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Finding a ‘safe’ place on the risk continuum: a case study of pregnancy and birthing in Lao PDR

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Abstract
This paper addresses two questions. Firstly: are the risk regimes faced, and perceived, by pregnant women in rural Lao PDR substantially different from those experienced by pregnant women in western societies? Secondly, if the Lao experiences and perceptions are different, can improvements in maternal health in Lao PDR be achieved without Laotians inheriting the risk regimes of late modernity experienced by many women in western societies? Secondary analysis is undertaken of data collected in 2005 for the evaluation of a pilot maternity waiting home in Bolikhan, Lao PDR. The results suggest significantly different risk perceptions and experiences between Lao and western communities based on contrasting views of embodiment, identity construction and cosmologies. In the Lao rural communities studied, there is little evidence yet of ‘risk society’ despite the introduction of western technologies and practices to improve maternal mortality and morbidity and it is argued that ‘risk society’ can be avoided.

Keywords: sociology, risk, birthing, maternal mortality, Lao PDR, development

Introduction: Paradoxes of Risk Society
Beck’s (1992) concept of risk society provides an explanatory framework to elucidate some of the contradictory imperatives which contribute to identity construction and embodiment experiences for many pregnant women in late modern mainstream western societies (Lupton, 1999; Lane, 1995; Zadoroznyi, 2001). Lifestyle risk discourses impact on pregnancy practices. Medical risk discourses influence both pregnancy and childbirth experiences. Many women in late modern western societies are still subject to the normalizing gaze (Foucault, 1991) of medicalized births (Martin, 1987) and heavily regulated pregnancies (Lupton, 1999) at the micro level. They are also faced with the macro deregulation of a ‘profusion of possibilities’ and choices of providers and settings for birthing (Zadoroznyi, 1999:268), deregulated and uncertain insurance arrangements, and privatization of services, all of which involve inherent risk contingencies and undermine their subjective wellbeing (Pesavento, Marconncini & Drago, 2005). How these conflicting risk imperatives of chaos and order (Turner, 1997) are interpreted, and acted upon by pregnant and birthing women, are tempered by dimensions of difference such
as ethnicity (Hsee & Weber, 1999), age (Reichman and Pagnini, 1997), geographical location, in particular rural living (Maternity Coalition, 2005a, 2005b; Health West, 2000) and social class, especially for the first birth (Zadoroznyi, 1999).

Thus the extent to which women feel they have power and control over their pregnancy and birthing embodiment, and develop a confident capacity to negotiate the restrictive imperatives of surveillance of their bodies during pregnancy, as well as the multitude of birthing options, economic imperatives and insurance arrangements, varies with social, economic and demographic positioning. However, for mainstream western women, from all walks of life, pregnancy and birth remain domains of risk and disquiet despite relatively low mortality and morbidity ratios in the twenty first century (Lupton, 1999, 2003b). The palpable risks of death, sickness and disability associated with pregnancy and childbirth have been largely replaced with the unintended ‘risks’ of both governmentality and unbridled choice which form part of a risk management cosmology. The ‘risk meanings and strategies’ which individuals reflexively develop ‘are attempts to tame uncertainty, but often have the paradoxical effect of increasing anxiety about risk through the intensity of their focus and concerns’ (Lupton, 2003b:13). These paradoxical effects include emotional alienation, obsessive concerns with avoiding risk, feelings of failure and inadequacy at not having the ‘perfect’ pregnancy or birth, the stress of too much choice, negotiating the vagaries of economic rationalism in service resourcing, over-medicalization and disempowerment (Lupton, 1999).

Lupton (2003:13-15) argues that there are “at least six major categories of ‘risk’ that currently appear to predominate in the concerns of individuals and institutions in western societies…(including) ‘lifestyle risks’ (and) ‘medical risks’ ”. Rather than being globalized, these risks are highly specific and their prominence ‘at this point in the history of western societies is indicative of the nature of the broader sociocultural, political and economic context in which they acquire meaning’ (Lupton, 2003b:14). These risk have an ‘important ontological status in our understandings of selfhood and the social and material worlds’ and ‘the heightened sensitivity to risk evident in the late modern era is developed through a highly reflexive approach to the world’ (Lupton, 2003b: 14-15).

