

CHAPTER 7

CULTURALLY APPROPRIATE STRATEGIES FOR REDUCING MATERNAL MORTALITY

This chapter builds on the findings of the Bolivian fieldwork of the project in order to draw some conclusions as to *culturally appropriate* strategies for reducing maternal mortality. In other words, we here depart from any notion that the problem of maternal death can be solved by a ‘technical fix’. Instead we look at ways in which the cultural dualism evident in medical thinking in Bolivia can itself become a resource in building solutions through dialogue. We argue in section 7.4 that this dialogue is already in existence, not least through the efforts of women’s organisations and the medical authorities in El Alto, but also through various research projects that have been undertaken in the 1990s. This project has tried to build on these initiatives, by incorporating dialogue between the two medical systems into its own approach to research and dissemination.

The chapter starts with a review of the project’s findings on thinking about maternal death in the communities where studies took place, particularly in the rural areas (section 7.1). This raises the difficult issue of the relationship between different systems of knowledge within the project itself, and in the whole area of planned interventions on health issues in development. However, part of the difficulty for rural people in accepting ‘the problem’ of maternal mortality as defined by outsiders lies in the fact that the *solutions* to the problem are also located outside the community, and outside the traditional culture and system of medical knowledge. We therefore argue that culturally appropriate solutions must build on traditional practices, and in section 7.2 we review those practices that have emerged from the project as positively beneficial for users. These, and other more contested practices, should be the object of further research and evaluation (section 7.3). We see no *technical* reason why they should not become part of standard hospital care in childbirth. However, the cultural obstacles are large, and must be located in the deep rejection of Andean culture by urban *criollo* and *mestizo* sectors in Bolivia. We therefore see the way ahead as through dialogue and ‘dialogical research’ along interfaces between the two systems of medical care (section 7.4). Finally, in section 7.5 we sketch some of the necessary conceptual and organisational work that needs to be done if a start is to be made on integrating the two systems of birth care, in both routine and emergency situations.

7.1 THE CONTEXT: TRADITIONAL THINKING ON MATERNAL DEATH

At the conclusion of their fieldwork in two rural communities of the highland *Altiplano* region, ILCA made the following reflections on local perceptions of maternal mortality:

- i) Although statistically, the rates of maternal mortality in these two communities were in line with national averages for the region, the actual numbers seem small in terms of life experience and personal memory. If community members can recall from 3 to 6 cases of maternal death over a period of 20 years, this does not lead to a perception of a major health problem.
- (ii) These rates of maternal death do not strike country people as alarming. They are used to accepting a high rate of death in all aspects of life: from maternal and infant death, to deaths on journeys, and from illnesses, etc.¹
- (iii) The rural authorities are aware that information on maternal death will put their communities in a bad light, and tend not to release this information to outsiders.
- (iv) Women do not always associate death in pregnancy, birth and the post-partum period with birth itself. Rather, they blame death on causes such as the cold, evil spirits, or family conflict.
- (v) For rural people, the very concept of death in childbirth does not really exist. In Aymara, it is said that a person has 'passed over to the other side', or has 'gone to cultivate chillis', The

¹ One could add that these perceptions of maternal death as opposed to death from other accidental causes are born out by the available statistics for a different rural region, that of Ocurí. (Figures quoted in this footnote are from SNS/IPTK, 1994 and SNS/IPTK, 1995). In the whole District of Ocurí, IPTK gives a figure of 83,522 for the total population in 1995. The same institution carried out a study of causes of death in the year 1993-4 and gives a figure for deaths from all causes of 1,945, an approximate annual death rate of 2.3%. There is a heavy bias towards deaths of males (55% of all deaths were male, and 45% female), perhaps indicating under-reporting in the area of female death. The figure for deaths from 'maternal mortality' is 66 cases. We have no exact figure for live births, but if measured over the expected number of pregnancies in the District, as 4% of the total population (3,341), the 66 deaths would give a maternal mortality rate for the District of 1,975 per 100,000 pregnancies. This figure is of course extremely tentative, and IPTK quotes publicly the maternal mortality figure for the Province of Chayanta, of which the District of Ocurí forms part, at 1,221 per 100,000 live births.

Nevertheless, the figure of 66 deaths related to birth and the puerperium in the age-group 15-49 must be put in the context of 86 deaths from 'poisoning' in the same age-group; or 124 deaths from 'diseases of the digestive apparatus', again in the same age-group. The total deaths in this age-group were 541, meaning that maternal mortality represents 12% of all deaths in both sexes between the ages of 15 and 49. This makes maternal mortality a lesser proportional cause of death among this age group than it was in Great Britain in the 1920s, where it was nearly 30% of all deaths of women aged between 15 and 49 (Tew, 1995: 303). This, of course, reflects higher overall death rates in Bolivia of the 1990s than in Britain of the 1920s in this age group. (In Britain the maternal mortality rate in 1929 was 582 per 100,000 per live births [ibid: 275], much lower than the current rate for Chayanta). But the main point is still born out: maternal mortality may not be perceived as the major cause of death in Bolivia, even in this age-group.

Aymara cosmovision is open towards the future, unlike the closed western conception, which sees death as the end of life.

(translated and condensed from ILCA 1995c: 108)

As illustration of some of these difficulties, ILCA cites the case of a narrative recounted to them of a woman's death in childbirth. Because of a marital quarrel, the woman had remained outside the house during the night of her labour, which led to the birth of a dead baby in the small hours of the following morning, and a haemorrhage that was fatal to herself afterwards. Such tragic circumstances are beyond the control of local specialists, and similar circumstances recurred in other accounts of maternal death recorded by ILCA (ibid: 109-10). Again, in the two cases of maternal death of close relatives of the women interviewed in Sucre, there were social factors involved. One was the case of a young woman who was unmarried, and had therefore received no ante-natal care because her family were apparently ashamed of the pregnancy. Her mother and sister were present when she died very rapidly of a haemorrhage after the birth, but no specialist care had been called in. The other was the case of an older woman who refused to go to hospital, although bleeding heavily both before and after the birth, and effectively chose to die at home, rather than burden her daughters who were living in Sucre (TCD/TIFAP, 1996). Midwives were not present in either of these cases.

Such social factors lead ILCA to conclude that maternal deaths will occur for the foreseeable future in rural areas, and that no amount of training of midwives in 'clean birth' will change this (1995c: 110). As this report has tried to show, the traditional Andean system of birth care cannot be held accountable for deaths where no such care was sought or given. The realities of women's experience of birth often diverge from the norms of care set out by traditional midwives. The traditional system is not an institutional system attempting to bring the whole population into its framework of care, as is the modern, biomedical system; but its techniques and practices need not be devalued for that. On the basis of the evidence it has amassed, this report will therefore argue that traditional practices and practitioners should be *incorporated into* the provision of emergency birth services for rural and migrant women.

More broadly, ILCA's comments force us to be 'reflexive' about the conception of this project. They raise the issue of whether 'reducing maternal mortality' is a local concern, or one that has been raised from outside. They also raise the possibility that outsiders' concern with reducing maternal death may actually be experienced as another form of colonial oppression by those whose cultures appear so deficient in the light of the new statistical indices. What may be a project 'paved with good intentions' like so many others (Porter, et al., 1991), may have the unintended consequences of alienating the

people whom the initiative was meant to ‘help’, and hastening the destruction of their culture.

It was for such reasons that the project team abandoned a focus on maternal death as such, after CIES’ first encounter with death in El Alto (see section 2.1.1.1). The focus on childbirth practices was one in which there was a lot of interest locally, and three studies on childbirth had been published in the years before this project’s fieldwork (AYUFAM, 1993; CIAES, 1991; GS/TAHIPAMU, 1994a).² The adoption of this focus by the team enabled a *positive* approach to be adopted towards traditional cultural practices, instead of the negative one involved in the focus on maternal death, and therefore made for more positive research relations. Some women did offer accounts of death in the context of interviews about birth practices, but the recall of these events was always emotional, and it would have been counterproductive to attempt to elicit such narratives in isolation.

