent on political allegiances, and can be lost with a change of government. This means that doctors can find themselves transferred very suddenly into 'the private sector', joining the ranks of their colleagues competing for private patients in the towns.

However, this competitive situation in the towns and cities exists alongside what often appears to researchers and others as a scarcity of doctors in rural areas.⁸ As in other countries, the medical professions are seen as routes to upward social mobility. Living in the countryside usually means coping with spartan conditions, as well as living away from family, separated by poor roads, long journeys and the almost complete absence of rural telecommunications. Such a life is not usually socially attractive to those who have invested money and time in gaining a medical qualification. Those who do gain rural posts often spend long times away from them because of these difficulties. Indeed, the problem of a scarcity of medical personnel is given public recognition in the scheme known as the 'year in the provinces', the compulsory year spent in the countryside immediately after qualification by doctors and nurses. However, the government has recently introduced escape clauses, so that even this year of rural service has ceased to be compulsory for those who can afford to buy themselves out.

Qualified nurses, who nowadays have completed a four-year degree programme, also face a lack of employment opportunities. For them, the problem is not only that of competition for scarce urban employment, and the insecurity created by political changes.⁹ It is also that as a profession, they are frequently undermined by the employment of auxiliary nurses, whose training is of only 9 months' duration. Often

⁷ While NGOs are active in rural areas, their activities are normally undertaken jointly with the National Health Secretariat. We do not know how the figures reproduced here have included doctors employed jointly by NGOs and the state.

⁸ These remarks come from the impressions of those of the project team who have lived and worked in the Bolivian countryside, some of whom have been able to stay in empty medical posts while doing so.

⁹ The problem of political patronage in relation to jobs in government health services was very clear in the experiences of the two qualified nurses who worked as researchers on the project team. One had lost her job in government employ after the last general election; while the other lost the job she had held for 21 years in a public hospital half way through the course of the project.

rural jobs are offered only at auxiliary nurse level, and qualified nurses complain that the government is not releasing the salaries that would allow empty rural posts to be filled.

However, the figures for geographical distribution of medical personnel in public service do not entirely bear out these impressions of the scarcity of medical personnel in rural areas. Table 6.1 is compiled from government figures for numbers of doctors and nurses in each Health Region.¹⁰ These have been divided by the total population numbers for each geographical Department,¹¹ since Health Regions are broadly based on Departments.¹² The results listed in the table show the levels of population per doctor and per nurse (including auxiliary nurses) in the nine Departments, which have been placed in rank order from the most medical personnel to the least.

TABLE 6.1 DEPARTMENTS RANKED BY DENSITY OF PUBLIC SECTOR DOCTORS AND NURSES/AUXILIARY NURSES (INDEX OF URBANISATION SHOWN IN BRACKETS)

Departments ranked by density of doctors (index of urbanisation in brackets)	Population per public sector doctor	Departments ranked by density of nurses (index of urbanisation in brackets)	Population per public sector nurse
Pando (26%)	1,586	Pando (26%)	656
Chuquisaca (29%)	2,192	Beni (21%)	780
Beni (21%)	2,282	Tarija (31%)	852
Tarija (31%)	2,369	Santa Cruz (51%)	1,336
La Paz (37%)	3,606	Potosí (17%)	1,622
Santa Cruz (51%)	3,843	Oruro (54%)	1,762
Oruro (54%)	3,864	Chuquisaca (29%)	1,860
Cochabamba (37%)	3,889	La Paz (37%)	2,262
Potosí (17%)	4,334	Cochabamba (37%)	2,680
TOTAL	3,315	TOTAL	2,052

Source: Compiled using figures for population from the 1992 Census (Atlas Bruño, 1994-5), and for medical personnel from an article in *La Razón* (2.10.95). See footnote 53 for more details.

¹⁰ The figures for medical personnel by Department in this table are taken from an article in the daily newspaper, *La Razón*, of 2nd October, 1995, entitled, 'The Public Health Sector has only 1,938 Doctors' (*La Razón*, 1995b). This article included a table from Dossier Estadístico, Secretaría Nacional de Planificación, Ministerio de Desarrollo Sostenible y Medio Ambiente (Statistical Dossier, National Planning Secretariat, Ministry of Sustainable Development and the Environment), June, 1995.

¹¹ Figures for population were obtained from the 1992 Census, as listed in the Atlas Bruño (1994-5).

¹² The exceptions are the Health Regions of Riberalta and Tupiza, which do not correspond to Departments. Figures for medical personnel from the Health Region of Riberalta have been put together with those from the Region of Beni, and set against the population of Beni Department; similarly, health personnel from the Health Region of Tupiza have been put together with those from the Region of Potosí, and set against the population of Potosí Department. It is possible that this has slightly deflated the population assigned to each doctor and nurse in the Departments of Beni and Potosí.

An index of urbanisation for each Department, based on the proportion of population resident in the Department capital,¹³ is given in brackets after the Department name.

The first two columns of this table show that the areas with the *most* public sector doctors per head of population are some of the more *rural* of the country: Beni, Pando, Chuquisaca and Tarija all have 30% or less of their population living in the capital of the Department. By contrast, the two most *urbanised* Departments, Santa Cruz and Oruro, with more than 50% of population living in the Department capital, have less than half the number of doctors per head that Pando has. However, the pattern is not clear-cut, since the most rural Department of all—Potosí, with only 17% of the population in the capital—fares worst in terms of doctors per head.

The third and fourth columns show the density of public sector nurses in the different Departments. Here there is a clearer division in terms of the flat lowland areas (Pando, Beni, Santa Cruz and part of Tarija), and the higher, mountainous areas of the country, with the lowland areas being better supplied. However, it is notable that within each of these geographical sub-divisions, it is the most *urbanised* Departments that fare worst. So, urbanised Santa Cruz has half the number of nurses per head that rural Pando has; and rural Potosí is distinctly better provided for than more urbanised La Paz or Cochabamba.

Although the figures presented here are only broad ones, and do not look at urban and rural sub-divisions *within* Departments, they do not suggest that there is any simple tendency for rural areas to have fewer medical personnel per head of population than urban ones. It is possible that there is actually a contrary tendency, for public sector appointments to lag behind immigration into the larger cities. Nevertheless, the fact remains that the population is very dispersed geographically in the most mountainous Departments—Potosí being a prime example—and that distance to the nearest medical post may therefore be literally ‘too far to walk’ for many people, so contributing to the impression of an under-provision of services in rural areas.

6.1.1.3 Midwifery as a biomedical profession

From the point of view of the provision of birth care, there is one very striking aspect of professional biomedical birth care in Bolivia, and that is the absence of a midwifery profession. Officials within the Health Secretariat explained that this was as a result of a decision taken in the mid-1970s to close down the university-based programme for training

¹³ Calculated from the figures on page 74 of *Atlas Bruño* (1994-5), which are from the 1992 Census.

obstetric nurses, which had existed up till then. Women who had been trained as obstetric nurses before the closure were resentful that the authorities in charge of nursing education in La Paz did not put up more of a fight against what they saw as professional encroachment by the doctors. However, this effective abolition of professional midwifery is now in the process of undergoing a small reversal, since *Plan Vida* has recommended a new programme for training obstetric nurses at post-graduate level in Cochabamba, which is being implemented at the moment.¹⁴

6.1.1.4 Implications for hospital birth attention

Hospital birth means, in effect, therefore, attendance by a doctor. The 1994 National Health and Demography Survey gives up-to-date figures both for place of birth and for attention in birth by different types of attendant (INE, 1994: Tables 8.3 and 8.4). The data shows that at present slightly over 40% of births nationally are taking place in a hospital or medical centre. It also shows a very close correlation between institutional birth (42.3% of all births) and attendance by a doctor (42.7% of all births).