Beck (1992) assumed that risk society is a globalizing trend which eventually will pervade communities worldwide. This paper puts forward the argument that improvements in health outcomes for pregnancy and birth in developing societies can be achieved without those societies
becoming ‘risk societies’ as described by Beck (1992). With Lupton (2003b), it is argued that risk society reflects a series of cosomologies that are currently specific to late modern western societies. As such, it does not represent the inevitable trajectory for pregnant and birthing women in developing countries as they ‘modernize’. However, all technological change carries political, economic, sociocultural and philosophical baggage (Nie, 1999) which can be transported and ‘installed’ with the technology if traditional worldviews are significantly disrupted by the process of introducing change (Volti, 1995). Preserving aspects of traditional cosmologies, while introducing measures to improve maternal mortality, morbidity and disability rates in developing countries, provides a buffer against the spectre of the ‘natural’ risks of pregnancy and childbirth being replaced by the ‘manufactured’ risks that characterize risk society (Giddens, 1999). As such, pregnant women will not automatically be transformed from the ‘contented sick’ into the ‘worried well’, characteristic of late modern western societies. Obviously a cosmology that accepts pregnancy as ‘having one foot in the grave’ (Tan, 2006) is not tenable in the twenty first century. However, with consultation, careful planning, and political will, pregnant women in developing societies can become the ‘contented well’. Lao PDR is used as an example to illustrate this potential for maternal ‘wellness without angst’.

Two caveats on the ‘culture’ of maternal care
Prior to addressing the particular case of Lao PDR, it is necessary to introduce two interconnected caveats. The first concerns valorizing traditional cosmologies and rituals and downplaying other social factors in explaining patterns of life. The second concerns underplaying the cultural aspects of western medicine. It is important that traditional practices are not uncritically romanticized. Much anthropological literature in the past adopted an historical and romantic approach to culture (Hollen, 2006). Cultures are not static and hegemonic, they do change and people do have differing levels of observance of cultural imperatives, for example in food choices, childbirth practices, and of healing and health promotive practices. And, of course, some traditional childbirthing practices and other reproductive health practices are downright dangerous (Hollen, 2006) and not negotiable. The challenge is to meld traditional and scientific beliefs and practices to maximise the well being of individuals and to acknowledge that scientific medicine itself is part of a cultural tradition which is evolving and also entails ‘risks’.

Manderson & Reid (1994:7-9) also suggest that we need to be wary of the uncritical acceptance of the culture-boundedness of health and illness. They argue that 'sometimes... the interaction or
influence of culture on health is highly significant (but that) ... the importance of culture is often overstated'. The political implications of such overstatement, they contend, is that sex, class and other dimensions of difference are overlooked as significant contributors to health experiences.

‘There is no doubt that a recognition of culturally specific needs, beliefs and practices in health care delivery has, in places, enhanced the accessibility and experiences of care for people... Paradoxically, however, it has also reified 'culture' as the pre-eminent variable in health behaviour and access to services. ‘(Manderson and Reid, 1994:22).

While sharing Manderson and Reid's cautionary sentiment, this paper suggests that much of the literature has erred in the opposite direction. Epidemiological studies have consistently found differential health status on the basis of cultural background on a population level, however, until recently little research has been published on embodied and subjective cultural experiences of health and illness in smaller groups. All health experiences and health practices and risks, including those experienced within the paradigm of scientific medicine, are culturally constructed. Lupton (2003a:1-5) emphasises that 'Medicine, or faith in medicine, is a creed' and that in Australia, as in other parts of the world, 'the claims to "truth" and political neutrality of biomedical knowledge' are under the microscope. So too is the notion that all societies inevitably pass through the same risk regimes when embracing some aspects of the culture of biomedicine. We now turn to the example of Lao PDR to examine the potential for an alternative path to maternal wellness which does not replicate ‘risk society’.

**Challenges and Opportunities for Lao PDR**

Despite a steady reduction in its maternal mortality ratio (MMR) since 1990, Lao PDR still has one of the highest MRMs (maternal deaths per 100,000 live births)¹ in the Western Pacific Region (Tulloch/Ausaid, 2005; WHO, 2006). In rural and remote communities the figures are more than double the national average (AbouZahr, 1996; Government of Lao PDR, 2004).

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¹ *Maternal death* (code 286): The death of woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental causes. Maternal deaths should be divided into two groups. Direct obstetric deaths and those resulting from obstetric complications of the pregnant state (pregnancy, labour and puerperium), from interventions, omissions, incorrect treatment, or from a chain of events resulting from any of the above. Indirect obstetric deaths are those resulting from previous existing disease or disease that developed during pregnancy and which was not due to direct obstetric causes, but which was aggravated by physiologic effects of pregnancy.