It should also be said that the project was not the only, or most prominent instance, of the use of the discourse of ‘reducing maternal mortality’ in Bolivia in 1994-5. The Executive Summary of *Plan Vida* was published in September 1994, and is sub-titled, ‘National plan for the accelerated reduction of maternal mortality, perinatal and infant mortality’. The full Plan was published in May 1995, and these events meant that the discourse of ‘reducing maternal mortality’ was frequently in the news during the year of the project’s fieldwork. In relating its focus on childbirth practices to the problem of maternal mortality, therefore, the project was not just orienting itself to the international agencies such as WHO and PHO with their concerns about reducing international inequalities in health. It was also relating more directly to national concerns and planning. However, ILCA’s questions remain valid, if such government concerns are seen as ‘outside’ ones in the rural communities with which the project was working.

It might be objected that the MotherCare project in Inquisivi province, which took place over the three years prior to the start of the present project, reported great success in interesting women in the topic of maternal mortality and in the provision of health services to ameliorate the problem. Its success in starting income-generating projects to raise cash to send women to hospital in emergencies has been taken up as a model by *Plan Vida*. However, MotherCare’s claims that it worked through community ‘autodiagnosis’ of needs does not stand up to close inspection. Women were asked very direct questions about maternal death, and were then asked to choose between alternative candidates for ‘most serious problem’ affecting women in childbirth, by means of cards

² These studies were all published in Bolivia, but there was also the work of the Flora Tristán Women’s Centre (1994) in Lima, Peru, whose report on childbirth practices was used in the planning of the fieldwork for this project.

displaying pictures of women with haemorrhage, etc. (MotherCare, 1993a: 4, 20-1). Community choice of priorities was therefore only allowed *within* a range imposed from outside. More disturbing is the fact that the MotherCare project claims a total absence of traditional midwives in rural Bolivia, and therefore felt justified in embarking on an ambitious new programme of training young women to be midwives in their communities (1993b: 14). This failure to make contact with traditional midwives by a large internationally-funded project is very serious, and must point once again to the need to employ qualified anthropological and linguistic personnel on such projects.

This discussion raises two ethical issues of research in this area. The first is the very real danger that outside projects framed within western conceptions of 'risk' will undermine cultural confidence in traditional practices of childbirth. Traditional midwives' emphasis on the need for a calm and supportive atmosphere around the woman giving birth is perhaps simply not compatible with the western focus on risk and danger in childbirth. To import these concepts is inevitably to move towards undermining the cultural confidence that makes it possible to provide that sort of atmosphere to the woman giving birth in the first place. To do so in the absence of accessible technological back-up is to invite a worsening of the present situation.

The second ethical issue is that of whose voice represents 'the community' and its interests, and of how research relates to the different possible voices —of men, of women, of community leaders, of midwives. A well-known factor is that generally women in Andean societies are debarred from speaking publicly on behalf of the community (Harris, 1980). The inadequacy of taking men's voices as representing women's needs has been part of the impetus on the part of governmental and non-governmental organisations to form 'Mothers' Clubs' from the early 1970s on in Latin America. Originally formed simply as the most direct way of channelling food aid to families, Mothers' Clubs have in recent years become much more a focus for the channelling of health programmes by international agencies. As such, Mothers' Clubs and other women's organisations have enabled women's voices to be heard through NGOs and other agencies, which have used this relationship to foster a climate of urgency around women's needs at international level.³

³ Yet this does not mean that gender relations have necessarily changed at local level. Within the present project, an instance of 'participatory planning' for women's health was found which did not include a single local woman. This was in the regional implementation of the national *Plan Vida* in Chayanta Province, where it was found that consultation with indigenous communities had meant the presence of various male leaders, but no women or midwives (TIFAP, 1995b: 44).

Yet the strong grounding of these women's organisations in the role of women as *mothers* has meant that women seldom couch their own needs other than in a discourse of family needs. Women may see their own possible death in terms of the problem of the children left behind, as did Doña Emilia in Sucre. Indeed, this attitude was a common response to thinking about maternal death at an *emotional* level; in other words, people's grief is often expressed on behalf of 'the children' rather than on behalf of the woman who has died. It also occasionally surfaced as part of a planning discourse on the economic costs to the state of maternal death, i.e. the burden of 'orphaned' children and social problems that result. The corollary of the strong identification of women with the role of mother is that men are less often identified in a parental role, so that children who have lost a mother are commonly thought of as orphans. From this point of view, the MotherCare project should be seen as of interest because it stepped right out of these ideologies, and proposed very directly to women that they should think about their own health as a problem in its own right. We would argue that our project did the same, though less directly, and with the crucial difference that it tried to look to solutions for women's health needs using community resources, and did not simply assume that solutions must come from outside.

Returning to ILCA's concerns raised at the outset of this chapter, it seems fair to say that community concerns about the imposition of the outsiders' agenda of 'the problem of maternal mortality' arise partly because of the kind of *solutions* entailed by this framing of the problem. Hence ILCA state in the same section of their report,

It is also evident that without greater medical intervention at a national level in attending emergency cases in remote rural communities, the high rate of maternal mortality in rural areas will continue to be the norm. However, the results of both phases of the project show that the majority of community members prefer to continue with their own cultural norms of health rather than receive ill-treatment at the hands of state medical personnel.

(translated from ILCA, 1995c: 110)

If the 'problem of maternal mortality' is to be raised in a culturally acceptable way, it goes without saying that the envisaged solution to the problem must not entail "culturecide." The problem and its solution must be articulated in ways which do not disempower the community and the traditional culture of which it forms part. The following section looks at findings of the study in relation to aspects of traditional birth care which have emerged as positive, and which can therefore form the starting point for the framing of community-based solutions to the problem of maternal mortality. These practices should also be taken seriously by the biomedical community, and we would recommend their evaluation in pilot studies of their adoption by the institutional health services.

7.2 POSITIVE ASPECTS OF TRADITIONAL BIRTH CARE

We here briefly review the aspects of traditional birth care which have emerged from the study as positive in their physiological and emotional effects on women giving birth.

7.2.1 Birth position

The study shows clearly that where women choose their birth positions freely, they adopt variants of the upright positions: squatting, kneeling, and 'on all fours'. The 'all fours' position was commonest in Inka Katurapi, the Aymara-speaking rural area furthest from an urban centre. There the midwives advocated this position, and most women adopted it even when a midwife was not in attendance. Squatting was a common position in the Quechua-speaking areas, both rural and peri-urban, and usually involved the woman supporting herself on something, or being supported by her birth attendant.

Researchers found some initial reluctance to talk about giving birth 'on all fours', since this is seen as the position in which animals give birth. They also found indications that the position of lying on one's back was seen by some as the 'civilised' position, at the opposite end of the spectrum from the position of the animals. This is leading to some imitation of the hospital lithotomy position in home births in rural and peri-urban areas, a process that can only worsen outcomes in home birth, given the physiological evidence in favour of upright positions.

Several women who had experienced hospital birth after home births either remarked on the difficulty of giving birth lying on one's back, or appeared to have purposely resisted the position by giving birth alone. Nowhere, not even in the rural hospital visited, was it found that the recommendation of 'humanised birth' in terms of offering a choice of birth positions was being seriously implemented. Biomedical staff, especially doctors, objected strongly to the idea of attending birth in these positions, on the grounds that they themselves would have to lie down, and hence be lower than the woman. This would not be the case with the 'all fours' position, but male doctors also found the idea of their faces being close to a woman's anus disturbing, and joked about it if this position was raised as a possibility. Nurses interviewed in one maternity unit told the story of a baby that had died after delivery in an upright position, because, they said, it had broncho-aspirated the amniotic fluid.⁴ They used this story, which is not physiologically credible to the

⁴ Interview with nurses in Hospital San Pedro Claver, Lajastambo, Sucre, 11.05.95 nurses.

midwife consultant on the project,⁵ to dismiss upright positions for birth on safety grounds.

These findings point overwhelmingly to the necessity of introducing training programmes for biomedical practitioners in attending births in upright positions. Such programmes need to incorporate not only teaching on Andean cultures' thinking on birth, but also practical lessons in understanding the physiology of a woman in labour from a different angle. The practical difficulty for biomedically-trained personnel in any culture in relating to a woman in labour who is in an upright position is acknowledged in a major English-language midwifery textbook. Silverton advises hospital midwives that vaginal examination of a woman on all fours:

may present some difficulties for the midwife in determining the fetal position, as the usual landmarks are in an unusual orientation. This can be helped by making a diagram of the findings to give clarity (1991: 297).

In Bolivia, however, such training would be able to draw on the skills of traditional midwives who are experienced in dealing with births in these positions, where they are prepared to share their experience and skills with biomedical personnel. Unfortunately, it would seem that there is already also a need for broad-based educational programmes that revalue the traditional birth positions, pointing out the known benefits for the woman and her baby.

