Health Cosmopolitanism: Melding universality and difference – the case of childbirth in post-conflict Timor Leste

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ABSTRACT

This study will consider the case of TBAs (traditional birth attendants) under the health cosmopolitan banner. Fifteen interviews with health administrators, obstetricians, midwives, traditional birth attendants and women in Timor Leste, provide evidence : (1) that the WHO (1992) directive to dismiss the inclusion of TBAs within the formal maternity care system has been precipitous (2) that TBAs could, with adequate training in emergency obstetric techniques and hygienic practices, assist in meeting MDG No 5, and (3) that TBAs may assist in sustaining hybrid cosmologies and serving other cultural aims. Although Millennium Development Goals embrace the idea of the universal right to health, a human rights framework remains abstract and legalistic. I argue that health cosmopolitanism offers a more inclusive lens. Applied to maternity care it shifts childbirth to a central focus of government policy, obliges all nations to contribute international aid yet recognises the interpretation of complex needs at the local level. It defines a philosophy of care that is person-centred (not professional or institution-centred), ensures equal access to quality care (based not on ability to pay or other obstacles such as geographical distance) and choice of carer and modality (Western, traditional or hybrid). It underlines the argument here that TBAs trained in emergency obstetric care and hygiene and funded by international agencies would ensure every woman has a known carer, plus choice of location, modality and provider. Health cosmopolitanism thus embraces universality, individual autonomy, reciprocal respect and global responsibility.

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Key words: Health cosmopolitanism, sociology of health, philosophical pluralism, Traditional Birth Attendants, maternity care.

The Safe Motherhood Initiative and the role of TBAs

This paper canvasses the debates around the efficacy of Traditional Birth Attendants (TBAs) in meeting Millenium Development Goal No 5 – Improving Maternal Health

and Access to Reproductive Health Services. My contention is that TBAs could assist in achieving medium-term goals associated with MDG 5 and that a WHO decision to deter their integration into the system in the early 1990s was hastily conceived. For many years and certainly in the 1970s and 80s, TBAs were germane to equity considerations and WHO-sponsored programs aimed at reducing Infant and Maternal Mortality rates (IMRs/MMRs) and in managing childbirth morbidities. TBAs were trained in antenatal, intrapartum and postpartum skills to detect early complications, ensure timely referrals and to reduce infection and postpartum haemorrhage (WHO 2014; Starrs 1988). Like other initiatives around women's health care, the TBA strategy can be situated under a human rights umbrella. However, when revised 1990 WHO estimates of maternal mortality (WHO 1966) revealed consistently high IMRs and MMRs, a joint statement by WHO, UNFPA and signatories to the Safe Motherhood Initiative (SMI)[1] announced the scaling down of TBA use. They were to be tolerated only as an interim measure and replaced by midwives or nurse practitioners with suitably acquired 'skills' on the grounds that TBAs were not 'trained birth attendants' (ARROW 2011); a moniker pertaining only to midwives/health workers who could refer women onto a clinic or hospital (Starrs 1988; Graham et al 2001; WHO 1992). Yet it can be argued that putting the burden of proof for high MMRs/IMRs on TBAs was unreasonable. First, baseline measures were missing when the TBA strategy was reviewed and found wanting. Second, social determinants of health such as poverty, illiteracy, lack of easy access to facilities including impassable roads and lack of transport and poor general health of mothers must be factored into the matrix of complex causal mechanisms contributing to adverse outcomes (Kruske and Barclay 2014; UNFPA 2003). Third, other community actors (family and village elders) are typically involved in decisions about perinatal care.

A more reasonable approach to the evaluation of maternity care models is to acknowledge the importance of physiological factors *and* relational care. The WHO Safety Birth Checklist targets bleeding, infection, elevated blood pressure and prolonged or obstructed labor as major risk factors for mothers worldwide. For infants, the focus is on recognizing and managing asphyxia, infection and complications of prematurity. In any setting, good maternity practices demand clean

[1] Including the United Nations, ARROW and the White Ribbon Alliance.

cord care, maintenance of sterile surfaces, the capacity to exercise emergency obstetric skills and timely referral of high-risk cases (The Childbirth Safety Checklist 2011). But the WHO directive omitted to factor in the importance of relational factors in producing 'a good birth', i.e. one that targets safety and embodies dialogical relations between carer and woman. The latter requires a known and trusted carer (a rare event still in most Western arrangements), sensitive and respectful dialogue and practices, consensual care, tolerance for informed dissent and provision of information and privacy. Respectful care is not only a human rights issue, but ensures emotional security and ease of birth and thus mediates physiological complications.