Official statistics are not available for levels of maternal morbidity, nor for chronic disability and compromised objective conditions of quality of life, resulting from pregnancy and childbirth complications, but evidence suggests that Lao PDR scores poorly on these indicators too (Government of Lao PDR, 2004). Thus the country is currently not on track to meet target 6, of the 2015 Millenium Development Goal (MDG) 5 on maternal mortality (UN Millenium Project, 2002), which is to reduce by three quarters, between 1990 and 2015, the maternal mortality ratio. Lao PDR has established 3 sets of indicators to measure progress on target 6: MMR, proportion of births attended by skilled health personnel and contraceptive prevalence rate (Government of Lao PDR, 2004). Currently, the country falls short on two indicators, namely MMR and proportion of births attended by skilled health personnel (See Figure 1). Given the dramatic increase in contraceptive prevalence rates in the last decade of the twentieth century it could meet, or even exceed, the third 2015 indicator target on contraceptive prevalence rates.

**Figure 1: Lao PDR: Progress on MDG 5 targets 1990-2015**

<table>
<thead>
<tr>
<th>Year</th>
<th>Target MMR</th>
<th>Actual MMR</th>
<th>Target Skilled attendance</th>
<th>Actual Skilled attendance</th>
<th>Target Contracept Prev.</th>
<th>Actual Contracept Prev.</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990</td>
<td>-</td>
<td>750</td>
<td>-</td>
<td>14% (1994)</td>
<td>-</td>
<td>13%</td>
</tr>
<tr>
<td>2000</td>
<td>-</td>
<td>530</td>
<td>-</td>
<td>17% (1999)</td>
<td>-</td>
<td>32%</td>
</tr>
<tr>
<td>2015</td>
<td>&lt;185</td>
<td>-</td>
<td>80%</td>
<td>-</td>
<td>55%</td>
<td>-</td>
</tr>
</tbody>
</table>

The decrease in Lao PDR’s official MMR from 750 deaths per 100,000 live births in 1990 to 530 deaths per 100,000 live births in 2000 has been mainly attributed to prevention strategies such as improved family planning access, immunization and reduction of anaemia by dietary supplements (Government of Lao PDR & UN, 2004). Thus western prevention strategies for improving maternal health outcomes have been incorporated by the Lao government into their maternal and child health planning and programmes with a high acceptance rate amongst the population (Government of Lao PDR & UN, 2004). In particular the dramatic increase in contraceptive prevalence rates from 13% to 32% has certainly had an impact on fertility rates and ultimately on MMR (Tulloch/Ausaid, 2005). However, more clinical interventionist strategies, such as attendance at births by skilled personnel have not been a crucial part of this decline given that the percentage of births attended by skilled personnel increased by only 3%
between 1994 and 1999 (14% to 17%), well short of the 2015 MDG target of 80%. The Lao government and international agencies agree that to come anywhere near meeting the MDG target for MMR in 2015 of less than 185 deaths per 100,000 live births a major impetus is needed to increase attendance at births by skilled personnel (Government of Lao PDR & UN, 2004: 35).

The ‘proven interventions against the four major causes of maternal death’ (haemorrhage, puerperal infection, eclampsia and obstructed labour) involve prevention, primary clinical care, basic essential obstetric care and emergency obstetric care (Tulloch/Ausaid, 2005). The early age of first parity in Lao is a key factor in birthing complications (especially obstructed labour and eclampsia) and disabling outcomes (such as vaginal fistula) that are often reported amongst women who deliver in hospitals and clinics, yet less than 10 % of mothers deliver in health care facilities (WHO, 2000). What happens to those women who deliver beyond the medical gaze and suffer complications (Tulloch/Ausaid, 2005)? Why do they not use the available facilities?

**Barriers to extending the skilled gaze**

Lack of access to, and utilization of, prenatal and birthing services is just one of the factors exacerbating geographical and environmental barriers to maternal health and safety (Government of Lao PDR & UN, 2004). It is often assumed that this is mainly because of distance and difficult terrain. When an obstetrical complication appears, it is often too late to reach appropriate medical intervention. However, other factors may also operate, as evidenced by the low usage of maternal health care facilities even by those who live close to such facilities (WHO, 2000; Crossette, 2006). Economic factors include the cost of hospitalization and prescriptions and the unwillingness of women to interrupt their work and leave the fields for more than a day to give birth (WHO, 2000; Government of Lao PDR & UN, 2004). Lack of confidence in currently available facilities may be a key factor and this fear may be justified given the poor condition of much of the equipment and existing health services at provincial, district and village levels (WHO, 2000; Government of Lao PDR & UN, 2004: Crossette, 2006). Some commentators argue that the ‘most important binding constraints to service delivery are not technical’ but rather are ‘systems issues related to financing, human resources development and management, infrastructure maintenance and supply management’ (Tulloch/Ausaid, 2005). Certainly political will is evident in the Lao government’s
plans to invest in facility and personnel training upgrades for maternal care (Government of Lao PDR, 2000, 2004).