7.2.2 Warmth

The benefits of warmth physiologically are well-known and detailed elsewhere in this report. There is also an over-riding cultural perception of the necessity of warmth during the birth process, in all the areas where the project worked. This is in line with humoral thought as it exists in combination with other elements in Latin American medicine. (Foster, 1993). The provision of adequate warmth, through the means of clothing, hot drinks using 'warm' herbs, and sometimes putting the woman over smoking or steaming herbs, is a positive aspect of traditional birth care. As such it should be encouraged, and not continually criticised as excessive.

The overwhelming evidence from the quantitative study was that hospitals are not providing adequate warmth. The practice of stripping women and placing them in a thin hospital gown is contrary to the encouragement of labour, especially in the freezing

⁵ This is the opinion of Cecily Begley, Senior Research Midwife, and consultant to the present project.

conditions of Andean nights and without central heating. The cold felt by women in hospitals is both physical and cultural. Biomedical staff should address these problem urgently if women are to be encouraged to attend hospital when necessary, and if those that do are to be given the quality of care that will ensure a positive experience.

7.2.3 The social and religious context of care

Inevitably, much of this report has been written with physiological concerns in mind, as it is intended in part for an audience whose concern is with maternal death as primarily a technological problem. However, we have tried also to make our audience aware that the ethnophysiology of birth in the Andes cannot easily be separated from its embedding in ideas that, in western thought, might be seen to pertain to the realms of 'religion' or 'astronomy'. The fact is that Andean cultures are now bounded by a culture that does outwardly treat birth as a technological problem, even if some have argued that hospital birth is as steeped in ritual as the initiation rites typical of tribal societies (Floyd-Davis, 1992). As urban society in Bolivia moves to adopting technology as its central belief, it may be increasingly difficult for Andean people to maintain belief in the 'black llama' dropping her amniotic waters to the earth as a model for their own birth practices. This may explain the anxiety that is arising around giving birth on 'all fours', which begins to be seen as the position of the animals, and 'uncivilised'.

Childbirth is also deeply embedded in thinking about women's place in kinship and domestic systems (Arnold, 1992). There is little doubt that to take the woman out of the domestic unit to give birth elsewhere is disruptive of conceptual thinking about gender and the household. Nevertheless, the study found some indications that migrants to peri-urban areas have found ways of reconstituting ritual before and after the woman's time in hospital. Anxiety about non-compliance with traditional rites would be greatly alleviated if more hospitals followed the examples of Ocurí and El Alto in returning the placenta to the mother after birth.

Finally, the importance of family relationships to a woman giving birth comes through the accounts again and again. Women place particular emphasis on the presence and cooperation of a husband or partner in and after childbirth, and for some, his behaviour at this time is symbolic of his overall care for her. To deny husbands access to hospital wards, so denying them the useful role that they clearly have in traditional society at this time, seems undermining of women's brave attempts to realise the companionate and cooperative aspects of marriage. Hospital authorities blame infrastructural problems for the fact that husbands and partners have not been admitted to labour wards (GS/TAHIPAMU, 1994b: 29-30). If this is the case, then these problems need more open

discussion, so that the authorities will put their weight behind planning for the necessary changes.

7.2.4 **Massage**

Traditional midwives in Bolivia are proud of their skills in massage, and confident of what they can achieve. They use massage as a means of ante-natal diagnosis of the position of the foetus, and are clearly skilled at external version. They are also aware of the benefits of their techniques to the mother, both during pregnancy and in labour. The use of coca-leaf in massage is a likely indication of the dating of these practices from pre-Columbian times.

Midwives frequently discriminate between right and wrong kinds of massage, and are aware that unskilled practitioners can apply too much pressure. The project researchers were struck, however, by the lack of complaints about the process on the part of women who had been massaged. One woman who had probably had external version performed talked of staying in bed in some pain for a day afterwards. But nowhere did researchers encounter the kinds of complaint about pain that were encountered in relation to the hospital practices of abdominal pressure both during and after the birth of the child, and which have been detailed in sections 4.1.3 and 4.1.5.

Much more could clearly be learned about these Andean techniques of massage. Practitioners tend to be fairly jealous of their secrets, however, and it is important that if further research is to take place, it should be within a framework where ways of returning the benefits of the research to the practitioners and users of these skills have been thought through.

7.2.5 **The traditional system of placental delivery**

The evidence from ILCA's study of two communities with different systems of managing the delivery of the placenta was presented in section 2.1.5. Women who were in an upright position for the birth of the placenta had shorter delivery times than did women who were lying down; and cases where the cord was not cut until after the delivery of the placenta also delivered in shorter times. It was argued there that the findings from this small-scale study, although not statistically significant, were suggestive enough of patterned differences to warrant research on a larger scale. It was also particularly interesting to find that the midwives in the area which practised the system of leaving the woman in an upright position and not cutting the cord, reasoned that to do otherwise ran the risk of causing retained placenta and haemorrhage. This is a very similar reasoning to

that employed by modern professional midwives who argue for the 'physiological management' of the third stage of birth (Inch, 1989; Begley, 1990).

On the other hand, the widespread existence of the alternative system of cord-cutting and lying down for placental delivery cannot be ignored, and has been assimilated into mythology and 'tradition'. However, we argue that the regional comparisons afforded by our study make it likely that the system of early cord-cutting and lying down is an introduction that is imitative of biomedical birth. If this is the case, it is an important instance of the adoption of biomedical practices into contexts other than that of the modern hospital where they can be relatively safely practised. We would argue that it is likely that biomedical practitioners have directly encouraged such imitation. Indeed, these cord-cutting practices are currently part of the syllabus in the Training Manual for Traditional Midwives (MPSSP, 1991; de Graaf, 1993). Not only does such encouragement of imitation need to be discontinued. These and other examples indicate that it is important also that biomedical practitioners are made aware of the dangers inherent in transmitting hospital practices into a home environment.

7.3 OTHER ASPECTS OF TRADITIONAL BIRTH CARE THAT WARRANT FURTHER RESEARCH

All the above aspects of birth care clearly warrant further research. While they are not currently part of institutional practices in Bolivia, there is a strong rationale for their physiological benefits to women giving birth. This rationale comes both from traditional midwifery and from modern midwifery research, and there is continuity between the two. There are also other aspects which warrant further research, but which have largely dropped out of use in modern midwifery. One of these is the whole area of herbal medicine and ethnobotany. This is a vital to traditional medicine, and forms a substantial part of the work of SOBOMETRA, the Bolivian Society for Traditional Medicine. While there is detail on herbs in all the internal reports for the project, ILCA went further than others in identifying plants by their native, Spanish and sometimes Latin names, and in classifying their uses in different stages of birth (1995b: Annex 2). While we are not able even to reproduce ILCA's detailed work in this Final Report, it is obvious that there is scope for a further research project focussed exclusively on the use of herbs and other traditional medicines. Particularly interesting, given the focus in this project on the birth of the placenta, would be a study of the use of herbal medicine in the treatment of retained placenta and haemorrhage. Such a study would need to incorporate anthropological and linguistic skills, if further study of the effectivity of traditional medicines is to be undertaken.

Another aspect of traditional birth care which we feel warrants further research is that of the *manteo*. There are a variety of reports from the different field-sites about when it is practised, how often, and whether before or after massage. The ILCA team that worked in Unkallamaya reported three different kinds of *manteo*. The accounts vary from something similar to the English nursery rhyme about ‘the old woman tossed up in a blanket’ to a much more subtle form of rubbing with a woven Andean cloth, which looked more like a form of massage. Once again, many of the midwives interviewed were disapproving of the rough use of this practice by men, who play a large part in performing it, and indicated that their own presence was necessary to supervise the men and help them do it. However, there is not enough information available for us to give a very clear account of the processes involved and the thinking behind them. Because this is an important Andean practice and is still very popular in the towns, we suggest that further research is important. It is also important because biomedical staff tend to blame problems in pregnancy and labour on the practice, a blame that cannot really be justified given the existing lack of knowledge.

7.4 STRATEGIES FOR IMPROVING WOMEN’S EXPERIENCES OF HOSPITAL BIRTH: THE PROCESS OF DIALOGUE

This section reports on initiatives taken by the project team intended to improve dialogue between the two medical systems in Bolivia as regards care in childbirth. It first reviews an antecedent to the project’s work in this regard, which was initiated by a women’s group in El Alto.

