

CHAPTER 12

TRADITIONAL BIRTH ATTENDANTS AND EMPIRICAL MIDWIVES: THEIR ROLE IN RESPONDING TO MATERNAL MORTALITY

12.1 OBSTETRICS, INTERNATIONAL HEALTH PROGRAMMES AND TRADITIONAL OR EMPIRICAL MIDWIFERY

The inflexibility of obstetrics is apparent at once in relation to the issue of empirical midwives. As western-style obstetric medicine has gained dominance, with models of care and practices which, as we have seen, have often remained unevaluated and unquestioned, the pressure to downgrade traditional birth attendants or empirical midwives has been extremely strong (Kitzinger, 1988; Wagner, 1994).¹ The history of the conflict between doctors and midwives in north Atlantic countries has been re-enacted in virtually every third world setting, primarily because to be modern has meant to have modern western-based systems of health care, and also to reject traditional systems. Just as in Europe in the eighteenth and nineteenth centuries, empirical midwives have been perceived as ignorant, dirty and illiterate. Their practices have been commonly dismissed as harmful without any attempt to evaluate them. What knowledge they work with, the local pharmacopoeia, practical support skills, and their understanding and use of local cultural rituals to encourage women are discounted (Kitzinger, 1988). In many countries, efforts have been made either to outlaw empirical midwives, often driving them underground, or to limit the scope of their work, on the grounds that their practices compound existing problems (Fleming, 1994). What is often at issue here is who has the authority, institutional and otherwise, to define expertise. Davies (1995: 59) points out that the notion of expertise which is employed by biomedicine is based on a formalised scientific training and that this training and resultant expertise lies at the heart of what western culture deems as professional. The principal political problem for midwifery, in developed western countries and elsewhere has been how to engage effectively with a system that denies professional standing and expertise to anyone not of that system.

¹ Just as there is no agreed position in the international literature on the value of midwives trained in non-western systems, there is no agreement on designation about midwives who work outside the western biomedical system. Writers such as Kitzinger and Wagner use the phrase 'empirical midwives', because they wish to highlight the levels of skill that non-western midwives have, empirical skills often equal to the empirical aspect of scientific training. The word 'traditional' can be used supportively when referring to such midwives. Equally it can be used dismissively to indicate a way of dealing with birth which is not 'modern'. In this chapter, 'empirical' as Kitzinger and Wagner define it, is used.

Wagner (1994) argues that Latin American countries, following on from the United States, have developed obstetric medicine with little or no reference to the skills of midwives, whether professionally trained midwives or empirical midwives. As the numbers of doctors have grown, the numbers of state-trained midwives has dropped and in some Latin American countries, including Bolivia, midwives simply have no professional standing at all. The costs of a health care system run in this manner are exorbitant. At the same time, socio-economic factors such as poverty receive less attention and perhaps most damagingly, given the dearth of resources, empirical midwives are refused formal recognition.

This lack of formal recognition became important for the Safe Motherhood Initiative in two ways. First of all, if empirical midwives used traditional practices which were damaging, then they needed to be regulated. As a labour force, they also suggested a solution to the severe shortage of trained midwives. Therefore, it became WHO policy to encourage programmes to train empirical midwives in western approaches and supervise their work after training (Fleming, 1994). In 1972, only 20 countries officially recognised empirical midwives. In 1978, the Alma Ata 'Health for All' Declaration stated that because of the long-established status traditional healers and birth attendants had in most societies, it was worthwhile training them to become part of the primary health care system (*ibid.*). By 1982, recognition had been extended to empirical midwives in 45 countries. However, it was pointed out that recognition was often ambiguous for it did not necessarily mean that the work of the empirical midwife was considered legal or that it was supported by legislation in those countries offering recognition and in general, their status has remained very variable (Owen, 1983).

In 1985, in a policy document on traditional birth attendants, (TBAs is the usual title and abbreviation in international health literature), the WHO acknowledged an uphill battle in gaining recognition for their approach to empirical midwives:

'Almost everywhere attempts to upgrade the skills and knowledge of empirical midwives and to mobilise them to play an effective role in the health system have met with resistance from organised groups of health professionals with vested interests in maintaining the status quo.... The development of a policy favourable to empirical midwifery depends upon the enlightened understanding of the nature of such care, and the role and resources of its practitioners, many of whom possess a fund of wisdom, knowledge, and experience that can only serve to improve the quality of care that countries provide for their populations' (WHO, 1985a).

