

ISSN 1473-1875

ISSN 1744-5019

Health Care for Women International



VOLUME 24 NUMBER 1

JANUARY 2006

The Journal of the International Council on Women's Health Issues

Taylor & Francis
healthsciences



CHILDBIRTH CARE-SEEKING BEHAVIOR IN CHIAPAS

Linda M. Hunt, PhD

Department of Anthropology and Julian Samora Research Institute, Michigan State University, East Lansing, Michigan, USA

Namino Melissa Glantz, BA

Department of Anthropology, University of Arizona, Centro de Investigaciones en Salud de Comitán, Comitán, Chiapas, Mexico

David C. Halperin, MD, MPH

Division of Population and Health, El Colegio de la Frontera Sur, San Cristobal de Las Casas, Chiapas, Mexico, Centro de Investigaciones en Salud de Comitán, Comitán, Chiapas, Mexico

This study was designed to better understand how women in a developing region choose between the multiple options available to them for birthing. We conducted focused, open-ended ethnographic interviews with 38 non-indigenous, economically marginal women in Chiapas, Mexico. We found that although medical services for birthing were readily available to them, these women most often chose traditional birth attendants (TBAs) for assistance with their births. They expressed a clear preference for TBAs in the case of a normal birth, but viewed medical services as useful for diagnosing and managing problem deliveries and for tubal ligations. They favored TBAs

Received 5 March 2000; accepted 23 April 2001.

We thank the staff at the Centro de Investigaciones en Salud de Comitán, Comitán, Chiapas, Mexico, in particular, Imelda Martínez, Patricia de León, Martha Barrios, and Gisela Sejenovich for conducting the interviews, and Rolando Tinoco for theoretical and technical support. Many thanks as well to Austreberta Nazar at El Colegio de la Frontera Sur, San Cristobal, Chiapas, Mexico, for her support. This study was funded by the Ford Foundation, Reproductive Health and Population Program, Mexico and Central America Office.

It is with much sorrow that we report that our coauthor, David Halperin, died on June 9, 2000. He is dearly missed. It is in his honor that we proceed with publication of this article, which is the product of a long-time collaboration between the coauthors.

Address correspondence to Dr. Linda M. Hunt, Associate Professor, Department of Anthropology and Julian Samora Research Institute, 354 Baker Hall, Michigan State University, East Lansing, MI 48824, USA. E-mail: huntli@msu.edu

because they valued being able to choose birthing locations and birthing positions and to have relatives present during the birth, all features they must give up for medically attended births in this region.

In rural Mexico, as in many developing regions of the world, pregnant women encounter multiple options for care during childbirth. Much time and money is currently being spent on public health efforts aimed at promoting the use of medical services in place of traditional birthing practices in such regions. (See, for example, Panamerican Health Organization & World Health Organization, 1996; Tsui, Wasserheit, & Haaga, 1997.) Despite their good intentions, these programs often fail to result in a significant increase in the use of medical services. (See, for example, Secretaría de Salud, 1992.) Our research on the birthing practices of a group of women in a developing region of Southern Mexico leads us to question the assumption that improving access to and knowledge about medical birthing services will necessarily increase their use. For a normal birth, these women clearly preferred using TBAs over medically attended births, even when the latter was readily available. In this article we consider some of the reasons and values underlying these preferences and suggest some ways that medically assisted birthing services in this region may fail to meet these women's needs.

Factors affecting which type of birth attendant women employ have been the subject of much discussion in public health and medical anthropology circles. (See, for example, Marckwardt & Ochoa, 1993; Marshall, 1997.) Studies have found several factors to be correlated with use of medical birthing. These include mother's level of education, availability of medical services, type of the community in which the mother lives, and the presence of programs promoting medically assisted births. (See, for example, Marshall, 1997; Sánchez-Pérez, Ochoa-Díaz López, Navarro i Giné & Martín-Mateo, 1998.) However, correlations of this sort may tell us more about the level of socioeconomic development of an area than about the reasons behind birthing choices. There have been several studies of women's perceptions of different types of birthing options in industrialized countries, but we know little about the basis on which women in the developing regions of the world evaluate and choose between traditional and medical birthing options. (For a notable exceptions see Elu, 1995; Jordan, 1993.) A better understanding of what women in such countries value about TBAs may facilitate the designing of prenatal and birthing programs that are more responsive to their needs and therefore are better able to provide effective services.

To more fully understand how birthing care decisions are made by women in a developing region, we interviewed women in the Border Region of the Mexican state of Chiapas regarding their use of the various types of birthing assistance available to them. Combining demographic data and open-ended interviews, we found that these women primarily choose TBAs even when physicians' services are readily available. In their interviews they indicated

that their birthing preferences are based on their assessment of the quality of the birthing experience they associate with each option, as well as their perception of the need for medical care for a particular birth. In this article we consider the perspectives of this group of women regarding what constitutes "good" birthing care. Our discussion focuses on reasons that TBAs are preferred over medically attended births. We explore aspects of TBA practice that women value over hospital-based practices and consider the circumstances under which doctors' services are sought.

This project was jointly conducted by the Centro de Investigaciones en Salud de Comitan (CISC), a small research nongovernmental organization (NGO) in Comitan, Chiapas, Mexico, close the Mexico–Guatemala border, and by El Colegio de la Frontera Sur (ECOSUR), a Mexican federal research establishment in San Cristobal de Las Casas, Chiapas.

LITERATURE REVIEW

Public Health Efforts to Improve Birthing Outcomes

Worldwide, nearly 600,000 women die every year due to pregnancy-related causes, 99% of them in developing countries (Tsui et al., 1997). Strategies to reduce maternal mortality have prioritized increasing the accessibility of health facilities and training medical personnel in management of obstetric complications. Recently, in recognition of the fact that women often prefer TBAs, programs have been undertaken to train TBAs in basic obstetric practices, especially in recognizing complications and taking measures to enhance their ability to refer patients to hospital obstetric units when complications occur. The World Health Organization, the Panamerican Health Organization (PHO & WHO, 1996), the National Council for International Health (Koblinsky, Timyan, & Gay, 1993), and the National Research Council (Tsui et al., 1997), for example, each make recommendations of this sort. In Mexico, such strategies have been recommended by the Safe Motherhood movement (*Maternidad sin Riesgos*; Romero, 1998), the national health system (Secretaría de Salud, 1995), and independent researchers (Castañeda et al., 1996). Several such initiatives have already been implemented at the program and policy level throughout the country.

