

# Mothers' Protagonist role in Safe Motherhood

By Marie Tyndall

*Safety and humanity in childbirth are of the most basic of human rights. This includes women's need for competent care, as well as for privacy, autonomy and informed decision-making, and the right of babies to be born without trauma in an atmosphere of trust and security. Midwives who work on the frontlines of childbirth care in remote communities in Latin America have the right to adequate training and to have the equipment and drugs to deal with complications, and a functioning referral system to ensure timely access to appropriate care for emergencies. The right to emergency obstetric services for life-threatening complications is fundamental to saving lives in Latin America. Childbirth should be safe and empowering for women and children alike; our future depends on it.*

## BACKGROUND

All women need and desire good health and the best care possible during childbirth for themselves and their babies. A medical emergency during childbirth is every pregnant mother's and family's worst nightmare. The image of a mother haemorrhaging or convulsing while giving birth, or of a baby not breathing in the moments following being born, fill us with terror and grief. Unsafe motherhood is the untold devastation of hundreds of thousands of children who each year lose the one person in the world who will see them through childhood. It wasn't until 1985, when WHO announced for the first time that half a million women were dying each year from obstetric complications, that public health authorities and some women's groups began to investigate and address how to make childbirth safer.

The well-being of communities in Latin America depends on the presence, health, and the intense physical labour of women and mothers at home and in the workplace, not to mention their willingness and capacity to have children. However, governments of the region have given little attention to the issue of safe motherhood. Each year in Latin America, 22,000 women die during pregnancy, childbirth or in the first 42 days after giving birth<sup>1</sup>. In addition, it is estimated that for each woman that dies, from 30 to 50 more women will experience an injury related to pregnancy and childbirth which will leave them incapacitated for a period, or with a permanent injury. What's more, approximately four million women resort to an abortion each year in Latin America, and most of these are carried out clandestinely and in dangerous conditions, often resulting in permanent injury, and five thousand deaths per year<sup>2</sup>. An estimated 800,000 are hospitalized due to complications. Of only five countries in the world where abortion is completely prohibited in all circumstances, even when the mother will probably die, four are in Latin America. The region confronts an enormous public health problem that threatens the lives of women, and exerts great pressure on already overextended health care systems.

Initially (1987), the *Global Safe Motherhood Initiative* encompassed the need to improve women's status, improve abortion services where it is legal, educate communities, and strengthen and expand core elements of maternal health – antenatal, delivery, and postnatal care – at the community and referral levels<sup>3</sup>. At that time, NGOs, UN agencies and governments focused on antenatal care for screening women to identify those at risk, and training traditional birth attendants in preventive measures to improve care during birth at the community level. Ten years later, at the conference marking the Initiative's 10<sup>th</sup> anniversary, it was shown that these strategies weren't working and the focus shifted to health sector interventions and increasing women's access to professional medical care.

The WHO issued a statement that the underlying reason for current high levels of maternal mortality and morbidity was the alarming shortage of trained midwives. The ideal is that all women be attended by professional midwives, and that emergency medical services be available for all births in case of complications or an unexpected obstetric emergency. Traditional birth attendants, trained or untrained, have been excluded from the definition of skilled attendants, because they lacked the clinical skills, drugs and equipment, or infrastructure to manage complications such as haemorrhage, eclampsia, or severe infection.

Maternal health and survival were also prioritized in the Millennium Development Goals which aim to reduce maternal mortality by three-quarters, between 1990 and 2015<sup>4</sup>.

In the year 2000, it was estimated that in urban centres in Latin America 70% of births were attended by doctors, 15% by other professionals, 10% by traditional or indigenous midwives, and 5% by other people. In rural areas, 30% of births were attended by doctors, 15% by other professionals, 40% by traditional birth attendants, and 15% by other people<sup>5</sup>.

## MIDWIVES

There are many terms used for midwife in the Americas, such as *matrona* in Chile and Bolivia, *enfermera partera* in Puerto Rico, *obstetriz* in Peru and Ecuador, *enfermera obstetra* and *partera tradicional* in Costa Rica and Nicaragua, *comadrona* in Guatemala, *enfermera obstétrica* in Brazil, *obstetriz licenciada* in Paraguay and Peru, etc.<sup>6</sup> The WHO-recognised midwives include only those that have graduated from a formal training program recognised by their government, of two or more years. In order to differentiate midwives of the government-trained group from the empirically-trained group, they came up with the terms professional midwife and traditional birth attendant, respectively. In Latin America, the professional midwives are high-school graduates who go on to study midwifery, often before having children themselves, so they are usually young and relatively inexperienced, compared to traditional birth attendants, who are usually older women with grown children. Becoming a traditional birth attendant is a calling, borne out of necessity. Conversely, becoming a professional midwife is a career choice. In order to keep with the spirit of the term midwife, I am using the term traditional midwife in instances where UN agencies would use traditional birth attendant.

