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HEALTH COSMOPOLITANISM:

THE CASE FOR TRADITIONAL BIRTH ATTENDANTS

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Abstract

Health cosmopolitanism is a hybrid concept that embraces conventional health objectives (safety, equity and universality) but incorporates the principles of cosmopolitanism (egalitarian individualism; reciprocal recognition; and reasoning from an impartial moral standpoint). In short, health cosmopolitanism embraces conventional Western measures of good health but insists that the cultural determinants of health (values, beliefs, cosmologies and philosophies) are equally germane to good physiological outcomes. The intention in this paper is to stipulate the plural bases for a social justice framework for maternity care that recognises people’s equal moral worth and their inherent capacities for self-determination and subjectivity; in this case, about the ways that women give birth (their choice of carers, modality of care and use of medicines including both Western and traditional medicines). Although this paper evaluates maternity practices in developing economies, health cosmopolitanism provides a benchmark to assess maternity policies and practices anywhere. This study will specifically consider the case of TBAs (traditional birth attendants) as an example of health cosmopolitanism.

I argue via evidence from around 50 interviews with health administrators, obstetricians, midwives, traditional birth attendants and women in Timor Leste, Vanuatu and the Cook Islands: (1) that cosmopolitanism is a preferable frame of reference in relation to healthcare because it goes beyond universal human rights to claim individual entitlement to self-determination (including the cultural determinants of health, or people’s beliefs, values and cosmologies) within a framework of global governance and reciprocal rights and responsibilities (2) that TBAs represent a key example of the cultural determinants of health (3) that negative evaluations of TBA performance based on one criteria are unreasonable (4) that if reintegrated into the mainstream maternity system TBAs could be key actors in meeting Millennium Development Goal No Five and finally, (5) reintegration would represent an enlightened policy of philosophical pluralism. Considerable reflexivity would be required on the part of international aid organisations, Ministries of Health and the medical fraternity to reverse the inexorable march towards the medicalization of birth in developing economies. Yet such a reversal would bring undoubted benefits to women in delivering a good birth, one that not only demonstrated physical safety but respected the cultural values and preferences of individual women.
Introduction

The Safe Motherhood Initiative and the role of TBAs

This paper is about health care pluralism in maternity services and specifically about the efficacy of Traditional Birth Attendants (TBAs) in meeting Millennium Development Goal (MDG) No 5 – Improving Maternal Health and Access to Reproductive Health Services. This MDG is especially relevant to developing economies because between ½ and 2/3 of women in developing economies are denied access to biomedical maternity services (WHO 1997). To remedy the current shortfall, around 400,000 midwives would need to be trained to cover the 45-60 million births per annum currently unattended by health professionals (Walren and Weeks 1999; Bryne and Morgan 2011). My argument is that TBAs trained in emergency obstetric procedures and with high-level midwifery skills could detect early complications, ensure timely referrals and reduce infection and postpartum haemorrhage (WHO 2004; Starrs 1997). They would not only meet medical safety goals but satisfy women’s cultural needs: they recognise traditional mores surrounding birth and participate in traditional cosmologies and use of bush medicines. Moreover, in this study, they also fulfilled wider goals associated with political freedoms, women’s autonomy and self-determination. Indeed TBAs were considered a positive addition to mainstream maternity goals up until the 1990s when revised WHO estimates of maternal mortality (WHO 1996) revealed consistently high IMRs and MMRs, at which time a joint statement by WHO, UNFPA and signatories to the Safe Motherhood Initiative (SMI)1 announced their scaling down. Henceforth TBAs would be tolerated as an interim measure until trained midwives or nurse practitioners could take their place. The operative measure was someone with suitably acquired ‘skills’ meaning someone who could refer onto other professionals, such as obstetricians and midwives, and those who could work within a clinic or hospital (Starrs 1997; ARROW 2013; Graham et al 2001; WHO 1992). The mark of medicalization was thus secured.

Yet more recent opinion has argued that putting the burden of proof to reduce IMRs and MMRs singularly on TBAs was unreasonable. First, baseline measures were missing when TBA efficacy was reviewed and found wanting in the 1990s. Second, complex social determinants of health such as poverty, illiteracy, lack of easy access to facilities including impassable roads and lack of transport as well as poor general health of mothers are significant causal mechanisms of adverse outcomes (Kruske and Barclay 2004; UNFPA 2003). Third, other community actors (mostly family and village elders) are typically involved in perinatal care. Fourth, cultural factors such as the low status of women are frequently overlooked determinants but it is evident that this accounts for low priority of health expenditure, especially within poorest communities.