Reliable estimates of the distribution of empirical midwives are not available. However, because almost all of the 500,000 maternal deaths which occur every year are in the developing world, the World Health Organisation estimates that empirical midwives or traditional birth attendants are frequently present when these tragedies occur. The largest single work force in providing maternal care may also arguably be the most frequent observers of serious complications in birth.

Perhaps because targeting all the underlying socio-economic and health factors is contentious, the focus of health planners has instead been on who is present when a woman dies and what their competence is. This is a double-edged focus, for as the above passage from the WHO indicates, the value of the TBA is hedged with an unease about what she does and what she represents. Policy makers are concerned with the nature of obstetric complications and how to prevent the occurrence of these complications or deal with them once they have happened. Therefore they are also concerned about what is usually done to assist women. Training programmes for TBAs have come out of this chain of thought. They are most frequently allied to two aspects of medical organisation we have already encountered:

- a) the risk model with its emphasis on the importance of early referral in case of complications,

and
- b) the three-tier medical system with the obstetric hospital at its apex.

The two key skills to be imparted to TBAs are how to deliver hygienically and how to prevent or control postpartum haemorrhage (WHO, 1992: 6). These skills are meant to be taught in a programme which also has the objectives of building links between 'modern health care services and the community'. The WHO wants to see an increase in the number of births attended by trained TBAs as well as an improvement in the skills, and status of individual TBAs. To accomplish this, it is necessary to make local communities aware of how the modern health care system and trained TBAs can help women. What the state can also offer is back-up in terms of supplies, supervision, and referral. Community participation in making choices about improvements in maternal health care programmes is cited as an important objective as well as the training of trainers and health care staff to work with building skills and 'team-building' (ibid.: 7).

TBAs then are seen as the link through which biomedical concepts of asepsis and identification of risk categories can be introduced to women and also a way to provide women with social and psychological support. However, implicitly, (and often explicitly), TBAs are seen as bearers of a cultural dimension which is a local

and peripheral aspect that can impede the acceptance of Western biomedicine or, alternatively, provide what biomedicine cannot give but sees as peripheral to its knowledges, namely the social support.² The tensions between these different and often simultaneously-held views about TBAs create many problems for TBA training programmes.

12.2 TRAINING TBAs: THE BOLIVIAN PROGRAMME

In Bolivia, the state health authorities have acknowledged that the western biomedical system shares the care of women with indigenous medical systems in which self-help is a strong theme. It is acknowledged that practices and techniques coming from these indigenous systems of care, such as *manteos* (a practice to relax the mother's body), and massages, are used very frequently to the exclusion of biomedical approaches. State health authorities argue that perhaps due to the suppression of medical practitioners during the colonial period and since the advent of the Republic, many practices were taken up in a self-help way by families so that the majority of births continue to be attended by family members only (Pomier, Murillo and Quispe, 1991: 7-8). They acknowledge that the value of birth at home is having a secure setting in which beliefs and traditions can be duly observed, especially the important belief that the woman needs to be protected from '*enfermedades malignas*' (literally, 'evil illnesses') to which she is vulnerable during birth. (Of course these beliefs and traditions are not just self-help practices but rather form part of a coherent and wide-ranging Andean ethnophysiology as our project findings have borne out).

While wanting to honour the deep roots traditional knowledges have in local communities, the government has been committed to the WHO objective of achieving a higher level of coverage with trained personnel. This first led the government to initiate TBA training programmes in 1975. By 1991, it was thought that more than 1,500 *parteras* had received training. But an evaluation in 1988 indicated that the level of knowledges and practices of the *parteras* continued to be in contradiction with the theory and practice imparted in the courses (ibid.: 9). This issue has not been addressed except to reinforce the importance of biomedical norms.

² This issue of social support during labour is more critical than medical authorities are generally willing to acknowledge. Oakley (1985: 848-9) cites an intervention study done in a Guatemalan hospital. Primigravidae women with no known medical problems were randomised into two groups on admission, one receiving the support of an untrained lay woman throughout labour and the other group not. Symptoms of foetal distress such as meconium staining and interventions such as augmentation and Caesarean section were much higher in the second group without social support.