Most women worldwide give birth outside of medical facilities, attended by TBAs. Recent estimations by the WHO indicate that in developing countries more than 60% of all births are attended by TBAs, family members, or occur with no assistance, and only 37% occur in medical facilities (WHO, 1993). In Mexico, a nationalized health care system has made physician-attended births accessible to almost all women in the country. The most recent available statistics indicate a national rate in Mexico in 1987 of medically attended births of about 74% (The Alan Guttmacher Institute, 1995). This is a notably higher rate than the global proportion cited above and may reflect the greater likelihood of medically attended births to be recorded as

compared with TBA attended births. But still it seems that at least one in four women in Mexico is cared for by someone other than a medical provider during childbirth. Although reliable statistics are not always available for rural areas, there is some indication that the percentage of TBA attended deliveries also may be quite high in rural Mexico. According to the National Survey of Fertility and Health in Mexico conducted in 1987, TBAs attend at least 44.5% of the births in communities with fewer than 2500 inhabitants, and 23.7% in communities of up to 20,000 (Encuesta Nacional de Fecundidad y Salud México, as cited in Castañeda et al., 1996). Data from the Regional Reproductive Health Survey conducted in 1994 indicates that in nine municipalities in the Border Region of Chiapas, TBAs attend 61.3% of the births in communities with fewer than 2,500 inhabitants, 48.6% of those in towns of 2,500 to 9,999, and 43.8% of those occurring in cities of 10,000 or more (ECOSUR, 1994).

Some studies in Mexico have found that the greater frequency of TBA use as compared with use of medical services for birthing can be explained by the higher costs for medical services and greater distance to health care facilities, as compared with TBA care (Castañeda et al., 1996; Center for Health Research, Consultation and Education, 1991). Other research, however, has found that even when women are close to health services, have the resources to obtain medical care, and/or are entitled to free or low-cost services, they still often do not choose to utilize the medical services (Elu, 1995). Thus, it seems clear that access and cost are insufficient explanations for why the women of Mexico prefer TBAs to medically attended births.

Contrasting TBA and Medical Birthing Care

Various authors studying birthing preferences have identified several significant differences between the care provided by TBAs versus that provided by medical personnel, which may affect women's preferences for birthing options. These include the orientation of the caregiver toward birth and intervention in the birthing process, the location of childbirth, and the caregiver's willingness to share power and authority with the woman.

Sakala (1993), for example, contrasts the orientation of medical personnel to that of TBAs: Medical personnel tend to be oriented toward pathology and dysfunction, to emphasize the dangers of birth, and to believe that birth should only occur in hospitals. Their general orientation is that women are likely to lack resources to safely and effectively birth their infants. By contrast, midwives focus on birth as a "normal" and "natural" process, and they emphasize the ability of the great majority of women to give birth vaginally and without excessive interventions. The midwives believe that the birth attendant can do many things to keep the course of labor and birth within a normal range. Their general orientation is that women are likely to be able to safely and effectively birth their infants in supportive low-technology environments (p. 1243). Sakala (1993) argues that this different orientation

has concrete repercussions in patient management; for example, physicians tend toward action and intervention, while the TBA's role is oriented toward watchfulness and patience.

The location of the birth is also an important consideration that will vary by type of provider. Medical personnel generally perform their services in health care institutions, while the most common scenario when the attendant is a TBA is for the birth to occur in the woman's own home. Jackson and Bailes (1995) and Cordero Fiedler (1996) contend that the location of the birth is an important determinant of where power and authority are situated during the birth. The physical location of birth reflects and creates social territories, which affect the biological processes of labor and birth and the woman's experience of those processes. They argue, for example, that delivering at home reflects birth as natural and healthy and reinforces the mother's control and authority over her body and the situation. Hospital birth emphasizes technology and places control in the doctor's hands.

Other authors have further elaborated the concept that the care provided by TBAs is an important source of power for women. Powell Kennedy (1995) found that, with a midwife, the laboring woman determines and directs her care. The perspective that women have the right to determine their care communicates a message of shared responsibility—and therefore shared power—between the woman and her TBA (see also Jordan, 1993).

In addition to orientation, location, and authority, Oakley (1977) highlights additional aspects of childbearing that may be important factors influencing birthing preferences. These include variation in cultural definitions of pregnancy and delivery, attitudes toward diverse childbirth positions, and the involvement of the support network members. Other research has indicated that women may prefer being cared for by a woman (Elu, 1995), that they may anticipate and fear painful and disrespectful treatment in the hands of medical personnel, and that they may perceive a similarity of cultural and social status with TBAs (Tsui et al., 1997).

It is noteworthy that nearly all previous research on birthing preferences has focused on middle-class women from industrialized nations. To date, few studies have systematically examined the basis of women's birthing choices in developing countries. For example, the compilation of works presented at the Mexican National Safe Motherhood Conference includes statistical analysis of factors associated with maternal mortality, as well as data on access, utilization, and quality of childbirth care programs. It does not, however, include any information on women's preferences for different care providers (Elu & Langer, 1998). While Tsui and colleagues (1997) do discuss factors related to seeking medical care for childbirth, using examples from Indonesia and Bolivia, they do not examine reasons TBAs are the preferred choice (Tsui et al., 1997). Castañeda and colleagues (1996) touch on women's preferences in their analysis of the concepts, resources, and process of care provided by TBAs in a rural area of Morelos in central Mexico, but this is not a central topic of their discussion.