A more reasonable approach to the evaluation of maternity care models is to acknowledge shortcomings in any system, traditional and Western. The WHO Safety Birth Checklist targets bleeding, infection, elevated blood pressure, and prolonged or obstructed labor as major risk factors.

1 Including the United Nations, ARROW and the White Ribbon Alliance.
factors for mothers worldwide. Recognizing and managing asphyxia, infection, and complications of prematurity are risk factors for infants. In any maternity setting, good practices highlight clean cord care, maintenance of sterile surfaces, the capacity to exercise emergency obstetric skills and timely referral of high-risk cases (WHO Childbirth Safety Checklist 2012). Cultural determinants are also central, yet often overlooked. To flourish throughout pregnancy and especially during labour, relational and cultural criteria are key elements of a good birth including a trained and known, read trusted, carer (a rare event still in most Western arrangements), sensitive and respectful dialogue and practices, consensual care, tolerance for informed dissent and cultural mores, and provision of information and privacy. These are not just key human rights issues; cultural determinants translate into emotional security bearing a direct relationship on physiological ease of birth. Culturally, TBAs are often preferred by mothers wanting an optimal (but often non-lithotomy) birthing position. Squatting or kneeling preserves women’s dignity and desire for privacy (Bajpai 1996a; Mathews 2005), it expedites delivery and ease of pushing and at the same time reduces foetal stress, labour pain and perineal trauma. Mothers register higher levels of satisfaction at home with a known, trusted carer (Bjardwaj et al 1995; Mathews 2005; Van den Brock et al 1999). Detractors of TBAs point to lack of accredited skills but, as some models show, TBAs could be trained to use emergency procedures and low-level life-saving technologies, such as Misoprostol, the non-pneumatic Anti-Shock Garment for postpartum haemorrhage, the haemoglobin colour scale to screen for anaemia in pregnancy (Van den Brock et al 1999), antibiotics, magnesium sulphate for eclampsia and safe blood supplies. MMRs and IMRs could be further reduced by government provision of the so-called social determinants of health namely better roads and transport, upgraded health facilities and universal literacy, targeting women in particular.

Conversely, training TBAs and even SBAs (Skilled Birth Attendants) in Western medical practices alone would fail to bring about better care or better outcomes because many Western practices have been antipathetic to good birth. For example, Western-trained professionals have typically ignored deeply-held modesty norms surrounding birth in traditional societies (Bajpai 1999; Mathews 2005) and have enforced the lithotomy position as routine practice (of benefit to the accoucheur only and not the woman or baby). Many SBAs fail to respect the woman and her needs: there is evidence of widespread abuse in childbirth in the developing and developed worlds on the grounds of race, ethnicity, age, language, HIV/AIDS status, traditional beliefs and preferences, economic status and educational level (Bowser and Hill 2010). Not only in developing economies but also in Western regimes, many routine interventions are unsupported by evidence (Chalmers et al 1989; Chalmers 1993; Jadad and Enkin 2007). The medical model inappropriately reduces the complex, cultural nature of birth to a narrow medical procedure and routinely pathologises birth and the female body such that Western consumers of maternity care remain significantly unsatisfied. Only 35% of Canadian and US consumers deemed the maternity system to be excellent (Declerq and Chalmers 2008) and in the US the MMR actually increased by 96% between 1990 and 2008 (7.1 deaths per 1000,000 to 13.3 deaths per 100,000) at the same time that the number of caesarean sections increased by 53% (Coeytaux et al 2011).
Clearly, there is room for improvement everywhere. Where nations have attempted TBA re-integration into the formal maternity care system, modest success has been achieved in decreasing maternal and peri-neonatal deaths and increasing the use of maternal health services (Sibley et al 2002; Sibley et al 2004). While it is difficult to attribute TBA training to any specific outcomes because TBAs are part of a complex set of interventions, there is a logic in repositioning the question of TBAs, or not TBAs, around a broader ecological perspective comprising complex interactive layers and mutually causal agents. As Waller and Weeks (1999) and Byrne and Morgan (2011) have argued, for around 30 million remote-area women in resource-economies, a TBA is the only help that most can count on so a policy to discourage TBAs is fundamentally unwise (Saravanan et al 2010). From a human rights/cosmopolitanism perspective, the final arbiter of such decisions would be the woman herself, yet genuine choice for the woman is rare, even in choice-driven Western regimes. In summary, the decision to jettison the use of TBAs and some traditional practices has been premature. Within the larger social, cultural, political and economic context, TBAs may play immediate, supportive and even life-saving roles.