Another factor which has operated as a disincentive to health facility usage in the past has been unwillingness on behalf of hospital and clinic administrators to cater for traditional practices such as soul calling ceremonies after caesarean section, traditional dietary restrictions and smoking of the mother and baby over a fire after birth (Government of Lao PDR & UN, 2004: Government of Lao PDR, 2000, 2004). However, in its *Health Strategy to the Year 2020 (2000)* the Lao PDR Government, for the first time, committed to ‘promoting and strengthening the use of traditional medicine and ‘integration of modern and traditional care’ as one of its six health development strategies.

The Lao PDR government (2004) has demonstrated the political will to address some of these issues, in particular, inadequate and poor quality health provision but also social, political, economic and cultural determinants of maternal death and illhealth (Government of Lao PDR & UN, 2004; Government of Lao PDR, 2004). In its official report on progress towards meeting the MDG Goal 5, the Lao PDR government identified: ‘the trafficking of girls and women’ and associated gender violence ‘that damages not just (women’s) physical health but also their emotional health’ as well as the problem of early marriage and early first parity,’ language barriers, poverty, malnutrition, illiteracy, superstition… and the use of opium…unsafe and illegal abortion’ and the quality of education and communication as key areas in need of urgent attention (Government of Lao PDR & UN, 2004:36-8).

The Lao government is also faced with the problem of whether the medical gaze can be extended, and Lao PDR reach the MDG target on maternal health, without subjecting women to another set of dangers, the paradoxical risks associated with medicalization, surveillance and a de-regulated public sector. Given critiques of the unintended outcomes of overmedicalization of the birthing process and excessive surveillance of pregnancy in western countries (Martin, 1987; Lane, 1995; Lupton, 1999; Zadoroznyi, 1999) it is important that those charged with instituting policies to increase skilled attendance at births in developing countries be aware of some of the possible risks to quality of life that come with greater surveillance and medicalization of birthing and pregnancy.
The Maternity Waiting Home
One initiative of the Lao PDR government, in partnership with WHO and UNDP, which addresses these problem, has been the establishment of a pilot maternity waiting home (MWH) near the Bolikhian District Hospital and accompanying outreach programme in eleven villages in Bolikhian District, Bolikhamxay Province. The concept of providing supervised shelter for pregnant women with ‘potential risks’ has a long history, spanning several centuries. These potential risk pregnancies include ‘those expecting their first delivery, women with many previous births, very young women, older women and those identified as having problems such as high blood pressure during pregnancy’ (WHO, 1996:2). The more recent iteration of the concept, the maternity waiting home, is a setting ‘where women can be accommodated during the final week or two of pregnancy, near a facility where essential obstetric care is available, and where women can be immediately transferred to a referral hospital’ (WHO, 1996) if emergencies arise. The maternity waiting home concept has been tried in over twenty developing countries over the past 90 years, originating in Africa, and in each context the maternity waiting home takes a unique form, ‘each appears to be slightly different in terms of both its creation and the services which are provided’ (WHO, 1996:2).

The Bolikhian Maternity Waiting Home (MWH) aims to be comprehensive and address many of the social and economic determinants of health as well as providing access to skilled personnel (Eckermann, 2005). It offers postnatal health promotion and education, as well as prenatal care in a relaxed and consultative environment, microcredit schemes to allow women (and their partners and relatives) to earn income while waiting to give birth and an opportunity for women and their families to share experiences with other families. Another unique feature of the Bolikhian MWH is the intention to preserve traditional practices that form part of the women’s cultural embodiment. Families are encouraged to stay with the women where possible. Land is available for growing vegetables and looms are provided for weaving. Sewing machines and cloth are available for use by clients. The home itself is architecturally designed like a traditional Lao house from the province, the facilities such as toilets are Lao style, there is a sauna to provide the heating requirements for mother and baby (steam replaces smoke to avoid respiratory problems for mothers and babies). Most traditional initiation (non-harmful) practices for the baby, and the recovery of the mother after birth, are adhered to including some restrictive dietary regimes and use of spiritual healers. Most
importantly, clients and potential clients are consulted whenever major decisions are made about facilities, services, and changes to practices. Regular feedback and evaluation is sought and the clients and families become actively involved in running the home. As part of the communist political framework at village level, the village committees, made up of representatives from the Lao Women’s Union, traditional birth attendants, village women, village men, village health committees, party cadres and the village chief, advice the management committee of the MWH. Only those traditional practices that are harmful to the mother and/or baby are not negotiable and are actively discouraged via health promotion and education sessions; these include using smoke instead of steam to warm the mother and baby and discarding the colostrum rather than feeding it to the newborn (Eckermann, 2005).

