

PART IV
RECOMMENDATIONS AND CONCLUSIONS

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CHAPTER 15

CONCLUSIONS AND RECOMMENDATIONS

15.1 MODELS AND PRACTICES OF BIRTH CARE

This report has identified various ‘models’ of birth care, as well as actual practices of birth and birth care in different social contexts. Part II of the report described the ‘traditional model’ of birth care in Bolivia, and compared it with actual experiences of home births in rural and peri-urban contexts. An explicit evaluation of this traditional model was undertaken with reference to the ‘physiological mode’ of birth advocated by modern professional midwives. Experiences of hospital births and actual practices of birth care in hospitals were viewed from the perspective of the traditional model, and evaluated primarily for how they live up to the cultural expectations of that model. In Part III of the report, the ‘obstetric model’ of birth and birth care was introduced, and evaluated for its capacity to provide solutions to the problem of birth care in the Bolivian demographic and social context.

The close attention to accounts of actual, lived experiences of birth has shown that there is often a considerable distance between what is advocated by any of the models in terms of care, and what is received by the woman giving birth. This is true as much of the traditional system of birth care as it is of hospital practices. In addition, the dichotomous division between traditional and modern systems breaks down under close examination of actual practices. It becomes clear both that there is an ongoing process of ‘borrowing’ and imitation of hospital practices in the traditional sphere, and that hospital practices have certain ‘cultural’ features which may perhaps be thought of as adaptations of universalistic norms to the local context. There was evidence also that women from rural migrant backgrounds are active in shaping these practices to fit their own cultural preconceptions and expectations. There is therefore an ongoing process of negotiation of knowledges and practices between the two systems, which takes place at the level of the social actors involved in giving birth and birth care.

However, the project was faced on the ground with dichotomous perceptions of the two systems, a dichotomy that is well sustained by setting out the preceptual ‘models’ of each system of birth. These dichotomous models parallel the way in which the ‘physiological model’ of midwifery has been counterposed to the ‘obstetric model’ with its

interventionist precepts. The additional factor in Bolivia is that of cultural difference. Midwifery in Bolivia is perceived both by its practitioners and its opponents as the practice of a different culture or cultures. At the deepest level, ILCA's work has shown how this cultural understanding of birth relates to indigenous Andean religious beliefs about the earth, the sky, and the sun. Although many of its metaphors derive from a llama-herding economy, this religious understanding still underpins cultural differences in birth practices in peri-urban economies. The persistence of practices understood as cultural differences depends on the versatility of Andean religion in adapting to different contexts and incorporating into itself elements of different conceptual systems.

The Bolivian government, in its response to international concerns about maternal mortality, is putting the main planning impetus into an increase in coverage of the obstetric model of birth. We have argued that this emphasis is inappropriate. It ignores the cultural problems in offering a technological model of birth to those who hold social and cultural models. It offers an outsiders' solution to what is seen at community level as an outsider-imposed problem, and in doing so fails to utilise and build on community resources. In devaluing traditional skills and knowledges, it will act to further undermine and discourage practitioners of these skills, leaving many women extremely vulnerable to the lack of any care in birth. Having said this, it is important to acknowledge that within government planning there are several elements, some of which have long histories and push in a different direction. Under this heading, we would recall the 'humanised birth' initiative, and the midwife training programmes which have been in existence for twenty years in Bolivia. Government planning is still building on these initiatives, and an important new element is there-introduction of training of professional midwives, under the auspices of the latest plan. The outcome of this complex mix of policies and plans will depend not just on 'where the money goes' or what new buildings come on line, but on the strengths of the social actors in negotiating between the different knowledge and cultural systems that are currently in play.