6.1.1.5 The social distribution of birth attention by traditional midwives

Although there is no figure available for the total number of traditional midwives practising at national level, the 1994 National Health and Demography Survey gives figures for the proportion of all births attended by traditional midwives (INE, 1994: Table 8.4). It also gives figures for place of birth (INE, 1994: Table 8.3), and each table is broken down by various social and demographic characteristics. As the total number sampled in each category is listed in addition to the percentages, it is possible to re-calculate the percentage of *home births* attended by traditional midwives. The results of this re-calculation are listed in Table 6.2, alongside figures for the percentage of all births attended by traditional midwives. Together, these figures give an idea of the relative importance of traditional midwives within the national picture.

The overall picture that emerges from this data is one in which traditional midwives are attending 10% of all births, and 18% of home births. Home births represent 57% of the total of births. As already noted, the data shows the correlation between institutional birth in a hospital or medical post and attendance by a doctor (42.7% of all births). The remainder of births (effectively the remainder of *home* births) in the sample were attended by a nurse or auxiliary nurse (4.5% of all births) by a family member or friend (40%), or by nobody (2%).

14 The Plan envisages a 6-month training course, with 30 places.

TABLE 6.2 PERCENTAGES OF BIRTHS ATTENDED BY TRADITIONAL MIDWIVES, BY SELECTED CHARACTERISTICS (FROM NATIONAL DATA FOR 1994)			
Characteristic	Home births as % of all births	% of home births attended by a traditional midwife	% of all births attended by a traditional midwife
Age of mother:			
< 20	52	24	13
20-34	55	18	10
35+	69	14	10
Order of birth:			
1	41	22	9
2-3	50	18	9
4-5	67	15	10
6+	75		
Area:			
urban	38	21	8
rural	78	16	13
Geographical region:			
highlands	71	12	8
valleys	56	17	9
lowlands	38	39	15
Level of education:			
none	89	10	9
basic	72	19	13
intermediate	44	25	11
secondary +	18	23	4
Total	57	18	10

Source: figures for place of birth and attendance by traditional midwives at all births taken from INE (1994) Table 8.3; figures for percentage of home births attended by traditional midwives calculated from the figures presented in INE (1994) Tables 8.3 and 8.4.

These figures undoubtedly show that the role of traditional midwives is likely to decrease with urbanisation and migration to the towns. If 13% of all rural births are attended by a midwife, only 8% of urban births are. This decrease is largely due to the much greater availability and take-up of institutional birth in the towns (62% of all births), as opposed to the countryside, where institutional birth is only 20% of all births. Interestingly, the decrease cannot be attributed in any straightforward way to the unavailability of care by traditional midwives in the urban areas, where the data show that a home birth is *more* likely to be attended by a midwife than a home birth in a rural area. Although home births

are a much lesser proportion of all births in urban than in rural areas, it is nevertheless the case that the level of coverage by traditional midwives in urban areas is greater than the national average. These findings do not lend support to any hypothesis that traditional midwifery will simply disappear with migration to the towns, but suggest rather that it is being reconstituted in new ways in urban conditions.

An important finding that emerges from separating out the figures for home births is that the *pattern* of attendance of births by traditional midwives is strikingly similar to the pattern of attendance by biomedical professionals. The likelihood that a home birth will be attended by a traditional midwife is greater for younger women and is lesser in the older age groups. It is also slightly greater in first births than in subsequent ones., but starts to increase again with the sixth and subsequent births As we have seen, it is also greater in towns than in rural areas. It increases with the level of formal education, and with the number of ante-natal visits to institutional medical centres the woman has undertaken; (the INE questionnaire did not ask about ante-natal visits to traditional midwives). The INE data show that all these factors *also* greatly increase the likelihood of a woman attending a hospital or medical post for her birth, and of being attended by a doctor (INE, 1994: Tables 8.3 and 8.4). What has been shown here is that the directional tendency is the *same* in seeking attention from a traditional midwife as in seeking insitutional medical attention.

One of the widest differences revealed by this reworking of the INE data is that coverage of home births by traditional midwives is lowest in the highland regions (the *altiplano*) and highest in the lowland rainforest regions (the *llanos*). These latter include the large city of Santa Cruz, but also the predominantly rural areas of Beni and Pando Departments. While coverage of home births by traditional midwives is high in Santa Cruz Department (36%), it is even higher in Beni and Pando Deptartments (47%). These figures can be compared with the highland Departments of Oruro and Potosí, where coverage of home births by midwives is relatively low (at 5% and 7% respectively).

A full understanding of these large regional variations is not possible on the basis of the INE data, and the lowland region lay outside the scope of our own project.¹⁵ Nevertheless, as regards the highland areas where the project did work, it is important to note that the INE data show that non-attendance by a midwife almost always means attendance by a family member. In the highland *altiplano* region, for instance, 77% of home births are

¹⁵ It is interesting that there appears to be a parallel between the greater provision of doctors and particularly nurses in the lowland regions, and the apparently greater availability of traditional midwives as birth attendants. However, more research would be needed to ascertain that like is being compared with like across these widely differing cultural regions.

attended by a family member or friend.¹⁶ Our own project findings show that in the highland regions, while a specialist role for midwives is certainly recognised, knowledge and skill in attending birth are very widely diffused throughout the society. If this represents a ‘traditional’ model of the diffusion of knowledge throughout society, one implication of this picture has to be that a move to more ‘modern’ forms of knowledge diffusion implies the widespread *deskilling* of family members as birth attendants.

6.1.2 National planning for traditional birth care

6.1.2.1 The view of traditional birth care in *Plan Vida*

The present *Plan Vida* sees the main way to reduce maternal mortality as through increased institutional coverage of birth, together with an improvement in the quality of hospital services. Concretely, over the five-year period from 1992 to 1997, it plans to increase institutional coverage of birth from around 40% to 60%, and to improve the maternal mortality rate in hospitals from 186 deaths per 100,000 live births in 1992, to 100 per 100,000 in 1997. The plan includes an impressive array of measures to increase community involvement in detecting and notifying cases of maternal danger and obstetric emergency. As well as improvements in communications, and training of a wide variety of community members, it recommends the implementation of ‘solidary funds’ at local level to enable women to be transported to hospital in emergencies.

The planned increase in institutional births is intended in itself to bring down the rate of maternal mortality in home births. Deaths in home births are expected to fall from the 1992 rate of 677 per 100,000 live births, to 470 per 100,000 in 1997. In addition, a part of this decrease is to be attributed to the increased training of traditional midwives. There are at present, between 1,200 and 1,300 traditional midwives who have received training from government or NGO programmes.¹⁷ *Plan Vida* intends that by 1997, 20% of all births should be home births attended by trained personnel (SNS, 1994: 100). This would amount to one half of all home births as envisaged in the plan. The document also envisages that 70% of personnel working for more than two years at local level in maternal health will be trained (SNS, 1994: 101, and paragraph 1.1 of ‘expected results’). One aim of this training is that:

¹⁶ These figures are, again, our own calculations on the basis of the data presented in INE (1994), Tables 8.3 and 8.4. The same calculations show that in the highland region, 3% of home births were unattended, while 6% were attended by nurses or auxiliary nurses.

¹⁷ Interview with Norma Quispe, National Director of Training for Traditional Midwives, 1.2.95: Barbara Bradby and Susanna Rance.

Not less than 70% of auxiliary nurses, traditional midwives and health promoters (will be) applying norms and procedures for health care and identification of signs and signals.

(*ibid*: paragraph 1.3 of ‘expected results’)

The Plan provides for elaboration of these norms, and for a programme of public education in recognition of danger signals.

However, the proposed activities of the Plan do not include any innovation on existing programmes for training of traditional midwives, which are considered in sections 6.1.2.3 and 12.2 of this report. In addition, support for home births attended by relatives, traditional midwives and health personnel’ is included as one of the regular activities of the health services, rather than any new project of the Plan (SNS, 1994: 82). From the point of view of this project, it is also disappointing that the inclusion of Traditional Medicine in the statement of objectives presented at the beginning of the May 1994 version of the Plan, was dropped from later versions of the Plan.¹⁸ In the original statement of objectives, Traditional Medicine was included alongside the Health Secretariat, the Insured Sector, the Municipalities, and the organized community, as part of the joint planning and consultative process. Despite this omission, the revised statement still includes an acknowledgment of the need to

take into consideration the diversity of backgrounds, traditions and customs of the different Bolivian communities and ethnic groups (*ibid*: first page of *Marco Lógico*, and page 35).