In relational terms, a woman is often better served by the local TBA known to the family who respects their right to squat or kneel to give birth to preserve dignity and desire for privacy (Bajpai 1996a; Matthews 2005) and also reduce foetal stress, labour pain and perineal trauma while expediting delivery time and ease of pushing. TBA attendance at home is also associated with higher levels of maternal satisfaction (Matthews 2005; Bhardwaj et al 1995; Van den Brock et al 1977). In terms of enhancing medical skills, TBAs could be trained in emergency procedures and in the use of low-level life-saving technologies, such as misoprostol, the non-pneumatic AntiShock Garment for postpartum haemorrhage as well as the haemoglobin colour scale used for screening anaemia in pregnancy (Van den Brock et al 1977). Other life-saving tools include antibiotics, magnesium sulphate for eclampsia and safe blood supplies. MMRs and IMRs could be further reduced by government provision of life-saving infrastructures including better roads and transport and upgraded health facilities. In the cultural domain, safety would be augmented by putting the welfare of women at the centre of government policy.

In summary, the decision to jettison the use of TBAs and some traditional practices has been premature. Within the larger social, cultural, political and economic context, TBAs may play immediate, supportive and life-saving role. WHO (1997) has estimated that between ½ and 2/3 of women in developing economies are denied access to biomedical services and that around 400,000 midwives would need to be trained to cover the 45-60 million births per annum to cover the shortfall (Walraven and Weeks 1999; Bryne and Morgan 2011). Where TBAs have been incorporated into the formal health service, the shortfall could be reduced; where they have been

incorporated success has been modest but could be galvanised by systematic education in emergency obstetric procedures and hygiene (Sibley et al 2004; Sibley et al 2002).

Childbirth in Timor Leste, place of birth and the vexed question of the carer

Yet TBAs have been ruled out of many developing economies. In Timor, for example, women have three options in delivering their babies: they may attend the hospital in Dilli (the only hospital in Timor) where they are attended by a midwife or a doctor - 27.8% choose this option of which the doctor attends 7.9%. For around one third of women outside easy access to Dili hospital, another option is to walk to the local health post to a nurse with some midwifery and emergency obstetric training. This has proved efficacious in improving maternal health bringing the MMR down from 650 in 1990 to 370 in 2008 (WHO/UNFPA/UNICEF/World Bank 2010), at least in urban and regional areas. However, an estimated 28.3% of women are attended by a TBA (World Bank 2007) despite a WHO directive in the 1990s formally discouraged this option in favour of a 'skilled' attendant defined as someone trained to manage 'the normal' and to refer complications to the hospital (WHO/UNFPA/UNICEF/World Bank 1999).

The question is, how may one assess the virtues of these options? Or, put another way, what constitutes a good birth or, more broadly, good healthcare? In responding to this question the Western medical model cites safety, equity and universality as the key pillars of good health care delivered most efficaciously through a centralised program staffed by highly trained medical professionals. In Timor Leste that would constitute the Dili hospital or one of the health posts scattered throughout the country. But the problem is that around one third of women refuse these options. The research findings found multiple factors at work – economic, geographical, topographical, social and cultural – and different interpretations of how to deal with these very real problems for remote area women.

Ethics clearance

As a post-conflict society, access to Timor Leste was difficult: repeated requests from Australia to conduct interviews with key figures in maternity care drew no response

leaving little option but to seek ethics clearance from the researcher's home university and then to enter the country and begin the ethics process in person. Once in Dilli ethics clearance was sought from the Ministry of Health; the Minister authorised a Letter of Introduction that permitted interviews to be conducted with key maternity personnel across the country. This project constituted exploratory research and utilised a convenience sample in the sense that it drew upon those available within hospitals, health posts and local communities. Yet it specifically targeted key personnel in a range of locations – urban, regional, urban and remote – in order to appraise a range of interpretations of 'a good birth'. Overall, fifteen respondents were drawn from health administrators, leading obstetricians and midwives in Dilli Hospital, traditional birth attendants, GPs, visiting Cuban doctors, NGO administrators, new mothers, pregnant women and, where possible, village elders. An interpreter was used for non-English speaking respondents. All respondents were apprised of the nature of the research. Consent was sought to record the interview. It was explained that the research was being conducted independently of government, NGOs or political parties and had been designed to elicit from them their understanding of what constituted a 'good birth'. To gain the confidence of respondents, ethics consent was recorded on tape rather than hard copy. Responses were transcribed and N-Vivo used to organise the material into themes and sub-themes. Critical Discourse Analysis (CDA) provided the methodological rationale for analysing the data because of its comprehensive coverage of different levels of analysis (semantics, structure style, cognitive schema adopted by author and reader; as well as the social context. The *critical* component of CDA (as opposed to a limited linguistic analysis of discourse) refers to the reciprocal relationship between the two sides of language – the socially-shaped nature of texts and the socially-shaping capacities of language. In research terms, I attended carefully to the range of discourses drawn upon as respondents described what medicines and practices would achieve a 'good birth'

