Sisters Walking Together: A Case Study of the CASA Model of Professional Midwifery Training

by

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A thesis submitted to Victoria University of Wellington in partial
fulfillment of the requirements for the degree of Master of Development
Studies

**School of Geography, Environment and Earth Sciences
Victoria University of Wellington**

2012

Abstract

Over the past three years there has been an increased focus on reducing global maternal mortality in developing countries. While substantial progress has been made, improvement remains slow in some areas. Making formal maternal healthcare services more acceptable, affordable and accessible to rural communities where the majority of maternal deaths occur, remains a considerable challenge. This study looks at the model of professional midwifery training employed at *La Escuela de Partería Profesional de CASA* [the CASA School of Professional Midwifery] in San Miguel de Allende, Mexico, whose aim is to train professional midwives who will provide culturally acceptable services in rural communities. It examines how the school's model reflects the development concept of community participation.

This study adopted a single case study methodology to examine community participation at the CASA School of Professional Midwifery. Data collection techniques included the use of Semi-structured interviews, Focus Groups, Participant Observation and Document analysis.

The study found that the CASA School included elements of participation within its model and highlights the different ways in which outsiders and insiders may arrive at implementing community participation-type processes in development initiatives. The study also finds that because of differences between the biomedical and development paradigms, the reality for many communities is that they are only permitted to participate in the maternal healthcare paradigms and models sanctioned by the state.

The conclusion was that the CASA model of professional midwifery offers a new way to think about the relationship between maternal health professionals and the community, and of integrating communities back into the maternal health discourse.

Acknowledgements

A very special thanks to the staff and students at the *Escuela de Partería Profesional de CASA* for sharing with me your passion and dedication for improving maternal health in Mexico. Thanks to Maricruz Coronado Saldierna, Débora Clavé, Maribel García Hernández and Doña Antonia Córdova Morales for your inspirational work. It has been an honour and a privilege to spend time with each of you. *Gracias*.

Thank you to Dr. Joan Skinner, for your guidance on this project, your enthusiasm, and for allowing me to draw on your broad knowledge of maternal health and global maternal health initiatives. Thanks to Dr. John Overton, for your time, expertise, and positivity over these last three years.

Last, but not least, my family. For my mother Anne, who planted the seed that has grown into my interest in maternal health, for all your support and for the unforgettable time we shared together in San Miguel de Allende. For my father Adrian, for the years spent inspiring me, teaching me, surprising me, and for sharing in every step of my learning. For my sisters, Megan and Rachel, my companions in life. And for Miguel, for your unconditional love and support. Each of you can share in this accomplishment, for without your support it would not have been possible.

August 7, 2011

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Abbreviations

CASA	CASA (<i>Centro para los Adolescentes de San Miguel de Allende</i> / Centre for the Adolescents of San Miguel de Allende)
ENEO	National School of Nursing and Obstetrics (<i>Escuela Nacional de Enfermería y Obstetricia</i>)
ICM	International Confederation of Midwives
IMSS	Mexican Institute of Social Security (<i>Instituto Mexicano del seguro social</i>)
JHPIEGO	Johns Hopkins Program for International Education in Gynecology and Obstetrics
MDG5	United Nations Millennium Development Goal 5
MMR	Maternal Mortality Ratio
MMrate	Maternal Mortality Rate
NARM	North American Registry of Midwives
NGO	Non Governmental Organisation
PRA	Participatory Rural Appraisal
SBA	Skilled Birth Attendant
SMI	Safe Motherhood Initiative
TBA	Traditional Birth Attendant
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

Glossary

Alma Ata Declaration	International Conference on Primary Health Care (PHC) Alma-Ata USSR 6-12 September 1978.
<i>El internado</i>	Internship
<i>El plan de estudios</i>	Curriculum
<i>El servicio social</i>	Social service
Episiotomy	A surgically planned incision on the perineum and the posterior vaginal wall.
<i>La cedula profesional</i>	Professional license
<i>La Escuela de Partería Profesional de CASA</i>	CASA School of Professional Midwifery
<i>La Secretaría de Salud</i>	Ministry of health
<i>Las clases de partería tradicional</i>	Traditional midwifery clases
Maternal morbidity	Refers to on-going health issues for women arising as a result of pregnancy or childbirth such as anaemia, infertility, prolapsed uterus, scarring and faecal or urinary incontinence.
Maternal mortality	The death of a 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 or incidental causes.
Maternal Mortality Rate	The number of maternal deaths in a given time period per 100,000 women of reproductive age
Maternal Mortality Ratio	The number of maternal deaths during a given time period per 100,000 live births during the same time. This measure only captures the risk of death of a woman once she is pregnant - in other words, the obstetric risk.
Oxytocin	A synthetic drug, similar to the natural oxytocin a woman's brain releases to stimulate contractions. Used to augment labour when a woman's labour is slow, or the contractions are not very intense. It is also used if the waters have broken and the labour does not start, or to co-ordinate irregular uterine contractions.