In so far as preceptual models are relevant in the evaluation of actual birth practices, we have been open in our estimation that the physiological model is more relevant than the obstetric one in the context of rural and migrant women giving birth in Bolivia. Our reading of the biomedical and other evidence indicates that this is the most appropriate model of birth in contexts where birth takes place out of reach of the technological back up to remedy any adverse effects of obstetric intervention. However, it is important to add that the overall social context is one in which 'choice' in the place of birth is largely determined by socio-economic and cultural factors. To give birth in hospital is characteristic of the middle classes and the organised working class. For those outside these classes, one way to mark their aspiration to enter them, or to give a sign of having

‘arrived’, is to go to hospital to give birth.¹ ‘Upward mobility’ on the socio-economic scale also involves acculturation, in the context of rural and migrant women. Hospital birth becomes a sign both of socio-economic success and of acculturation to urban life.

In this overall context, women may themselves have a series of contradictory expectations of hospital birth, fostered in part by obstetric claims to ensure safe and rapid deliveries. Women may, for instance, come to expect a series of interventions by hospital personnel, within an overall structure governed for them by their desire to avoid what they see as the ultimate intervention of the Caesarean section. In this situation, the physiological model may find itself in conflict with women's expectations of ‘help’ and ‘attention’ in hospital.² In the medium term, this situation can best be remedied by the interaction between traditional midwives and modern proponents of the physiological model. There is already a small move within the International Confederation of Midwives to establish links with Bolivian traditional midwives. When the new programme to train obstetric nurses in Cochabamba is further underway, there will be better opportunities for building this kind of alliance between traditional and modern midwifery.

15.2 RECOMMENDATIONS

Recommendations that arise from the work of the project are divided into five sections:

- Dialogue-building measures;
- Measures to allay cultural fears of hospital birth and to improve the quality of care;
- Measures to arrest the decline of traditional midwives in rural areas;
- Measures to improve the provision of emergency care in health systems , and
- Recommendations for further research

In detailing with these recommendations, we indicate where they are building on or relate to initiatives already recommended or implemented by the Bolivian authorities.

¹ The disruption of the organised working class in Bolivia with the closures of mines from the mid-1980s on has produced a ‘downwardly mobile’ sector of migrants in peri-urban areas who may be used to giving birth in clinics. The project was not able to research the insured sector of health care, nor the effects of these movements on it. However, it is clear that many migrants to El Alto are displaced mining families, and that for such women, the choice between home and hospital may be primarily an economic one.

² See Chapter 4, section 4.1.2 for an explanation of how women use these terms.

15.2.1 Dialogue-building measures

The concepts of articulation and dialogue elaborated in Chapter 7 need now to be extended to include dialogue on a number of different levels. At the international level, there is the ongoing articulation of research around physiological and obstetric models of birth. Unfortunately, much of this research is not currently available in Bolivia, due to barriers of language and accessibility, and the project makes a concrete recommendation to overcome this problem. Within Bolivia, a more equal dialogue needs to be fostered between traditional midwives and biomedical personnel at various levels, including that of the auxiliary nurses, who are increasingly becoming an important social actor around birth in the countryside. Dialogue needs also to be extended from its present focus on traditional midwives to family care more generally. The role of husbands needs to be more explicitly articulated, and the problems in carrying these gender roles over into the peri-urban and hospital contexts acknowledged and thought through.

Specific measures under this heading include:

- Programmes of awareness training for biomedical personnel, to increase knowledge of traditional birth systems and the role of midwives in them, and to train biomedical personnel in responding to women from different cultural backgrounds. The need for such programmes was highlighted by the National Director of Midwife Training Programmes in relation to hospital personnel. The project would point to the level of rural auxiliary nurses as another important interface where awareness training is needed;
- Training in native languages for biomedical personnel. Language training needs to be acknowledged as necessary and incorporated into the training of medical and nursing students;
- The fostering of dialogue between traditional midwives practising in urban contexts and biomedical personnel. Useful precedents have been set in El Alto by the Health Secretariat and NGOs. These need to be built upon and extended to other urban centres;
- The furtherance and continuation of dialogue such as that set up by the Solidarity Group and TAHIPAMU between women who are users of services in El Alto and hospital medical personnel;