The training syllabus of 25 hours is meant to extend over 4 days. *Parteras* are taught about general care during pregnancy, the importance of antenatal checks, complications of pregnancy; how to recognise danger signals during pregnancy and the identification of high-risk cases and how to refer these cases on to the nearest health centre or posta; preparation of materials needed for birth; washing hands before handling a woman, washing the perineal area of the woman giving birth; receiving the baby and immediate attention; cutting the cord; attention to the mother; complications during birth and in the postpartum period and referral of those at risk or in danger.³ At the termination of each course, they are issued with a packet of supplies, cord ties, razor blades, nail scissors, antiseptic solution, gauze, and soap (*ibid.*: 17). Training and packet contents reinforce the five ‘cleans’ of maternal health programmes: clean hands, clean surface, clean razor blade, clean cord tie, clean cord stump.

The Bolivian programme reflects the concern that ‘any training should help TBAs to perform more safely the tasks they already perform’ (WHO, 1992: 16). Their problem continues to be trying to reconcile traditional knowledges with biomedical techniques and knowledges, a problem complicated by the lack of evaluation of both systems. There is little evidence that the *partera* is valued in respect of her practices, or beyond her knowledge of the local language, nor that she already considers issues of safety in her practices. For example, the strictures on clean hands in the training syllabus do not acknowledge the existing Andean tradition of never touching a woman near her vagina in a normal birth without complications.⁴ What the *partera* does, her techniques, how she draws on the Andean system of medicine, the contribution of the Andean model of physiology to her work, are not worked through in the course syllabus which appears to concentrate solely on biomedical approaches. Even though the government states that it wants to promote the knowledges and skills of *parteras* (Pomier et al., 1991: 10), there is little evidence to suggest that the perspectives from the few studies which have been carried out on knowledges and beliefs, such as the CIAES study (1991), have been incorporated into teaching syllabi.⁵ Furthermore, the burden of linking into the state health care system appears to fall

³ Teaching on the use of oxytocin and ergometrine are not included in this programme but these are drugs which can be bought without a prescription if there is access to a chemist or pharmacist as they are regularly sold over the counter (Bartos et al., 1992: 50) The omission of discussion or teaching is striking, more especially as there does not appear to be any mention of oxytocic release from immediate breastfeeding. Also, there does not appear to be any discussion of herbal *mates* which might have useful oxytocic effects.

⁴ In emergency situations such as a retained placenta, there is an acute awareness of possible contamination and the Andean practice is to wash hands in urine to prevent contamination. See also 3.1.4 and 5.1.2.

⁵ Some tiny level of cultural sensitivity has entered into teaching of state health care personnel. In the *Manual Guía para el auxiliar de enfermería del area rural* (1986), auxiliary nurses are urged to wash the perineal area after administering an enema to the woman in labour, if cultural habits of the woman in labour and her family permit this. This marks some effort to recognise that intrusive interventions like enemas are not welcome. The general instruction is nonetheless misplaced, given the uselessness of these procedures. See Enkin et al. (1995: 200-1).

disproportionately on the shoulders of the individual partera who is instructed to report monthly to the local state health officials about the births she has attended and what activities she has carried out, to attend monthly meetings where her supplies can be topped up (Pomier et al., 1991: 23-4; *Ministerio de Previsión Social y Salud Pública*, 1992: 268-272). This is in addition to the referral procedures during pregnancy and birth. There is no discussion about problems of language and cultural assumptions on the part of state health care that might make any of these activities very difficult to carry out in practice. Nor is there any recognition that the teaching on referrals is largely unworkable. In the instance of referring high-risk women during pregnancy, risk screening is not operable because maternal characteristics have so little predictive capacity. In the case of emergencies, women and *parteras* need to be assured of the receptivity and responsiveness of the state health services, for referral to work in this instance.