There is also an acknowledgment that existing health services need to improve not just their technical delivery but also the quality of delivery. The Plan refers to the ‘insurmountable barriers’ and the ‘traumatic experience’ of using the health services that many clients take away with them (*ibid*: 97). And in the same context of ‘potential obstacles’ to the implementation of the plan, there is a reference to the fact that:

Users demand the creation of institutions which coordinate traditional medicine with western medicine and together develop science and empirical knowledge (*ibid*: 98).

However, this need is mentioned in connection with child illnesses and not specifically in relation to childbirth and maternal health. The Executive Summary of *Plan Vida* contains no reference to traditional medicine and says nothing specifically about the inclusion or training of traditional midwives. As against this thrust towards relocating birth in

¹⁸ Concretely, the phrase ‘Traditional Medicine’ was dropped from the repetition of this statement of objectives on page 35 of the May document, and also from the version of the ‘*Marco Lógico*’ that appears in the Executive Summary which was published in September of 1994.

institutional settings, it should be said that the small print of the Plan contains a major emphasis on local participatory planning, on community ‘autodiagnosis’ of needs, and on local education initiatives. It also emphasises several times the need to

guarantee the participation and integration of women in the planning, implementation and evaluation of all the actions envisaged, in both individual and organised form, as both subject and object of all the basic interventions, and above all, with respect for women’s socio-cultural integrity (*ibid*: 39, 87).

If participatory planning processes are followed, then they should enable women to express their own needs and expectations for culturally appropriate birth care, as well as for the highest possible standards of safety. It has been the experience of this project that there is a ‘courtesy bias’ towards women saying they are satisfied with existing services, even where in-depth interviewing has revealed they are not. This bias has been found in other studies of the ‘quality of care’ in developing countries (Mensch, 1993: 249), and will need to be taken into account in participatory planning initiatives.

6.1.2.2 The cultural adaptation of hospital birth: ‘humanised birth’

Since 1989, a strand of national planning has focussed on the need to ‘humanise’ birth, and has included thinking that acknowledges the different cultural traditions present within the country. Its origins among the MEDICON group of doctors are discussed in section 9.2 of this report. They rejected many routine features of hospital birth, and argued for the presence of a woman’s partner during birth, and for the adoption of the position in which the woman felt most comfortable. This approach was crystallized in a government initiative known as the ‘Programme for the Protection of the Pregnant Mother and Prevention of Mental Handicap’, launched in 1989 and known in brief as ‘humanised birth’. In recognising the need to give real liberty in choice of birth position, and in arguing for the presence of partners at birth, the authors of this initiative were according real recognition to the different cultural traditions of Bolivia.

A recent newspaper article reports on this programme, as implemented in three health centres in La Paz. The director of the programme, Maria Teresa Benavides explains that her approach:

makes birth an experience that is not painful, by means of relaxation and breathing techniques, yoga and other types of exercise, practised throughout pregnancy. The approach incorporates the future father, who also learns relaxation. Music and colour therapy are also used, which are useful techniques for achieving emotional equilibrium between the mother and the new being. In order for birth to be humanised, both parents, and especially the mother, should follow the course throughout pregnancy (*La Razón*, 1995b).

The Director claims that this approach brings down the Caesarean rate, and also shortens the length of time in labour. She gives data on 213 births at these centres, and states that 65% of women having their first baby had labours of between 2 and 6 hours. She also states that 80% of the total number, including first births, were 'tranquil in their behaviour, achieving good breathing and relaxation'.

If the approach expressed in the above quotation owes more to the 'alternative birth movement' of Northern countries than to Bolivian cultural traditions, the programme does also allow scope for the incorporation of important features from those traditions. This was very clear in the approach of Dr. Virginia Camacho, overall Director of the Programme of Reproductive Health in the National Health Secretariat. In an interview that the Project Coordinators held with her, she brought in a strong commitment to the tenets of 'humanised birth' in the context of talking about the cultural barriers between traditional midwives and the institutional medical system. Such measures as allowing the woman to give birth in whatever position she liked, returning her placenta to her, assuring that the room is sufficiently warm, and encouraging the presence of partners or relatives, are essential in her view to achieving a better rapport between the two systems of birth care.¹⁹

In this way, the notion of 'humanised birth' can be seen as particularly important in terms of building bridges between the traditional and institutional systems by its supporters. The project found that the notion has had a diffuse effect on thinking about childbirth in the wider study area; but its impact on actual practices is as yet more limited (see chapters 3 and 13). We report below on some aspects that had (and had not) been incorporated in the establishments studied by the project (section 6.2.1.3).

6.1.2.3 State training of traditional midwives

Norma Quispe, National Director of Training for Traditional Midwives explained in the interview she gave to the project that the training programme first came on line in 1976.²⁰ At that time courses were run in five Departments of Bolivia, over the period of a month. This initiative was evaluated in 1980 and it was found that the course content was too crowded, and that midwives were not retaining much of the anatomical and physiological teaching. A shortened programme of training, lasting two weeks, was then extended to eight Departments. A subsequent evaluation in 1982 by the Panamerican Health

¹⁹ Interview with Dr. Virginia Camacho, *Secretaría Nacional de Salud*, La Paz, 1.2.95, carried out by Barbara Bradby and Susanna Rance.

²⁰ Interview with Norma Quispe, National Director of Training for Traditional Midwives, 1.2.95: Barbara Bradby and Susanna Rance.

Organisation again argued that the course content was too much for non-literate people, and recommended changes in teaching methods and the involvement of biomedical personnel. Following that report, the course was reduced to one week, and interactive methods such as role play were introduced into the teaching. The evaluation carried out in 1989 found that there was still a lack of connection into institutional health services, and that there was a need for follow-up on the participants. The Director of the Programme explained that of approximately 1,200 registered traditional midwives, only about half, 620, report regularly to the health authorities on their activities.

Since 1991, the course content has been pruned to the 'absolute minimum' and now lasts only four days. Follow-up has been formalised in a national system of 'monitoring' the work of traditional midwives, involving their own recording of their work in a notebook of charts using pictorial images. In 1994, Bolivia was chosen to participate in an international evaluation of midwife training, carried out by UNFPA. The evaluators found that 'clean birth' practices had increased, but again underlined the lack of connection to the institutional health services, and the need for more follow-up.

The 'top-down' international planning and evaluations tend to emphasise the need to teach the basis of the biomedical approach to birth, and to incorporate traditional midwives into the health services as agents of referral to institutional services. Norma Quispe stated that in recent years there has been a shift away from simply teaching 'clean birth', towards teaching midwives to recognise the 'danger signals' in pregnancy and birth, and refer women on to hospital. However, in conversation, she moved away from these top-down' concerns to express a much more empathetic view of the traditional midwives' role and situation. Trained as an obstetric nurse herself, in one of the last graduations of the mid-1970s, she claimed to have since learnt a lot from traditional midwives. She was particularly admiring of midwives' abilities in external palpation, and in using the mother's pulse to monitor the course of a birth.

The National Director also gave a clear indication that the problem of integrating midwives' role with that of the institutional health services could not simply be blamed on unwillingness of midwives to refer on difficult cases. Often, the situation has been the reverse: that health services have refused to treat cases of women brought in by traditional midwives. This problem was confirmed by Dr. Virginia Camacho, National Coordinator of the Reproductive Health Programme, where the midwife training programme is located.²¹ She cited the failure of an agreement on coordination between the Maternity

²¹ Interview with Dra. Virginia Camacho, *Secretaría Nacional de Salud*, La Paz, 1.2.95, carried out by Barbara Bradby and Susanna Rance.