**Cosmopolitanism/ health cosmopolitanism**

At the heart of the new cosmopolitanism is the agreement that western global economic dominance has come to a halt. The rise of India and other Asian economies in the wake of the global financial crisis has upstaged the modernist Westphalian convention that individual sovereign states remain the appropriate unit for solving key policy problems. Cosmopolitanism embraces three elements: that persons are equally worthy of dignity and respect; that this principle of moral autonomy should translate into global political institutions and decision-making; and that universal concerns should be interpreted in the context of local settings and preferences (Held 2010). Universality and egalitarian individualism within a global (rather than nation-state) context defines the new cosmopolitanism; a melding of ‘universal concern and respect for legitimate difference’ among individuals, regions, states and communities (Appiah 2006). Cosmopolitanism takes the discourse of human rights (‘the dignity and worth of the human person’), posits it as the obligation of the global community and insists on interpretation at the local level. Specifically, all people everywhere need equality of recognition and respect - first, from primary carers (allowing the child (or adult) to develop emotional security, or self-confidence), second from legal institutions (ensuring self-respect) and third, for personal achievement (ensuring self-esteem) [28,29].

Translated into the field of childbirth arrangements (and the general field of healthcare), health cosmopolitanism defines a philosophy of care that is person-centred (not profession or institution-centred), ensures equal access to quality care (based not on ability to pay or other obstacles such as geographical distance) and upholds choice of carer and modality (Western, traditional or hybrid). Cosmopolitanism holds the global community (not just the nation-state) responsible for the health care of all. This tripartite model for justice in health care underlines the
argument here for the reinstatement of adequately trained TBAs (see above) offering safety, equity and universality as well as culturally-sensitive models interpreted at the local level by local inhabitants to ensure every woman has a known carer, plus choice of location, modality and provider.

Methodology

Field studies were conducted in Timor Leste, Vanuatu and the Cook Islands in 2008, 2009 and 2010 respectively. Ethics clearances were sought from Deakin University Human Research Ethics Committee prior to the research program. In addition, ethics clearance was obtained from all Ministries of Health in Timor Leste, Vanuatu and the Cook Islands to interview health officials, administrators, leading obstetricians, senior midwives and other midwives at urban, regional and remote locations, traditional birth attendants, new mothers, pregnant women and, where possible, village elders. Interpreters were employed to facilitate discussions. Interviews took ten minutes to over an hour depending upon willingness of participants, individual confidence, social location and language competence.

All material from fifty interviews and several focus groups were transcribed and de-identified and major and minor themes were categorised and ordered using N-Vivo9. Critical Discourse Analysis (CDA) provided the methodological rationale for analysing the data because of its comprehensive coverage of different levels of analysis (semantics, structure style, cognitive schema adopted by author and reader; as well as the social context (van Dijk 1991). CDA was used critically (not just as a limited analysis of language) but to incorporate both sides of language – the socially-shaped nature of texts and the socially-shaping capacities of language (Fairclough 2003). In research terms, this means I attended carefully to the range of discourses in respondents’ repertoires to construct what medicines and practices would achieve a ‘good birth’.

Evidence: Discourses from the Field

TBAs as nation-building: The case of Timor Leste

In Timor-Leste, 28.3% of women are attended by a TBA; 27.8% are attended by a midwife, and a doctor is present only for 7.9% of births (World Bank 2007). Timorese women had three options: they may attend the hospital in Dilli (the only hospital); visit the nurse at the nearest health post, or remain at home and call the TBA. The government has formally discouraged homebirth in favour of a ‘skilled’ attendant i.e. someone trained to manage ‘the normal’ and to refer complications to the hospital (WHO/UNFPA/UNICEF/World Bank 1999).
Young women in urban and remote locations responded that hospital or clinic care was much safer than staying at the village although this response may have signalled compliance since I travelled with the NGO officers who disseminated education on child spacing and safe birth). The statistics indicated that women largely complied with government policies: around 1/3 of pregnant women attend an official health post of some kind to deliver their babies. The reduction in the Maternal Mortality Rate (MMR) from 650 in 1990 to 370 in 2008 indicates considerable progress in improving maternal health (WHO/UNFPA/UNICEF/World Bank 2010), especially in urban areas. Yet there remain major problems in relation to high-risk emergency care for remote women because of social determinants of health - impassable roads, scarce transport, high costs of transfer and the notoriously low status of women. As the Director of Obstetrics explained, villagers in Timor and in other developing economies were unlikely to commit scarce funds to transport a woman in difficult labour to hospital and for this reason alone the official policy of encouraging women to attend the hospital and the phasing out of TBAs made perfect sense.