<i>Parteras</i>	Lay midwives
<i>Parteras profesionales</i>	Professional Midwives
<i>Parteras tituladas</i>	Titled midwives
<i>Parteras tradicionales</i>	Traditional midwives
<i>Prácticas comunitarias</i>	Community field experiences
Puerperium	Period of around six weeks following childbirth when the mother's reproductive organs return to their non-pregnant condition.
Skilled Birth Attendant	WHO defines a skilled birth attendant as “an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, childbirth and the immediate postnatal period, and in the identification, management and referral of complications in women and newborns” (WHO, 2004).
<i>Tamales</i>	A traditional dish made of a starchy corn-based dough, which is boiled in a leaf wrapper.
<i>Tortillas</i>	Flat bread
Traditional Birth Attendant*	WHO defines a traditional birth attendant as “a person who assists the mother during childbirth and who initially acquired her skills by delivering babies herself or through an apprenticeship to other traditional birth attendants” (WHO, 1992).

Note*

In Mexico, traditional birth attendants (TBAs) are referred to by various names, these include: *parteras tradicionales* [traditional midwives], *parteras indígenas* [indigenous midwives], *parteras comunitarias* [community midwives], *parteras capacitadas* [capacitated midwives] and *parteras empíricas* [empirical midwives]. In this research, we will use the Mexican term *partera* or the English term *traditional midwife* to distinguish these midwives from the *parteras profesionales* or professional midwives being trained at CASA.

Introduction

This thesis looks at the model of professional midwifery training employed at *La Escuela de Partería Profesional de CASA* [the CASA School of Professional Midwifery] in San Miguel de Allende, Mexico. The study's research question is: *How does the model of midwifery training employed at the Casa School of Professional Midwifery reflect the concept of community participation?* The study provides an understanding of how one model of professional midwifery training is attempting to improve the cultural acceptability of formal maternal health services in rural communities. CASA's aim is to train professional midwives who, upon graduating, will not only have the skills to work in rural areas but will also be able to meet communities' needs through providing culturally appropriate services. This has resulted in a training programme which emphasises the importance of learning traditional midwifery knowledge and practices. The principal mechanisms for this are weekly classes taught by a traditional midwife, and by students having the opportunity to live and work with traditional midwives during community field experiences.

This study is valuable in terms of information gathered as there is a well established body of evidence that tells us that in the absence of community participation it is unlikely that communities' acceptance and uptake of formal maternal health services will occur (Howard-Grabman, 2007). However the construct of community participation is itself not without criticism. This criticism can broadly be divided into two main categories: criticism of the technical limitations of participation when put into practice, and criticism of the theoretical and conceptual limitations of participation both of which will be addressed in more detail in the chapter on the Relationship between Community Participation and Maternal Mortality Outcomes (Parfitt, 2004; Cooke & Kothari, 2001).

Over the past decade there has been an increased focus on reducing global maternal mortality in developing countries, and while substantial progress has been made improvement remains slow in some areas. In fact, only 23 countries (out of 181) are on track to achieve the United Nations Millennium Development Goal 5 concerning maternal health (MDG5) by 2015 (Hogan et al., 2010, p.1). This is not because of a

lack of knowledge but rather because it is now widely accepted that there will not be a substantial reduction in maternal mortality without skilled birth attendants (SBAs) at delivery or access to emergency obstetric healthcare. However, because the social causes of maternal mortality are so complex, simply providing healthcare services will not in itself guarantee that they will be accepted and used by those who need them. The challenge is in finding ways to make these services more acceptable, affordable and accessible to rural communities where the majority of maternal deaths occur.

The World Health Organisation's (WHO) approach to accelerating activity on MDG5 includes an emphasis on the provision of skilled midwives. Accordingly, there is a real need for research focusing on what specific aspects of midwifery training might help in the process of making midwives' services more acceptable to rural communities. This is where the concept of community participation comes in. Within development thinking discourse, community participation is regarded as one of the key mechanisms for improving the conditions in which people live. In fact many health researchers and practitioners now believe that for maternal healthcare initiatives to be successful communities need to be actively involved throughout the whole process. As has been noted, participation remains a concept filled with many ambiguities in terms of what it means and how to implement it. While a growing body of literature points towards the need for more community involvement in global maternal health initiatives, there are few concrete examples published of community participation in the training of skilled birth attendants (SBAs).