Given that some women cannot access the MWH, training of TBAs and other health workers, by the outreach teams from the MWH, has been started in the villages to screen for symptoms such as eclampsia, high blood pressure and anaemia and to undertake deliveries at home. Hopefully in time, when the communications infrastructure is available, mobile phone contact for advice during delivery will also be possible. This has been trialed very successfully in Egypt where, ‘mobile phones have been central to progress (in improving maternal and child health) in indirect-as well as …direct ways’ (WHO, 2005). The WHO World Health Report 2005 notes that in Egypt mobile phones have helped reduce ‘response time to obstetric emergencies by enabling contact with formal and informal means of transport, and facilitating consultations between traditional birth attendants and mid-wives, as well as between mid-wives and physicians’ as well as providing contact with ‘mothers or sisters when (women) require health-specific decision-making support’ (WHO, 2005).

This paper reports on secondary analysis of data collected as part of a World Health Organization evaluation of the Bolikhan Maternity Waiting Home. The evaluation research was designed to establish what the barriers were to women using the maternal care facilities in Bolikhan, what risks families who had used the facilities and villagers from the surrounding villages foresaw, and what changes would be needed to make the facility more accessible, affordable and acceptable to them. This secondary analysis specifically addresses the cosmologies that villagers and health care providers in the
Bolikhan district employed to maximize healthy pregnancies and births and to manage risk.

**Methods**

**a) Original evaluation**

The original evaluation, undertaken in 2005, involved a triangulated methodology combining a review of documentation, participant observation, individual interviews and focus group discussions with key stakeholders, to gather data on satisfaction with services (at the MWH, hospitals and mobile clinics) and to assess likely future usage patterns. Barriers to usage and suggestions for facility modification to overcome those barriers were also recorded. It entailed reviewing the documentation from the MWH and mobile clinic teams, making three fieldtrips to the Bolikhan MWH, the Bolikhan District Hospital (BDH) and the Bolikhampay Provincial Hospital (BPH) and visiting five villages during the mobile clinic rounds. Using an interpreter, I conducted focus group discussions and individual interviews with the staff of the MWH, mobile clinic workers, clients and former clients of the MWH and their families and a cross-section of the community in three villages in the Bolikhan District including village chiefs, traditional birth attendants, village health committee members, representatives from the Lao Women's Union and male and female villagers (Eckermann, 2005).

Participants were recruited by the mobile clinic coordinator. The sample size for interviews was 6-8 individual interviews per village and one focus group (8-12 participants) per village. In total 39 individuals were interviewed, 3 focus groups were conducted in the villages and 2 in the MWH (a total of 58 focus group participants). Each interview was approximately 30 minutes and each focus group 60-90 minutes. World Health Organization protocols for informed consent, ethics clearance and ethical conduct of research were applied.

The responses to the interviews and the proceedings of the focus groups were recorded in English in a written form and the records were checked with the interpreter for accuracy after each session. The interpreter and I participated, as members of a visiting Lao Maternal and Child Health team, in meetings and ward visits at the Bolikhan District Hospital and Bolikhampay Provincial Hospital, in discussion sessions with clients and staff at the Maternity Waiting Home and in activities of the mobile clinics. Notes were taken by the interpreter and myself to record the experience.

**b) Secondary analysis**
For this paper I undertook a secondary analysis of the data from this evaluation to assess the cosmologies that pregnant women, and other stakeholders in pregnancy and birthing care, who formed my original sample of participants, expressed around risk, pregnancy and childbirth. This involved reviewing my field notes, the interview and focus group data and the official documentation of the mobile clinic teams, the hospitals and the maternity waiting home and identifying themes that dealt with risk discourses, cosmologies and practices.