7.4.1 The women’s workshop in El Alto

The El Alto Solidarity Group was founded in 1984, and has 130 women members in eight districts of El Alto. It organises an Agricultural Cooperative and a series of child-care centres and also engages in training and self-development activities. Since 1989, it has received the support of TAHIPAMU (Workshop for Women’s History and Participation) in furthering their objective of ‘providing space for reflection to women’s groups, so helping women to recognise their capacity as agents of social change’ (GS/TAHIPAMU, 1994a: cover page). Arising out of a series of workshops on women’s health in 1993, the women of the Solidarity Group discovered that their experiences of hospital birth were not unique, and that there was a collective story there needing to be put together. With the support of TAHIPAMU, they decided to carry out interviews with women both inside and outside the Solidarity Group, and these were transcribed and written up as a short

book, *Hagamos un Nuevo Trato* (GS/TAHIPAMU, 1994a).⁶ The Director of TAHIPAMU, Ineke Dibbits, gave a talk on the work of this study to the project team at its first seminar in October 1994.

The statements of women in these interviews about hospital birth highlight a number of themes that appeared also in the present project. Cold, fear, and above all, ill-treatment and lack of communication from institutional medical staff come through the accounts repeatedly. Not all the accounts are negative, and the book also contains accounts from women satisfied with the treatment they received. The women interviewed were on the whole quite committed to birth in a hospital or clinic, many of them having been displaced from mining centres, rather than from rural settings. The accounts reveal much confusion with regard to expectations of biomedical treatment, and with regard to what actually happened to the women in hospital. However, the overwhelming need that speaks from the pages of this book is for improved communication between hospital staff and women, including an awareness of racist and sexist attitudes on the part of biomedical staff.

In August of 1994, TAHIPAMU and the Solidarity Group organised a 'Forum for Debate' between their members and five Directors of Hospitals and other health officials in El Alto. The officials had all been given the book to read before the event. The whole session was subsequently transcribed and circulated as a transcript (GS/TAHIPAMU, 1994b). Despite frequent rhetoric about the need and wish to *listen* to feedback from patients, the transcript shows that the doctors present did almost all the talking at the event. The Director of the Regional Health Secretariat in El Alto was the most open of those present to the criticisms, admitting the need for change on an institutional and a personal level. He blamed the situation on medical training, which does not include training in communication and human relations. He also talked of the way hospitals have been designed for the comfort of doctors rather than patients, and was the only doctor in the course of the whole project who pointed to the irrationality of doctors' refusal to attend a woman giving birth at ground level. Other officials were more defensive and while admitting the need for improvement, tended to suggest that the women had exaggerated their stories, or that ill treatment was a thing of the past. They argued that the treatment of people would change in the new hospital that has come on line in El Alto; and defended rushed treatment of patients in crowded public hospitals.

⁶ This title is difficult to translate into English, owing to the multiple meanings of 'trato' which are played on in the title. *Trato* means 'treatment' in the sense of 'relationship'; it also means a 'deal' or 'contract'. It is commonly used in popular speech to indicate the manner in which biomedical staff treat their patients. It also has a negative sense, as in 'scolding' or 'ill-treatment'. The primary sense of the title is then, 'Let's make a new treatment [of us by medical staff]'. However, for the sake of simplicity, it has been translated where necessary as 'Let's make a new relationship'.

Recognition of the need for improvement in relationships was shown by the doctors' talk of 'workshops in human relations' that had been held in their institutions. The very fact that busy and high-ranking health officials were willing to spend time meeting a group of migrant women about their complaints is indicative of a wish to change. However, analysis of the transcript shows that the place of *cultural* issues in the exchange was either non-existent or very veiled. For instance, a long discussion about hospital food contains dietary advice from the doctors which could be taken as responding to some cultural practices of those present; but ends up talking in terms of hospital procedures regarding anaesthetics and of the meagre budgets available for food in public hospitals. One doctor claimed to understand the feelings of Aymara people as to how they want to give birth, but went on in the same breath to speak of the need to educate Aymara men and midwives to attend birth 'in cleaner conditions' (GS/TAHIPAMU, 1994b: 17). No doctor raised the issue of language, except to say that a frequent problem was that 'women do not understand their doctors' (ibid: 33). A nurse raised the issue of the majority of city people being Aymara speakers, and the need for 'all of us, doctors and nurses, to learn' (ibid: 36). However, her suggestion was not taken up, or even apparently properly heard in the discussion.

In general, the debate showed very clearly that the issues raised by the women of El Alto are being responded to by the health officials in terms of western models of 'human relations', and of 'doctor-patient relations'. While these models provide useful frameworks for generalising the issues raised by the women, they *elide the specificity of the cultural dimensions* of the women's criticisms. Where culture was mentioned openly by doctors in the encounter, it was usually as an 'obstacle' to the fulfilment of institutional medical procedures. For instance, the issue of the traditional dress worn by migrant women was raised by two different doctors as an obstacle to their giving time to attend to patients in the clinic, since, according to these doctors, it takes a woman so long to undress.

More disturbingly, an examination of the women's discourse shows that they too, found it difficult to articulate cultural issues, but tended to phrase their complaints in the dominant discourse of 'human relations'. The following intervention—the only one in the whole encounter that *did* articulate a cultural question—shows this clearly. This woman spoke after a long speech from a doctor, at the end of which he challenged the women to say how they would like to be attended in their next birth:

Doctor, you know, what I would like would be that, as it says in the book, 'Let's make a new relationship', what we want is that the doctor should become more human with the person at that

time, that he be human. (...) We want him to be human. And also (I want) to say: Why not respect the customs of each person, if it is not too much to ask, is it? (.) Because there are many people who are not used to having their baby in bed, even less in the labour ward. We have different ways of having our babies. Sometimes I would like it if these customs were respected just a little, Doctor, if it is not too much to ask? (GS/TAHIPAMU, 1994b: 31-2).

The request starts off couched in the repeated use of the discourse of ‘humanising’ birth, and of ‘humanising’ relations in the hospital. The speaker breaks with this discourse where she says ‘And also I want to say’, and goes on to speak of *customs*, which is the word used in popular discourse to indicate traditional culture. In this way, there is a clear recognition that cultural issues exceed the bounds of the ‘humanising’ discourse, which is clearly welcomed by the speaker, but which is not enough. The whole request is phrased with the requisite politeness and tact. However, even this request *was never taken up or answered* during the event. Instead the doctor who replied took up a previous question which he could answer in terms of the lack of resources and infrastructure in his hospital.

We offer this analysis by way of a reflection on the terms of the debate at this encounter between socially unequal participants. That the event took place at all is tribute to the years of organisation engaged in by the women involved, and to the willingness of the health authorities to respond to women’s complaints. The methodology of including the health authorities in the discussion was one that we tried to emulate in our own project’s methodology, even though we could not attempt the kind of organisational work that the Solidarity Group have engaged in over a long period. In this way, research itself becomes ‘dialogical’, trying to accommodate different points of view within its method. That TAHIPAMU’s methodology in this case included transcription of the proceedings was a further valuable step in the elaboration of such a dialogical research methodology.

7.4.2 Project dissemination in conjunction with the National Health Secretariat

The present project endeavoured to generate and sustain dialogue with the National Health Secretariat during the course of the fieldwork through meetings at national and regional level. Copies of some of the project’s internal reports were handed over to the relevant health authorities. The signing of the formal Agreement with the National Health Secretariat led to a commitment to joint dissemination of the project’s findings (see section 2.2.2.3). Following on from this, a joint dissemination meeting was organised with the Secretariat in July 1995. (see section 2.2.2.5).

The dissemination event was introduced and closed by National Health Secretariat officials, who emphasised the projects’ importance in relation to the strategies for

reduction of maternal mortality proposed in *Plan Vida*. From the project, the rural teams spoke on the importance of linguistic and cultural recognition for indigenous practices. They also argued that the notion of ‘clean birth’, taught to traditional midwives on training courses, involves a misunderstanding of traditional practices. The peri-urban teams spoke on the high expectations of women in relation to hospital birth, and the overall levels of satisfaction, despite negative findings on several aspects of this experience, notably in relation to the rates of reporting of ‘cold’ and ‘fear’.

