GLOBAL CASE STUDIES

in Maternal and Child Health

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This book is dedicated to all the mothers to be, mothers, newborns, and children around the world. It is also dedicated to all the people who donate money, time, energy, commitment, and passion to making the world a healthier place, especially for mothers, newborns, and children everywhere.
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Foreword

Birth is remarkable, unique, essential—and intrinsically dangerous. In the modern world it is hidden behind green drapes and IV drips, safe but secret, removed from daily life and sometimes from conscious awareness.

Ruth White’s *Global Case Studies in Maternal and Child Health* brings descriptions of birth from around the world in all its wonder, pain, and danger. It is an ingenious and intriguing way to make readers and students think about this most profound and dramatic of all events. Professor White gathers wonderfully vivid writers from Belize, Malawi, Timor-Leste, New Zealand, Haiti, Liberia, and even the jungles of the Amazon to tell the story of birth, of traditional birth attendants and skilled midwives, the security of birthing homes and the chaos of delivery in an environment torn by war.

*Global Case Studies in Maternal and Child Health* is designed to both engage and help the reader. It can stand alone, or it can supplement and enrich more conventional training material by providing real-life examples. It also contains excellent theoretical and conceptual perspectives not easily found elsewhere.

Birth is powerful, mysterious, and perhaps magical, but in an almost sinister way. We put a newborn baby on YouTube, but usually not the birth canal. Birth is not something we usually make jokes about, although the comedian Gracie Allen succeeded with her quip, “When I was born I was so surprised I didn’t speak for a year and a half.”

Birth is an obvious metaphor for the creation of the world. Great sages are often reported as having unusual births. It is said that one Sufi poet was born through his mother’s hand. Mithra arrived in a burst of light. In some Rabbinic texts, Moses is said to have been born already circumcised and able to walk. In the Old Testament, Sarah, mother of Isaac, was 175
years old when he was born, and in the New Testament Jesus is delivered normally but conceived abnormally.

Sadly, even today, some religions have a strongly patriarchal streak. Birth is sometimes framed as polluting, as in the Old Testament (Leviticus 12:1–8) where “A woman who becomes pregnant and gives birth to a son will be ceremonially unclean for seven days.” Moreover, as women are so often defined as inferior to men, the Biblical law goes on: “If she gives birth to a daughter . . . then she must wait sixty-six days to be purified from her bleeding.” Until well into the 20th century, the Churching of Women was a Catholic and an Episcopalian rite, and it still sometimes takes place in the Eastern Orthodox church. It signifies that in some evil way birth must be polluting, demanding a ritual purification before a new mother can fully enter a church.

The true story of the evolution of human birth is much more surprising and revealing than the musings of ancient mystics, edicts of misogynist priests, or maneuverings of U.S. state and federal legislators. Let’s circle back to a fundamental question: Why is human childbirth so dangerous?

Between 1785 and 1812, Martha Ballard, a midwife in New England, kept a careful diary. She attended women in labor, as midwives have done for hundreds of thousands of years, but she had no way to deal with obstructed labor, postpartum hemorrhage, or puerperal fever. One in 200 of her mothers died, which was probably the natural maternal mortality rate before modern obstetrics.

The biology of becoming a mammal did have a reproductive downside for females. A cock bird can help the hen incubate the egg and feed the fledglings, and many birds are monogamous. But when mammals began to lactate there was no way that lactation in the male could be synchronized with birth, even if that male had fathered that baby. The evolution of lactation left women literally holding the baby. Most mammals are polygamous or promiscuous, and males often grow big to compete with one another for access to females.

Then life got more difficult for one set of mammals. The primates began to develop bigger and bigger brains, and then there was a problem pushing the baby out of the pelvic canal.

Finally, one species of primate began to walk on two legs, and the pelvic ring had to become even stronger. If the human pelvis were large for easy birth, women would waddle like ducks. If the human pelvis were narrow
enough so women could run well, the baby could not be delivered. The current birth canal is an unsatisfactory compromise. When it comes to the burden of reproducing, Darwinian evolution has placed a colossal asymmetry on women: childbirth is difficult and dangerous because while it has been a huge advantage to evolve the big brain that characterizes our species, it is costly for women.