Results

a) Original evaluation

The evaluation research found that the MWH has improved access to essential and emergency obstetric care in Bolikhan District. The substantial increase in births at the BDH in the 3 months since the MWH’s had opened revealed that the MWH has been successful in bringing pregnant women within close proximity to both essential and emergency obstetric services. However, the delivery equipment at both the BDH and the Bolikhan Provincial Hospital (BPH) needed urgent upgrading and midwifery training for nurses was urgently needed to enhance pregnant women’s chances of benefiting from such access. The road between BDH and BPH needs upgrading for more rapid emergency transfer in the rainy season when the road became impassable. These improvements would also enhance the level of confidence in maternal and child health services amongst the communities in Bolikhan District.

The MWH and mobile clinics have been very well received by all sectors of the community in all villages with exceptionally high approval ratings and a clear indication of intention to utilize and support both the mobile clinics and the maternity waiting home. This support was also forthcoming from the traditional birth attendants who have become the major referral source for the MWH. Attendances at the mobile clinic and information sessions in the first round, and the special information session for men, were very high in all villages. Former and current clients of the MWH and their families indicated high levels of acceptability, accessibility (financially, culturally and geographically) and effectiveness in terms of a successful and supportive birthing experience. The word ‘safe’ was used extensively in the interviews, to refer to the MWH and participants claimed that it was an even greater motivator than the economic motivation of a free service. Health workers for the mobile clinics and MWH staff also
expressed high levels of satisfaction with their roles in supporting women and their families and reported very positive experiences in their roles.

The key suggestions for change and improvement identified by the various stakeholders included: provision of new equipment and instruments for safe delivery in the District and Provincial hospitals, more activities and health promotion information and education in the MWH for pregnant women and their families, opportunities for more money earning ventures at the MWH, updated equipment and transport for the mobile clinics, and improved ambulance facilities between the District and Provincial Hospitals. It can be concluded that the MWH and mobile clinic are reaching their objectives of making safe delivery possible for women previously denied this service by geographical isolation, cultural resistance and economic restraints. It was recommended that funding continue for this initiative and that additional funds be sought to upgrade training of nursing staff and update equipment and facilities at the MWH, the BDH, the BPH and for the mobile clinic activities. Intersectoral cooperation is needed with: telecommunication providers to upgrade coverage in the Bolikhan District such that remote advice can be provided for pregnant women unable to access the MWH, and with the department of transport to provide an all-weather road from Bolikhan to Paksane where the larger provincial hospital can deal with emergencies.

b) Secondary analysis

The secondary analysis of the data collected for the evaluation research revealed the impact of a unique set of contradictory imperatives on concepts of risk in constructing identity and embodiment amongst pregnant women and in the construction of childbirth and pregnancy understandings among all villagers (Eckermann, 2005). Most villagers interviewed still harboured a fatalistic view of pregnancy as being inherently risky and used phrases such as ‘pregnancy is being half way across the river’ but did not seem particularly disturbed by this ‘natural’ risk. Health care providers were far more optimistic about pregnancy outcomes. Certainly there was some awe at the capacity of western medicine to provide a ‘safe’ pregnancy and birth but there was also considerable criticism of the alienating practices in the Provincial hospital, especially the unwillingness to cater for traditional practices such as dietary regimes, heating and, in the case of Hmong villagers, soul calling ceremonies after surgery. Thus the ‘safety’ of a hospital birth did not outweigh the other risks associated with hospital stays for birthing. However, all participants in the research had a far more positive evaluation of personal and second hand ‘heard’ experience of the Maternity Waiting Home. Clients (women and their
families) who had used the MWH emphasized the issues of ‘safety’, ‘comfort’, ‘support’ and ‘independence’. The only criticism came mainly from male partners who would have liked more activities during their stay. This problem was exacerbated by a recent scare of avian flu which necessitated shutting down chicken and duck raising in the province.

Given that Lao PDR is one of the poorest countries in the Asia, it is heavily reliant on donor agencies, international organizations and non-governmental organizations. As such, economic rationalism is not as obvious and all-pervading as it is in the west. The principles of communism set the tone for consultative processes at village, district and provincial as well as the national level. This produces a mixture of frustration (decision-making is often a long drawn out process), and empowerment for villagers. Individual villagers know that they can attend meetings where key decisions are taken and have their say. However, there is a significant amount of surveillance from the Party on their activities (Pholsena, 2006). To acquire coupons for free transport to clinics and to be declared ‘poor’ to access free medical services requires considerable bureaucratic and intrusive procedures.