12.3 AMBIGUITIES IN THE TREATMENT OF TBAs

According to Norma Quispe, head of the programme for the training of *parteras* in the *Secretaría Nacional de Salud*, the official position is that there is no wish to encourage new *parteras* but to work only with existing ones to train them in western-approved methods (data from joint project interview, Bradby and Rance, *Secretaría Nacional de Salud*, 1 February, 1995). This approach appears to be in line with a shift in WHO position about empirical midwives which is markedly less enthusiastic than it has been (Fleming, 1994). In 1985, the *Fortaleza Declaration on Appropriate Technology for Birth* contained the following recommendation:

‘Informal perinatal care systems (including traditional birth attendants), where they exist, must coexist with the official birth care system and collaboration between them must be maintained for the benefit of the mother. Such relations, when established in parallel with no concept of superiority of one system over the other, can be highly effective.’ (WHO, 1985b)

By 1992, the situation was more ambiguous. In its most recent policy document on traditional birth attendants, the WHO wrote that the ultimate aim is for all women and children to have access ‘to acceptable, professional, modern health care services’. Until ‘more qualified personnel have been trained, are in position in a modern health service, and are accepted by the community’, TBAs should continue to be trained but only as a measure ‘in order to bridge the gap’ (WHO, 1992: 2). To be fair, the statement also says:

‘Conditions vary so greatly throughout the world that decisions to initiate, invigorate or discontinue a TBA programme should be made only after a thorough review of the complex array of issues, resources, and sociocultural factors, including the wishes of families and the TBAs themselves’ (ibid.: 3).

The statement hardly reinforces the notion of parallel systems, operating non-hierarchically that is part of the Fortaleza document. TBAs are seen as anachronisms who in time will be replaced by their literate daughters who will have a range of training options leading them into a western-style health care system as professional midwives and auxiliary midwives. In overcoming illiteracy, there will be the opportunity to teach all women information and skills that are now only being taught to TBAs (ibid.: 17). Presumably the WHO means here principles of clean birth and the recognition of the importance of seeking biomedical help throughout pregnancy.

From the perspective of health planners, there are sensible suggestions about the implementation of TBA programmes in the WHO document, such as developing process and outcome indicators for ongoing evaluation. A dialogue with the community to identify criteria for selection of women to be trained as TBAs is certainly urged as important for the success of any training programme. But the WHO does not now feel in a position to urge countries to recognise TBAs, to make their practice legal or even to define core functions of a TBA, and it is highly doubtful that sound advice on community participation is common in planning training schemes. Fleming (1994) suggests that one reason this pulling back from TBAs has occurred is because they have not been seen to have any appreciable impact on reducing the rate of maternal mortality. However, in considering all the factors that lead to maternal death, to focus on TBAs as ineffective or even partially responsible seems perverse. Maine argues, for example that unless there are realistic and functioning emergency care facilities in place, training TBAs to refer women makes no sense at all (MIDIRS, 1994b: 146).

12.4 EFFECTIVENESS OF TBA PROGRAMMES

In discussing the limitations of TBA programmes, the WHO indirectly acknowledges the fact that TBA training cannot be used as a single policy solution to improve maternal health care, that referral and support systems must be strengthened, not least because there are essential obstetric functions which can only be carried out in a health centre or hospital. The 1992 policy statement mentions the problem of transport; it diplomatically avoids the problem of inadequate treatment at health centres once women arrive there. The WHO is less discerning and less imaginative about the issue of illiteracy, arguing that this greatly restricts the effectiveness of

TBAs in carrying out their work because they cannot deal with record-keeping and written communication with state health care staff about patients. This unthinkingly reflects the assumption that the only way to set up a system of referral and to process women through it, is to use a western-based system, relying on written work. The very strength of oral cultures, that of recall, is unwittingly discarded and yet it is an obviously valuable tool. How valuable is borne out by a recent study on the issue of recall of major obstetric complications where the MotherCare group matched good hospital records in a Philippines hospital against women's accounts and found accurate reporting by women, especially so with complications such as dystocia and haemorrhage (Stewart and Festin, 1995). The train of events that may lead to disastrous birth outcomes do not go unrecognised, and this is a positive resource to be utilised, not a disadvantage.

Two other aspects are worth noting. The WHO expresses the opinion that TBAs cannot be a substitute for a professional midwife for, with limited training they cannot make critical judgements about or treat 'the wide range of complications associated with pregnancy' (WHO, 1992: 14). This over-medicalised way of defining pregnancy is far from helpful in the face of such unresolved circumstances at the level of cultural difference. It also fails to take into account how western-trained midwives are redefining their work and expertise in terms of supporting pregnancy and birth as a normal process rather than one subject to a 'wide range of complications' (Flint, 1986; Kitzinger, 1987).