Throughout Latin America, in spite of massive programs to bring childbirth into clinics and hospitals, women in rural areas continue to birth in their homes with a traditional or indigenous midwife, often without any possibility of medical backup in case of a complication or emergency. The ambitious goal of the Global Safe Motherhood Initiative, of all births being attended by professional midwives or doctors in clinics or hospitals is simply out-of-reach for millions of women in Latin America, whose only help close at hand is the traditional midwife. Efforts to save the mothers most at-risk should first address making emergency obstetric services available to those who are furthest away from help. The ability of traditional midwives to handle emergencies is generally very poor, and this is the main reason why women continue to die in childbirth. It is a matter of social justice for midwives, and for childbearing women, that health care systems form alliances with traditional midwives, and to ensure that traditional midwives have telephone or radio access to obstetric specialists in medical centres for quick referral when they encounter complications.

Previous efforts to train traditional midwives have not focused on life-saving skills for obstetric emergencies, but as long as they continue to be the primary care providers for many rural women, traditional midwives need essential and emergency obstetric skills and equipment to deal with the most common complications<sup>7</sup>. These include drugs such as antibiotics (for severe infection), pitocin and misoprostil (for haemorrhage) and anticonvulsives (for eclampsia), and skills to deal with retained placentas and difficult deliveries<sup>8</sup>. In cases when a caesarean section is indicated, midwives in rural communities need communication with a medical centre with facilities for surgery and blood transfusion, and ambulance or helicopter services for transportation, depending on the distance and the road conditions. And, of course, these services must be free of charge.

Doña Josefa Mira is a traditional midwife in a rural community called Berlin in El Salvador<sup>9</sup>. She told us how during the war she had to abandon her village and flee to the mountains, seeking safety for herself and her children. For several years she slowly gained first-hand experience as a midwife to the women around her who were also fleeing. Doña Josefa is now the director of a birth centre where she practices midwifery with two other midwives, who also learned through experience. They have an ambulance, and transport women with complications to the hospital, which is an hour away. Their clients are often high-risk because the local community is very poor, and these traditional midwives are trained and equipped to handle complications, except of course those which require an instrumental delivery (forceps or vacuum) or caesarean section. These are transferred to the hospital. They rely on foreign aid and donations to run their clinic, since their clients are too poor to pay. The loving attention local women receive at this clinic is considered by local women superior to the impersonal nature of birthing in the hospital, and their safety record compares favourably to hospital safety in their country.

Accounts of women's reluctance to seek medical care for childbirth because they perceive services to be inaccessible or inadequate are numerous. Guatemalan indigenous midwives recount how the only medical back-up they have nearby for an emergency is at a private clinic, and that their clients cannot pay the fees. In addition, traditional and indigenous midwives are often not respected by medical staff, and despite their efforts to establish a rapport, most can not call an obstetrician for advice or help when a problem arises at a home birth. In addition, women that have their babies with traditional midwives in Guatemala cannot register their babies. Only babies born in medical institutions are eligible for registration.

## HOSPITAL BIRTH

Institutional violence against women in childbirth in hospitals is widespread, and is a contributing cause of maternal mortality and debilitating poor health. Birth in Latin American hospitals is highly medicalized and many standard routine obstetric procedures that have been proven to be ineffective, excessively painful or dangerous continue to be practised. During labour these consist of frequent vaginal exams by doctors, nurses and students, artificial rupture of membranes, enemas, IVs, isolation during labour, immobilization, withholding of food or oral liquids and the use of drugs to accelerate the birth. During the birth further risky routines are carried out including uterine fundal pressure to hasten delivery, dorsal-lithotomy position with stirrups for delivery, directed sustained pushing and breath-holding, episiotomy, premature cutting of the umbilical cord, separation of baby from mother and manual exploration of the uterus. All of these practices are routinely imposed without informed consent by the childbearing woman. Because of the potentially harmful nature of these practices<sup>10</sup>, the exclusion of women-patients from decision-making about their own bodies, and what many women consider the hostile environment of maternity units in general, institutional violence against women in childbirth is an everyday occurrence.