- The incorporation into existing programmes of an awareness of the role of men in traditional birth care. Many programmes run at present for women only through Mothers Clubs and other organisations could find ways of bringing men into the dialogue around birth practices, while hospitals need to evaluate their own difficulties with accommodating men as birth partners;
- The translation into Spanish of the Cochrane data base. This data base on pregnancy and childbirth comprises the complete text of *Effective Care in Pregnancy and Childbirth*, 2nd edition, by Enkin et al., which is a systematic review and evaluation of all studies on obstetrics and gynaecology published since 1950. The database is updated on an annual basis and offers the most current research findings, reviewed in the light of previous studies. It is available from Update Software, Summertown Pavilion, Middle Way, Oxford, OX2 7LG, UK;
- Further work on dissemination of the findings of this project. Much new ground has been covered by this project, which could usefully be integrated into processes of dialogue such as are recommended above. For this to happen requires a series of dissemination measures at different levels to be undertaken in conjunction with the National Health Secretariat in accordance with the Agreement signed with this project.

15.2.2 Measures to allay cultural fears of hospital birth and to improve the quality of care

It was an objective of this project to identify reasons for the under-use of existing services by rural and migrant women. This objective was endorsed by the health authorities in Bolivia. One conclusion of the project would be that the phrasing of the problem in terms of 'cultural barriers' to the uptake of services is not helpful, as it shifts the onus for increasing understanding onto members of the oppressed cultures. It was also found that, while there was a tacit understanding by its proponents that implementation of the policy of 'humanised birth' would in practice involve cultural adaptation on the part of biomedical services, this was not spelled out and tended to be obscured by the universalising discourse of 'human relations'. From the point of view of traditional culture, the overriding fears around hospital birth are the fear of the Caesarean section, the fear of the danger of unburied placentas, and fears of the invasion of sexual privacy represented by hospital practices of manual penetration.

Specific measures where action could be taken in this area include:

- Conceptual elaboration of the government policy of ‘humanised birth’ in its application to women of different cultural groups. There is a need either for the addition of a concept such as ‘culturally appropriate birth’, or possibly for its rephrasing as a new programme in such terms;
- Policies of giving women a choice to take their placenta home with them. These have been successfully implemented in some hospitals and need now to be extended to other hospitals offering services to rural and migrant women;
- Implementation of the policy of offering a choice of birth positions to women. This is already advocated in the ‘humanised birth’ programme. The project work suggests that specific training is necessary for biomedical personnel in order to rethink birth from the different perspective. Here a dialogue with traditional midwives is essential in order to incorporate their experience and skills in this area;
- Programmes of bilingual ‘health advocates’ for monolingual native-language speakers. Here the example is from other countries, such as Britain, where such programmes have already been successfully implemented and evaluated in relation to women from ethnic minorities giving birth;
- Measures to reduce the manual penetration of women giving birth, especially by men and by medical students in training situations.

15.2.3 Measures to arrest the decline of midwives in rural areas

This is an important area, since many women are being left without access to specialist traditional birth care in rural areas, through the combined effects of migration to the towns, and biomedical discouragement of traditional midwives. However, it is an area in which project researchers were themselves critical of existing initiatives to try and arrest the decline of midwives. It is possible that specific measures will be of little use unless accompanied by a generalised change in attitude towards traditional birth practices. It is contradictory to try to train traditional midwives through new programmes and at the same time to teach them that all traditional practices are ‘dirty’ and need supplanting with different practices.

We therefore refer to the general recommendations as regards dialogue between the two systems of birth care made above, and in addition have two specific recommendations to make in this area:

- Rethinking of the concept of ‘clean birth’ as it is being applied in midwife training programmes. This has the effect at present of classifying traditional practices as ‘dirty’. Despite the fact that there is no evidence to support the claim of lack of hygiene by midwives, this terminology devalues ethnic practices and by implication the whole culture of which they are part. It undermines confidence in a system which has some very strong points, and some skills that may be unique on a world scale and are in danger of being lost;
- Organisation or facilitation of further ‘Midwives’ Encounters’ such as the project undertook in El Alto in conjunction with the National Health Secretariat. Such encounters are essential for midwives to build up a sense of themselves as a professional body within traditional medicine, and to articulate their practices with confidence.