The Findings: Birthing in post-conflict Timor - three options

Health Post: Since the phasing out of TBAs in the 1990s, some remote families opted for the local, government-funded health post staffed by a nurse with midwifery

and emergency obstetric skills. The birthing room is annexed to the nurse's consulting room adjacent to the public waiting room where women take up the lithotomy position on a high, narrow surgical bed with their feet in stirrups. There is little privacy for the mother, no options regarding birth position and the nurse is available for restricted hours, although she would attend night-time deliveries.

The Dilli Hospital: For urban-based, low-risk women, this was the most viable option and even some mountain women regarded it as safer than staying in the village. As one young remote-area mother with a 3-month old baby said: ….*home is not safe because far from hospital and far from clinic and the midwives don't have time to come*. Obstetricians and midwives agreed. Celeste, a senior midwife at Dili Hospital who had practised in the remote mountain areas for eighteen years testified that **…..** *women like to come to the hospital and the clinic because everything clean.* Alfreda, another midwife at the hospital, added that it was dangerous at home because it is ….*not sterilised and secondly if the baby is already out and the placenta will not come out.*

Dr Gatt, the Director of Obstetrics, confirmed that all women whether attending the health post or hospital needed to be attended by *a skilled person… at least a trained midwife [because] she will know if it is normal then she will carry out [the birth]. If not normal she will refer [to the hospital]. Birth at home was not dangerous but … the obstetric problems at home are emergency problems; number one is delayed decision from family to seek help, then they cannot find transportation to the health centres and then they arrive to the health facility and then no health personnel to do the job so they have to refer on and this takes time and affects definitely the maternal mortality and complications will be more* **….**

The problem with a hospital birth, however, was that women were then confined to a narrow, high bed for the birth, they had no rope to help them stand and manage the pain and nor were they were permitted to squat on the floor to deliver, as in the preferred traditional mode. As Celeste, the midwife explained; practices changed in *2007/2008 because [*of the*] training method from the WHO Safe Motherhood policy*

directive [when] *TBAs and these squatting positions were ruled out.* Also, remote women worried *about who will give food to them when they come to the hospital* [and that they] *did not have enough clothes for themselves and the baby.* Also poor rural families found it difficult to find the money to rent transport in an emergency and often rural communities refused to commit the funds, as Dr Gatt also confirmed. According to one administrator from a women's NGO, many women feared hospital because ….. *the (Indonesian-trained) midwives shouted at them if they made a noise during labour and shamed them for lack of clothing and hygiene.*

Call the TBA: Many remote families favoured this option over others for practical and spiritual reasons. TBAs were not only present and often known to the villagers but they preserved traditional cosmologies and observed customary beliefs and practices that remained key elements of local communities but not observed in hospital births or in health clinic births. However, as Celeste said: although… *they* [TBAs] *are skilled and during the Indonesian time they have been trained, now the government does not allow them and now only people like the midwife can do the process***.** This was not entirely reasonable, she said, because the TBAs were safe and highly skilled carers and capable of hygienic practices, if properly trained. As she stated: *If all the instruments* [are] *clean it is safe to do it at the house* especially if they had a *sterile sheet on the ground* and the mother is educated not to 'smoke the baby', referring the traditional belief widely held ….*that the smoke will make the umbilical cord dry up and not bleed***.** This was not safe practice and nor was it safe to put ash on the cord or throw away the colostrum.