Hospital of a large Bolivian city and local urban midwives. In this case, doctors refused to take in cases brought to them by traditional midwives, on the grounds that the midwives themselves had made the mistakes, and that to take the women in would increase the hospital's maternal mortality statistics.

From the point of view of traditional midwives themselves, the 'top-down' concern about their integration must therefore be rephrased as the cultural and social problem of the lack of respect of biomedical practitioners towards their knowledge and skills. This problem is shown very concretely in the retreat of the national training programme away from working with traditional midwives in urban areas. The training programme is now conceptualised as principally for rural areas. The National Director argued that this situation reflects the view of doctors and obstetricians, that where hospitals exist, there should be no need for traditional midwives. Their attitude ignores the under-utilisation of hospital services in urban areas. Such attitudes were a direct cause of the failure of the programme in one small Department capital, where 80 midwives had been registered but where the hospital services did not offer meaningful collaboration. Instead, the midwives told stories of doctors taking midwives to the police, accusing them of over-charging for their services. Although there are notable exceptions, such as the efforts both of the Regional Health Secretariat and of NGOs in El Alto, these attitudes seem generally to have virtually eliminated any training or planning for traditional midwives in urban areas.

Another concern of the National Director was the problem of offering training to young women who have had no previous experience of attending births, as opposed to building on the skills of older and experienced midwives. This problem was apparent also at local level in the fieldwork of the project and is discussed in section 6.2.1.2. For Norma Quispe, this problem has led her to increase the time put into accrediting and selecting participants for the training courses. She talks of the 'distortions' introduced into the programme when the voluntary local health promoters known as *Responsables Populares de Salud* enrol for a course and then declare their services as midwives. She is aware of the long apprenticeship usually undergone by traditional midwives, and welcomes the fact that very often older women bring young daughters or granddaughters along to the training sessions. In view of these possible distortions of the programme, she argues that there is a need for formal criteria for selection, and more formal instruments for evaluation in follow-up work.

These concerns of the National Director of the midwife training programme are already beginning to broaden the programme out from the international preoccupation with targeting midwives themselves for training and integration. Norma Quispe spoke of the programme's plans for offering training and supervision to health teams in the *institutional*

sector in their dealings with traditional midwives. From the present project's point of view, this recognition of the need for training on *both* sides is a potentially very important step towards breaking down the cultural barriers to a full understanding of traditional birth practices in Bolivia. It indicates that there is an awareness at high level of the need for genuine cross-cultural dialogue between systems of care. Such awareness and the initiatives to which they may give rise will deserve future support from all quarters if they are to succeed in forwarding the case of traditional midwives within the existing structure of the professions attending birth in Bolivia.

6.2 FINDINGS AT LOCAL LEVEL: THE ‘VIEW FROM BELOW’

If the previous section reported on how traditional midwives are seen as part of a system of health care from the perspective of national planners, this section reports on the project's findings on how midwives themselves see the biomedical system and their relationship to it. It looks first at the issue of coverage of birth by the different systems of care through perceptions of availability at local level in the areas where the project worked (section 6.2.1). It goes on to look at an important gap in the view of the structure of the professions presented in the preceding section, which only became visible at local level, namely the apprenticeship that is involved in training to be a traditional midwife (section 6.2.2). It became evident during the project fieldwork that differences are emerging between those midwives who have been trained in the traditional system in this way and those who have received some form of biomedical training for attending birth (section 6.2.3). Midwives' relations to the institutional sector of health care is then looked at through three case studies (section 6.2.4). Finally, the issue of diffuse versus specialist knowledge within traditional society is briefly revisited (section 6.2.5)

6.2.1 The availability of birth care

6.2.1.1 Traditional specialist care

The brief report here is drawn not from the quantitative data about actual attendance at birth, but from observations from the qualitative interviews about the availability of traditional midwives to attend births. The ILCA team, in particular, drew clear conclusions from its work in the Aymara rural communities that traditional midwifery is on the decline in the countryside. In Unkallamaya, for instance, the midwife who was best known in the community had died four years previously, and she and others had not left successors equipped with their knowledge. The team attributes this decline, shown in the total absence of attention by traditional midwives among women interviewed in the quantitative phase, to the process of acculturation that the community has been going through. In addition to

the growth in commercial activities, the main influence has been the establishment of a group of Seventh Day Adventists in the area. This, and the general increase in school-going, have meant the growth of inter-generational conflict and an unwillingness on the part of younger generations to take on the teaching of their elders (ILCA, 1995c: 49-50).²²

In Inka Katurapi, although there are still four practising midwives, all are elderly, and again, the same lack of obvious transmission to successors is evident. However, the existence of practising midwives enabled the team to document the pattern of midwives attending first births (they were present at 4 out of 5 cases in the quantitative stage), while later births are usually attended by the husband or a member of his family. The midwife has the role not only of attending birth, but of teaching the young woman how to look after herself during birth and what help she needs, so that in subsequent births she can direct her husband to help her. In all cases where a midwife had attended women in second or subsequent births, it was found that the woman was classified as having a predisposition to difficult births in the form of a ‘golden uterus’; and in some of these, she was also classified as having a ‘dry birth’ (ILCA, 1995c: 44,49).

TIFAP found that in Tumaykuri, only one woman is known as a specialist midwife in the community. She is now about 75 years of age, and again there is no known successor to her skill. In addition, she has established herself as a midwife in the town of Llallagua, at several hours’ truck journey from the community, and only returns from time to time. The process of migration probably plays a large part in the decline of traditional midwifery in the countryside. The only specialist midwife encountered in the peri-urban areas of Sucre was a migrant from the area of northern Potosí. And the majority of the forty or so midwives who came to the Midwives’ Encounter in El Alto (see below, section 6.2.3) were also migrants from rural areas or mining centres.

It is difficult to make firm statements about the availability or otherwise of traditional specialist care in the peri-urban areas. It is important to point out that government and NGO health programmes had rather different attitudes to traditional midwives in the two peri-urban areas in which the project worked. In El Alto, a large programme funded by the Dutch Government had been working through the Health Secretariat with urban traditional midwives in a health district adjacent to those where this project worked. The

22 This pessimistic view is not entirely compatible with the qualitative report on Unkallamaya, which presented profiles of two midwives, one male and female, still practising in the community (ILCA, 1995b). It is true that the elderly woman midwife had practised mainly at the births of family members, but this was also the case with women midwives interviewed in other areas of the project. The testimony of her knowledge and experience presented in the transcript of a long taped interview with her is similar to those presented by midwives elsewhere.

Regional Health Secretariat was very open to taking up the issue in other districts, and it was within this sort of context that it was possible for CIES to organise the Midwives' Encounter in El Alto in conjunction with the Health Secretariat.

By contrast, in Sucre, the situation was perhaps more typical of the country as a whole, in that the biomedical health services virtually denied the existence of traditional midwives in urban areas. For instance, the Regional Director of Midwife Training Programmes, Angélica MENDIA, stated that she had carried out a survey a few years ago to ascertain how many midwives were working in urban areas in Sucre, and that the survey had fund that there were none.²³ When the researchers from the present project showed surprise at this finding and asked how the study had been carried out, she explained that institutional health centres had been asked to report on traditional midwives practising in their areas. All replied that there were no midwives working there. However, it is evident from the findings of this project that some women *are* receiving attention in birth from midwives in peri-urban Sucre. That the biomedical authorities are not aware of this is cause for concern, since midwives may increasingly be driven underground in order to escape criticism from the institutional sector.

Apart from the specific problem in urban areas, there are two general difficulties with interpreting the data from this project or from any other source on the availability or the decline of traditional midwifery. The first is that midwives generally work first and foremost with members of their own families. Hence, questioners who ask whether a birth was attended by a midwife or by a relative may receive the answer that attention was by a relative, and will need to probe further to find out if the relative was also seen as a midwife. The second problem is that of the definition of a woman as a midwife by the wider community. It is apparent from our data that women are not generally given a title as 'midwife' unless they also attend births of women outside their own family. It is possible that many midwives only acquire this title quite late in life, and after attending many births in their immediate family. If this supposition is correct, then it becomes peculiarly difficult to make firm statements about the decline of traditional midwifery. More research is clearly needed on the life stories of midwives themselves, and on how the gap left by the death of a midwife is filled in rural communities.