The WHO also expresses reservation about the expense of setting up TBA programmes and maintaining supervision thereafter. Maine (1991) carried out a cost-effectiveness exercise of seven different options which are common components, either singly or in combination of most maternal health programmes. It was meant to be illustrative of both costs and benefits, albeit with very limited data on which to make a judgement and numerous assumptions about start-up and training costs and about effectiveness. The two most expensive options were in order: staffing ten health centres with transportation to an urban hospital and staffing and equipping five health centres with transportation to five rural hospitals. The least expensive option was a TBA programme. The most effective in saving lives was the option of five health centres and transport to a rural hospital. In terms of saving lives, a TBA programme was the second least effective option. Maine's point is that cost alone may not be the most meaningful measure. Her analysis throws doubt on the WHO position about the expense of TBA programmes. Equally though, she points out that TBAs alone cannot solve the problem of maternal mortality and that it is unrealistic to expect them to be able to do so.

In 1991, Maine wrote that there were few evaluations of TBA programmes and none had thus far indicated any impact on maternal mortality but, as already indicated, such programmes can never be examined in isolation anyhow. She picks up on the fact that local patterns of handling birth have to be known and understood before planning any training programme. Her example is of localities where it is a point of pride for women to handle their birth on their own and not call in the TBA until it is time to cut the cord (an aspect of birth management also discussed in Chapters 3.1.5, 3.6 and Chapter 13.4.3 below). The other huge problem she identifies is the lack of effective means of linking TBAs to a functioning referral system (Maine, 1991: 37) which inevitably reflects their anomalous status vis-a-vis the biomedical community.

The root of many of the continuing problems about TBA training programmes is their ambiguous relationship with western-style health care systems. They are both bridging measure and obstruction in the eyes of programme planners, not least because this latter group continue to design training programmes solely from the perspective of a western-style approach to pregnancy and birth. A recently published study of beliefs and practices about disease and complications during pregnancy, labour and the postpartum period held by women and TBAs in rural Bangladesh has been criticised on just these grounds (MIDIRS, 1995: 456-7). The study itself found that many of the traditional treatments offered reflected a continuing strong belief in the spiritual causation of disease; that the belief systems of TBAs had not been altered by training programmes. Postpartum problems were well recognised but effective care at village level was not available. The researchers concluded that although biomedical postpartum health care was essential at village level, unless the clash between local belief systems and the biomedical model of care was resolved, women would not participate.

The reviewer comments that the study highlights the extremely common situation where maternity services are developed solely from the western biomedical perspective which makes such programmes largely unworkable. But rather than attributing the lack of improvement in maternal morbidity and mortality figures to TBA training programmes and opting instead to develop obstetric services only, planners are advised to examine the basic premises of TBA training programmes to see where and why they are failing, most usually around the issues of cultural fit. Training cannot be carried out before knowing what the range of knowledges and practices are, what they mean, what their value is, nor without community participation as distinct from seeing training separate and at one remove from the

community.⁶ As befits a review in a major midwifery journal, the writer argues that TBAs must be seen as one of the greatest assets for developing countries, not as liabilities, and comments how ironic it is that the decision at international level appears now to be to move away from TBAs and, instead, adopt a fully obstetric model just when this has been rejected in the West.

12.5 MODELS OF GOOD PRACTICE: THE FORTALEZA EXPERIENCE

The reason the 1985 conference on appropriate technology for birth was held in Fortaleza, Brazil (see Chapter 3.2 above) was because the participants had been inspired by the work of Jose Galba Araújo. He was an obstetrician firmly in the western tradition who nevertheless over a period of years developed a health care system where empirical midwives and state health care professionals worked in tandem to ensure the best outcomes for women. In the 1970s, the state of Ceara in northeastern Brazil had a population of over five million, surviving on subsistence farming, on land affected by serious drought and, in the urban areas, a very low wage economy. Migration from the land to the capital city of Fortaleza was an established trend despite the poor quality of life on the urban perimeter. The widespread poverty was reflected in the poor nutritional status of its children with only 30% of its young children achieving normal weight. Poor health conditions in the region also included high rates of maternal and infant mortality and there was no way to redress them through the health care system as it stood, given that professional health care staff were over-represented in the urban setting of Fortaleza and badly under-represented in the rural areas. (Araújo, 1985: 863).