If, as the story of evolution tells us, having a big-brained baby is so important that until the advent of modern obstetrics 1 in 200 parturient women died, then surely we should use that big brain to make the wonder of childbirth as safe as possible for all women—whether in the forests of the Amazon or a friendly birthing house in New Zealand. We should use that brain to listen to the wisdom of traditional birth attendants, which all too often is lost. We should use that brain to respect women and not let men try to overrule a woman’s choice as to whether and when to have a child. Both professionals and students alike should read and discuss Ruth White’s *Global Case Studies in Maternal and Child Health*.

I feel privileged to contribute to this groundbreaking volume. As a medical student, I wanted to be a neurologist—until I saw my first birth. Today, as a physician and a biologist who has worked all over the world, I feel even more privileged that the first birth I saw turned me into a male obstetrician—a male midwife.

*Global Case Studies in Maternal and Child Health* puts that experience on paper, and it has the potential to change the perspective of some readers so they use their big brains—whether female or male—to make birth a joyful, wanted, and safe process for the mother and baby.

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**NOTE**

Acknowledgments

This book started as an idea for my sabbatical project. I placed one call for proposals on a Listserv, and the call went viral. Thanks to all the people who read the call and responded, even if they did not submit a chapter, and even if they did and the chapter was rejected. I would like to express my deepest gratitude to the contributors and the publisher for their support and patience as life, work, death, and illness got in the way of me completing the manuscript in a timely manner. Without the support of my friends, family, and colleagues, I would not have made it through the challenging personal and professional moments of this project and the life challenges I faced during the process. Thank you to all the people of Njeru, Uganda, and the people who work with the Maama Omwaana project who taught me lessons in community collaboration and gracious hospitality that will forever inform my work in community-based public health. They were the inspiration for this book. And finally, a heartfelt thank you to Dr. Nap Hosang and Dr. Malcolm Potts—two of my health professors at UC Berkeley—who made a public health professional out of a social worker.
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Introduction

I was talking to my daughter’s paternal aunt in Uganda the night before I left after a 5-week visit in 2004. Right before I left she asked if I could help her with a clinic that had been started in her community about 2 years prior. I asked her to send me the annual report and I would go from there. She went into her room and brought me a two-page document that summarized everything the clinic had done and wanted to do. I told her that when I returned to Seattle I would do some research and see how I could help.

Upon my return to Seattle, my research into how to work with this clinic was very challenging. There were lots of research reports about strategies that worked for specific health outcomes, but no easily accessible case study that could help me problem solve about how to work with this community. Where to start? What to do? What not to do? What worked? What didn’t? Of course, each community is different, and thus each solution is different. However, like everything in life, we need not learn the same lessons repeatedly, and sometimes the analytical focus of research does not allow for broader strategies. It is due to this dearth of examples that I proposed this book because I could not find a book like it. There were case studies in mental health, community organizing, and every other aspect of health, but I could only find one other book of stories from the field of maternal and child health. It took me much longer to write this book than I planned, but here it is.

Global health is a growing field in the area of public health, medicine, nursing, and other health professions. In the public health arena, maternal and child health is one of the most popular specializations and is regaining traction as an important aspect of development that explicitly includes two of the ten Millennium Development Goals (MDG)—maternal
health and child health—but it also implicitly includes other MDGs, such as gender equality and HIV/AIDS.

Although the focus on women and children has been part of the global health strategy for many decades, particularly in the field of microfinance with the success of the Grameen Bank, the new initiatives from the U.S. government spearheaded by Hillary Clinton have explicitly made this area of public health the focus for all USAID funding for years to come.

Professionals in the area of global health find the telling of stories to be useful because stories go beyond the theoretical and into the practical. Practical applications of theory that are grounded in research help us to explore and understand some of the salient issues we should consider when developing and implementing a new program or trying to evaluate the factors that contribute to the success or failure of an existing one.