In terms of looking at the involvement of traditional midwives within professional midwifery healthcare training this research comes at a time when many countries in Latin America (and worldwide) are rapidly moving towards a Western biomedical model of maternal healthcare. At the same time they continue to remain heavily dependent on the services of a steadily decreasing number of traditional midwives in rural communities. Given this heavy dependence on the use of traditional midwives and the known link between community participation and improved health outcomes, a focus on the incorporation of traditional midwifery in SBA training is particularly relevant.

The methodology chosen to examine community participation at the CASA School of Professional Midwifery was a qualitative case study approach, which emphasises in-depth inquiry rather than a quantification of facts (Stark & Torrance, 2005). Qualitative research seeks out the *why* and *how* of phenomena, not just the *what*, *when*, and *where* (Yin, 2009). The strength of the qualitative research paradigm is the richness of information provided on the lived experience of the participants and a focus on less quantifiable factors such as religion, gender roles and embedded and often hidden cultural constructs (Family Health International, 2005: pp. 1-2). The weaknesses of the qualitative case study approach include the potential for researcher bias, difficulties in determining the boundaries of focus (what to include and exclude), and demands on participants, particularly in the case of a single case study where there may be a small number of participants. At a theoretical level the most frequent criticism is that of generalisation on the grounds that as single case studies are bound by both location and context they are incapable of providing generalized conclusions (Yin, 2009). Yin challenges this by arguing that rather than relying on the statistical generalisation that underpins quantitative methodologies, case studies can be subjected to analytical generalisation which allows the researcher to attempt to generalise a particular set of results to some broader theory (Yin, 2009, p.43). Some of the limitations of the qualitative case study methodology can be overcome through the use of multiple data collection sources. There are two main reasons for this. Firstly, it helps facilitate a holistic, inside view of the phenomena. As Baxter and Jack describe it, ‘each data source is like one piece of the puzzle, with each piece contributing to the researcher’s understanding of the whole phenomenon’ (Baxter & Jack, 2008, p. 554). The second, and principal, rationale for using multiple sources of data is that it enables the triangulation of evidence. Triangulation involves the combination of ‘two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods’ (Thurmond, 2001, p.253). The data collection techniques for this research include the use of Semi-structured interviews, Focus Groups, Participant Observation and Document analysis. These techniques will be covered in more depth in the Methodology chapter.

By looking at CASA’s unique approach to professional midwifery training, this research provides insight into the incorporation of community participation into future professional midwifery training. Furthermore, by sharing the insights gained

by CASA's own experiences with an alternative approach to midwifery education, this research will hopefully contribute to the current global maternal health discussion on how to increase women's access to formal maternal healthcare services.

Thesis Structure

In terms of overall organisation this thesis is divided into six chapters. The first chapter, *Theoretical Background to Maternal Health*, provides the theoretical background to maternal health in developing countries. This includes an exploration of issues of gender inequality and the affordability, accessibility and acceptability of health services. It then examines the current debate about the role of traditional birth attendants (TBAs) in improving maternal health. It briefly reviews the current maternal health situation in Mexico and then looks specifically at maternal health in the state of Guanajuato where the research was undertaken. The chapter closes with a brief history of birth attendants in Mexico.

The Relationship between Community Participation and Maternal Health Outcomes. This chapter examines the theoretical framework of community participation. It offers an overview of the concept of community participation, highlighting the distinction between participation as a means and as an end, and the discourse around genuine versus pseudo participation. It then looks at some of the criticisms of the concept. The chapter ends with a description of community participation in health literature.

Methodology. This chapter addresses the research methodology, this includes the research inquiry, a description of the qualitative case study approach, methods used, and research procedures. This chapter also highlights the relevant ethical issues of the research.

Description of the CASA School of Professional Midwifery. This chapter covers a description of the CASA School of Professional Midwifery, its history, teaching model, students, and the challenges the programme faces.

Casa and Community Participation. This chapter reflects on what the findings of this study may tell us about the overall concept of community participation in maternal health training. This includes a focus on community participation within the dominant Western biomedical model of health.

Discussion and Recommendations. Provides an overall reflection on the research, and provides a number of recommendations and identifies possible areas for future research.

Theoretical Background to Maternal Health

Introduction

Improving maternal health in developing countries is a key focus for many development organisations, agencies and governments around the world. This chapter presents an overview of maternal health in developing countries and the strategies now being employed to improve outcomes. It then examines the current maternal health situation in Mexico and the provision of maternal healthcare services in the state of Guanajuato. The brief history of Mexican birth attendants illustrates not only the changes in Mexico's thinking and policies concerning maternal health, but also provides the context whereby the CASA School of Professional Midwifery finds itself as the only professional midwifery school in the country.