The practice of obstetrics all over the world has been criticized for being slow to keep up to current research evidence, not only in Latin America. It has been shown that many maternity care providers are more likely to base their practice on personal preferences, outdated assumptions, or "expert" opinions. In both private and public hospitals, this dilemma is reflected by the lack of an agreed protocol for management of normal labour and individual practitioners are permitted to continue with obsolete and harmful practices without sanction or even comment. The World Health Organisation Reproductive Health Library (RHL) classifies all the routine practices mentioned above as ineffective or harmful<sup>11</sup>. Simple practices that are proven to be beneficial, such as companionship, and freedom of movement and position, are ignored. By applying an evidence-based model, women's rights will be enhanced<sup>12</sup>.

The misuse of the drug misoprostil is another example of how women are denied the right to make informed choices about their care and as such, are put at great risk. Also known as cytotec, doctors in both public and private hospitals commonly use misoprostil to induce labour. The extent of its use for induction is completely unknown since it is a drug that is not officially recognised for use in pregnant women. In fact, the insert in the packaging warns against its use in pregnant women. However, the appeal of cytotec to induce labour is that it is fast-acting, readily available and very cheap, compared to other drugs for induction, such as prostin and IV pitocin. It is no longer an over-the-counter drug because of its potential to induce first-trimester abortion, but doctors continue to have unlimited access to it, and many claim to find it useful even when labour induction is not clinically indicated, and use it as a way to program their patients. The reason that cytotec has not been approved for labour induction is that no safe dosage has been established, indeed the tiny white pill must be broken up into tinier pieces in order to get an appropriate amount, and the dosage of the pill fragments is completely imprecise. Even in small amounts, cytotec is associated with hyper stimulation of the uterus which decreases dramatically the oxygen the baby receives. Hyperstimulation may lead to uterine rupture, which may happen with little warning. It is probable that there are many maternal and neonatal life-threatening emergencies, and even deaths, associated with cytotec, but that the real cause of death (cytotec) is not documented in the records, in order to protect the doctors responsible. For this reason, cytotec should never be used for induction (which is very different from using it to control postpartum haemorrhage, in which case it can save lives).

The extent and consequences of routine invasive procedures performed in maternity units throughout Latin America has not been investigated. Little is known about the extent of the harmful effects of routine episiotomy, for example. For many years now, most women giving birth in hospitals have been cut with scissors during the birth of their babies. The pain, infected wounds and the scars that may last a lifetime, are rarely spoken of due to the shame associated with women's bodies, and also the idea that it's necessary, and therefore simply something that women have to endure. For many women, episiotomy is associated with pain during intercourse for months or years to come.

For health care providers, the medicalization of birth also has profound affects. They work in an atmosphere of tension and potential disaster without understanding first how women function when supported and encouraged to give birth normally (without routine invasive procedures). In addition, most (public) health centres and hospitals in Latin America are understaffed, the facilities are inadequate and salaries are very low.

In a film about Central America, midwives tell how hospital staff can be rude and hostile and, on occasion, even slap women<sup>13</sup>. Anthropologist Robbie Davis-Floyd, in a review of anthropological studies of childbirth, describes how professional midwives in hospitals often treat women very badly, ignoring their needs and requests, talking to them disrespectfully, ordering them around, and sometimes yelling at them and slapping them<sup>14</sup>. In a review of the literature, several categories of institutional violence against women in childbirth have been observed and documented. They include neglect; verbal violence, including rough treatment, threats, scolding, shouting, and intentional humiliation; physical violence, including denial of pain-relief when technically indicated; and sexual violence<sup>15</sup>.

Women who have had traumatic birth experiences or have been attended by uncaring or rude staff are often so traumatized that their personal relationships and self-worth are adversely affected, and they may feel grief and shame that can last a lifetime. This explains, in part, the negative feelings many women have about childbirth, and the fact that so few women actually assert their needs in subsequent births, or put in a complaint. Postpartum depression, extending even into the second year after the birth, correlates with the number and invasiveness of medical interventions and the woman's feelings that her needs and wishes had been ignored<sup>16</sup>. Many women, when speaking of their experiences, express the same emotions, even use the same words, as those who have been sexually assaulted or abused<sup>17</sup>. Bolivian women giving birth in hospital felt sexually abused lying on their backs with their legs open and in stirrups, and male doctors doing repeated vaginal exams, sometimes one after another<sup>18</sup>.