To understand what factors might affect preference for TBAs in a developing region where medical birthing services are widely available, we conducted in-depth, open-ended interviews with women in rural Mexico in the Border Region of Chiapas. We discussed their childbirth experiences and the bases of their decisions regarding birthing options. In this article we present some factors affecting their choice of caregivers as well as the values the women perceived in the different childbirth care options available to them.

SETTING

This study was conducted in Chiapas, the southernmost state of Mexico, contiguous with Guatemala. It is an area of high altitude valleys and tropical jungles, which has been the site of well-publicized political and military conflict in recent years. The women we interviewed were from areas that were not directly involved in these conflicts. It is a predominantly rural area, where agriculture is the principle occupation, and corn and beans are the primary crops. Economically and in terms of its general health infrastructure, it is one of the poorest regions in Mexico (Halperin Frisch & De León, 1996; Hunt, 1996; Salvatierra, Nazar, Halperin, & Farías, 1995). Forty-four percent of the population of Chiapas is under 15 years old (Salvatierra et al., 1995). The life expectancy at birth is the lowest in Mexico, and maternal mortality rates are highest (Elu & Langer, 1998; Instituto Nacional de Estadística, Geografía e Informática [INEGI], 1997).

Medical Childbirth Care Options in the Border Region

We interviewed women from 22 communities in the Border Region, which ranged from small villages of fewer than 300 people to the local city center, which is home to more than 62,000. A variety of medical childbirth options are available to these women in both public and private institutional settings. The state-sponsored maternity services are offered in both primary care and second-level facilities.

Many of the smaller villages have rudimentary primary care facilities, *casas de salud*, staffed by nurses or *promotores* (health promoters). *Promotores* are men and women from the village who have received basic training in first aid, including taking blood pressure and pulse, giving shots, identifying patients in need of immediate referral, and recognizing common respiratory and digestive illnesses.

While prenatal care is available in these clinics, they do not offer childbirth services, but instead refer patients to larger facilities. Some of the larger villages have *centros de salud* or *unidades médicas rurales*, staffed by newly trained physicians who are fulfilling the social service requirements of their medical education. In addition to prenatal care, services for normal childbirth delivery are also available in these facilities; however, they are not equipped

to perform cesarean deliveries and must refer such births to the second-level hospital. The health centers charge around 120 pesos for a normal delivery, which is between four and five times the daily minimum wage. (At the time of the study there were approximately 10 Mexican pesos to the U.S. dollar, making 120 pesos approximately U.S. \$12.00, and the monthly minimum wage was 850 pesos, or 28.33 pesos per day.)

There are two second-level health care facilities located in the urban centers of the region. These hospitals offer complete prenatal and childbirth services, including cesareans, and are staffed by obstetricians/gynecologists. Patients at the hospital are charged on a sliding scale based on place of residence and a brief socioeconomic assessment. The prices for a normal delivery (including 24 hours hospitalization) generally range from 166 to 300 pesos. For a cesarean, patients are usually charged about 300 pesos. When the hospital is short of supplies, the cost to patients may be even higher, as they may be required to buy their own oxytocin, intravenous solution, catheters, antibiotics, and analgesics, adding up to 250 pesos to the cost.

In addition to state-sponsored medical facilities, private practitioners also offer childbirth care in the majority of the communities of residence of our study participants. For example, in the local city center there are at least four private maternity hospitals (*sanatorios*), which are staffed by obstetricians/gynecologists and offer complete childbirth services. A normal delivery in these facilities costs around 3,500 pesos, and a cesarean about 4,500 pesos. In at least two rural communities in which we interviewed, there also are general physicians who may monitor deliveries, although their space, equipment, and specific ob-gyn knowledge are limited. At any sign of complications, these physicians will refer women to a larger facility.

Other Childbirth Care Options in the Border Region

Another important option for childbirth care in the region is TBAs. TBAs or *parteras* (midwives) are lay women who attend deliveries in the laboring women's homes. As Cadenas Gordillo and Pons Bonals (1992) have noted,

If we wanted to define *parteras*, we would have to start by saying that they are women who have had children (often alone, and that is how their midwifery experience began), generally from the community, where they assist other women during the last months of pregnancy, childbirth, and the first few weeks after it. (p. 15. Translated from the original Spanish by NMG.)

In nearly every community in our study, there is at least one TBA providing birthing service to the general public. Some have attended institutional training programs, but many have learned their practice through experience with their own babies and accompanying their mothers or other relatives assisting deliveries. For the most part, TBAs in this region do prenatal checkups for free, or ask only small compensation, such as a kilogram of sugar,

a few eggs, or coffee. When it comes time for the delivery, TBAs charge their patients differently, depending on the community. Some TBAs do not charge at all, saying that they offer their services for the good of the community. Others establish a set price per delivery, which varies from region to region. In the smaller communities they may charge 50 to 100 pesos; in the urban centers, as much as 800 pesos (Miranda, Head of the Midwife Program, ECOSUR and the Grupo de Mujeres of San Cristóbal, personal communication, 1998).

In this area, the use of TBAs and medical services are not mutually exclusive. The same woman may be cared for by a doctor during one delivery and a TBA during a subsequent delivery, or vice versa. In addition, TBAs in this region often refer complicated obstetrical problems to physicians even after labor has started. However, we found no case of the reverse, of a physician referring a woman to a TBA.

Some women in the region rely on friends or relatives for birthing assistance, using neither TBAs nor medical services. Often these assistants are the mothers or mothers-in-law of the birthing woman, who may have considerable experience with childbirth but only provide help to their own family members. A few women give birth assisted only by their husbands, and at times completely alone. In the following analysis, we group all nonmedical births into one category to contrast them with medically assisted births.

METHODS

The data presented here were collected as part of a larger study of reproductive concepts and behaviors of a convenience sample of mestizo women in the Border Region of Chiapas. (Mestizos are people of mixed European and indigenous ancestry.) These women were from 22 different communities, including 3 urban centers of more than 10,000 people and 19 rural villages of fewer than 10,000 people. (For more details on this study see Nazar Beutelspacher, Molina, Salvatierra, Zapata, & Halperin, 1999).