Overview of Maternal Health in Developing Countries

Worldwide more than 340,000 women die every year from complications or conditions during pregnancy and labour (Hogan et al., 2010). Ninety-nine percent (99%) of these maternal deaths occur in developing countries. The highest number of maternal deaths occur in poor rural areas where births predominantly take place at home rather than in healthcare facilities (Kamal, 1998, p. 43). Millennium Development Goal 5 (MDG5) concerning maternal health aims to reduce the Maternal Mortality Ratio (MMR) by three quarters by the year 2015 (United Nations, 2004).

Accurate measurement of maternal mortality is difficult even though there are several widely-used definitions, for example the Maternal Mortality Ratio (MMR), and Maternal Mortality Rate (MMrate). The International Classification of Disorders (ICD 10) uses as its statistic pregnancy related death and the Proportion Maternal among Deaths of Females of reproductive age (PMDF) - which provides an estimate of the probability of a 15 year old female dying from a maternal related cause (WHO, 2010). Even where definitions exist maternal deaths may go unrecorded for a

variety of reasons including poorly developed civil systems for recording births and deaths, women's pregnancy status being unrecognized at the time of death, death of women of reproductive age going unreported, lack of medical professionals to determine cause of death, death from pregnancy related conditions occurring well after the pregnancy and not being considered to be related to this, and the miscoding of deaths. The World Health Organisation (WHO, 2010) has adopted as its primary statistic for measuring of maternal mortality the Maternal Mortality Ratio (MMR) which it defines as the "Number of maternal deaths during a given time period per 100,000 live births during the same time-period" (WHO, 2010, p. 6). This is the measure that will be referred to in this thesis.

While some of the other seven MDGs are well on their way to being achieved, the reduction in maternal mortality so far, although substantial, has remained slow and geographically varied (United Nations, 2008). As mentioned before, of the 181 participating countries only 23 countries are on track to achieve MDG5 by 2015 (Hogan et al., 2010, p. 1). The direct and indirect medical causes of maternal mortality are well known, and the means to prevent nearly all of these have been available for over 70 years (Maine & Rosenfield, 1999, p. 480). Yet despite this we have not seen a dramatic improvement in maternal health. Given that this is not because of a lack of knowledge it is reasonable to assume that the majority of maternal deaths could be averted and the question of what is being implemented be subject to scrutiny.

The impetus for MDG5 came from a 1987 conference in Nairobi where three international agencies, the World Bank, WHO and the United Nations Population Fund jointly promoted the Safe Motherhood Initiative (SMI) in an attempt to reduce global maternal mortality. Central to this initiative has been the WHO *Mother-Baby Package* which identifies "Four pillars of Safe Motherhood" antenatal care, clean and safe delivery, essential obstetric care and family planning (WHO, 1994). Despite a focus on these areas there has not been the hoped for increase in improved maternal health outcomes.

Maine and Mbizvo (1999, pp. 480-481) believe that the lack of progress in improving maternal health is not because there is insufficient resources available to

do so, but rather that the Safe Motherhood Initiative has lacked a ‘clear strategic focus’. They argue that over the years there have been many misconceptions about how to reduce maternal mortality and that a range of strategies have been tried including attempts to identify and target “high risk” pregnant women, improved access to family planning and antenatal care, and the training of traditional birth attendants (TBAs) (Roth & Mbizvo, 2001, p.11; Bullough et al., 2005, pp. 1181-1182). Currently the Safe Motherhood Initiative is primarily focused on improving skilled attendance at delivery because ‘while most obstetric complications can be neither predicted nor prevented, they can successfully be treated’ (Maine & Rosenfield, 1999, p. 481).

It is now widely accepted that there will be no substantial reduction in maternal mortality without SBAs at delivery and/or access to emergency obstetric healthcare (Maine & Rosenfield, 1999; Donnay, 2000; Bullough et al., 2005). MDG5 follows this path and aims to have 90% of all births worldwide being attended by SBAs by 2015 (United Nations, 2004). However, many countries are far from achieving this percentage and it will be a huge challenge for them to do so (Hogan et al., 2010, p. 1). Moreover, there is the issue of what type of SBAs need to be trained to best accomplish these aims. For example, the WHO’s approach to accelerating activity on MDG5 includes an emphasis on the provision of skilled midwives.