In 1975, Araújo began to set up a system which grew to 40 obstetric units located in the rural areas surrounding Fortaleza, staffed by traditional birth attendants. He first established units in the district surrounding the town of Guaiuba where there was a high maternal mortality rate. It is worth quoting in full his and his staff's reactions to what they saw as the resounding benefits of working with TBAs:

'These women who in most cases acquired their initial skills by delivering infants of their own or those of close family members, eventually acquired a local reputation as women with experience in their work, after which they continued to practice by helping other women in

⁶ There is a genuine problem here. If training is to be pedagogic and prescriptive on the five 'cleans' and advice on referral systems, programme planners can easily locate training in the local community — even though training on referral may be largely irrelevant without extensive reforms. In skills training, say a review of local practices on retained placenta and teaching about manual removal or bimanual compression of the uterus to treat postpartum haemorrhage, there is an issue about how to teach real instances at local community level, when by their very nature they will not occur very frequently. These are the kinds of issues that ought to be under review when rethinking TBA training programmes.

the community have their babies. The voluntary nature of their work and the devotion and solidarity displayed by these traditional birth attendants were the characteristics that most impressed us. We also had the feeling that the cultural identification between these birth attendants and the women in labor gave a special human closeness to their attendance to spontaneous and natural childbirth, a characteristic which is difficult to achieve in a hospital.' (Araújo, 1985: 864).

The aim was to bring about an improvement in maternal and child health without imposing major cultural changes on the communities. Aware of the extent to which TBAs felt ridiculed and criticised by doctors in the past, it was important to work to gain their confidence. In his experience, these were women 'who have a keen sense of the practical and the obvious' (Araújo, 1980: 294).

Araújo argued that to plan such a programme in the first instance 'one must be aware of the cultural characteristics such as local beliefs, behaviour and value systems in the community... one needs a clear understanding of the existing indigenous medical system. Such knowledge is essential in developing a programme that will be acceptable to the entire community' (Araújo, 1980: 297). To gain that knowledge, many TBAs were interviewed, many of these taped, from which the obstetrical teams learned amongst other facts, that TBAs knew how to recognise a breech presentation and that such a presentation could end in a normal birth; that they could diagnose a transverse lie. They were aware of the value of abdominal massage to speed labour when necessary. They could recognise the position of the head and dorsum. They used a vertical or sitting position in labour squatting in delivery and they too had a prohibition on touching the vaginal parts resulting in low rates of puerperal sepsis. Most interestingly, 'the TBA generally cuts the cord *after delivery of the placenta*' (1980: 295 —emphasis J. M-L). Although there was no tradition of encouraging the baby to be put to the breast at once, the more usual pattern being within the first twenty-four hours after birth, gradually immediate suckling was introduced and encouraged so that women had the benefit of oxytocic release in helping the placenta to deliver (Araújo, 1980: 295; 1985: 867).

Initially the doctors worked with local leaders to set up supports for the units. Community leadership did most of the planning of the obstetric unit at local levels and even selected the TBAs to train and work in the units. The programme nonetheless was patterned on a western hospital model of care in many respects. The units ranged in size from one bedroom, attached to the home of a TBA, to eight to ten bed units. Women were encouraged to deliver there rather than in their homes. TBAs were taught to refer women to hospital in Fortaleza for delivery if the following

occurred —antenatal complications of eclampsia and haemorrhage; complication of labour such as placenta praevia, abruptio placentae, prolapsed cord or limb; or malpresentation. TBAs were selected on the basis of their having leadership skills, literacy, and proximity to the obstetric centre. They ordinarily worked an eight hour shift with four TBAs in attendance in the larger units. The units delivered on average 30- 35 babies a month and, Araújo argues, there was no panic or fright, frequent features in the hospital setting. The Caesarean section rate of those women referred to hospital was 4% (Araújo, 1980; 1985).

The TBAs' training on referrals was evaluated at one point. Between October, 1980 and July, 1981, the 40 units referred 12.4% of 1,878 pregnant women to the university hospital in Fortaleza to give birth there. Transport was not a great problem. There was an ambulance available and no site was more than 90 minutes from the university hospital (Janowitz et al. 1985). There is no detailed discussion in the evaluation study of referrals about cultural or linguistic problems, how these were approached. The authors do say that nurses visited the units once or at most twice a week and were actively discouraged from visiting more frequently and from attending deliveries so as not to undermine the confidence of the TBAs. Taught to refer in a limited number of circumstances, the TBAs seemingly did so with the confidence apparently of knowing that women so referred would receive proper and appropriate treatment promptly. There was a small percentage of high-risk women who did not need to be referred on the judgment of the university hospital and of low-risk women who should have been (Janowitz et al., 1985). After ten years of operation, the State of Ceara had the lowest maternal and perinatal mortality rates in Brazil (Caldeyro-Barcia, 1994).