The interviews were conducted by four mestizo women (two nurses, a doctor, and a psychologist). All were between 25 and 35 years old and had prior experience in health care and health research in the region. The interviewers also received training in open-ended interview techniques, specifically for this study. To find study participants, interviewers knocked on doors and entered shops, explaining the study and seeking women who had been married or in a long-term couple relationship, and had at least one child. The informants were chosen based on their willingness to participate, accessibility, and ability to express themselves in Spanish. (Many of the women in this area speak an indigenous language as their first language and are not fluent in Spanish.) Interviews took place in informants' homes and were tape-recorded and transcribed. The interviews lasted from one to four hours and resulted in more than 4,000 pages of transcribed text. Because this was a mostly illiterate population, informed consent was obtained verbally.

Interviews followed a focused, open-ended ethnographic interview guide, addressing a wide range of topics related to reproductive and sexual health, including concepts and practices in childbirth. A questionnaire was also included to collect basic demographic and general health status information. In this article we focus on the women's discussion of their birthing experiences. In addition to a general question about these experiences, we also asked specific questions regarding each birth: What did you do? How did it go? Where were you? and Was anyone else with you?

Responses to the questionnaires were coded into a database and analyzed using SPSS (Norusis, 1993), and descriptive statistics were generated to characterize sociodemographic and care-seeking patterns. The qualitative data were analyzed in two phases, following Miles and Huberman (1994). An initial descriptive phase consisted primarily of data reduction and data display tasks. This phase entailed reviewing the transcript of each interview, marking categories and topics of interest, and producing a brief summary of each case. This initial analysis resulted in a typology of 12 types of statements the 38 informants had made regarding childbirth. For example, these categories included statements about the quality of birthing care, the cost of the services, techniques used by the care provider, preferences for different types of birthing care, and support available for the woman during the birth and postpartum. We then created an Microsoft EXCEL database (Copyright© 1985–1997, Microsoft Corporation), coding these categories as well as demographic and descriptive data for each of the 179 births discussed by our subjects.

This was followed by an interpretive analysis phase in which we searched for patterns among the descriptive data through systematic comparison of the variables and examined emerging hypotheses within and between cases. We examined the relationships between these categories, other key variables such as age and education, and the type of birthing care chosen. This included the identification of possible patterns, the reduction of key variables into tables, and the analysis of these tables to examine trends. (For a more detailed description of our methodology, see Glantz, Halperin, and Hunt, 1998.) All phases of data coding and classification were cross-checked for inter-rater reliability by having at least two members of the research team code and compare sample cases.

FINDINGS

Characteristics of Women Using TBA and Medical Services

We collected information on the birthing experiences of 38 women. Selected demographic characteristics of these women are summarized in Table 1. In this article, in addition to presenting qualitative data, we also note frequencies, percentages, and associations for various variables. We do this to show the distribution of various characteristics, behaviors, and concepts

Table 1. Demographic characteristics of 38 women by type of birth attendant they had used for majority of births

Characteristics	TBA or other for majority of births (N = 28)		Medical care for majority of births (N = 10)		Total (N = 38)	
	N	(%)	N	(%)	N	(%)
Age						
<29 years	6	(21%)	9	(90%)	15	(39%)
30+ years	22	(79%)	1	(10%)	23	(61%)
$X^2 = 14.12, d.f. = 1, N = 38, P < 0.001$						
Education*						
0-2	8	(29%)	0	(0%)	8	(21%)
3-5	9	(32%)	2	(20%)	11	(29%)
6-8	8	(29%)	2	(20%)	10	(26%)
9+	2	(7%)	6	(60%)	8	(21%)
Missing data	1	(4%)	0	(0%)	1	(3%)
$X^2 = 4.44, d.f. = 1, N = 37, P < 1.00$						
*Dichotomized for chi-square calculation as <6 or >6 years of school.						
Living children						
1-4	16	(57%)	9	(90%)	25	(66%)
5 or more	12	(43%)	1	(10%)	13	(34%)
$X^2 = 3.44, d.f. = 1, N = 38, P < 1.00$						

Health insurance

Insured (IMSS or ISSSTE)

Not insured

$X^2 = 3.44, d.f. = 1, N = 38, P < 1.00$

Community Size

Rural (<10,000)

Urban (>10,000)

$X^2 = 0.1, d.f. = 1, N = 38, P = 1.00$

Medical birth services in community*

None

Basic

Advanced

$X^2 = 1.0, d.f. = 1, N = 38, P < 1.0$

*Dichotomized for chi-square calculation as none or basic/advanced.

Time to medical services

< 30 minutes

> 30 minutes

Missing data

$X^2 = 1.6, d.f. = 1, N = 34, P < 1.0$

Prenatal care used

Only TBA

Any medical

Missing data

$x^2 = 2.6, d.f. = 1, N = 36, P < 1.0$

8 (29%)
20 (71%)

1 (10%)
9 (90%)

9 (24%)
29 (76%)

18 (64%)
10 (36%)

7 (70%)
3 (30%)

25 (66%)
13 (34%)

7 (25%)
19 (68%)
2 (7%)

1 (10%)
6 (60%)
3 (30%)

8 (21%)
25 (66%)
5 (13%)

21 (75%)
4 (14%)
3 (11%)

9 (90%)
0 (0%)
1 (10%)

30 (79%)
4 (10%)
4 (10%)

13 (36%)
13 (36%)
2 (7%)

2 (20%)
8 (80%)
0 (0%)

15 (40%)
21 (55%)
2 (5%)

within our study group. This should not be taken to imply an expected prevalence or tendency in a larger population, because this study is not designed to produce generalizable or predictive findings. Instead, we include these numbers to give a sense of the characteristics and range of variation of the women we interviewed.