15.2.4 Measures to improve health systems provision of emergency care

At present, emergency care is centralised in hospitals, and where a role is given to traditional midwives, it is simply that of identifying and referring on cases in an emergency. The project did, however, gather reports of midwives themselves performing various kinds of emergency care successfully, such as the turning of hand presentations, and the removal of retained placentas. The problem as identified by the project is much more that of low coverage of rural births by traditional midwives. There is no guarantee that there will be a midwife accessible in rural areas when emergencies arise. At a general level, the project would urge health planners to consider giving a more responsible role to traditional midwives in emergency care, including the diffusion of life-saving technologies for haemorrhage and retained placenta. If, however, emergency care is envisaged as being accessed through a centralised hospital system, better communications are essential. This includes the need for bilingual advocates for rural women entering hospital in emergency, as mentioned above. It also includes road and radio communications, which are already in government planning, but which should be given the utmost priority if rural women are not to be disadvantaged.

Concretely, two measures to be found in existing plans are recommended for prioritising, while the third is our own suggestion in relation to reports of maternal death collected by the project:

- Improved communications in rural areas, including two-way radio systems. The project recommends that these improvements be given high priority, and that community members, including women, are trained and given access to radio use;
- That a high priority be placed on the need for increased access to traditional midwives, particularly in rural areas;
- That pilot programmes of the diffusion of life-saving technologies to traditional midwives be planned and evaluated, particularly those that can prevent a woman dying of retained placenta or haemorrhage.

15.2 5 Further research

Although there are many aspects of the work of the project which warrant further research, three areas need to be prioritised. Firstly, the different systems of care during the birth of the placenta that were identified in the field studies led to different outcomes in terms of time taken for the placenta to deliver. Given the importance of retained placenta in traditional thinking about maternal death, this seems a priority area to investigate, so that clear recommendations on the best method can be made in educational programmes. Sample numbers were small in our study, however, so that there is a priority need for a large-scale study comparing the two systems. Secondly, the area of ethnobotany and the various uses of herbal medicines in birth and after birth needs further research. This has been an area of controversy between biomedical and traditional practitioners in Bolivia in recent years, and there is a need for more systematic study involving pharmacologists. Thirdly, the differences in hospital treatment of different social classes of women need further study. At the moment these differences have shown up in the accounts of women themselves, but were not apparent in the interviews with biomedical staff done by the project. The present picture needs complementing with the views of doctors and nurses on the phenomena described by women to the project. The low rate of Caesareans experienced by a particular group of women from a 'poor' socioeconomic background is a potentially important finding given current concerns about the 'epidemic' of Caesareans in Latin America.

Therefore, recommendations for further research are, in brief:

- A large-scale study of the two different systems of placental management identified by the project. The background to the study is that one system approximates the ‘physiological model’ of birth and placental delivery, while the other is closer to biomedical practices of intervention. The study should incorporate the skills of linguists and anthropologists with a knowledge of ethnophysiological categories, if it is to be effectively carried out;
- Further research on herbal medicines used during childbirth. Studies need to further document herbs used and local knowledges, as well as the uses of certain herbs, and their pharmacological effects. A particular focus should be on herbs used in the prevention of haemorrhage and retained placenta, given that these emerged as the priority areas of rural women’s concern around maternal death. Again, such a study calls for the inclusion of linguistic and anthropological skills, as well as botanical, pharmacological and medical ones;
- Further research on the different hospital treatments received during birth by women of different socio-economic levels and cultural backgrounds. There is a particular need to document how doctors and other hospital staff see the low Caesarean rate among certain groups of women as having been achieved, within a context where overall rates are much higher.