The Project Coordinator emphasised the significance of vertical birth positions to traditional birth practices. She pointed out that the national ‘Humanised Birth’ programme, in operation since 1989, has not yet everywhere produced flexibility with regard to birth positions in hospital. It was argued that if genuine flexibility is to be introduced, training programmes should be put in place for medical personnel that draw on the experience of traditional midwives in attending women giving birth in vertical positions.

The National Coordinator chaired the ensuing lively session of debate, in which there was much support for the findings and recommendations of the project expressed by other groups working in the area, and by SOBOMETRA, the Bolivian Society for Traditional Medicine. Health Secretariat representatives voiced some of their doubts regarding traditional practices, but agreed on the need for further dialogue and research and for more cultural tolerance.

7.4.3 Dissemination in El Alto in conjunction with the Health Secretariat

The dissemination event held by CIES in El Alto in August 1995 in conjunction with the Regional Health Secretariat carried on this work of dialogue that has been central to the project’s methodology. Speaking to an audience of women’s groups, local government representatives, health officials and NGOs, the researchers from CIES presented the project’s findings from the study in El Alto, and talked of the need for greater mutual knowledge between the two medical systems. The Director of ILCA talked of the need for language-teaching in medical faculties to facilitate the work of communication. In the discussion, one hospital consultant asked why the ‘gynaecological position’ for birth is always taught in medical school, and likened its distortion of the female body to that of a ‘crooked tree’. Another NGO representative said that one should not need to invoke large-scale studies and huge bureaucracies in order to accommodate vertical birth positions in hospitals: one simply needed ‘common sense’, to make use of physiology and gravity.

In summing up this meeting, the Regional Director of Health in El Alto, Dr. Adalid Zamora, stated that the time had come for less talk and more action in terms of

implementing the recommendations of the project. Dr. Zamora had devoted much time over the year to collaboration with the project, and had put aside his own reservations about many aspects of traditional health care in order to support the opportunities for dialogue between the two systems. His open attitude, in working both with this project and with that of the Solidarity Group and TAHIPAMU, was invaluable in bringing together those who otherwise might never have spoken directly to each other.

7.4.4 Conceptual dialogue and personal networks

The examples of dialogue described in this section show that dialogue needs to take place between people but also between discourses. The meeting between representatives of the women's Solidarity Group and health officials did not necessarily lead to dialogue between cultural knowledge systems, because it was easy for the women to be co-opted by the language of human relations proposed by the institutional sector as part of the solution. Given the unequal status of discourses of biomedicine and traditional medicine in Bolivia, it is difficult to see how dialogue will arise between these discourses as systems of knowledge, without planned interventions to promote it. It is therefore necessary to find ongoing ways of promoting dialogue between knowledge systems. The problem is not only to convince biomedical personnel that it is in their own interests and those of their patients to listen to what traditional medical practitioners have to say. The discrimination and stigmatisation experienced by practitioners and users of traditional medicine at the hands of the biomedical professions have led to distrust on their part also.

In practice, dialogue between knowledge systems depends also on personal and inter-institutional networks, and the project tried to play a small part in facilitating some such networks. The experience has shown the importance of dialogue between state organisations and NGOs—the so-called 'third sector'. NGOs are often understandably reluctant to engage with state organisations whose policies and personnel are often subject to party political concerns even at a local level. But a failure to engage with the official sector can be just as damaging, leaving NGOs marooned on their own moral highground.

7.5 THE ARTICULATION OF CULTURAL SYSTEMS OF BIRTH CARE

In this final section of this Part of the report, it is argued that the relationship that has been found between different systems of birth care in Bolivia can be conceptualised as one of 'articulation'. This concept, which was prominent in theoretical debates about development in the 1970s (Rey, 1973; Bradby, 1975), uses an anatomical metaphor to describe the relationship between two systems as that of two limbs around one joint. At

the same time it plays on the second meaning of ‘articulation’ as the ‘speaking out’ or ‘spelling out’ of a discourse. As such, it means both the coexistence of different systems with a certain degree of autonomy, and their locking into a relationship of hierarchy and subordination on the global scale. In the political-economic debates from which it arose, it conveyed the idea of the *unexpected* survival and coexistence of ‘pre-capitalist’ modes of production, in close conjunction with commercial capitalism.

In a similar way, it can be argued that the survival of Andean medical systems in the face of institutional biomedicine is similarly ‘unexpected’ from the point of view of biomedical science. The explanation of this survival must be complex and is beyond the scope of this report. However, a few remarks are in order. One might start from the structural functionalism of Émile Durkheim, when he argued that modern science is like religion, in that both require ‘belief’ in order to gain acceptance (1965: 486). Belief in this sense means that the knowledge system must fit with other elements of the collective world-view (*ibid.*)⁷ There is something of this perspective in ILCA’s argument that traditional birth practices still retain wide adherence because of their ‘fit’ with an Andean cosmovision. In a parallel way, it helps to explain how a societal ‘belief’ in technology and in the body-as-machine may ensure compliance with obstetric and other hospital practices in birth (Davis-Floyd, 1993).

However, if we theorise a too close ‘fit’ between medical systems and wider world-views, we have difficulty in explaining the links, changes, and negotiations between the two systems that are evidently taking place in an ongoing process at the moment. To explain such changes, it is useful to invoke an ‘actor-oriented’ perspective (Long, 1992). This approach acknowledges that social structures do not determine outcomes, but that differential responses arise in similar circumstances. These differences are the result of the choices, interactions, and negotiations of social actors. While using the concept of agency, the actor-oriented approach sees actors as more than ‘individuals’. The fact that actors choose between a stock of discourses which are shared by other actors, makes them social. Some of the most interesting choices that emerged in the Bolivian fieldwork were those entered into by actors at the interface between the two systems: the doctors choosing whether to perform Caesarean section or apply the ‘traditional’ method of abdominal pressure to a woman in labour; the traditional midwives choosing whether to

⁷ ‘On the other hand, it is not at all true that concepts, even when constructed according to the rules of science, get their authority uniquely from their objective value. It is not enough that they be true to be believed. If they are not in harmony with the other beliefs and opinions, or, in a word, with the mass of the other collective representations, they will be denied; minds will be closed to them; consequently it will be as though they did not exist. Today it is generally sufficient that they bear the stamp of science to receive a sort of privileged credit, because we have faith in science. But this faith does not differ essentially from religious faith’ (Durkheim, 1965 [1915]: 285).

work with the rural hospital or independently of it; the medical post staff who chose to summon and blame the traditional midwife for a stillbirth; the rural auxiliary who is trying to persuade women to stay less time in bed after birth; or the migrant women who go to hospital, but still manage to give birth alone on their own beds.

These and other interfaces are points of nodal articulation between the two systems, where individuals and organisations must often relate in both directions. Although the extent of knowledge flow across these points of articulation may be limited, they are points where the two systems form views of each other. They are points at which individuals must choose between different alternatives, or integrate bits of one system with bits of the other, in a process of negotiation of knowledge, practice and identity. The question of identity is important here, but again takes us beyond the scope of this report. In a study of medical systems in the Bolivian highlands, Libbet Crandon-Malamud (1991) has argued that individuals negotiate social and ethnic identity through their use of different medical belief systems. Ethnic identity becomes a fluid succession of roles, and medicine becomes a resource in the assumption of those roles. This analysis has resonance in the accounts of peri-urban women in Sucre, where 'medical pluralism' takes the form of believing in two systems at once, where compliance with the staff of the medical post becomes a route to upward social mobility in the neighbourhood, and where a safe birth in hospital is ensured by the performance of traditional Andean practices before setting out.

For actors to negotiate their identity through these articulated medical systems, it is necessary that the systems are seen as culturally distinct, and are not simply one seamless web of interlinked relations, as Crandon-Malamud sometimes suggests (1991: 22). Here we come to the second meaning of 'articulation', as the speaking of difference. Theories of ethnicity teach us that people differentiate themselves from others on ethnic grounds where they meet with other groups on territorial boundaries (Barth, 1969). By extension, we can see a consciousness of cultural distinctness in medical systems as being *articulated* at points of dialogue where the two systems meet. The articulation of cultural difference at these interfaces is one way of resisting the subordinating effect of the recognition of the hierarchical structure of knowledges between 'scientific' biomedicine, and the rest. Appeals to human relations obscure the fact that disrespectful treatment of those of different cultures is a form of racism. The articulation of cultural difference exposes racism, by positing the equality of all cultures. Hence, and in general, we encourage the articulation (speaking) of cultural difference at the interface between systems, because only in this way can a strong articulation, in the sense of a conjoined integration of the two systems be built.