The women in this study reported using TBAs much more frequently than using medical services for assistance with their births. The data regarding the type of birthing option used for 83% (149/179) of their births appear in Table 2. Seventy-four percent (28/38) had the majority of their births attended by TBAs, by relatives, or alone, while only 26% (10/38) used medical services for most of their births. (We differentiate TBAs from relatives, defining those women who have cared for women other than their immediate family members as TBAs.)

The percentages and observed frequencies of eight demographic variables are shown in Table 1, contrasting those who had used mostly TBAs and those who had used mostly medical services for birthing. Using chi-square analyses, we found age was the only variable with a significant difference between the two groups ($\chi^2 = 14.12$, $d.f. = 1$, $N = 38$, $P < 0.001$). This finding may reflect the fact that younger women are more likely than older women to have given birth after 1983. In that year the Mexican National Health Care System underwent massive expansion (Hunt, 1996), which included substantial increases in the availability of medical birthing services throughout the country. Younger women therefore have had much more opportunity to use medical services for birthing than did their older counterparts.

It is noteworthy that variables such as availability of medical birthing services in the community ($\chi^2 = 0.7$, $d.f. = 1$, $N = 38$, $P = 1.0$), access to such services ($\chi^2 = 1.6$, $d.f. = 1$, $N = 34$, $P < 1.0$), and having health insurance ($\chi^2 = 1.4$, $d.f. = 1$, $N = 38$, $P < 1.0$) were not significantly associated with attendant choice. Thus, cost and access issues do not seem to explain the preference for TBAs among the women in this study. To better understand the basis for their birthing choices, we turn now to the open-ended interviews.

Table 2. Type of birth attendant reported by 38 women for 149 births

Birth attendant	N	Percent
TBA	108	(73)
Doctors	31	(21)
Relatives	5	(3)
Alone	5	(3)
Total	149	(100)

Women's Preference for TBA over Medically Attended Births

Cost

The women's perception of the cost of TBA versus medical care for childbirth is complex and includes consideration of several factors in addition to simply the cost of the service itself. Informants' assessment of the cost of hospital/clinic birthing services ranged from "nothing" to "expensive." Even when they were not charged for the birth itself, subjects said they still often had to assume the cost of transportation and prescribed medicine as well as food and lodging for accompanying family, which could result in considerable added expense. On the other hand, although TBA charges may sometimes exceed those of medical institutions, these additional costs are avoided because women attended by TBAs usually birth at home. Still, some women perceived using medical services to be less costly than using TBAs. For example, one study participant commented, "These days, some people go to doctors because they don't charge, while *parteras* do."

Interestingly, many women who described the TBAs' services as "expensive" still had opted to deliver with TBAs. Some even sent for TBAs who were widely known to charge more than doctors and who came from distances surpassing the distance from their home to a doctor. It is also noteworthy that of the nine participants who had health insurance, just two had opted for an insurance-covered hospital delivery; in both cases this was for only one birth (out of four in one case and nine in the other). Thus, cost considerations do not seem to be a central factor in the preference for TBAs over medical births for the women in this study.

Positions and Techniques for Childbirth

Comments in the interviews indicate that some women may have been reluctant to seek physicians' care in part due to physicians' insistence that women assume a supine position during labor. Many prefer to give birth in a squatting position, which TBAs not only permit but often promote. As one woman put it, "I have my babies squatting down, because lying down face up, well, I just can't."

In addition, participants indicated that they view TBAs as possessing a much wider range of tools, techniques, and "tricks of the trade" to use during labor than do physicians. One woman talked about giving birth with her midwife: "The *partera* knew secrets. She tied a shawl around my waist and gave me a little bottle of oil to swallow. I took it and the placenta came out." Another described a difficult birth: "The *partera* opened me up and checked. She said that the baby was stuck in a bag. She popped the bag that wouldn't let the baby through, and that's how she got the baby out."

Women also said that TBAs knew a variety of herbal remedies, such as teas and baths, that are helpful during labor:

The day that I was going to give birth, the *partera* sent me to bathe with *naranja agria* [bath water infused with sour orange leaves] . . . as hot as I

could stand. My goodness! She'd make you sweat. But I think that it's good that way because it makes the delivery quick. And she would always give us chamomile tea.

Several women mentioned that the TBAs use injections and prescribe aspirin and other over-the-counter pharmaceuticals as well, and they spoke positively of this combination of herbal and pharmaceutical treatment. For example, one participant noted that the midwife recommended "a little chamomile tea and a Mejoral to warm her, and in just a bit the baby was born." (Mejoral is a popular over-the-counter remedy made of acetaminophen and caffeine.)

A few women noted that doctors do not have the capability of repositioning the baby that TBAs have. TBAs use manual techniques, such as rubbing and massaging the mother's abdomen to maneuver the baby into the right position. This is especially important when the midwife has detected a breech or transverse position. The comments of one woman indicate the value that women may place on these techniques:

The doctor checks with an apparatus to see how the baby is doing inside, but I don't feel that they help in that. . . . Well, I had to be cared for by *parteras* because they help to see if the baby is badly positioned. They help to put it in the normal position with their hands.

Many informants indicated that the TBA offers more complete care for both the mother and the baby after birth as well. The women described how, after receiving the baby, the midwife bathes it, cuts the umbilical cord, and dresses it, as well as bathes the woman and ensures that she has completely recovered from the delivery. One woman explained, "The midwife took care of me until I had recovered. She tended to the baby and left me all cleaned up." Sometimes the TBA will make a follow-up visit. As one woman described, "Afterwards, the midwife tends to the baby, and three days later, she comes to give it a *baño de Temazcal* [vapor bath] and warming remedies, and she always cures the baby in terms of the umbilical cord, its bath."

Participation of Relatives and Birthing Location

Of the births for which location was recorded, all medically attended births occurred in hospitals or clinics, while all others (TBA, relative, or alone) occurred in the woman's own home, in the home of a relative, or, in one case, in the TBA's home. We found no case of a TBA caring for a woman in a clinic, nor of a doctor assisting a woman in her own home.