## HOME BIRTH

In addition to cultural acceptability and avoiding medicalized obstetrics and violence, for women with low-risk pregnancies, giving birth in their homes with midwives may be the safest option. Studies in Europe and North America have proven that hospital birth is not safer than home birth when the attending midwives are experienced and work in close proximity to a hospital to transfer women to when complications arise. Statistician Dr. Marjorie Tew studied patterns of hospitalization in Europe between 1958 and 1970, and found that when women went increasingly to hospital to have their babies, mortality rates increased<sup>19</sup>. She found that even for high-risk pregnancies, women who gave birth at home consistently had better outcomes than those who were attended in the hospital. She concluded that greater safety in childbirth could have been achieved if women had continued to have their babies at home, and that other factors were more influential in making birth safer such as better sanitation, clean water, improved general health and nutrition, improved women's status, and reduced fertility rates.

For obstetric emergencies, obstetric intervention saves lives. Between 10 to 25 percent of births will have a complication requiring medical intervention, and this rate varies according to the population. The greater the poverty, the higher the rate of complications will be. Where women's status is low, maternal mortality rates are high. Where women's status is high, maternal mortality rates are low. In healthy populations, the need for medical intervention is less, and the iatrogenic effects of hospital routines produce unnecessary risks and increased rates of complications. In a large North American study of homebirth with professional midwives, planned home birth was associated with lower rates of medical intervention and maternal and neonatal mortality was not higher than in hospitals<sup>20</sup>.

The assumption by International policy-makers that Traditional birth attendants do not contribute to safe motherhood is short-sighted. While it is true that obstetric emergencies can occur at any birth and emergency services need to be available for all women, childbirth in the home has many advantages.

The advantages of home birth over hospital birth have to do with intimate, physiological nature of childbirth. This physiological nature is universal and should be considered as essential criteria for safe motherhood programs in all the diverse contexts that women around the world give birth in. In order for the process of birth to flow safely and fluidly, a woman has to feel as relaxed as possible, protected, safe, respected and most importantly she needs privacy, just as in any sexual act. From this perspective, the hospital represents the most inappropriate environment imaginable – the lack of privacy, the cold sterile atmosphere, bright lights and presence of complete strangers. Given the favourable conditions of privacy, familiarity and comfort of the home, birth can flow more easily, without intervention in the woman's home.

## THE WAY FORWARD

The social movement to humanize birth in Latin America has been gaining momentum, especially since the year 2000 when the Latin American and Caribbean Network for the Humanization of Childbirth formed in Ceará, Brasil.<sup>21</sup> There are now groups working in almost all Latin American countries, and enormous conferences where hundreds, and sometimes thousands, of activists and health care providers convene to establish new standards of care in their respective countries. Support for the humanized model of care is found in a growing body of scientific evidence and the WHO model for care in normal birth.

Examples of effective measures used by traditional midwives, but not by professionals in the hospitals, are emotional support throughout labour, freedom of movement and the woman choosing her own position for birth, with an emphasis on using upright postures. Recent Safe Motherhood publications now recognise that strategies that rely on the medical model of birth, with an

emphasis on hospital-based care and outdated hospital routine procedures, to be obstacles to achieving safe motherhood. What's more, traditional practices in childbirth have not been explored, and there is a need to study them further and incorporate them into new approaches that could make childbirth safer and more satisfying for all women.

Several years of planning by international experts and agencies are behind the *Global Initiative for Mother-Baby Friendly Care*, to be launched in 2008. This Initiative takes into account the widespread over-medicalization of childbirth that has been promoted throughout the world, and seeks to make childbirth safe and empowering. This initiative will set the standard for maternity services to strive for if they wish to be awarded with the Mother-Baby friendly status.