6.2.1.2 Biomedical care

All of the rural communities where the project worked had, in theory, some access to biomedical care in birth. Qaqachaka, Inka Katurapi, Phichichua and Tumaykurí all had

²³ Interview with Angélica MENDIA by Mary Aguilar and Barbara Bradby, Regional Health Secretariat, Sucre, 6.2.95.

medical posts, and Unkallamaya had access to hospitals in Viacha. However, staffing in medical posts is intermittent. Only in Inka Katurapi, where the *sanitario*, (a para-medic with auxiliary nurse training) was himself from the community, is there evidence of ongoing activity. In Qaqachaka, the medical post was occupied by the anthropologists, who themselves were often called on to perform first aid in the community. In Phichichua, the medical post had only recently been staffed, and people still preferred to go to one in a neighbouring community. In Tumaykurí, the auxiliary nurse had an accident on her bicycle and was not replaced, so that the post was unstaffed for the majority of the time of the project's work there. In addition, in most of these places, radio systems were not installed which could have facilitated emergency aid in birth.

The role of auxiliary nurses in attending birth in the rural areas was found to be problematic in several cases. Ethical issues are raised when the auxiliary nurse apparently imposes himself or herself on a woman in birth uninvited, or even after the woman has expressed a wish that the nurse does not attend. Cases of this happening were reported from both Inka Katurapi and from Tumaykurí, and must be seen as one result, at local level, of the pressure coming from international planners down through national planning to increase the 'institutional' coverage of birth. Auxiliary nurses must report regularly to the area health authorities on the number of pregnant women they have secured for biomedical ante-natal controls, and the number of home births they have attended. This process is known as the *captación de embarazadas*, —literally, the 'securing' or 'winning over' of pregnant women. An estimate is made of the number of pregnancies that would be expected in a given population which the nurse is serving, and her/his performance is judged against this estimate. Expected pregnancies are estimated at 4% of the total population in any one year. When ante-natal coverage does not match up to targets, nurses feel pressure to increase it. This can have the unfortunate effect of putting nurses in the position of blaming pregnant women for 'evading' control by the institutional health services. Nurses sometimes accuse women of 'hiding' their pregnancies, or of moving to another area to 'escape' the control. The implied metaphor of the institutional health services as a net extended to capture pregnant women is not one likely to foster understanding between the different cultural and birth care systems at local level.

In the peri-urban areas, institutional birth care is in theory within reach of all the areas covered by the study. The issues here, as dealt with elsewhere in this report, are much more the combination of economic and cultural factors which lead to the general under-utilisation of hospital services, and the evident 'empty beds' syndrome. It is true that lack of transport can still be a reason for a woman not going to hospital from a peri-urban suburb who might otherwise have done so. In Sucre, some married women told of how

their husbands had gone out to find taxis to take them into hospital when the baby came in the night. Others, who perhaps did not have partners or whose partners were not so cooperative, stayed at home. In El Alto, it was found that the majority of women in Senkata had births at home, this being an area without institutional health services of its own. However, we would stress that, in general, institutional health services are available and accessible in urban areas, and that the reasons for under-utilisation must be sought more in the combination of cultural and economic factors that are reviewed in this report.

6.2.1.3 ‘Humanised birth’

The fact of availability of biomedical birth care did not mean that the package known as ‘humanised birth’ was generally on offer to women attending. A variety of reasons must be invoked to explain this. What are seen as practical difficulties, such as lack of privacy on hospital wards, came in the way of partners’ attending the birth. A lack of biomedical flexibility and training meant that women were very seldom, in practice, offered a choice of birth position. All of the hospital studies showed a high rate of complaints about the cold of the birthing rooms. On the other hand, some women who gave birth in institutions in El Alto had their placentas returned to them, and this was also the case with the majority of women who gave birth in the rural hospital of Ocurí. These are important initiatives which promote cultural understanding, and will need to be built upon in future. (See sections 4.1.5 and 7.4.1, and also Chapter 13 for more discussion of these aspects.)

6.2.2 The traditional apprenticeship system

It became evident in all the work with midwives at local level that there is a gap in the official thinking with regard to traditional birth care, inasmuch as this is seen as ‘informal’ health care. The concept of ‘informality’, which had been the starting point also of the present project, is taken by some as implying that traditional midwives are untrained and that their knowledge is unsystematic, in contrast to the medical professionals of the ‘formal’ sector. The project team felt that this misunderstanding was so important that they decided to drop the terminology of ‘formal’ and ‘informal’ altogether.

The most basic form of apprenticeship is that which a girl goes through in helping her mother or grandmother attend births. One midwife who came to the Encounter in El Alto (see below) had been going to births with her mother for nearly twenty years before she ever attended one on her own. During this period, the younger woman is taught by the older one, as Doña Lydia explained in relation to her own training:

My mother taught me. When she taught me she was already an old woman (grandmother) herself. She could no longer attend births, go out and attend births. She was already an old woman, and so, being old, she said to me, "Go, daughter! In this way, and like this, and like this ((demonstrating)). Here you can feel the baby. And you will help the woman onto her haunches like this. Look! here are its hands, and here is the head. You can feel it!" she said. She taught me to massage like that.

Doña Lydia explained that she already had three children of her own before she attended births on her own. Before that she used to go along with her mother, to help. But when her elderly mother began to have problems with incontinence at night, she could no longer go out to attend, and sent her daughter out on her own. Once Doña Lydia had attended one birth, others came to request that she attend them too.

By contrast, it appears that Doña Lydia's own mother had undergone a more specialised and 'formal' kind of training. Her mother had travelled to a village that is well known for its midwives, although Doña Lydia herself disclaimed knowledge of where the place is. Her mother used to say that a mass has to be offered there, and that she had made the journey there in order to become a midwife. Doña Lydia added that the village is full of 'legitimate' midwives, using the Spanish word '*legítimo*' in her native Quechua, a word that evokes excellence in a craft, as well as, in this context, the notion of having been consecrated into the profession through the offering of the mass. This reference to a place that acts as something akin to a 'school' of midwifery points once again to a parallelism between the 'formal' sector of the traditional medical sphere, and the 'formal' sector of the biomedical sphere.

Doña Lydia's description of apprenticeship to her mother echoes the accounts of many of the midwives who came to the Encounter (see below). Many of them described their learning as coming from their mothers or grandmothers 'by inheritance'. One woman started to accompany her grandmother when she was 12 years old, as her grandmother was getting deaf. Another started going at 10 years of age. But these women would not generally start attending births on their own until they themselves had given birth several times. Some of the midwives present were themselves already teaching their daughters, so as to pass on the knowledge.

6.2.3 Trained midwives versus traditional midwives - the Encounter

The Traditional Midwives' Encounter was held in El Alto in February 1995, as part of the project's activities. The event was organised by CIES in conjunction with the Regional Health Authority. It attracted over forty traditional midwives, far more than had been expected, and was attended also by members of ILCA and the two Project Coordinators.

It was written up in the national press, and the Ministry of Health made a video of the day.

The objectives of the Encounter were formulated in terms of the project's learning about the practices and training of traditional midwives, and their relationship with the institutional sector. Although not strictly a dissemination event, it served in practice to put the project on the map in terms of national debates on childbirth and on traditional medicine. Organised as a highly participative event, with morning workshops followed by enactment of role plays of various types of birth in the afternoon, the final plenary revealed a rift between those midwives who accepted the teachings of the institutional medical sector and those who did not.