It has also been questioned as to whether merely increasing access to SBAs and critical obstetric healthcare is ‘sufficient to address the multitude of factors that contribute to poor maternal health outcomes’ (Roth & Mbizvo, 2001, p. 11). Maternal mortality is recognised as being more than just a medical problem, and simply increasing access to SBAs and critical obstetric healthcare facilities will not necessarily solve the ‘problem’ of maternal mortality. For a start, there is no guarantee that communities will even use the health services provided (Sai & Meashan, 1992; Skinner & Rathavy, 2008; Kamal, 1998). This is why many maternal health researchers and practitioners are now looking towards increased community involvement in maternal health initiatives (Barnett, Nair, Lewycka & Costello 2005; Costello, Osrin & Manandhar, 2004; Howard-Grabman, 2007; Howard-Grabman 2000; Rosato et al. 2008). It has been argued that as the majority of pregnancy and labour experiences in developing countries take place in the

community that the Millennium Goal for maternal health is not being reached due to the failure to incorporate community participation into health programmes (Rosato et al., 2008, p.962). When viewed from this perspective poor maternal health is a problem that illustrates the place inequality, discrimination and marginalization, and inequalities in gender play in preventing the uptake of better practices in poor, rural, and indigenous communities.

Several studies have demonstrated that asymmetrical relations of power that place women at a disadvantage within the household, the community, and within healthcare facilities are barriers to good maternal healthcare (Roth & Mbizvo, 2001, p.12; McCarthy & Maine, 1992). Many of the causes of maternal mortality are exacerbated by the presence of gender inequalities within communities. There are well known correlations between maternal mortality and education level, age, parity and birth spacing (McCarthy & Maine, 1992). Without education, women have limited access to appropriate information about reproductive health, limited knowledge about their own bodies, and have a limited ability to exercise their right to reproductive healthcare (Pan American Health Organization, 2005).

Undoubtedly, one of the biggest gender inequalities affecting maternal health is that women often do not have decision-making power over their own bodies (Roth & Mbizvo, 2001, p. 12). In many communities, it is the husband and family members of the pregnant woman who decide where she is going to give birth, and who will assist during labour (Roth & Mbizvo, 2001, pp. 12-13; Atkin, 1994, p. 213). They also decide whether she receives traditional or modern medicine and whether or not she goes to a hospital if complications do arise. Even in situations where there are serious complications, there are many communities in which husbands and family members do not want their wives or daughters to go to a hospital.

These problems are very complex but all point towards gender equality and women's empowerment within the community as being an essential part of the solution (Pan American Health Organization, 2005). The growing recognition that for changes in social norms and practices to be successful they need to take place within the community has led to a community rather than a facility approach to improving maternal health outcomes (Barnett et al., 2005 p. 1171).

The social causes of maternal mortality are complex and merely increasing access to SBAs and critical obstetric healthcare as proposed under the original SMI will not necessarily solve the ‘problem’ nor does the provision of health care services guarantee that they will be accepted and accessed by those who need them (Kamal, 1998, p. 45). There are a range of reasons why communities may not want to use these services. Skinner and Rathavy (2008) identify “the problem of the three A’s”: affordability, accessibility and acceptability of the healthcare centre and its staff. Distance and cost are key reasons why women in rural communities may not access formal healthcare services. Health centres are often inaccessible due to distance and geography but also because some centres are not open all day or during the night (Skinner & Rathavy, 2008; Grupo de Parteras “Gushish” de Tlacolula, 1998, p. 54). Costs can include the transport to a health facility and any medical supplies that the woman may have to procure for herself (Roth & Mbizvo, 2001, p.13). Lack of acceptance can be due to a lack of trust in medical specialists, which may be exacerbated when the specialists do not speak the local language, and/or have a lack of understanding of local cultural traditions surrounding pregnancy and childbirth. Collectively factors such as not receiving appropriate responses to their problems, not being treated with respect and failing to consider economic, socio-cultural, linguistic, and political imperatives, all combine to limit and/or delay access to health information and services (Howard-Grabman, 2000).

Thaddeus and Maine (1994) present an explanatory model of maternal mortality outlining delays in seeking, reaching, and obtaining care as key factors leading to maternal death. This is known as the Three Delays Model, and includes the following three categories of delays: delay in deciding to seek care if complication occurs, delay in reaching care, and delay in receiving care once arriving at a healthcare facility. Research into maternal deaths in developing countries confirms the presence of these delays as key factors in maternal mortality (Roth and Mbizvo, 2001, p. 12).