The descriptions are almost akin to a district midwifery service in the Dutch sense with the addition of the element of giving birth in the unit rather than at home, rather like cottage hospitals.⁷ There is no mention of how Araújo secured finance and backing for this scheme nor is there any detail about working with anthropologists or sociologists to understand local customs. The principle informing the units was, in large measure, the obstetric model of high-risk/low-risk, but seemingly modified in the light of two crucial factors:

⁷ This may have been possible in terms of local customs. Women do go to give birth in the homestead of the local TBA, for example, in the Nyabondo region of western Kenya (see English, 1992). The obstetric teams could have built on an existing custom to accomplish birth outside the actual home.

- a) Great confidence in birth as a normal process and in the TBAS to deliver normally —this must account for a referral rate of 12.4%, well within the 15% estimate of births which will need hospital attention because of complications;
- b) A reliable transport and transfer system unhindered by great physical distances between the localities and either larger health centres or a full teaching hospital where full emergency treatment could be given.

The team assessed and encouraged TBAs to retain valuable aspects of local birth practices, such as a vertical position for delivery, dealing with a breech birth as a normal birth; not cutting the cord until after placental delivery. They introduced what they hoped would be valuable practices, such as early postpartum suckling.

Maine (1991: 37) argues that the success of the TBAs in Fortaleza was due to the fact that they were trained, received weekly supervision, and had access to an ambulance for referring women on to hospitals. But surely it is more than these elements of training, supervision and referral which can be found on paper about most TBA schemes. What appears to be rare is that every effort was made to reinforce valuable local practices and to give TBAs confidence in their work, not to overshadow or demean them (even down to the detail of their delivering without nurse supervision). This sensitivity, combined with good training and workable emergency transport and services made Fortaleza a model of good practice, well in advance of its time. Caldeyro-Barcia comments that Araújo's health system was a 'unique achievement' based on his ability to recruit empirical midwives, preserve their practice and train them to quite a high degree in western technologies such as accurate blood pressure measurement, detecting glucose and proteins in urine etc. (Caldeyro-Barcia, 1994). His colleagues agree that Araújo's untimely death just before the Fortaleza conference in 1985 deprived Latin America of one of its most powerful voices to protect women's needs in labour and birth (*ibid.*)

A recent assessment in Guatemala, in 1991, of maternal outcomes when women were referred to hospital, identified all the problems that the Fortaleza experiment appeared to have overcome: women with complications in labour not wanting to go to hospital because of maltreatment, language barriers, and fear of surgical operations, including sterilisation, and therefore not seeking out the TBA until it was too late and/or the TBA not referring the woman in good time for adequate treatment (O'Rourke, 1995). To encourage TBAs to refer women sooner, a hospital staff training programme was implemented to see how outcomes for women could be improved. The hospital training had two objectives, training to improve the standard of care for women being brought in on an emergency basis and training to improve understanding of TBAs and

women referred by them. Staff were actually taught about TBA practices and how they helped to improve the well-being of the women. TBAs were encouraged to visit the referral hospital and to attend the deliveries of women they had referred. Following on from this, a separate programme was carried out to improve training for TBAs on identifying high-risk complications in labour and on the need to refer women promptly in such instances. A subsequent evaluation measured for improved patient satisfaction with treatment. Numbers of referrals began to increase after an initial 8-month period and the evaluation then measured for factors such as how long women had to wait before being seen in hospital once they arrived, their perception of their treatment, how staff behaved towards them etc. more women who needed immediate treatment did receive it. The study team concluded that some beneficial shifts on hospital attitudes and practices had taken place and that women and TBAs were given greater respect.