How to achieve 'a good birth'

The gap in services in the government drive to centralise birth prompted two non-government models to fill the breach. GP Dan Murphy's clinic in Dilli and the Café Cooperative Timor adopted political strategies to target high MMRs and IMRs by way of first redressing the low status of women. Villagers were invited to nominate women they trusted as midwives then Murphy's urban clinic provided a free live-in, three-month training course in basic hygiene and emergency obstetric procedures. At the heart of his initiative was a strategy to put mothers at the centre of the family and healthcare by encouraging them as a first step to develop self-confidence and self-respect (referencing Honneth's schema of tripartite social justice) as bases upon they would continuously build a strong presence in community decision-making. As Murphy put it:

East Timor has quite a rich supply of resources as in oil, the trick is how do you put this to use for the average Timorese person, particularly people in the mountain villages who have been living the same kind of lifestyle for centuries. How do you give them dignity, security and opportunities to develop their life as they see fit…. Well when you are a doctor you can have an influence one on one with the patient you are dealing with, but if you broaden your viewpoint a little bit and say actually the idea is to reduce the level of suffering due to conditions, I can't be limited to saying that medicine A helps condition B. No, broaden your viewpoint and many times you come to the conclusion that in poor countries most of the time most of the illness comes from cultural and socio economic political conditions…… The only way this country is going to develop anywhere near to its capacity and only way to be an example to other countries is to give the status of women its highest priority In this country this means the time around child bearing; that is the key to making this country closer and closer to the dream that we all had. So we try to give high priority to women and women's issues and we have a very active maternity - 100 deliveries a month. We want them (TBAs) to know what to do if the woman has had her baby and is now bleeding, how do you massage the uterus so that it won't get firm and they don't bleed to death. We want them to know how do you give two breaths to a baby not breathing and bring it to life and we want them to know what is hygiene around the time of delivery. How do you keep a baby from getting cold? What are the practical things that you can do? How do you recognise a high risk situation and what can you do about it and how can you plan for it? All these kind of things. The women are usually illiterate, the villagers chooses them because the village sees them as someone you can trust. They come here and there is a list of things for them to do, a list of things they are supposed to learn, a little exam at the end to make it a certificate and then they go back to the village as a midwife.

In effect, 'Dr Dan's' model embraced the physical *and* relational qualities of a good birth by spearheading political and cultural change. Similarly, the Café Cooperative Timor purchased and sold coffee from villagers and with the proceeds provided a

'cream basket' comprising a sterile pack of razor blades, a ground sheet, antiseptic cream, a new sarong and clothes for the baby. At the centre of these enterprises was a determination to develop an as-yet fragile sense of female autonomy by putting women at the forefront of community priorities and in the process address high MMRs and IMRs.

Co**smopolitanism/*health cosmopolitanism***

The case study of birth in East Timor illustrates a new model for the delivery of health care and maternity care in developing economies with limited resources and capacities although the model is relevant to developed regimes as well because Health Cosmopolitanism takes the discourse of human rights ('the dignity and worth of the human person'), posits it as the obligation of the global community and insists on interpretation at the local level. Specifically, all people everywhere need equality of recognition and respect - first, from primary carers (allowing the child (or adult) to develop emotional security, or *self-confidence),* second from legal institutions (ensuring *self-respect*) and third, from workplaces and other institutions that recognise personal achievement (ensuring *self-esteem*) (Van Hooft 2010; Honneth 2003).

Conclusion

Translated into the field of childbirth arrangements (and the general field of healthcare), health cosmopolitanism defines a philosophy of care that is person-centred (not professional or institution-centred), ensures equal access to quality care (based not on ability to pay or other obstacles such as geographical distance) and choice of carer and modality (Western, traditional or hybrid). Cosmopolitanism holds the global community (not just the nation-state) responsible for the health care of all. It underlines the argument here for the reinstatement of adequately trained TBAs (see above) because the local TBA could offer safety, equity and universality interpreted at the local level to ensure every woman had a known carer, plus choice of location, modality and provider.

Only two programs – those undertaken by the Café Cooperative and Dr Dan's clinic – had achieved *health cosmopolitanism* (although both funded locally). For Dr Dan's program, universality and safety had been interpreted at the local level: women chose their own TBA who was then trained to identity pathologies and manage emergency

procedures. This achieved the wider political aims of bringing women into the public sphere and fostering self-respect and self-confidence. Local women could also avoid the stinging rebukes of the Indonesian midwives and the indignities of facility-based birth. For the Café Cooperative Timor, the sterile kit targeted safety and universality objectives, and enabled women to remain at home with local carers who were known and in easy proximity. Having a baby in the village meant social autonomy for women and provision of resources in sparsely serviced economies.

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References

Appiah K.A. *Cosmopolitanism: Ethics in a World of Strangers*. New York: Norton 2006: p.xiii.