7.5.1 From 'humanised birth' to cultural choice

The existence of a policy of 'humanised birth' in Bolivia goes a long way towards providing a framework for meaningful choice for women giving birth within the institutional system. However, its discourse of humanism does not necessarily translate into an awareness of different cultural approaches to birth, as we saw in the analysis of the debate between women and doctors in El Alto. It may just as easily be translated into 'New Age' discourses of birth emanating from the North, or into older Northern, alternatives, such as the psychoprophylactic approach of Grantley Dick Read (1942). Nevertheless, within the hospital system, it provides the framework for freedom of choice of birth position, for freedom from unnecessary interventions and degrading rituals such as pubic shaving, and for the attendance of partners in birth. In a few areas, the question of cultural difference is highlighted more explicitly, in the policy of returning the placenta to the mother.

It is certainly a major problem that 'humanised birth' has, on the whole, not been implemented, or only very partially. There are efforts on several fronts to address this problem from within the institutional health services. However, the work of the project would suggest that it is necessary to reconceptualise 'humanised birth' as 'culturally appropriate birth', if it is to have more purchase as a concept. Such a reconceptualisation gives expression to Bolivian cultural diversity, rather than subsuming birth there under the generalised 'western' or 'Northern' concept of 'human relations'. It is our experience that many Bolivian doctors have a pride in their cultural heritage, but that it is difficult for them to give expression to these feelings within the terms of their professional discourse at the moment. The reality of 'cultural diversity' has recently been acknowledged in government policy on education, where the right to education in one's mother tongue has been announced for the first time by the present government. Cultural diversity has been admitted in a small way in the language of *Plan Vida*. It remains to be seen if it will be translated on a larger scale into the language of planning for health and birth care.

Furthermore, 'culturally appropriate' birth care will need to move beyond the 'humanising' of birth in hospital to include also the choice to give birth at home. At the moment, it seems that this possibility is accepted only reluctantly, as a second-best solution by health planners. If it could be accepted in a more positive light, with the Dutch case providing a European example of acceptance and integration into the institutional sector,⁸ then it might pave the way for the possibility of giving birth within

⁸ In 1986, home births in the Netherlands were 36% of all births, a slight rise from the decade before, and in contrast to trends in all other countries (Tew, 1995: 348). Tew shows that the peri-natal mortality rate kept on falling, regardless of this increase in home births. In the Netherlands, independent midwives

the institutional system with a traditional midwife in attendance. At the moment, this happens in rare cases, as the project teams found in some rural hospitals, but is not officially acknowledged. It is possible that many rural and migrant women might like such a hybrid solution, wanting to feel close to the promise of safety given by the hospital, but wanting at the same time the comfort and physiological advantages of the familiar cultural system.

7.5.2 Articulation of care in home births

This section briefly addresses problems that have emerged from the work of the project as major ones which have to do with the articulation of cultural systems of care in home births.

7.5.2.1 The supply of midwives in rural areas

The project has noted in all the rural areas where it was working that there is a very small number of traditional midwives practising. Many of the midwives who were interviewed were elderly, but in no cases was it apparent that younger women were learning the skills of these older women. Midwives spoke of the young not being interested. One midwife in a rural town spoke of traditional birth being too much bother now that there are doctors, perhaps summing up the attitudes of many of her counterparts.

Part of the shortage of midwives in rural areas seems to be due to migration into urban areas. Midwives have a skill which can command a monetary income in the peri-urban areas, with much more frequent demand for their services in urban concentrations than in the dispersed conditions of the countryside. At the Midwives' Encounter in El Alto there were younger women who had learned to be midwives from older women in the country and then migrated. The propensity to migrate on the part of those who have a skill which can command higher income elsewhere is an economic fact of life in market economies.

The problem is, of course, that this tendency, along with the undermining of traditional midwifery by biomedical models, is leaving rural women with ever fewer skilled traditional birth attendants in the countryside. Even where women live within walking distance of medical posts, it is difficult to see the intermittent presence of an auxiliary nurse with a bare minimum of midwifery training as equivalent to the attention of an experienced local midwife. Clearly, rural health programmes are aware of these

are allowed to bring cases into hospital and attend them there. Nevertheless, the statistics on peri-natal mortality bear out Tew's repeated finding of the pattern that home births are safer than hospital births, and that birth attended by a midwife is safer than birth attended by a doctor (ibid: 349-54).

problems and are trying to address them. Both IPTK and MotherCare have directly recruited younger women into training programmes to be midwives. However, the project researchers were critical of attempts to train younger women as midwives directly, since these women did not command enough respect in the community to be taken seriously as midwives. A longer-term view will be necessary to see whether these women do later on forge roles as midwives for themselves in the community, and if so, what part the training course played in this process.

In the medium term, the only factor that is likely to change this process of decline of rural skills is a re-evaluation of these skills on the part of the biomedical authorities, and hence a change in wider social attitudes to traditional midwives. Such a re-evaluation would lead programmes to look to integrating *older* women, and as teachers as well as learners. The integration of a 76-year-old traditional midwife into teaching on the training programme in Ocurí presents one possible model, despite the difficulties, as she herself wishes to retire from practising. Her description of her sessions in the hospital as two-way processes where each side learns from the other was a positive appreciation on her side, and one which was reciprocated by hospital staff in their acknowledgment that she does much of the teaching for them on their courses. Re-evaluation would also lead to encouragement of traditional apprenticeship, where experience acquired over a long period of time is valued in itself, as much or more than the knowledge that can be gained on short courses.

7.5.2.2 Recognition of midwives in urban areas

The situation in El Alto is probably exceptional in that there is a large programme in reproductive health running in Health District III, financed by the Dutch government, which has instituted an urban programme of training for traditional midwives. Indeed, the CIES team chose not to work in this district because the conditions there were out of the ordinary. However, it is likely that this programme has meant that there is a more open supply of midwives practising in adjacent districts of El Alto. In Sucre, which seems more typical of the rest of the country, it was clearly difficult for traditional midwives to practise openly in this way. This led to a situation of conflict or of semi-clandestinity vis-a-vis the biomedical authorities. In the short-term, this situation leads to difficulties of liason between traditional midwives and the institutional system, since biomedical authorities may refuse to deal with them. In the longer term, as in the rural areas, it can only lead to a decline and disappearance of skills, and a resultant narrowing of the range of care available to women.

The scheme operating in El Alto had its drawbacks from the point of view of the midwives. Some of those who came to the Encounter spoke of their doubts about working with the NGOs involved, as all it seemed they were required to do was to refer women on for hospital birth. Elsewhere, individual midwives have opted for attitudes of hostility towards the hospital system. These strategies of, on the one hand, cultural incorporation/subordination, and on the other, a semi-clandestine cultural hostility, are neither of them long-term solutions to the problems. What is needed is the recognition on the part of the urban medical professionals, firstly, that midwives exist as a valid alternative profession to their own, and, secondly, that midwives have cultural and practical skills that medical professionals are not trained in. Again, the call is for dialogue to be a two-way process.

7.5.2.3 Discouraging imitation of obstetric practices in home births

At several points in this report, we have highlighted ways in which biomedical practices appear to have shifted from the institutional sphere into that of home birth. It is difficult to tell whether this is through a process of imitation of what may appear to be safer practices, or whether these shifts in practice are the effects of previous and present training programmes. In either case, the effects are likely to be physiologically hazardous. Tew has shown clearly how the safety of interventionist practices in hospitals was assured only by the discovery of a cure for sepsis in 1936 (Tew, 1995: 284-5). Only then did the maternal mortality rate start to fall, and in the twenty years before that it appears actually to have risen slightly in Europe and North America. Rates of death from post-partum haemorrhage declined in the 1950s after the discovery of the application of ergometrine and Syntocinon (*ibid*: 180-1). Where births are taking place out of reach of modern antibiotics and other pharmacological products, any interventions in the physiological process of birth must be seen as highly dubious.

The biggest danger of a further shift towards hospital practices in home births is what appeared to be a tendency for younger women to adopt a lying-down position for birth. This has already been adopted in many areas as the position for birth of the placenta. Together with early clamping and cutting of the cord, there is good reason to suppose that these practices increase the risk of haemorrhage, and this pattern was discernible in the contrast available with a small sample of women who had resisted these practices within the project area. Other examples of medical imitation were the strong abdominal pressure exerted by one woman who attended a home birth unexpectedly. In her own case, she had experienced a severe tear after such pressure had been used on her in hospital, but seemed grateful for having avoided a Caesarean. Again, the problem highlighted is that of transferring such practices out of a context where their collateral damage can be repaired.