The debate that ensued showed that the Bolivian Society for Traditional Medicine (SOBOMETRA) was itself immersed in conceptual problems, as its spokespersons had endorsed the *rejection* of traditional childbirth practices in line with the teaching of the medical profession. Several of the midwives who still follow traditional practices proved articulate defenders of their own position and practices. They also showed that they were unhappy at being subjected to dual pressures: on the one hand from medical professionals, who want them to act mainly to refer clients on to them; and on the other, from their own clients, whose readiness to blame midwives often mirrors that of the medical profession.

This discussion was said by the participants to be the first time that these issues had been publicly aired. The event was valuable to project researchers in terms of being able to locate the changing position of the traditional midwife in relation to the institutional medical sector. It also demonstrated how the framework and methodology adopted by the project could be used to generate debate and dialogue of use to those practising in the area of childbirth care today.

6.2.4 Midwives' relation to the institutional medical system

It was evident from the experiences told at the Encounter that those practising as traditional midwives have come there in a variety of ways. Some have gone through what has been described as the traditional apprenticeship with an older woman. Others were brought into midwifery by a chance event, such as having to attend a relative in an emergency. Some of those who had long experience as traditional midwives had subsequently taken a short government training course. Others had come into midwifery by being taught 'informally' by doctors, and had then done a training course.

These routes to midwifery, whether training was traditional, or through a government course, or both, themselves give rise to various possible types of relationship with the biomedical system of birth care. This section (6.2.4) looks at case studies of the kind of relationship that had been formed by various midwives with whom the project worked in the field studies. These range from an outright rejection of the institutional biomedical system, to the alternative of working for it or with it in some way. Midwives themselves are not entirely free to choose the form of the relationship, and some have received criticism by institutional medical personnel, leading to a situation of conflict.

6.2.4.1 The trained midwife in a rural area of northern Potosí

A view ‘from below’ of the effects of a rural midwife training programme is afforded in the TIFAP Qualitative Report on the rural site of Tumaykuri (TIFAP, 1995b). This community lies relatively close (one hour by truck) to the rural hospital of Ocurí, run by the non-governmental organisation, IPTK. About three years ago, two women from Tumaykuri had been chosen to go on a midwife training course held in the hospital in Ocurí. Both were in their thirties, with small children. Neither had any previous experience as a midwife. The difference from traditional training and apprenticeship is apparent in what one of these women, Doña Damiana, said about being chosen to go on the course:

Mmmm. “You are going to be traditional midwives!” they said. You see I went on the course without wanting to. I didn’t know anything. “You’re going to learn, yes, you are,” they said, d’you see? “They’re going to teach you. Those who don’t know how are going to learn,” they said. That’s what they said when they picked us (translated from TIFAP, 1995b: 48).

The other woman, Doña Gregoria, explained how she felt and still feels about attending births:

We are afraid, you see. They told us, “You’re going to look for women; you’re going to look for them, and then you will have to attend them.” But then, we have to be minding the sheep, and cooking for our children, and that means I don’t go out to other places. “Wherever it may be, you must attend the birth,” they told us. But I’ve got far too much to do to be able to attend births.

(translated from TIFAP, 1995b: 48)

She explained that she has only once attended a birth, as she is too afraid.

Clearly, attending births in houses which may be hours of walking away on steep terrain is only something that only the most dedicated are willing to undertake. Such a

sense of dedication to a calling comes through traditional midwives' accounts of their training through 'inheritance' of a body of knowledge, but is absent from these 'trained' midwives' accounts. In addition, attending births is only possible for women at certain stages of the life-cycle, either before they themselves have children, when they go out as apprentices, or as 'grandmothers', when they no longer have direct responsibility for small children.

The project researcher was indeed concerned that there was only one traditional midwife in Tumaykuri, and that she was very old and was anyway living in Llallagua most of the time. If the skills of traditional midwifery are not to die out, there may be an urgent need for attempts at revival of the apprenticeship training. In the absence of this, it might be thought that IPTK was filling a gap in the traditional system by providing training for the two women in this way. However, the content of their training is not such as to encourage this interpretation. As recounted by the two women themselves, a large part of the teaching consisted in a series of prohibitions on traditional practices, which are described as 'dirty', and are to be supplanted with the 'clean' practices of biomedicine. Other than that, the women are taught to refer cases of long labour or haemorrhage to the hospital in Ocurí, and to gently pull on the umbilical cord if the placenta is not born soon after the baby. They were also taught that women should not stay in bed after birth for more than three days, or their blood would begin to 'smell'.

The project researcher commented that these women were not accepted as '*parteras*', or traditional midwives, by the community. They were simply too young, and not of an age when respect is accorded to women because of their experience in dealing with birth. It is possible, of course, that this will change over time, and that one or both of the women may gain a reputation for being able to attend birth. We have seen that a chance attending of birth in an emergency can in any case be the entry into traditional midwifery for a woman (or man). It does not seem from the experience of these two women that undergoing a training course is on its own enough to acquire the professional status of midwife in a rural community.

6.2.4.2 Midwives in the rural town of Ocurí

The rural hospital in Ocurí has been running training courses for traditional midwives for some years now. To supplement the work of the Sucre-based rural teams, two researchers from the TCD team went to Ocurí during the quantitative phase of the fieldwork, and while there, interviewed two traditional midwives in the small town. Both were elderly and had practised for many years.

The younger of the two, Doña Serafina, was 76 years old, and had good relations with the hospital. In fact, both she and the hospital personnel said that she did much of the teaching for them on their training courses for midwives. Her description of her participation in these courses is one of dialogue between herself and the hospital personnel:

They call me to the hospital so that I can inform them and so that I can teach them. And they in turn teach us; and they ask us questions. In this way each informs the other. That's why they call me. And I can never miss the courses, not even a little bit of them, or they'll be coming to look for me again. What we give women to drink, what we use to warm them with smoke, —of course they want to know all these things as well. But they also teach us things. That's how it is at the courses I go to.

Doña Serafina is a monolingual Quechua speaker and had learned to attend births in her own community in the countryside. Later on, when she was still young, but married with three children, she was living in the small mining settlement of Lipes, near to Ocurí, and was taught to attend births by two nurses in the 'workers' hospital' there. Her connection with institutional childbirth, therefore, goes back a long way. However, her description of how she attends birth is very similar to that of other traditional midwives: she uses herbal medicines, massage, and the poultices known as *tiliay* locally. The practice that she does seem to have adopted from the biomedical sector is of sometimes attending births in a lying position.

However, Doña Serafina does not like attending births now. This is partly because she is not young any more, and she has not the energy for it. She no longer walks long distances to attend births, and only attends her daughters-in-law. And the payment involved is a derisory 5 or 10 pesos Bolivianos. She also cited the experience of attending a woman whose baby's head had broken off inside her as another woman tried to pull the baby out during a breech birth. Doña Serafina said that she had given the woman medicines and massaged her for a week to release the head, and then waited another week for the placenta, which had eventually been born with a terrible stench. This had nauseated her and put her off attending birth, although the woman survived. However, this episode seems to have taken place a good while ago, and the underlying reason for Serafina's wish to give up attending births must be found in her relationship with the hospital:

That's how I attend birth. But I don't do it any more. Now there are doctors, I can't be bothered with it. I just send them to the doctors.

When questioned as to whether the women go willingly, she answered:

They just go, because the doctors always say to me, "When you no longer attend, send them on to us right away," they say to me. "Send them on."

Doña Serafina approves of hospital birth, saying that they only operate when it is necessary, and that the women always give birth rapidly. But her remark on the difference between hospital practices and her own is instructive:

The only thing is that they do not give the women medicines to take like we do. That's all.

Doña Serafina used the Spanish word *medicinas* embedded in her native Quechua. This word is quite frequently used as a substitute for the Quechua word *jampis* and shows the conceptual equivalence for native speakers between traditional remedies and 'medicines' as used in biomedical discourse. Serafina's confidence in her ability to help women give birth does not seem to have been much undermined by her relationship with the hospital. Rather she sees the two systems as equally valid, and is abandoning her own practice because of the effort involved for little pay, and because the doctors seem to want her clients. She cited the cases of four women whom she had delivered after they had returned from the hospital, apparently because there was no one to attend them there. She also told of one case where she had taken a woman to the hospital, but, before anyone had seen her, the woman gave birth. Doña Serafina was holding the baby when the staff arrived. The staff apparently greeted her with good humour, inviting her back to help them out.