Current Debate About the Role of Traditional Birth Attendants (TBAs)

There has been much questioning of the role that TBAs can continue to play in improving maternal health in the biomedical age in which we now live. Amongst

many biomedically trained health professionals and policy advisers, TBAs are regarded as an antiquated leftover from the past, their existence continuing only due to the lack of coverage of modern healthcare systems (Davis-Floyd, 2001, p. 5-6). However, TBAs have long been part of the maternal health discourse, primarily because the highest proportion of maternal deaths are in poor rural areas in developing countries where births predominantly take place at home and where TBAs deliver more than 80% of births (Walraven & Weeks, 1999, p. 527; Kamal, 1998, p. 44). During the 1970's through to the early 1990's, the training of TBAs was a popular strategy in trying to reduce the MMR in developing countries (Flemming, 1994, pp. 143-144). This approach was backed by the WHO, and most large NGOs offered training programmes. The idea behind this was that by training TBAs in basic midwifery skills, hygiene, and in the early detection of complications, this would bring about a dramatic reduction in the MMR (JHPIEGO, 2002). However, subsequent studies have shown that there is not sufficient evidence to suggest that training TBAs does in fact result in a decrease in maternal mortality (Walraven & Weeks, 1999, p. 527; Donnay, 2000, p. 94). This may be because TBAs do not have the necessary skills or access to critical obstetric technology that are required for reducing rates. As a result many NGOs and development agencies now emphasise SBAs and increased access to emergency healthcare facilities rather than the training of TBAs

There is, however, a growing body of literature that argues that trained TBAs do still have a critical role to play in the maternal health of their communities, not necessarily as primary birth attendants but as facilitators between the community and health services. The authors of these studies assert that TBAs should continue to be trained and to be integrated into healthcare systems on the grounds that trained TBAs are recognised as often important and much respected members of the community who are highly knowledgeable about the local cultural and traditional beliefs surrounding pregnancy and birth (Kamal, 1998; Walraven & Weeks, 1999; Moran, Sangli & Dineen, 2006). The viewpoint of these authors is that it is essential that TBAs are included in community maternal health education and mobilisation efforts as they can play a vital role in facilitating access to needed information and health services (Perreira, Bailey, de Bocaletti et al., 2002, p. 19). In other words, TBAs can facilitate in 'bridging the gap' between the community and health services (Howard-

Grabman 2000). A joint JHPIEGO/Maternal and Neonatal Health publication states that ‘just as the TBA needs to work with a skilled provider in order to have an impact on maternal mortality, the skilled provider needs the TBA to help build a relationship with the community’ (JHPIEGO, 2002, p. 2). This helping of SBAs to ‘build a relationship with the community’ is essential when it comes to answering the question of how to make formal maternal healthcare services more affordable, accessible, and acceptable to rural communities; a question that we need to take seriously considering the varied progress made so far in meeting MDG5.

Maternal Health in Mexico

Mexico is a country of many inequalities and disparities between rich and poor, rural and urban, and between the genders and ethnicities. There are 56 officially recognised indigenous groups in Mexico, each with their own language, cultural beliefs and traditions. Of the total Mexican population 18.2% live below the poverty line (CIA, 2010). In 2000, 67.3% of the maternal deaths registered in Mexico were concentrated in the southern and south-eastern states of the country where many inhabitants live in extreme poverty in rural and indigenous areas (Lozano, Hernandez & Langer, 1994, pp. 44- 45; Diaz de Leon Ballesteros Diaz, Gasman, & Campos Nava, 2002).

Mexico shares many of the same maternal health characteristics as other developing countries. In 2008 the national MMR was estimated at 85 (range 74-96) deaths per 100,000 live births (UNICEF, 2008). This means that in Mexico around four women die every day due to complications during pregnancy and childbirth. By way of comparison WHO estimated there were 358,000 maternal deaths worldwide in 2008 which gave a maternal mortality ratio of 260 maternal deaths per 100,000 live births, while the MMR in developed countries was 14 per 100,000 (WHO, 2010).

The Mexican estimate is likely to be a conservative estimate as some health practitioners believe that many more women than this are dying in the country each year and that it is impossible to know the true rates of maternal mortality in Mexico as not all the data is recorded, available or reliable (Langer, Hernandez & Lozano, 1994, p. 29). Some small scale studies undertaken in urban areas in 2002 have

suggested that the official information about the MMR might have been unrecorded by as much as 50% (Diaz de Leon Ballesteros et al., 2002). The lack of recent recorded or available data became very apparent during my research. For this reason some of the data used and research cited is unfortunately more than a decade old.

While the national MMR of 85 may not appear high by Latin American standards for example Guyana has an MMR of 270, Bolivia 180 and Ecuador 140 (WHO, 2011) there are wide disparities between rates in marginalised rural and indigenous communities and those in urban centres within Mexico, for example, a 1994 report on rural indigenous communities in the state of Guerrero indicated MMR reached 283 deaths per 100,000 live births (Lozano et al., 1994, p. 44).

The most common direct medical causes of maternal mortality in Mexico include: toxæmia, haemorrhage, complications during puerperium and complications surrounding abortions, especially induced abortions that take place in inadequate conditions (Lozano et al., 1994, pp. 49-50). The majority of these deaths could be avoided through the application of simple technologies, well within reach of all developing countries (Gutierrez Trucios, 1994, p.14). The challenges that Mexico faces in its struggle to improve maternal health are a lack of healthcare service coverage across the country, and the need for more political support towards improving maternal health.