Yet the unintended consequence of this was that birthing women in remote communities who were unable for whatever reason to attend hospital were unsupported unless they attended the local, government-funded health post. The problem here was that the health posts were staffed by Indonesian-trained midwives who were culturally antipathetic to local villagers in a birthing room that provided neither comfort nor a great deal of privacy. Typically, the mother would visit the health post just before delivery, go to the birthing room annexed to the nurse’s consulting room adjacent to the public waiting room and deliver her baby in the lithotomy position on a narrow surgical bed with her feet in stirrups. At the health clinic there was little privacy for the mother, no options regarding birth position and the nurse was available for restricted hours only.

Even urban women delivering at the Dilli hospital faced culturally distasteful practices. They were required to put their feet in stirrups (with loss of privacy and dignity), family were discouraged, it was expensive, women were treated with disrespect and the hospital was often too far away. A major factor was disrespect. The Indonesian-trained midwives shouted at the local women if they made a noise during labour and shamed them for poor clothing, inadequate hygiene and illiteracy. Not surprisingly, almost 1/3 of women called the local TBA who brought numerous advantages. Privacy and personal dignity were achieved with a sarong over private parts, the women had a known carer and enjoyed support from family and traditional customs. For Timorese women, therefore, the TBA option was not only a pragmatic response to severe shortages of hospital-trained staff, rural isolation, the low status of women and financial duress, it represented an exercise in
nation-building at the most formative level. By avoiding the Indonesian midwives at the health posts and hospital, 1/3 of women registered their resistance to over two decades of human rights abuses by Indonesian military to reclaim individual autonomy and cultural independence.

In Timor Leste a concern to overturn the endemic cultural disrespect for women lay at the heart of two non-government models of maternity care. The first was created by Dr Dan Murphy, a US-trained GP who ran a busy inner-city practice in Dilli, who targeted high MMRs and IMRs by first redressing the low status of women. By asking villagers to nominate women they trusted as midwives then providing a free live-in, three-month training course in basic hygiene and emergency obstetric procedures and by encouraging the mothers to become involved in community political life, ‘Dr Dan’ spearheaded both political and cultural change as well as addressing the alarmingly high infant and maternal mortality rates. In effect, Dr Murphy targeted the social and cultural determinants of health to bring about ‘a good birth’: one that targeted physical as well as relational outcomes. Similarly, the Café Cooperative Timor funded urgent midwifery services in villages by purchasing coffee from villagers and selling it on the international market. Pregnant women received a ‘cream basket’ comprising a sterile pack of razor blades, a ground sheet, antiseptic cream, a new sarong and clothes for the baby. In summary, the use of TBAs by these two very different organisations not only offered pragmatic but safe solutions to inadequate resources, they also represented an exercise in nation-building by eschewing the legacy of Indonesian imperialism. Not the least of their objectives was a determination to develop an as-yet fragile sense of female autonomy through literacy programs and participation in political life, both of which would promote women’s capacities and do much to alleviate the high MMRs and IMRs.

‘The tyranny of distance’ argument for TBAs: the case of Vanuatu

Vanuatu is an island archipelago consisting of approximately 82 relatively small, geographically scattered islands of volcanic origin (65 of them inhabited), with about 800 miles (1,300 km) between the islands in the north to those in the south. Eighty percent of the population lives in rural villages growing their own food supplies. These geographically isolated communities have minimal access to basic health and education services but churches and non-government organizations provide a minimal level of support. There has been a rapid increase of urban and peri-urban populations in informal, squatter settlements around Port Vila and to a lesser extent in Luganville where health services provide reasonable health care, often supported and enhanced by visiting doctors.
There are frugal welfare state services so women are obliged to pay around $A7 for maternity services, effectively a significant burden on urban women whose families are engaged in a cash economy at the lowest quintile. Education is non-compulsory and school attendance among the lowest in the Pacific. In 1999 the literacy rate of people aged 15–24 years was about 87% and in 2006 around 78%. It is now commonplace for young women and teenagers to flaunt traditional mores by conceiving babies out of marriage; a practice being addressed by a comprehensive reproductive health program aimed at young people.