Asian-Pacific Resource and Research Centre for Women (ARROW). *Redefining Rights: Thematic Studies Series 4: Maternal Mortality and Morbidity in Asia*. Kuala Lumpur: ARROW. 2011:33.

Bajpai S. Advice and restrictions during pregnancy. In S. Mira S. ed. *Her healing heritage: Local beliefs and practices concerning the health of women and children: A multi-state study in India.* Chapter 4, Bombay: Chetna Publication. 1996a.

Bhardwaj N. Kulkade J.A. Patil S. and Bjardwaj S. Randomised controlled trial on modified squatting position of delivery. *Indian Journal of Maternal and Child Health.* 1995; 6(2), pp. 33-9.

School of Public Health, University Research Co. LLC. 2010.

Byrne A. and Morgan A. How the integration of traditional birth attendants with formal health systems can increase skilled birth attendance. *International Journal of Gynecology and Obstetrics.* doi:10.1016/j.ijgo.2011.06.019.

.

Graham W, Bell J.S. and Bullough H.W. Can Skilled Attendance at Delivery Reduce Maternal Mortality in Developing Countries? *Safe Motherhood Strategies: A Recent Review of the Evidence.* In De Brouwere and Van Lerberghe eds, Antwerp: ITGP Press. 2001

Honneth A. Redistribution as Recognition; A Response to Nancy Fraser. In *Redistribution or Recognition? A Political-Philosophical Exchange*, eds. Fraser N. and Honneth A. trans. Golb J. Ingram J. and Wilke C. 2003:134 110-197. London: Verso.

Held D. *Cosmopolitanism: Ideals and Realities.* Cambridge: Polity Press. 2010.

Kruske S. and Barclay L. Effect of shifting policies on traditional birth attendant training. _*Journal of Midwifery and Women's Health*. Jul-Aug; 49(4):306-11. 2004.

Mathews Z. Birth Rights and rituals in rural south India: Care seeking in the intrapartum period. *Journal of Bio-social Science*, 2005; 37(4), pp. 385-411.

Sibley L. Sipe T. Armelagos G. Barrett E. Finlay V. Kanta A. *Traditional birth attendant training effectiveness: A meta-analysis*. Washington (DC): AEF/SARA Project, 2002.

Sibley L., Sipe T.A, and Koblinksy M. Does traditional birth attendant training improve referral of women with obstetric complications: a review of the evidence. *Social Science and Medicine* 2004:59, pp. 1767.

Starrs A. *The Safe Motherhood Action Agenda: Priorities for the Next Decade.* New York. Inter-agency Group for Safe Motherhood and Family Care International. 1988.

The Childbirth Safety Checklist, Asian Scientist 4/8/2011:1: (www.asianscientist.com/health) Accessed 30th March 2012.

United Nations Population Fund (UNFPA). Annual Report 2003. New York. UNFPA 2003.

Van den Brock N. Ntonya C. Mhango E. and White S. (1999) Diagnosing anaemia in pregnancy in rural clinics – is the new WHO colour Scale useful? *Bulletin of the World Health Organisation*. 1977:77, pp. 15-21.

Van Hooft S. Cosmpolitanism, Identity and Recognition. In ed. van Hooft S. and Vandekerchhove W. *Questioning Cosmopolitanism* Dordrecht: Springer. 2010.

Walraven G. and Weeks A. (1999), The role of (traditional) birth attendants with midwifery skills in the reduction of maternal mortality. *Tropical Medicine and International Health*. 1999: 4(8) pp. 527-529.

World Health Organisation *The World Health Report 1997 Conquering Suffering Enriching Humanity*. WHO Geneva. 1997.

WHO/UNICEF/UNFPA statement. Geneva: World Health Organization. 1992.

World Health Organization. *Making pregnancy safe: the critical role of the skilled attendant*. A joint statement by WHO, ICM and FIGO. Geneva. 2004

World Health Organization. *Care in normal birth: A practical guide, report of a technical working group.* Geneva. Maternal and Newborn Health/Safe Motherhood Division of Reproductive Health: World Health Organisation. 1966.
WHO/UNFPA/UNICEF/World Bank. *Reduction of maternal mortality: a joint statement.* Geneva: WHO. 1999.
WHO/UNFPA/UNICEF/World Bank. *Trends in Maternal Mortality: 1990 to 2008*. Geneva:WHO. 2010.
World Bank. *Timor-Leste Survey of Living Standards.* World Bank 2007.