Mexico's population of over 100 million inhabitants are spread over a landmass of more than 1,950,000 square kilometres (CIA, 2010). The provision of nationwide healthcare service coverage is further complicated by the fact that Mexico is made up of more than 100,000 remote communities which have 25,000 inhabitants or less (CASA 2003: 21). These are communities with difficult or no access to basic healthcare services. In 2002 the Ministry of Health recognised that around 370,000 women in Mexico are without access to medical services during pregnancy, labour, and following the birth of their children (Diaz de Leon Ballesteros et al., 2002).

Mexico is a highly patriarchal society where women are often expected to become pregnant at an early age, and give birth to many children over their lifetime. Inequalities between the genders can be seen throughout all levels of Mexican

society. For example, Diaz de Leon Ballesteros et al. (2002), write that *la salud de la mujer aun no es considerada como prioridad por parte del gobierno federal* [‘The health of women is still not considered a priority by the Federal government’] However, the country does recognise maternal mortality as a problem. In 1990, the Mexican Ministry of Health was one of 37 health ministries in the Americas to approve *El plan de acción regional para la reducción de la mortalidad materna en las Américas* [The Regional Action Plan for the Reduction of Maternal Mortality in the Americas]. As a United Nations member they signed the Millennium Declaration and committed themselves to meeting the eight MDGs by 2015. While Mexico has seen improvements in maternal health over the last two decades these have not been dramatic. Over the 18 year period 1990-2008 the MMR in Mexico decreased from 93 to 85 a reduction of 8% compared to worldwide decline over the same period (WHO, 2011).

When we consider that for every maternal death there is believed to be another 16.5 cases¹ of maternal morbidity (Langer et al., 1994, p. 26; Datta, Sharma, & Razack, 1980) then there is much that remains to be achieved. Maternal morbidity refers to on-going health issues for women arising as a result of pregnancy or childbirth such as anaemia, infertility, prolapsed uterus, scarring and faecal or urinary incontinence (Prual et al. 2000, p. 573). What is needed is effective action within communities and the government. Gutierrez Trucios (1994) writes

Current knowledge about the problem is sufficient to establish concrete actions to be carried out through programmes to reduce maternal mortality. However, what is lacking is strong political decisions/action to bring together forces to prevent this tragedy and the ability to apply this knowledge and translate it into effective and efficient action at local levels.² (p.14)

Maternal Health in the State of Guanajuato

The CASA School of Professional Midwifery is located in the state of Guanajuato, the sixth most populated state in Mexico. In 2000 its population measured 4,663,032 inhabitants or 4.78% of the total population of Mexico (CASA, 2003, p. 23).

¹ Some scholars take this further and believe that for every maternal death it is possible to identify 100 cases of illness/maternal morbidity (Koblinsky et al., 1993)

² My own translation from the Spanish.

Guanajuato has a higher than normal average of rural population than that of the country as a whole with 32.8% of the population living in rural locations. Of the 8932 localities that make up the State, 7872 have less than 500 inhabitants (CASA, 2003, p. 23). These figures provide an idea of the dispersion of the population, and help to understand the difficulties in providing basic health and education coverage.

Guanajuato has a fertility rate of 3.3 children per woman. This is the third highest rate in the country; the national rate being 2.9. The State's MMR has seen little change over the last two decades. In 2000, it was at 37 per 100,000 registered live births. The majority of these deaths occur in rural and suburban areas of the State.

According to figures collected in the year 2000, the public institutions of the Health Sector in Guanajuato included 25 hospitals, 57.4 units of external consultation, 1620 surgeries, 397 birthing rooms, 2462 beds, and 86 operating theatres. These figures correspond to 0.33 surgeries, 0.49 beds and 0.08 birthing rooms for every 1000 inhabitants (CASA, 2003, p. 24). All this clearly illustrates the insufficient coverage of formal healthcare services in the State of Guanajuato and the subsequent risks this poses for women.