The treatment of women and TBAs prior to the intervention programme mirrors many accounts that this current project uncovered in the course of fieldwork (see Chapters 5, 13.4.3 and 14) and leads us to contest the perspective that the problem with TBA training programmes is the TBAs themselves who are seen as anachronistic and outmoded. Without the obvious leadership qualities of a man like Araújo, the problems identified in Guatemala continue to bedevil women and TBAs when they try and liaise with the state health care system. Their language, their approaches to women in pregnancy and birth are devalued to the detriment of the women themselves. The study suggests that major work has to be done at the point when hospital staff are first gaining their qualifications about different approaches to labour and birth and about their value. But even that cannot be done until there is a commitment to do very thorough evaluations of indigenous systems of medicine and care as part of a review process which also encompasses an evaluation of hospital policies and practices. We will return to this issue of evaluation of hospital policies and practices in Chapter 14.

Here, it is useful to reiterate that a social model of birth emphasises the normality of pregnancy, and birth, and midwives; both those trained in the western biomedical tradition and those trained within local indigenous systems have an enormous amount to offer childbearing women. The downgrading of TBAs is especially serious when set alongside a continuing serious problem of shortage and maldistribution of midwives within the state health services in developing countries. A review of the training and distribution of midwives in 29 countries carried out in 1989 indicated that even where there is an infrastructure for midwifery training, these countries would require a very substantial reinforcement of numbers to redress current

shortages (Kwast and Bentley, 1991). Yet the midwife has the potential to be the critical linchpin in the community of people caring for women, an invaluable link between TBAs and medical doctors and hence her importance in the so-called maternity care pyramid (see Chapter 10.3). Both groups of carers, midwives and TBAs (or empirical midwives to use Kitzinger's and Wagner's designation —see note 1 p. 277) share the following profile:

‘The good midwife has deep knowledge and vast experience, which she brings to bear on each unique situation, using them to help her sense the nuances of a process that she can only facilitate rather than steer’ (Stivers, 1993: 132).

12.6 CONCLUSION

With rare exceptions, obstetrics has not had good relations with empirical midwives, nor have governments. Although the WHO has made a concerted effort since the 1970s to encourage the validation and training of empirical midwives or traditional birth attendants, the policy of positive reinforcement of the TBAs as a valuable national resource for developing countries has been gradually overridden. There seems evidence to suggest that current thinking sees TBAs being phased out over time to be replaced by a fully western model of health care for women during pregnancy and birth. This turnabout in policy and implicit endorsement of an option which is realistically beyond the grasp of most developing countries, appears to have arisen from an inaccurate assessment of what TBAs as distinct from TBA training programmes can accomplish.

Official government policy about *parteras* in Bolivia has been caught up in and reflects these policy shifts despite the fact that in principle the government recognises that health care is shared between two systems of medicine. The writing about TBA training programmes internationally has continued to be highly generalised and the work of translating these generalisations into a sensitive appraisal at local level often remains undone in Bolivia as elsewhere. A sound working knowledge of local practices, whether they are beneficial, neutral or harmful in impact, has not, as a matter of course, fed into the work of devising a training programme for TBAs. The TBA programmes in Bolivia have been predominantly about western-style approaches to pregnancy and birth, with insufficient attention to local practices and their incorporation in training. The other grave drawback in training programmes has been a reliance on teaching TBAs to assess and refer women during pregnancy on the basis of high-risk/low-risk scalings. This is not a workable strategy, as we have seen

earlier. Additionally, if women are being referred in an emergency situation and are unable to access appropriate treatment for whatever complex of reasons, commitment to the system breaks down.

TBAs cannot of themselves be a solution to maternal mortality and morbidity but they can make a substantive contribution. It seems an inescapable part of the equation that women also require access to good and appropriate emergency obstetric facilities which will be necessary say for at most 15% of births (which can only sometimes be predicted in advance). Thorough evaluations of local practices and the contributions *parteras* make to women's health, along with committed work to solve the social and economic resource problems of emergency referrals, including staff attitudes, could potentially transform maternal health care in the Altiplano in Bolivia. The work of Araújo in Fortaleza, Brazil indicates that such assessments are possible. TBAs and state health care personnel can work harmoniously on behalf of women, if the commitment is there on the part of the latter to listen and respond at local level, rather than use models which have little applicability especially when accompanied by attitudes which are dismissive of women and TBAs. The lessons of Fortaleza are reinforced by a recent study in Guatemala where hospital staff improved their attitudes to local women referred by TBAs after specific training programmes about the value of TBAs and their practices for women.

The importance of sustaining and extending the training of midwives alongside the extension of support for TBAs is that these are the two largest workforces dealing with pregnant and childbearing women who share a common agenda about the normality of birth, an agenda which is critical to women's well-being.