Women expressed a strong preference for giving birth in their own homes, rather than in medical institutions. Several women criticized hospital services for excluding relatives from being present during labor and delivery. One woman told us, "My husband wanted to be there with me, but they didn't let him in." At the largest hospital in the area, for example, while there is no written regulation prohibiting family members, midwives, or others from accompanying laboring women, staff do not allow companions to be present once the woman has been admitted for childbirth. As one doctor

there explained it, the reasons for this include lack of space, privacy for the laboring woman, the need to maintain a sterile environment without distractions, and the likelihood of interference with the physicians' procedures or of increasing the nervousness of the laboring woman.

In contrast, women said they appreciated that TBAs allow others to participate in the birthing process. This is facilitated by the fact that the woman is usually in her own home. One woman said, "At home, my husband is there with the *partera*, and I feel better because he helps me during the labor pains; he holds me." In her own home, the laboring woman enjoys the care provided by other family members, and her husband and mother often play a critical role in the delivery. Husbands, in-laws, siblings, and parents all participate in a variety of important activities, such as calling the TBA, preparing teas for the woman, and helping to hold the woman while she squats and pushes in the final stage of delivery. In all but one case, the TBA allowed the husband to assist her and witness the birth.

Study participants also indicated that the sex of the attendant was a consideration for them. In the Border Region, the obstetricians–gynecologists in the state-sponsored medical facilities and in private medical offices were all men, at the time of the research. Several subjects commented that they were ashamed to be examined by a male provider. The TBAs who cared for our informants, on the other hand, were all women, making them a more comfortable choice for this type of care. One woman explained to us, "Women always like to deliver with a *partera*, because many say they're embarrassed to be seen by a male doctor."

A major concern about going to the hospital mentioned by several women was that they would be among strangers and may become the subject of gossip by hospital personnel. One woman explained, "There are workers that aren't from around here, so they end up telling the world that so-and-so was here and all that, and that's what embarrasses women and makes them not want to go to the clinic." Birthing with a TBA allows the woman to stay in her own home, helping to ensure privacy and avoiding the risk of gossip.

Opting for Medically Attended Births

Thus far, a variety of reasons that may contribute to women's preference for TBAs have been presented. Still, there are several conditions under which a physician's care in pregnancy and childbirth is sought by these women.

Prenatal Care and Identifying Complications

All of the women we interviewed indicated that they had had prenatal care for at least one of their pregnancies. Thirty-nine percent (15/38) had only seen TBAs for prenatal care, while most (55%, 21/38) had consulted a physician at some point during their pregnancies, even when they might also be seeing a TBA for prenatal care. Interestingly, fully 36% (13/36) of those who delivered most of their babies without medical assistance had consulted physicians for prenatal care (see Table 1). In examining the prenatal and

delivery patient lists of the regional hospital, we found that only about 5% of the women who attended the prenatal clinics during 1997 subsequently delivered in the hospital. This further illustrates that many women may use medical services at some point during their pregnancy, while preferring a nonmedical delivery.

The women's comments further indicate that prenatal medical services are often sought by women who need medical prenatal care only to identify possible complications prior to delivery. If no complications are found, they will choose to have their babies with TBAs. As one study participant explained, "I went to the clinic beforehand so they could see how everything was going. If it seemed necessary, they were going to take me to the clinic for the delivery. But because there wasn't any need, it was born here at home with a *partera*." Another said, "My second delivery wasn't like the first, it was normal and there wasn't any need for them to take me to the hospital."

However, when either the TBA or the doctor identified a complication during pregnancy, such as a very large baby or twins, the women would seek doctors' services for the delivery. One participant remembered, "I was a little scared that the baby wouldn't be born because I was so big, so they took me to the hospital." Another participant who had had her first six children cared for by a TBA, described the conditions that led her to have her last child under a physician's care:

The same woman cared for me in all of my deliveries. It wasn't until this last one that I went to see the doctor because I had lots of problems. About 15 days before the baby was born I began to feel bad. I began to have symptoms, pain and all. The baby would start to come out, but then it would slip back in again. I spent 15 days like that, with a little bleeding and a little pain, too. I suffered a lot to have that baby. It was the last one and the one that scared me the most.

Labor and Birthing Complications

Complications encountered during the course of labor, such as prolonged labor and poor position of the baby, may also lead women to seek a physician attended delivery. In most cases, when women in our study encountered such problems, the TBA referred them to a doctor. In one case, a woman told us, "I was having serious problems, I even lost consciousness, and the *partera* told them to take me to the hospital in the city."

We have data for 126 births on whether there were complications during delivery. Contrasting type of birth attendant in normal versus complicated deliveries, we found a statistically significant difference ($p = .019$). Normal births were most likely to be attended by TBAs; only about 20% (19/96) of the TBA births involved complications. In contrast, fully 43% (13/30) of the medically attended births involved complications. (See Table 3.) This indicates that medical services are likely sought either when complications are anticipated or when they are encountered in the course of delivery.

Table 3. Birth complications by type of birth attendant reported by 38 women for 126 births

Type of birth	TBA or	Medical	Total
	other attendant	attendant	
	N (%)	N (%)	N (%)
Normal birth	77 (80%)	17 (57%)	94 (75%)
Complications in birth	19 (20%)	13 (43%)	32 (25%)
Total	96 (76%)	30 (24%)	126 (100%)

$$x^2 = 6.63, d.f. = 1, N = 126, P < 0.010.$$

Tubal Ligation

In addition to addressing birth complications, another reason we found that some women had opted for a medically attended birth was that they wanted to have a tubal ligation performed. Twenty-one percent (8/38) of those interviewed had had a tubal ligation. They were evenly divided between women who had mostly TBA attended births and those who had mostly medically attended births. It is notable that all of those who had tubal ligations had their last delivery under medical care. While we do not have data on how many had undergone the procedure at the time of the delivery, two women noted that they had their tubal ligation at the time of the delivery. Both indicated that this had been a premeditated decision for them, rather than one made in the hospital following the delivery. One told us that, "The same *partera* helped me with my first three children, but not with the last one because I went to the hospital to get a tubal ligation." The other explained, "Sometimes what they do in the hospital is operate on the women to get the baby out. Then a lot come to the hospital and they operate on them so that they won't have anymore children." Thus, it seems some women may have chosen to deliver with a doctor because they wanted to have a tubal ligation performed following the birth, and "kill two birds with one stone."