Like Timor-Leste, the official maternity policy is to encourage women to birth at a hospital in either Luganville, Tacea, Pt Vila or Santo or at one of the health posts located on the islands where women can deliver their babies. Most do so. As in Timor-Leste, the young women interviewed regarded the health facilities as the safest place to deliver their babies although this could have been acquiescence rather than genuine choice.

Notwithstanding the difficulties in accessing emergency medical care or travelling to hospitals and incurring the considerable costs, there is a strident policy of actively discouraging TBAs even though the two obstetricians and many of the hospital midwives regarded them as competent and highly-skilled in providing safe and responsible care with regard to hygiene and traditional knowledge. Nevertheless, the dominant Western medical culture assigned negative labels such as ‘bad’ and ‘unsafe’ to traditional practices and to TBAs themselves. According to one obstetrician, *birth is a dangerous business* and despite the isolation of the majority of women it was even more dangerous to endorse TBAs. *The whole referral system will collapse*, he argued, if he did. The old women of the village would advise the young women it was safe to remain in the villages and TBAs would cease to refer high-risk cases to the hospital. Even when I suggested that banning TBAs actually increased the risks for women because of the lengthy travelling time (at least one hour’s air flight or many days sailing) and prohibitive cost, the obstetrician remained resolute that endorsement of TBAs would undermine the entire maternity system.

There was no doubt that the lack of endorsement of TBAs had filtered through to the village level; the traditional handing down of knowledge to younger women had virtually ceased except on the fringes, like the live volcanic island of Tanna. On a visit to Tanna the young mothers and tribal elders (TBAs among them) explained they not only harvested herbs for childbirth but for every other ailment as well. Particularly prolific was the *kastom leaf* used by remote and urban pregnant women to make the baby come quicker and with less pain. Women typically used these bush remedies administered by the elders then walked to the health-post to deliver their baby in much the same way as East Timor.
women – without question in small narrow beds in the lithotomy position attended by the nurse. Juxtaposing traditional and Western medicines and philosophies posed little difficulty for women and healers who neither deferred to Western medicine nor rejected it, maintaining an adherence to traditional medicine, cultural mores and animistic cosmologies alongside fundamentalist Christian doctrines.

TBAs as a human rights issue - the case of the Cook Islands

The Cook Islands is an interesting case because it represents the high water mark of a public health model adapted to maternity services. For the Cook Islands Ministry of Health no expense had been spared to reduce the Maternal and Infant Mortality Rates in line with the Safe Motherhood Initiative. Their comprehensive, cautious and inclusive policy of maternity care had resulted in a comparatively low Infant Mortality Rate (6.8/1,000), a very low caesarean section rate (12-14%) and a zero MMR despite the prevalence of high-risk lifestyle factors (high alcohol consumption, poor nutrition, poor exercise, smoking) among many villagers with flow-on effects for pregnancy, notably obesity, diabetes and hypertension. Yet the maternity system had proved remarkably successful in bringing down the IMR from 37.4/1,000 (16 deaths) to 7.1/1,000 (2 deaths) in 2009 due a number of factors. How can we explain this remarkable success?

First, the general health service is public-funded, tightly organized and net-like in coverage across the twelve inhabited islands. To ensure all residents were incorporated from cradle to grave, a cadre of community health workers visited each village, school and clinic to ensure that children were immunized and monitored until 16 years after which young people were managed by a dedicated reproductive health worker who visited schools and community groups to educate young people on sexual safety, STDs etc. The health system of surveillance and compliance built upon an underlying system of traditional stratification where power was invested in the village chief and elders. Non-compliance was minimal because the chief personally ensured the non-complier attended the appointment. A preventative health approach was administered via radio and regular workshops in communities directed at parents in churches, schools, sporting groups and community groups. As the Minister of Culture explained, _if people don’t come to us we go to them_. In short, a highly differentiated, modern society (with a complex division of labour) built upon a stratified, traditional chiefly structure of power and authority combined to present a seamless approach to health-care compliance. Attendance at antenatal and postnatal checks is strongly encouraged due to the prevalence of ‘lifestyle’ diseases. All primipara and high-risk women deliver their babies at the only hospital at Rarotonga including those living in any of the
outer 12 inhabited islands. The Ministry of Health funds all air transfers but only for the mother; relatives travel by sea.²

Although boasting admirable outcomes, it became evident on closer scrutiny that the maternity system was creaking under the weight of an expensive infrastructure and the radical deskillings of midwives and women. All women are treated as high risk which means that not only is it prohibitively expensive to fly in all remote mothers but once installed in hospital women are attended by the one obstetrician who works around the clock to attend all births. A blame-and-shame culture (mistakes were paraded and offenders ridiculed) had the effect of de-professionalising and demoralizing midwives. Those that could had already decamped to NZ to practice, hopefully to the full scope of their profession. The enculturation of birth as inevitably high risk had caused women to lose trust in their own bodies to birth without intervention of some kind. Yet almost universally women reported using traditional medicines to clean out the insides. At the end of the day, they claimed the right to manage at least some aspects of their own health, pregnancy and birth although this was a case of choice by default rather than design.