Unfortunately, some of these imitations have now taken root and been adopted as ‘traditional’ by the cultures concerned. We have already indicated that further research is needed to see which vestiges of older methods remain in these cultures that could provide the basis for a revival of beneficial traditional practices. However, what is urgently needed is a revision of the content of training for traditional midwives, so as to include the main points of the ‘physiological model’ of birth, which must be the best practice for birth attention outside of a hospital and pharmacological context.

7.5.2.4 The diffusion of life-saving technologies

This last point raises the issue of why life-saving technologies are not more widely diffused, particularly those that can save a woman from post-partum haemorrhage. While we would argue that there is an urgent need for ethno-pharmacological research on the properties of indigenous herbs used for stemming haemorrhage, it is also the case that modern methods exist and are in use in hospitals. It is ironic that ergometrine is usually administered orally in hospitals, a remedy that could technically be available to all rural women, if the social will were there to make training in its use more widely available. Knowledge of how to give an injection is already quite widespread in Bolivia, with some voluntary health educators being able to do this. Again, it is tragic that women are dying from this cause, when saving does not mean the enormous upheaval of hospital birth in a faraway place, but simply the organisational will to make the pharmaceuticals available.

7.5.3 Articulation of care in hospital births

7.5.3.1 Translation and advocacy

For dialogue to take place between those of different linguistic cultures, translation is necessary. This simple point is usually not obvious to those who speak the dominant language, —one could cite the British interest in the promotion of the English language abroad. Bolivian doctors, too, generally see the language problem as one of their patients not understanding them. The reaction of the native-language speakers who were researchers on the project team was to call for the incorporation of the teaching of Bolivian native languages in medical schools. We support this call. Even a very rudimentary command of Quechua or Aymara could help a doctor or nurse in some situations.

However, those of us on the team who were not fluent speakers of native languages can see the impracticality of attempting to turn already over-loaded medical students into

fluent linguists. This is not to deny the necessity of teaching something about the languages, about indigenous cultures and their medical systems, and the ethno-physiology of the body in native languages. But intermediate solutions need to be sought alongside such teaching, particularly as regards women who are mono-lingual entering hospital for antenatal care or birth. These women showed a particular fear of hospital staff and hospital treatment in their comments; and in one or two cases, mono-lingual women had extremely bad experiences and outcomes from giving birth in hospital.

One example of an intermediate solution is the experience of various schemes of link-workers and health advocates in Britain, where issues of racism and cultural difference in health have also become a focus of debate (Ahmad, 1993). Childbirth has been a specific area of concern, where some ethnic minorities appear to be having worse outcomes than others, and where there is a tendency on the part of health professionals to put the blame on cultural background for these outcomes (Parsons et al., 1993). Schemes devised to overcome these inequalities through provision of link-workers or health advocates were reviewed in section 4.3.2.

In Bolivia, there would seem to be ample potential for a scheme such as these specifically oriented towards advocacy for monolingual native language speakers experiencing hospital birth. There is already a network of general health 'link-workers' in the form of the *Responsables Populares de Salud*. Traditional midwives who report to institutional health authorities form another network of link-workers. The need envisaged here is different from either of these existing networks, but it is possible that it could build on them. The questionnaire fieldwork covered one case where a mono-lingual woman giving birth on her own in the rural hospital in Ocurí called out to the hospital washerwoman to help her. This shows that, where available, mono-lingual women do already make use of bi-lingual women informally as 'link-workers'. The development of a formal scheme which builds on such existing informal practices could help to increase dialogue not only between individual women and biomedical personnel, but also between the two systems of birth care.

7.5.3.2 Systemic articulation in routine hospital care

Although two midwives interviewed by the project claimed to have attended births in hospital, these were highly exceptional, and such practices were not given official recognition by hospital staff. Both midwives were also probably exceptional in the degree of self-confidence they had vis-a-vis the biomedical system. The reasons why traditional midwives are not working more routinely in hospital environments appear to be social rather than physiological. Although the social barriers loom large, the work of

the project points to the necessity for attempts to overcome them. We argue that traditional midwives' practices could add substantially to the safety and well-being of women in hospital birth. Practices such as a choice of upright birth positions, suitable warmth, the availability of traditional massage and herbal teas, and the possibility for a husband or partner to attend and to hold his wife, would all add to the comfort of women in hospital. As well as being validated in cultural terms, some, such as the upright birth positions and a generally non-interventionist policy towards birth, have received substantial validation in modern scientific studies conducted by midwives.

Various ways of achieving the introduction of traditional practices into hospital birth can be envisaged. Units for traditional midwives could be set up attached to hospitals, or biomedical personnel could be trained in traditional practices. A possible intermediate model here is the system set up by Glaubo Araujo in Brazil, which is reviewed in Chapter 12 of this report. Traditional midwives' units were set up in a rural area with reasonable access by road to hospital facilities. The midwives were given autonomy to manage birth on their own, and to decide when to transfer women to hospital. In Bolivia, intermediate rural maternity homes have been envisaged in *Plan Vida*. What is lacking is any mention of traditional culture or traditional birth care in the running of such homes. Araujo's experiment has shown the value of giving autonomy to the practitioners of traditional cultural birth care in the implementation of such intermediate schemes.

As the National Director of Midwife Training Programmes emphasised, there is a need for awareness training for biomedical personnel in this area. We would also point to the fears and other emotional difficulties expressed by biomedical staff when it was suggested that they might attend women giving birth in an upright position. These fears would need to be tackled through awareness training which included both cultural and women's health components. As Silverton points out, substantial rethinking of traditional biomedical training is needed in order for the birth attendant to conceptualise both mentally and manually the descent of the foetus in an upright position. This rethinking needs to be part of an explicit training programme for biomedical personnel to learn how to attend women giving birth in upright positions. Such programmes would provide an exciting opportunity for making cultural links across Bolivia and for cooperation between the different systems of birth care. They could also build on international links such as those already established between personnel in the National Health Secretariat and the followers of Glaubo Araujo and Caldeyro Barcía in Brazil and Uruguay.

7.5.4 The problem of emergency care

This chapter started by outlining traditional thinking on maternal death, as reported from one rural community. It was there obvious that until deaths from other causes start to decline in Bolivia, maternal mortality will not assume the paramount importance as a cause of death that it took on, for instance, in Britain of the 1920s and 1930s (see footnote 11, p. 150). It is not that the loss of an adult woman and mother is taken lightly: on the contrary, it is taken very seriously, and her role in production and survival is well recognised. There would be no thought of valuing the survival of a baby in childbirth over that of the mother, for instance. It is rather that death in and around childbirth is only one of many causes of death that can befall an adult woman.

It was also clear from accounts of death in childbirth that social factors are very often involved in maternal death. The absence of care in childbirth could be attributed to marital violence and to family shame around a case of non-marital pregnancy, in two cases that came to light. The removal of these sorts of prejudices is a society-wide problem that needs to be tackled at that level.⁹

For these reasons, the problem of emergency care in childbirth is much wider than a problem of the provision of obstetric facilities. The first priority might be to achieve a reorientation of outsiders' thinking about maternal mortality in rural communities, which recognises that the problem is conceptualised as the death of adult women, not simply their death in or around childbirth. There are then possible ways in which biomedicine could work with and through traditional categories of blood flow and loss to achieve a more general picture of anaemia as a factor in women's health, for instance. Women are well aware that their general state of health is shown in their blood flow, and that this affects their likelihood of an easy or difficult birth.

If it is decided that it is desirable to try to *change* or influence traditional thinking on maternal mortality, it is essential that maternal mortality rates are not used as another tool with which to disparage traditional cultures and ways of life. This means that it is necessary for solutions to be developed using primarily resources *internal* to communities, and not imposed as external technical fixes. The first of these internal resources might be the practice of traditional midwives, but a close second would be the factor of widespread diffusion of knowledge of traditional birth care throughout the society. If these resources are recognised in outsiders' interventions, rather than disparaged as part of the problem,

⁹ The Gender Sub-Secretariat had made violence against women its priority in a widespread poster and educational campaign in Bolivia in 1995.

this will start a process of confidence building which might result in fewer births being unattended in rural and peri-urban areas. It might result in greater value being attached to the maintenance of midwifery traditions within isolated rural communities, so that specialist traditional care is more readily sought out and available in emergency situations. Only if specialist traditional care is available and is working well in an agreed form of coordination with outside, institutional medical facilities, can it be expected that women will be referred on in emergency situations. For this to happen requires that dialogue be established not just with midwives, but with the whole community, with an emphasis on reaching women within the community, and not just talking to male representatives.