The most influential impact on embodied identity and conceptions of risk comes from the multiple traditional practices of Lao and Hmong culture, Buddhism and animism, often in unexpected combinations. Amongst the Hmong villagers, the integrity of the three souls of the body is the driving force of life and perceptions of their identity- most risks (including all illness) are interpreted as being generated by disharmony between these souls (Fadiman, 1998; Liamputtong, 2000). Pregnant Lao women will not eat the meat of the white buffalo for fear that it will harm the baby and keeping both baby and mother hot after birth are just some of the crucial practices that cannot be transgressed (Eckermann, 2005). Some traditional practices are more symptomatic, rather than generative, of risk. The most telling, which points to the normalization of infant mortality, is the tradition of not giving the baby an official name until a year after birth (Lee, 1986).

Lao PDR had dramatic disruptions to its population as a result of several decades of war and the civil strife which developed as an aftermath of war (Pholsena, 2006). These disruptions have not only contributed to national and personal poverty but have had a substantial effect on the political and spiritual life of the country and have provided impetus in some communities to have large families to ensure that at least some offspring survive.
These often competing imperatives also impact on women’s and men’s perceptions of their options, their futures, and their capacity to control the birthing process. The MWH at Bolikhan provides an opportunity to blend traditional and medico-scientific practices of pregnancy and birthing in a way that does not unravel women’s embodied identities, which in some cases is a multiply constituted and negotiated ‘dance’ between Hmong, Lao, Buddhist, animist, scientific and communist knowledges, beliefs, values and practices. The manufactured risks of late modernity (Beck, 1992; Giddens, 1999), especially the iatrogenic risks of overmedicalization including compromised bonding between mother and child, are less likely to be experienced when women and their families remain in control of the pregnancy and birthing experiences both individually and through representation on the village committees and are able to keep their traditional belief systems in tact.

**Discussion**

The medico-scientific perspective on risk in pregnancy and childbirth was often presented in the late twentieth century as a monolithic approach which ignored women’s preferences and disempowered women by forcing their legs apart, strapping them into stirrups and subjecting them to a series of degradation practices in the name of safety for themselves and their babies (Martin, 1987). While this still represents the experience of a minority of women giving birth in both western and non-western cultures, it is certainly no longer the norm in the twenty first century, even in hospital settings. The critiques of medicalization of major transitions in women’s lives, which were generated by feminists such as Martin (1987), have had an impact on pregnancy and birthing practices throughout the world as witnessed in the debates about reproductive health at The International Conference on Population and Development (Cairo 1994) and United Nations Conference on Women (Beijing 1995). The rights approach to reproductive health agreed upon in 1994 and 1995 has had some limited influence on health policies and services in some countries (ARROW, 2005) and the medico-scientific approach is no longer hegemonic and inflexible. However, women’s identities during pregnancy and birthing are still circumscribed by the medical gaze. Surveillance and regulation of women’s bodies during pregnancy and childbirth persists from a variety of sources, including from ‘concerned strangers’ in restaurants (Lupton, 1999), and impacts on women’s embodied identity. This is part of the ‘culture of medicine’that constructs western risk perception (Lupton, 2003) derived from an era of greater reliance on prescriptive biomedical imperatives and which forms the background for ‘risk society’ (Beck, 1992).
Communities which have not experienced the same history of uncritical fascination with the rationality of bioscience, and effects of the panopticon in all spheres of life, do not need to inherit our history in their policies and practices of risk avoidance in pregnancy and childbirth. Even the popularly promoted measure of training traditional birth attendants in western medical practice has been questioned by the very organization that initiated it (WHO, 2006:24).

Factors outside of the realm of bioscience may be just as effective for countries to address in reducing maternal mortality, morbidity and disability. Political will appears to be a key factor in ensuring the success of risk reduction programmes in pregnancy and birthing. There is ample evidence from around the world that the best way to reduce mortality and morbidity rates is increased female literacy rates (Redwood, 2005). The state of Kerala in India is the classic example where despite having the lowest GDP and highest population density in India, it has the lowest mortality and morbidity which is largely attributable to high levels of female literacy and education (Thankappan & Valiaithgan, 1998). Economic development alone is not sufficient unless it is accompanied by political will to institute major social reforms such as education of women and girls. Greater involvement of men in childbirth in some countries, greater participation of men in contraceptive decision-making, and changing domestic roles in the family as women’s employment participation rates increase have been shown to significantly affect reproductive practices and improve pregnancy outcomes (ARROW, 2005). However, attending to social, economic and political factors is not enough. To avoid massive dislocation of populations, changes in health care delivery environments also need to be negotiated (Fadiman, 1998).