Discussion: Applying the health cosmopolitanism benchmark

All three case studies in one way or another underpin the main argument here - that achieving a good birth is not just a matter of clinical excellence or attending to the social determinants of health. The cultural determinants of health, specifically the right of women to choose the way in which health care is delivered (including which modalities and carers informed by traditional and modernist cosmologies/philosophies) are important features of a mature system of health cosmopolitanism. Indeed, safety, equity and universality are not achieved unless the dignity of the individual and respect for individual choice are institutionalised via appropriate programs delivering care within an overall framework of global responsibility. According to the benchmark only two programs – those undertaken by the Café Cooperative and Dr Dan’s clinic – had achieved the main parameters of health cosmopolitanism (although mainly funded locally). For Dr Dan’s program, universality and safety had been interpreted at the local level: women chose their own TBA who was then trained to identify pathologies and manage emergency procedures which had the virtue of addressing wider political ambitions of bringing women into the public sphere and fostering community respect for women as well as their own self-respect and self-confidence. Local women could avoid the stinging rebukes of the Indonesian midwives and the cultural indignities of facility-based birth with

² The cost of maternity care is kept low for residents (at $NZ25 per birth). Foreigners are charged around $1,500 per delivery, although most European women travel to New Zealand or Australia for the birth. There are no private maternity services.
its lack of social supports and lack of respect for traditional mores. For the Café Cooperative Timor, the sterile kit targeted safety and universality objectives, and enabled women to remain at home with trusted carers of choice. The use of TBAs and traditional medicines continued to flourish mainly in the remote areas of Vanuatu but urban villagers also used traditional medicines for birth and other conditions alongside Western practices. Banning TBAs altered the place of birth but not customary cosmologies and healthcare. The Cook Islands’ model demonstrated the unintended consequences of eliminating TBAs. MMRs and IMRs had been reduced to Western levels but the maternity care budget imposed a heavy burden on a fragile developing economy. Predicated on the goodwill of distant relatives to house the mother for many weeks antenatally, the system was less than robust especially since the midwifery workforce had been morally undermined and deskilled. In parallel, routine medical interventions at birth undermined women’s self-confidence in their ability to give birth unassisted, a situation that now defines maternity care in the Western world.

Conclusion

I have argued that TBAs (where they have survived) play a key role in birth and health care but their value needs to be assessed within a wider canvas: one more expansive than both Western medicine and a modernist health framework. In the developing nations discussed in this paper TBAs signified the pursuit of cultural determinants germane to good health and good outcomes. In Timor Leste they acted as proxies for nation-building and social autonomy for women. In Vanuatu’s remote locations they addressed the vexed problem of access to resources and in meeting human rights of women to exercise choice and political and social autonomy over the ways in which they birthed. Importantly, they preserved traditional cosmologies and observed customary beliefs and practices that remain key elements of local communities. Not all practices undertaken by TBAs will be deemed safe, yet it seems imprudent and hasty to eliminate TBAs when they hold the potential to deliver efficacy and safety without loss of dignity for women especially given training and equipped with low-level technologies. I have argued that health cosmopolitanism is a term that eclipses narrow medical determinations of health (and birth) extending the vista to the wider cultural context. Within the maternity arena, health cosmopolitanism conveys ‘universal concern and respect for legitimate difference’ interpreted in the context of local settings and preferences. It incorporates good physiological outcomes and recognises the importance of social determinants in achieving good health. Yet it goes further still and brings into focus the cultural determinants of health, the values, beliefs, cosmologies and philosophies, that form the identities of individuals and which need to be honoured in delivering safe, equitable care and good birth. I have argued here that TBAs could be an important feature of health cosmopolitanism in meeting MDG 5 but
such a policy would require a dramatic about-face from governments and medical staff in developing economies. How possible this is remains an empirical question.
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