DISCUSSION

In this study we have examined how a group of women in the Border Region of Chiapas used and evaluated traditional versus medical birthing services. They showed a pronounced preference for TBAs over medically assisted births, despite having direct knowledge of and open access to medical assistance for birth. Their birthing decisions, therefore, cannot be understood as simply a reflection of the adequacy of the information and opportunity they have for medical services. Clearly, the women we interviewed used TBAs more frequently because they placed greater value on TBA services than on medical services for normal births. They viewed medical services as appropriate primarily for special circumstances such as managing a com-

plicated birth. These women preferred TBAs for a variety of reasons. They believe TBAs possess a much wider range of tools, techniques, and “tricks of the trade” to facilitate a smooth delivery than do physicians. TBAs recommend teas and baths that help the women relax and can hasten the birth. They know and are able to perform manual techniques to help reposition the baby in the case of breech or transverse presentation.

The women appreciated that TBA attended births usually took place in their own homes, and could readily include the participation of family members. They were uncomfortable with the presence of strangers in the hospital situation and preferred that family members be allowed to be present. Furthermore, when assisted by a TBA during labor the woman was free to choose the position she found most comfortable, rather than being required to assume a supine position, as is often the case in hospital deliveries.

These women also felt TBAs offer more complete care for both the mother and the baby after birth than do physicians. This includes bathing the woman and ensuring that she has completely recovered from the delivery, and sometimes even making a follow-up visit to check on both the mother and the child. Furthermore, in this region, TBAs are always female, while the physicians who assist with hospital births are all male, which is also an important consideration for many of these women.

It seems that the women in this study view most births as normal life events that do not require medical intervention but instead can be best managed within the family with the help of local, knowledgeable women. Medical services are not shunned, but are viewed as useful primarily for identifying and attending to *problem* births. They use medical birthing services to screen for problems and to assist in birthing when complications arise.

Many women reported seeking prenatal medical care at least once during each pregnancy to identify possible complications prior to delivery. If none were found, they preferred to have their babies with TBAs. In fact, we found that women who had a prenatal visit with a doctor were no more likely to deliver using medical services than were those who did not ($\chi^2 = 2.6$, $d.f. = 1$, $N = 36$, $P < 1.0$; see Table 1). When either the TBA or the doctor identified a complication during pregnancy, such as a very large baby or twins, the women would readily seek doctors' services for the delivery. But more often than not, no problems were found, so TBAs were used.

Complications encountered during the course of labor, such as prolonged labor and abnormal positioning of the baby, also lead women to use medical services for delivery. Contrasting the type of birth attendants used in normal versus complicated deliveries, we found that normal births were most likely to be attended by TBAs, and that medically attended births more often involved birthing complications ($\chi^2 = 6.63$, $d.f. = 1$, $N = 126$, $P < 0.010$; see Table 3). We also found that some women opted for a medically attended birth when they wanted to have a tubal ligation performed at the time of delivery. It seems clear that these women were making reasoned choices

about the type of birth attendant they preferred in light of their particular needs for a given birth.

CONCLUSION

Because this study included only a relatively small convenience sample, we can draw only tentative conclusions. Before these findings can be generalized to a broader population, they would need to be further examined with a representative sample. However, our findings are consistent with those of other medical anthropologists who have pointed out that women who perceive childbirth to be an everyday affair—rather than a medical risk—may not be interested in using medical services for childbirth (Marckwardt & Ochoa, 1993; Jordan, 1993). Similarly, the women we interviewed expressed a clear preference for TBAs in the case of a normal birth.

This gives us some insight into the basis on which women in a developing region, Chiapas, Mexico, evaluate and choose between available birthing options. The women in this study did not lack knowledge of or access to medical birthing services, but instead they valued various characteristics of the care provided by TBAs over that available in medical birthing. They do not eschew medical births, but instead reserve their use for special situations, like managing problem deliveries and for tubal ligations.

It is important to note that these women view birthing as a natural event—one that is best carried out within the context of home and family. However, the medical birthing services available in the area prioritize the technical and problem-oriented aspects of birth management over the characteristics of the birthing experience itself. It is not surprising, therefore, that women view medical services as useful primarily when the circumstances of the birth are outside the range of normal or when special services are desired. Programs designed to promote medical birthing services in regions such as this may be more effective if they were to take the women's preferences into consideration in their design. Features that would make these programs more appealing to local women might include allowing women to choose birthing locations and positions, the freedom to have family members present, and increasing the availability of female practitioners. Rather than focusing primarily on improving knowledge of and access to medical births, international maternal health programs should strive to incorporate the features of TBAs that women value. If this is accomplished without compromising the quality of medical care, such programs would become better able to provide effective services to local women.

REFERENCES

- The Alan Guttmacher Institute. (1995). *Hopes and realities. Closing the gap between women's aspirations and their reproductive experiences*. New York: The Alan Guttmacher Institute.