At the moment, the emphasis in planning for emergencies appears to be on bringing women in to centralised facilities. Ways of overcoming communications and transport problems, such as two-way radios and ambulance services, are being devised primarily within that framework. However, the staffing of medical posts in rural areas with low-level biomedical personnel (auxiliary nurses) represents an alternative strategy. Project researchers noted problems with the present operation of rural auxiliary nurses as birth attendants, but they also noted that they are making some use of ergometrine and other potential pharmaceutical life-saving technologies. This is an area where further research is clearly warranted, to see how life-saving pharmaceutical technologies could be more widely diffused to rural areas, obviating the need for the dangerous process of transferring women in emergencies across very difficult terrain. Again, the installation of functioning two-way radio communications would facilitate consultation with hospital authorities in emergency situations.

Finally, the arguments advanced in this report point to the need for the integration of traditional midwives into emergency care. This could take place through training programmes in the use of life-saving technologies, such as are offered to auxiliary nurses. Or it could involve the midwife forming part of emergency teams in the case of transfer to hospital, with a reciprocal awareness training programme for biomedical staff. We would here return to the points raised at the beginning of this section and chapter. No progress along any of these lines can be made while maternal mortality is posed as a problem of rural lifestyles and cultures, only soluble by outside technical solutions. And cultural unwillingness to use biomedical facilities will persist, paradoxically, until there is the kind of re-evaluation of traditional practices which would enable a more genuine cooperation to take place between the two systems of birth care.

7.6 SUMMARY: CULTURALLY APPROPRIATE STRATEGIES

For at least some of the communities studied in this project, the preoccupation with maternal mortality is seen as an outsiders' concern, which can be used to devalue and undermine their traditional way of life. While a woman's death is viewed very seriously, other causes of adult death, including disease, poisoning, and road accidents, loom very large on local agendas. While the international concern with maternal mortality reflects in part a worthy outsiders' attempt to improve the status of women in traditional communities, analysis of actual cases of maternal death show that the social factors entering into deaths are complex and will need to be addressed on different levels.

These problems can be to some extent alleviated if solutions to the problem identified at the international level are not similarly phrased as outsiders' solutions, but take care to involve and make use of existing local resources. In practical terms, this project has identified a number of such resources in terms of positive aspects of traditional birth care: vertical birth positions, the emphasis on warmth, calm and patience, and an impressive command of techniques of massage. Other aspects clearly warrant further research, such as the multiple systems of locally-based herbal knowledges that are in evidence, and the two systems of placental management described in Chapter 3.

These practical aspects are important, and are generally in line with practices recommended by modern professional midwives. Building on them will avert the dangers represented by the transference of obstetric practices of intervention outside of the hospital context. But just as important as these practical aspects is the need to build on and foster dialogue between the two systems of birth care. This project attempted to make links with previous initiatives that had brought together women with biomedical practitioners to discuss birth practices. The rhetoric of 'participatory' research sometimes excludes a meaningful engagement with the authorities who frame policy, and our experience leads us to posit that research should rather be 'dialogical' in engaging with the different social actors involved in negotiating policies and practices. While we do not claim that our project has been exemplary in this respect, it had some success in engaging with personnel within the National Health Secretariat, and in interesting them in taking on board and disseminating its findings. These dialogical links both with women's groups, national policy makers, and local practitioners, both traditional and biomedical, could form the basis of further work in this area.

An analysis of a dialogical event where women talked directly to hospital Directors, shows how attempts by the women to articulate cultural concerns around birth were coopted by the dominant discourse of 'humanised birth' and human relations. The

difficulties of liberal humanism in engaging with cultural, ethnic and gender differences have led to its crisis and the rise of postmodernist thinking. The recognition of cultural differences, in Bolivia as in other societies, represents a challenge to ideas of the nation which has yet to be fully confronted. In the area of health systems and birth care, the powerful homogenising effects of 'western' medicine are still seen as a 'modernising' force, in a way which goes against the postmodern fragmentation of identity involved in cultural articulation.

The project's work suggests that the confident articulation of cultural systems of birth care would do much to improve experiences and outcomes in both home and hospital births. At the moment, for instance, the existence of traditional midwives is simply denied by biomedical practitioners in many urban areas. This tends both to create anxiety for midwives around practising their skill, and to drive them underground from the point of view of their relation with the institutional medical system. This is not universally the case, and examples can be found where good relations have been fostered with traditional midwives, and where ways are being sought to increase the supply of midwives in rural areas. In these cases, midwives felt themselves as practitioners of a traditional system that is separate from the biomedical one, but nevertheless could articulate their practice in relation to and even within a hospital setting. Such examples need to be built upon if traditional midwifery is to be used and encouraged as a local resource in the solution to maternal mortality. They could, for example, allow for the greater diffusion of life-saving technologies into the countryside, such as the use of ergometrine in cases of haemorrhage.

The articulation of systems of birth care as separate systems joined to each other through nodal points would also encourage the improvement of the quality of care in hospital birth. Such an improvement is essential if the rates of hospital maternal death are to be brought down. The project found that some of the greatest difficulties with hospital birth were experienced by women whose language was not spoken by hospital staff. While there is a clear need for more linguistic and cultural training for medical students and nurses, the experience of other countries points to the need also for programmes which employ bilingual women as 'advocates' for monolingual women giving birth in hospital. Ways of introducing culturally important practices into the hospital setting need also to be found. Such practices would include vertical birth positions and keeping the woman well wrapped up and warm. Biomedical personnel with whom the project was in dialogue were keen to implement these findings, and may already have done so. It is a longer-term problem to see how traditional midwives themselves could be facilitated to work in articulation with the institutional medical system.

To conclude this Part of the report, we emphasise once more that the work of cultural dialogue is not simply a means to an end, but is in a sense an end in itself. In order to achieve this in research or evaluation of new health initiatives, it is vital that such initiatives be interdisciplinary, working with anthropologists and linguists as well as biomedical and women's health specialists. It is also important that it be inter-organisational, bringing together NGOs and state organisations as *participants*, as well as working with the women's groups who are more usually thought of as the 'participants' in participatory research. For research to be genuinely participatory it needs to include all the social actors involved in decisions around birth care, and not just those which satisfy populist credentials. For these reasons, we prefer the term 'dialogical' research, where different actors are brought in at different points in the process and in different roles.

We, as European researchers writing this report, have also become social actors around this issue. We are aware that we are bringing what, in some ways, is yet another outside agenda to bear on the complex cultural problems of Bolivia. We have tried to be explicit about this agenda, in our advocacy of the 'physiological model' of birth care as the most appropriate guideline for attempts to introduce any change into existing cultural practices. There is much continuity between the practices of traditional midwives in Bolivia and those of modern, professional midwives, which must ultimately derive from common experiences of caring for women giving birth. A Swedish midwife doing research in Bolivia was herself keen to learn from traditional midwives. And there seems a logical case to be made that if traditional midwives are to be 'trained' by anybody, it should be by other midwives.

However, the fieldwork in Bolivia has also forced us all to be more conscious of the cultural divide as itself constitutive of problems in birth care. To us, the way forward is not by attempting to teach any Northern 'model' of birth care, be it based on physiological or interventionist principles. Rather, it lies in the articulation of cultural differences around birth care from within Bolivian society. This project has tried to articulate a statement of traditional birth care and experiences of birth in Bolivia, as part of the ongoing attempts to show how the systems of birth care actually operate and where they interrelate. From there it has gone on to indicate some ways in which culturally appropriate practices can be encouraged and integrated with the institutional health services. We have called the kind of integration envisaged an 'articulation', because this conveys the sense of cultural autonomy that is necessary for success. We have also indicated areas for further research, and ways in which such research could continue and promote dialogue.¹⁰ We hope that this report and its dissemination will contribute to this ongoing dialogue.

¹⁰ The conclusions and recommendations of the project are summarised in Chapter 15.