Pranee Liampittong Rice (Rice et al, 1994) documents an instance in Australia where she was able to negotiate a compromise with hospital administrators for a Hmong immigrant woman from Lao PDR to have her traditional embodiment (believing in the integrity of the three souls of the body) catered for within an Australian hospital setting (with a soul calling ceremony to re-instate one of the souls ‘lost’ during caesarian section) while not compromising the need for intervention (caesarian section in a sterile environment) to save the woman’s life. Relief of such ‘morbidity’ came from cultural rituals conducted by a Hmong priest in the theatre where the surgery took place rather than by psychiatric care or pharmaceutical and medical intervention and these cultural rituals were not in conflict with the biomedical requirements of aseptic surgical intervention. The belief that health is only possible when the three souls of the body are present in the body, forms the backdrop against which many Hmong people whether located in
their home country or as immigrants to western countries make their reproductive health choices
and assess risk (Fadiman, 1998). This belief also provides the context for their health
experiences. Any threat to the integrity of the three souls of the body requires a soul-calling
ceremony to return the soul to its rightful position within the body.

If practices such as this could be replicated in other settings, amongst immigrant groups in
Australia, as well as in other countries (Fadiman, 1998), the apparently inevitable risk
replacement process could be avoided. The MWH in Bolikhhan, and a recently opened one in
Bokeo Province, along with those proposed as part of a ‘Silk Homes’ project of 17 MWHs in the
southern provinces of LaoPDR (The Silk Homes Proposal, 2006) provide an option for
undertaking similar risk negotiation exercises among Hmong and Lao communities in rural Lao
PDR. The finding that morbidity after a caesarean section related more to cultural fears and
beliefs about one of the souls leaving the body after ‘cutting’ than to post-natal depression or the
physical aftermath of surgery (Rice et al, 1994) also has implications for examining how women
see their embodiment in other minority cultures such as amongst indigenous communities. If
western measures of ‘successful’ birthing ignore these beliefs and values, women who believe
and trust in traditional methods are likely to suffer significant undiagnosable ‘disquiets’, possibly
even mental and physical illness (Fadiman, 1998), rather than wellbeing, during and after
childbirth.

Conclusions
The ‘obsessive self regulatory behaviour’ (Lupton, 1999:5), aimed at reducing risk to herself and
her unborn infant, of a pregnant white urban woman from Melbourne is not replicated in the
experience of a pregnant Aboriginal woman from a remote settlement in the Northern Territory
(Cass, 2004) or a pregnant Hmong woman in rural Lao PDR (UNDP, 2001). Fundamentally
different risk regimes, associated with pregnancy and childbirth, prevail across the economic and
social development divide, including in indigenous communities within ‘developed’ nations (Blair
et al, 2005). Research conducted in 2005, in Bolikhamsay Province of the Lao Peoples’
Democratic Republic (Lao PDR) was used to illustrate the impact of a different set of contradictory
imperatives on concepts of risk in constructing identity and embodiment amongst pregnant Lao
women. Included in the Lao PDR set of imperatives for risk avoidance were: emerging aspects of
the instrumental rationalities of western medicine, principles of communism, and the multiple
traditional practices of Lao and Hmong culture, Buddhism and animism. These often competing
imperatives also impact on women’s and men’s perceptions of their options, their futures, and their
capacity to control the birthing process. It is possible that, with truly consultative planning and management, and negotiation between traditional and rational imperatives for healthy embodiment, communities now faced with high infant and maternal mortality can avoid the paradoxical risks of ‘risk society’ that have developed in the west as well as free themselves from the tyranny of harmful traditional practices. The nexus between the ‘comfort ‘aspects of tradition (without the tyranny of tradition) and the technically useful aspects of scientific medicine (without the culture of obsessive concerns about risk) can produce the conditions for good quality of life on both objective and subjective dimensions.

REFERENCES


Maternity Coalition (2005a) ‘Rural Lives will be lost unless swift action is taken: Calls on Minister to provide Midwives with Medicare provider numbers’ News Release Thursday 10th March 2005, Victoria.


Tulloch, J. /Ausaid (2005) ‘Challenges in meeting the Health MDGs in the Asia Pacific Region’ Seminar on progress towards Millenium Development Goals related to health, Burnett Institute, Melbourne, 25th October 2005