- Cadenas Gordillo, B., & Pons Bonals, L. (1992). Las Parteras: Influencia de su saber en las relaciones de poder al interior de la comunidad indí gena. Unpublished manuscript. Chiapas, Mexico: San Cristóbal de Las Casas.
- Castañeda, X., García Barrios, C., Romero Guerrero, X., Nuñez-Urquiza, R. M., Gonzalez Hernández, D., & Langer Glass, A. (1996). Traditional birth attendants in Mexico: Advantages and inadequacies of care for normal deliveries. *Soc. Sci. Med.*, 43(2), 199–207.
- Center for Health Research, Consultation and Education (CIAES) MotherCare Project. (1991). *Qualitative research on knowledge, attitudes, and practices related to women's reproductive health* (Working Paper No. 9). Cochabamba, Bolivia: CIAES MotherCare Project.
- El Colegio de la Frontera Sur (ECOSUR). (1994). Encuesta regional de salud reproductiva. Unpublished survey. Chiapas, Mexico: San Cristóbal de Las Casas.
- Cordero Fiedler, D. (1996). Authoritative knowledge and birth territories in contemporary Japan. *Medical Anthropology Quarterly*, 10(2), 195–212.
- Elu, M. (1995). Mexico: Maternal deaths, fertility patterns, and social cost—an anthropological study (Summary of the final report submitted to the Safe Motherhood Research Programme, WHO, Geneva, 1991). *Wld. Health Statist. Quart.*, 48, 47–49.
- Elu, M., & Langer, A. (Eds.). (1998). *Maternidad sin riesgos*. Mexico City: Comité Promotor por una Maternidad sin Riesgos.
- Glantz, N., Halperin, D., & Hunt, L. (1998). Studying domestic violence in Chiapas, Mexico. *Qualitative Health Research*, 8(3), 377–392.
- Halperin Frisch, D. C., & De León Montenegro, H. (Eds.). (1996). *Salud en la Frontera México-Guatemala, Guatemala-México*. San Cristóbal de Las Casas, Chiapas, Mexico: El Colegio de la Frontera Sur.
- Hunt, L. M. (1996). Inequalities in the Mexican national health care system: Problems in managing cancer in Southern Mexico. In J. Subedi & E. Gallagher (Eds.), *Society, health, and disease: Transcultural perspectives* (pp. 130–147). Upper Saddle River, NJ: Prentice-Hall.
- Instituto Nacional de Estadística, Geografía e Informática (INEGI). (1997). *Mujeres y hombres en México*. Aguascalientes, Mexico: Author.
- Jackson, M. E., & Bailes, A. J. (1995). Home birth with certified nurse-midwife attendants in the United States: An overview. *Journal of Nurse-Midwifery*, 40(6), 493–502.
- Jordan, B. (1993). *Birth in four cultures: A cross-cultural investigation of childbirth in Yucatan, Holland, Sweden and the United States* (4th ed.). Prospect Heights, IL: Waveland Press.
- Koblinsky, M., Timyan, J., & Gay, J. (Eds.). (1993). *The health of women: A global perspective*. Boulder, CO: Westview Press.
- Marckwardt, A., & Ochoa, L. (1993). *Population and health data for Latin America*. Columbia, MD: Demographic and Health Surveys Macro International Inc., Pan American Health Organization, Bureau for Latin America and the Caribbean U.S. Agency for International Development.
- Marshall, A. (Ed.). (1997). *The state of world population 1997. The right to choose: Reproductive rights and reproductive health*. New York: United Nations Population Fund.
- Miles, M., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded source book* (2nd ed.). Thousand Oaks, CA: Sage Publications.
- Nazar Beutelspacher, A., Molina, R. D., Salvatierra, I. B., Zapata, M. E., & Halperin, D. (1999). Efecto de la desigualdad socioeconómica de las mujeres sobre la atención prenatal en la Región Fronteriza de Chiapas, México. In Esperanza Tuñón (Coordinadora), *Género y Salud en el Sureste de México*, 2 (pp. 13–30). Mexico City: ECOSUR, UNFPA, COESPO.

- Norusis, M. J. (1993). *SPSS for Windows: Base system user's guide*, Release 6.0. Chicago: SPSS Inc.
- Oakley, A. (1977). Cross-cultural practices. In T. Chard & M. Richards (Eds.), *Benefits and hazards of the new obstetrics* (pp. 18–33). London: Heinemann.
- Panamerican Health Organization & World Health Organization. (1996). *Evaluación del plan de acción regional para la reducción de la mortalidad materna en las Américas 1990–1994*. Washington, DC: Programa de Salud de la Familia y Población, División de Promoción y Protección de la Salud.
- Powell Kennedy, H. (1995). The essence of nurse-midwifery care: The woman's story. *Journal of Nurse-Midwifery*, 40(5), 410–417.
- Romero, L. (1998). Experiencias con parteras empíricas. In M. Elu & A. Langer (Eds.). *Maternidad sin riesgos en México* (pp. 161–166). Mexico City: MacArthur Foundation, Family Care International, UNICEF.
- Sakala, C. (1993). Midwifery care and out-of-hospital birth settings: How do they reduce unnecessary cesarean section births? *Soc. Sci. Med.*, 37(10), 1233–1250.
- Salvatierra, B., Nazar, A., Halperin, D., & Farías, P. (1995). *Perfil epidemiológico y grados de marginación del Estado de Chiapas*. San Cristóbal de Las Casas, Chiapas, Mexico: El Colegio de la Frontera Sur.
- Sánchez-Pérez, H. J., Ochoa-Díaz López, H., Navarro i Giné, A., & Martín-Mateo, M. (1998) La atención del parto en Chiapas, México: 'dónde y quién los atiende?' *Salud Pública de México*, 40(6), 494–502.
- Secretaría de Salud. (1992). *La mujer adolescente, adulta, anciana y su salud*. Mexico City: Secretaría de Salud, Dirección General de Salud Materno Infantil.
- Secretaría de Salud. (1995). *Norma Oficial Mexicana para la atención de la mujer durante el embarazo, parto y puerperio y recién nacido*. Mexico City: Author.
- Tsui, A., Wasserheit, J., & Haaga, J. (Eds.). (1997). *Reproductive health in developing countries: Expanding dimensions, building solutions*. Panel on Reproductive Health, Committee on Population, Commission on Behavioral and Social Sciences and Education, National Research Council. Washington, DC: National Academy Press.
- World Health Organization (WHO). (1993). *Coverage of maternity care: A tabulation of available information* (WHO/FHE/MSM/93.7). Geneva, Switzerland: Author.