This book was developed for anyone who has ever considered working in a setting outside of his or her own cultural environment. Though there are no explicit cultural guidelines suggested in any of the examples outlined in this book, the various locales force us to consider important contextual issues that apply outside of specific cultural settings. These case studies present the reader with ethical, practical, and theoretical challenges that develop critical thinking and analytical skills, as well as provide examples that can inform future work.

The success, failure, or cost-effectiveness of the case studies was not a consideration for inclusion in the book. Instead, there was a focus on variability in contexts, program goals, financing, and strategy. The goal is not to provide models for replication but to inspire creativity, develop ethical standards, and reflect on the role of self in the context of global health. With regard to the latter, it is hoped that readers will begin to consider the varied roles they can play in the promotion of the wellbeing of mothers, newborns, and children. Though it may seem adventurous and glamorous to travel internationally to be engaged in global maternal and child health, it can also be highly effective (and cost efficient) to take a hands-off approach that develops human capacity on the ground without direct intervention from abroad. This is becoming much easier than it used to be with the help of technology.

The case studies in this book were gathered through several rounds of Listserv announcements that seem to travel the world in several cycles over a year. It was a challenging exercise to find a standard for each case.
study because each story is different and each story is told uniquely in a way that not only reflects the author, but also the message of the story. These case studies are meant for medical and allied health professionals, and will bring to life theoretical and conceptual ideas discussed in primary texts through the analysis of lived stories of maternal and child health programs around the world. Ethical, practical, and theoretical questions will develop critical and analytical thinking skills and provide students with practice models they can use in their present or future work.

SOME GENERAL LESSONS FROM THE STORIES

You Don’t Need a Degree to Solve Public Health Problems

Solutions are not located only in the capitals of the north or towers of ivory. People who live with public health problems often have public health solutions, but they are rarely asked what they think or for their collaboration. Addressing challenging maternal and child health issues does not require one to build a program in an office in Washington, DC, London, New York, or Geneva and then work with local people on a foreign idea.

There Is No One Solution to a Problem

For every problem in maternal and child health there are many solutions that are shaped by culture, location, resources, and people. We know what works well in many places, but there are few solutions that work everywhere. Immunizations are a solution that works everywhere. Getting someone to get that shot is different in different places. Furthermore, we don’t always need new solutions; sometimes we just need to fix what went wrong the first time.

Money Isn’t Everything

A lot of the money spent on public health projects that transcend national boundaries is spent on crossing borders—airfare, mailings, translation, transportation, and dual administration. A lot of the money pays northern salaries for southern projects, where southern staff members make a fraction of their northern partners. There is much underutilized human capacity in the south because northern grants come with northern staff.
I remember being at Makerere University’s social science department and seeing old computers, while the budgets of their affiliates included laptops for research. Foreign researchers were all over the country, while local academics who were trained at some of the top universities in the world had a hard time finding money to do the same work in their own country.

*Indigenous Voices Must Have a Place in Academia*

Like most texts with a global scope, the voices in this text are—in all but three cases—those of the highly educated foreigners and outsiders who work with the marginalized and oppressed populations of the world. Granted, they are writing for an audience that reflects who they are, but the stories they tell would be different if told from the perspective of the people who the readers of this text intend to work with. Although I explicitly asked for submissions to be coauthored with people whose stories populated the papers, the dominance of north over south in terms of authorship is striking, and yet it is understandable given that academic Listservs were the primary way of requesting submissions. I will accept responsibility for the way in which this limited my desired audience.

Indigenous voices are rare in academia. Our academic lens filters experiences in very specific and structured ways. It is my hope that as technology expands our ability to present information, we help expand the diversity of voices that are legitimated in the academic sphere, whether through YouTube, Twitter, blogs, or Skype. This will not only change what we learn, but also how we learn, how we engage with our world, and most importantly, the strategies we choose to utilize in solving some of the world’s most challenging health issues.