Doña Serafina has not trained any of her daughters or daughters-in-law in her practice. When asked why not, she explained:

But they are teaching it in the hospital, and all the young women come to the hospital.

Once again, we find an optimistic belief in the interest of the hospital staff in carrying on the traditional system. Doña Serafina was perhaps unusual among midwives encountered by the project team in her ability to assimilate biomedical practices and traditional ones. She talked without contradiction of the thread given out to her by the hospital for tying the cord, which she uses to tie the cord to the woman's left toe when the placenta is delayed. When she was younger she had worked alone in the clinic in Lipes when the nurses were away, again apparently seeing no contradiction between her traditional practices and the more modern setting of the clinic.

By contrast, the other midwife interviewed in Ocurí, Doña Teofila, who appeared to be well into her eighties, would have nothing to do with the hospital, and tended to disapprove

of their practices. She saw them as operating far too much, and boasted of having delivered women after hospital staff had given up. However, the reason she gave for not attending the hospital courses, despite repeated calls to her to go, was as much social as professional. She spoke of ‘jealous people’ who would even come to blows with her if she went to the hospital. She said that she had delivered two babies in the first six months of 1995, and her estimates of payment were much higher than those given by Doña Serafina —30 pesos for a girl, 50 for a boy. She attends anyone who comes to her, and sees them several times in pregnancy. Despite the different relationship with the hospital, Teofila’s practices are remarkably similar to those of Doña Serafina. The one notable difference between them is that Doña Teofila only delivers women in a squatting position, and said that she does not deliver lying down.

6.2.4.3 The migrant midwife in peri-urban Sucre

Doña Lydia, who was interviewed in Sucre as part of the qualitative phase of the fieldwork, was a migrant from Qhara Qhara, a community not far from Ocurí, which lies on the road from there to Sucre. She was therefore from the same broad cultural area as the other midwives written about in this section on relations with the institutional medical services.

The doctor and auxiliary nurse currently working in the Medical Post in ‘Yanachaki’, where Doña Lydia lives, claimed that there were no traditional midwives in the neighbourhood. As researchers, when it became evident from talking with the women who were members of the Mothers’ Club that there was a midwife practising in the area, we therefore assumed that her practice was somewhat clandestine, and took care not to reveal her identity to the staff in the medical post. However, when we came to interview her, some of the most intense parts of her narrative were those where she told us of a dispute that had erupted between her and the staff in the medical post. She returned to this theme several times in the course of the interview, and more especially when her two daughters came in and started talking about how they themselves discouraged her from practising as a midwife. However, it was not clear how long ago the dispute had taken place, and whether it involved the nurse currently practising in the Medical Post, who had only been there a year, or someone previous to her. We were never able to clarify this situation from the point of view of the Medical Post, and left without knowing whether the current staff were the ones who had actively tried to stop the midwife from practising.

Doña Lydia first introduced the incident into the interview as part of an explanation of her practices of ‘straightening’ the position of the foetus during pregnancy. According to

her, women give birth easily if they have been massaged during pregnancy to ensure that the baby is upright; difficulties arise when it is lying diagonally or to one side and has not been straightened out. Even with those neighbours who have no money and come running to her at the last minute, she is able to ensure the correct position of the baby through massage and the woman then gives birth. She goes on:

With this treatment they are healthy; they don't have a dead baby. When the baby is dead, they suffer (...), they suffer a lot, and I have to exert a lot of force, too. Down below here, Domingo's baby, its head was burst open, completely mashed up it was; and that para-medic came along (...) and looked at me, and said, "How come you extracted that baby with your hand?" But however would I get a baby out with my hand!? I don't know how to do that; I don't know how to do that. I know how to do my massaging, from here, and along here ((demonstrating)), I push from this way, and I put the baby straight. That's all I do to make a woman give birth.

Doña Lydia gave the most lengthy account of the incident after we had asked her whether she ever talked with the staff in the medical post. She replied that she did go there, but did not speak 'of these matters.' She was frightened, she said, and when the interviewers expressed surprise, and argued that she should be proud of the good she was doing for women, she gave the following emotional account of the incident with the medical post:

They came to me, from (...) from the medical post here; the lady came, and so I went with her.
"You got it out with your hand, didn't you?" she said to me.
"I did *not* do it with my hand," I said. "You can ask her, the woman whom I attended. I never do it like that," I said, "no, no!"
"You can't attend births like that," she said to me, "And what did you do with her placenta?" she said to me.
"But I did *nothing*. Her placenta came out of its own accord," I said to her.
"It's here," she said, and they showed it to me.
"But I have come here to inform about the baby that was dead," I said. "It died when they were in a fight." ((weeping as she spoke)).
That's how the person from the medical post got me to inform. What was the lady's name? I can't remember.

Soon after this account, the midwife's 18-year-old daughter, speaking in a rather broken Spanish, indicated the broader institutional reasons for the disapproval of the medical post:

When she make them give birth, the nurses get angry, you see, saying, "Why don't they bring them *here*?" That's why she doesn't speak to them.

A short while later, the daughter confirmed her mother's story in relation to the incident recounted above:

Yes, she doesn't talk to the nurses, eeh, my cousin who lives down there, she gave birth to a baby, and she had been beaten eeh, when she was pregnant and expecting, a young man from close by here, I don't know, i:::n her stomach it died, her, her baby (...) her baby died, nnn, and after (...) tha:::t, they ca:::lled my mother, saying, she made that baby die.

Earlier on, Doña Lydia had said that both her daughters and her husband criticised her attending births, and tried to stop her, saying that she only went to the births to get drunk. Doña Lydia explained this as a misunderstanding of the ritual taking of alcohol during birth, both to pour libations to the Mother Earth, and to perform a ritual of blowing over the head of the woman giving birth. However, she also said that the soul of the dead baby was putting the blame on her and 'purging' her, so making her 'go mad' when she drinks. Later on in the interview, after the entry of her daughters, and after the quotation above, the elder daughter confirmed the family's active discouragement of Doña Lydia's practising as a midwife, putting it in the overall context of her relationship with the medical post:

She doesn't want to attend births, because, because, they, they were angry with her from over there opposite ((indicating the medical post)). That's why she doesn't want to. We too, we don't want her to attend birth. "You're not going to attend births any more, not any more," I too have said to my mother.

It is not our purpose here to attempt to reconstruct a 'correct version' of what actually happened in the birth of the dead baby. The point is that the reaction of the nurse seems to have been instantly to blame the midwife, criticising her for attending at all, and for irrelevancies, such as the mode of disposing of the placenta. It is also unlikely that the accusation that the midwife had 'put her hand up' had any foundation, or that this could have explained why the baby's head was crushed. No support was given to the midwife in what for her was clearly a traumatic episode —the language she used to describe the destruction of the head was very strong— and where she believes that she is still being pursued by the soul of the dead baby, a potentially dangerous condition for her. If the crushing of the head was a result of an obstructed labour, then she needs to be given the confidence to refer such cases as emergencies to hospital, rather than castigated in this way.

In the context of poverty where people do not even come to be seen and massaged during pregnancy, because, as Doña Lydia herself said, 'They have no jobs,' then great understanding is needed. She herself may have been put in the difficult position of

attending a birth outside her own system of getting to know the woman and the developing foetus during pregnancy. The context is one where people come to her *in part* because they cannot afford to go to hospital. Economic supports obviously need to be put in place if such people are to be encouraged to go to hospital in an emergency. But first and foremost must be the building of confidence between the midwife and institutional medical staff. The present climate of distrust, accusation and resulting clandestinity can benefit no one.