Marking its twentieth anniversary, the Global Safe Motherhood Initiative will hold a landmark global conference, called *Women Deliver*, to be held in London, England in October of this year. Two thousand specialists, including policy-makers as well as developing-world activists and local NGOs, will share their most recent findings and strategies, with the hope of creating political will to save and protect the lives of women and their babies. Innovative safe motherhood strategies must support all caregivers who are on the frontlines, including both midwives in hospitals and those in remote communities, and their right to comprehensive training to treat obstetric emergencies, and the right to use the necessary medications to save mothers and their babies. Safe motherhood philosophy should unite the goal of free and rapid access to life-saving care and technologies with a humanized, evidence-based and women's rights model of care. And finally, safe motherhood respects women and their bodies, the right to be informed about obstetric procedures, have options about where, how and with whom birth will take place, to have privacy and autonomy, and to make choices freely. Having a baby can be and should be safe and empowering.

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<sup>1</sup> Alan Guttmacher Institute--An Overview of Clandestine Abortion in Latin America: <http://www.agi-usa.org/pubs/ib12.html>

<sup>2</sup> Jen Ross. Illegal Abortions Rampant in Latin America. WeNews 11/28/04. <http://www.womensnews.org/article.cfm/dyn/aid/2086/context/archive>

<sup>3</sup> Starrs A. Preventing the tragedy of maternal deaths: a report on the international safe motherhood conference. New York: Family Care International, 1987.

<sup>4</sup> Millennium Project. [http://www.unmillenniumproject.org/reports/goals\\_targets.htm](http://www.unmillenniumproject.org/reports/goals_targets.htm)

<sup>5</sup> Going to scale with professional skilled care. Lancet Maternal Survival Series. <http://www.thelancet.com/journals/lancet/article/PIIS0140673606693823/fulltext#fig1>

<sup>6</sup> O.P.S. Comunicado de Prensa. Parteras: términos y títulos en las Américas. <http://www.paho.org/Spanish/DD/PIN/ps060519b.htm>

<sup>7</sup> Fariyal F. Fikree, Heidi Worley, and Erin Sines. Delivering safe motherhood: Sharing the evidence. Population Reference Bureau. February 2007. <http://www.immpact-international.org/uploads/files/ImmpactPolicyBrief.pdf>

<sup>8</sup> Nadia Hijab & Czikus Carriere. Prevención de la Muerte e Incapacidad Materna. Febrero 2002. <http://www.mailman.hs.columbia.edu/popfam/amdd/docs/ProgramOrientationDistribution-Sp.ppt#259>

<sup>9</sup> Marie Tyndall. Video: Central American Midwives. 2004.

<sup>10</sup> B Chalmers, V. Mangiaterra and R. Porter, **WHO Principles of perinatal care: the essential antenatal, perinatal, and postpartum care course**, *Birth*, 2001; 28: 202-207.

<sup>11</sup> **Department of Reproductive Health and Research**, World Health Organization (WHO), Geneva, Switzerland.

<sup>12</sup> R. Cook, B. Dickens, A. Wilson and S. Scarrow, **Advancing Safe Motherhood through Human Rights**, WHO, 2001.

<sup>13</sup> [www.central-american-midwives.org](http://www.central-american-midwives.org).

<sup>14</sup> Robbie Davis-Floyd. Anthropological Perspectives on Global Issues in Midwifery. 2000 *Midwifery Today*. <http://www.midwiferytoday.com/articles/globalissues.asp>

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<sup>15</sup> A. F. Lucas d'Oliveira, S. G. Diniz, y L. B. Schraiber, **Violence against women in health-care institutions: an emerging problem**, *Lancet* 2002; **359**: 1681-85.

<sup>16</sup> J. Lumley, **Events and experiences in childbirth: Is there an association with postpartum depression?** Presented at Innovations in Perinatal Care: Assessing Benefits and Risks, *Birth*, Boston, October 1992.

<sup>17</sup> S. Kitzinger, **A Workshop with Sheila Kitzinger**. Presented at Innovations in Perinatal Care: Assessing Benefits and Risks, *Birth*, San Francisco, November 1990.

<sup>18</sup> Like a video: The sexualization of childbirth in Bolivia. *Reproductive Health Matters*. Volume 6, Issue 12, Pages 50-56 (November 1998). <http://www.rhmjournal.org/article/PIIS0968808098900076/pdf>.

<sup>19</sup> Marjorie Tew. *Safer childbirth: a critical history of maternity care*. Third edition. Free Association Books Ltd. 1998.

<sup>20</sup> Kenneth C Jonson, Betty-Anne Daviss. Outcomes of planned home births with certified professional midwives: large prospective study in North America. *BMJ* 2005;330:1416 (18 June).

<sup>21</sup> Relacahupan. <http://www.relacahupan.org/lared.html>