6.2.5 Midwives' relation to family care

The reports of ILCA and TIFAP in the rural areas argue not only that specialists exist in birth attention within the traditional medical system, but also that there are distinct specialisms. There are those who specialise in massage of the mother, and others who specialise in massage of babies; while one specialist midwife with whom ILCA have worked has specialised in the attention of difficult births and presentations.

On the other hand, there is evidence that knowledge of the techniques and practices of birth attention is very widely diffused throughout the society. ILCA's finding that small children could already identify and name numerous herbs used in birth is reminiscent of the data brought together from early anthropologists by Lévi-Strauss in *The Savage Mind* (1966). There too we find that it was not just ritual specialists who in societies all over the world could name an astonishing range of plants and their uses, but all members of the group, with similar references to the knowledge of children (*ibid*: 3-5). ILCA emphasise that midwives expect to find the range of herbs necessary to their practice in the house when they arrive to attend a birth: each family must have its 'medicine basket'.

This paradox does mean that there is some ambiguity in the definition of who is a traditional midwife. Doña Gerónima in Sucre described her mother, who was also Doña Emilia's mother, as '*media partera*', —'half a midwife'. She described her knowledge of massage with chewed coca-leaf, and her ritual knowledge of driving away evil spirits from the body with *sewenqa* (Pampas grass), a plant much used in birth. But Doña Gerónima was reluctant to describe her mother outright as a midwife, because she had not apparently attended births outside the family. The mother herself denied that she was a midwife, now old and preoccupied with her suffering from tuberculosis. This means that where the family includes cousins of varying degrees, an elderly woman like her may have attended many births over many years and still not be called 'midwife'.

We have therefore a situation where a high degree of diffusion of technical knowledge throughout the society does not preclude the development of specialisms grounded in a reputation based in outside the immediate family. Among the specialists themselves we find incipient manifestations of the social closure typical of professions in modern society. This closure often has a gender component. Many of the female midwives complained of ‘ignorant men’, of men who exert too much force on the woman’s stomach, or who knock the woman about in performing the *manteo*. Midwives were also not exempt from racism against indigenous cultures: the midwife in Ocurí who had helped deliver the broken head of a baby blamed the accident on an ‘old Indian woman’, whom she also described as a ‘peasant’ or ‘country woman’. Yet she herself had been born in the country and spoke only Quechua. We have also seen that many midwives are critical of doctors’ haste to operate, and see their own practices of massaging and giving herbal remedies in an atmosphere of calm, warmth and support as professionally superior.

6.3 CONCLUSIONS ON THE RELATION BETWEEN THE TWO SYSTEMS

A review of national and international data shows that Bolivia is relatively well provided with doctors, but has a low proportion of nurses to doctors. Despite appearances, the evidence does not support the view that rural areas are worse served by public medical personnel than are urban areas. The absence of a midwifery profession is a notable feature of biomedical birth care, and a start on remedying this has already been made by the government. As regards the provision of traditional midwives, there is evidence that coverage of rural births by midwives is relatively low. In fact, urban home births are more likely to be attended by a traditional midwife than rural home births. This suggests both that rural midwives are migrating to the towns, and that the expectation that a birth will be attended by someone other than a close relative increases in urban areas.

The recent planning for the reduction of maternal mortality in the national *Plan Vida* works mainly through increased institutional care, but also includes plans for increased coverage of births through ‘trained’ traditional midwives. Midwife training dates back to the mid-1970s, since when the content of courses has been reduced from four weeks to four days, following a series of evaluations. Those in charge of the training programme show appreciation of the skills of traditional midwives, and of the need for a more genuine dialogue between the systems of birth care. They point out the need for awareness training for biomedical personnel in this area, an important proposal which could lead to genuine inter-cultural initiatives, and which needs to be picked up and supported in future planning.

The ‘humanised birth’ initiative, dating from the late 1980s, is an existing attempt to introduce cultural tolerance into institutional birth. It has had limited acceptance so far

among medical institutions, and may be taken up in ways which draw from Northern alternative birth movements rather than from Bolivian cultural heritage. Nevertheless, the project found that in one rural hospital, and in hospitals in El Alto, cultural elements such as the return of the placenta are being respected. Less often, a choice of birth position is being offered.

At the local level, researchers were generally pessimistic about the survival of traditional midwifery skills. Older midwives are dying without passing on their knowledge, as young people learn urban ways and reject their elders' teaching. The emphasis on 'clean birth' in official training programmes sometimes slides over into an explicit condemnation of traditional practices as 'dirty'. In addition, traditional practices, such as herbal teas, massage, and the *manteo*, have been described as dangerous. Migration of midwives into urban areas would also seem to be a problem, leaving women with little access to specialist traditional care in the countryside. In the urban areas, the problem is more that of the discouragement of traditional practitioners by institutional medical personnel. Nevertheless, the Encounter of Midwives organised for the project by CIES in El Alto demonstrated a thriving urban culture of traditional midwifery, where the medical authorities have been receptive to cooperation and coordination with midwives.

Biomedical care in rural areas is increasing rapidly at the level, mainly, of auxiliary nurses who are staffing medical posts. Official policy puts pressure on auxiliaries to discover a certain number of pregnant women and secure them for institutional birth, which may mean birth attended by the auxiliary nurse. This policy can lead to conflict between auxiliaries and traditional midwives at the community level, and in some cases to the unethical imposition of an auxiliary's presence on a birthing woman. These changes are generating debate at community level, which could well be harnessed through a participatory approach to planning, as is advocated by *Plan Vida*. However, researchers found that, to date, local women and traditional midwives had not been involved in participatory meetings organised to discuss the Plan.

Cases studies of different ways in which traditional midwives relate to the institutional medical system show a variety of relationships. In the rural town of Ocurí, one midwife said that the teaching process in the local hospital was a two-way one. Hospital staff said that this midwife taught younger women on their midwife training programme. Her own practices appear to be largely traditional ones, although she also said that she sometimes attends women lying down. Another midwife in the same town had rejected several overtures from the hospital to get involved. She repeated the frequently heard criticisms of hospital for operating unnecessarily, and said that she did not attend women lying down. In a rural community not far from Ocurí, two women who had been taken on the

midwife training programme there claimed that they had simply been told they were to go on it, even though they had no experience as midwives. Being too young and lacking experience, as well as having small children to look after, they described themselves as too afraid to attend births even after the course.

In the peri-urban areas, there was a contrast between the situation of traditional midwives in Sucre and that in El Alto. While the authorities in El Alto have been receptive to coordination with midwives, those in Sucre claim that there are no midwives practising in the urban area, and there is no programme of training or coordination there. Some midwives at the Encounter in El Alto argued that their role was undervalued by institutional medicine, who want them to act simply as referral agents. There was also an evident split between those who had learned midwifery through a traditional apprenticeship, and those who had learned through a training course or from a doctor. Nevertheless, many are clearly practising traditional midwifery in the urban context, and the airing of differences was welcomed by the participants. A case study in Sucre shows how a dispute had developed between staff in a local medical post and a traditional midwife, over the case of a dead baby. This incident caused the midwife much distress. She and her family believed the accusations were false. Nevertheless, her husband and grown-up daughters were trying to dissuade their mother from practising, as they were fearful of further censure from the medical authorities.

The conclusion to this chapter must be that the problem of the availability of birth care in Bolivia is more one of the relationship between the two systems than it is a simple one of underprovision of services. Even where relations between the two systems are relatively good, midwives are divided over the issues raised by biomedical birth care and where they fit into it. Discouragement and sometimes overt disapproval of traditional practices by biomedical staff runs the risk not only of undermining midwives, driving them underground and preventing them from passing on their knowledge to the younger generation. The danger is also that women giving birth will acquire a lack of confidence in the system, which will lead to a self-fulfilling prophecy of women wanting and needing hospital care where none may be available. Such a scenario is not the only possible future one, however. There are plenty of contrary indications of biomedical personnel who are interested in fostering a positive relationship and engaging in constructive dialogue with traditional midwives. In the following chapter, it is argued that furthering this dialogue is the only way to improve birth care in both sectors, and so ultimately improve maternal outcomes.