A Brief History of Skilled Birth Attendants in Mexico

Mexico, along with many other countries, has witnessed great changes in the types of maternal health professionals being advocated and trained. The first half of last century saw the prominence of skilled midwives in the country. In 1911, the School of Nursing was incorporated into the National University and offered two courses: Nursing and Midwifery. Each course had the same entry requirements, and both had doctors as directors and teachers (CASA, 2003, pp. 7-8). In 1935, the entry requirement for midwifery changed and prospective midwives needed to have completed both secondary school and nursing to be accepted into the obstetrics programme. This followed the widely accepted belief that to be a good midwife you first needed to be a nurse. These professional nurse-midwives were called *parteras tituladas* [titled midwives] and were employed in hospitals (Davis-Floyd, 2001, p. 5). Davis-Floyd writes that the presence of these midwives was instrumental in bringing women to hospitals to give birth (Davis-Floyd, 2001, p. 5). In fact, up until the

1950s, the majority of the births taking place in hospitals were attended by these midwives (CASA, 2007, p. 434). However, by the 1950s the training of ‘titled midwives’ at the National University was stopped without any explanation, and a one year obstetric nursing course was created instead.

In the early 1960s, the *Instituto Mexicano del Seguro Social (IMSS)* [the Mexican Institute of Social Security] prohibited *parteras tituladas* from attending births in social security hospitals. Other hospitals soon followed suit (CASA, 2003, pp. 8-9; Davis-Floyd, 2001). In 1968 the degree of Nursing was created, and a one year post-nursing obstetric course was integrated into the studies. This degree continues up to today. These graduates receive the official title of *Licenciadas en Enfermería y Obstetricia* (Graduates in the degree of Nursing and Obstetrics). Despite their graduate status they are not autonomous birth attendants. As Davis-Floyd (2001) notes ‘these women mostly work as high-tech labour and delivery nurses in addition to performing administrative work and teaching’ (p. 5).

From the 1970s onwards the number of skilled midwives in Mexico decreased with their place being taken by doctors (CASA, 2003, pp. 8-9). Health services promulgated the idea that all births should take place in healthcare facilities attended by specialised birth attendants. Thus, Mexico has experienced an increasing medicalisation of pregnancy and childbirth and seen birth moved from the area of the home and the midwife to that of the health institution and specialist. With this change Mexico, like many other developing and developed countries, is witnessing a dramatic increase in the rate of caesarean-sections and other birthing interventions. Figures from a WHO study in 2005 show that the cesarean rate in Mexico was 30% in public hospitals, 40% in IMSS hospitals, and more than 70% in private hospitals (WHO, 2005, cited in CASA 2007, p. 432). This means that Mexico has one of the highest rates of cesarean sections in Latin America. The worldwide increase in birthing interventions has been so dramatic over the last two decades that some health researchers consider it to be “epidemic” (Wagner, 1994, p.174). The abuse and over use of this technology has scholars worried for the safety of women in both developing and developed countries³. There is growing concern that Mexico along

³ The WHO recommendation is that caesarean sections make up less than 15% of all births and less than 9.5% in wealthy, westernised nations (WHO 1985).

with other developing countries will end up fully duplicating the Western biomedical model of maternal healthcare, where, when it comes to place and the equipment used, there is often no longer any distinction between a birth with complications and a normal birth (Ferrari, 1982).

This medicalisation of birth has implications for the training of professional midwives. Davis-Floyd (2001) puts this into the Mexican context:

Commonly, government officials and MDs dismiss midwifery by arguing that there are plenty of doctors and nurses in Mexico; that the poor are entitled to the same care as is the middle class; and that, therefore, progress in maternal health care does not mean either preserving traditional midwifery or creating a new kind of midwifery but, rather, giving everyone access to hospitals and doctors. This argument is representative of what has been called the “megarhetoric of developmental modernization” (Appadurai 1996:10), which identifies a single point in a given area toward which development should be progressing (Appiah 1997:425) in health care, that single point is Western biomedicine. (pp. 5-6)

The fact remains that Mexico continues to depend heavily on traditional midwives to provide care for women in rural communities throughout the country. During a semi-structured interview I conducted with Maricruz Coronado, the Director of CASA programmes, she talked about the use of the different birth attendants in Mexico:

There are rural communities where 100% of births are attended by traditional midwives. But in the cities, in the big cities, well 100% are attended by doctors in the medical system. We are so few [professional midwives] that we don’t even count. We attend around three hundred births a year... Right now in communities women continue giving birth in their houses with traditional midwives. I am from a ranch and my mother had 14 children and all 14 were born in the community with traditional midwives. This is still happening. (Interview with Maricruz)

Traditional midwives still remain the principal birth attendants in many rural communities in Mexico. Given the importance of the traditional midwives it is worth looking at their role in some detail.

Traditional Midwives in Mexico

Since pre-Columbian times, births in Mexico have been attended by *parteras* [traditional midwives]. This has continued through the colonial period until present

day. A 1994 study conducted by the Ministry of Health noted that traditional midwives still continued to attend a third⁴ of all births in the country. In many rural and marginalised areas they attended up to 80% of births (Secretaria de Salud , 1994, pp. 139-162). It is difficult to determine the current percentage. Based on 2004 figures it is known that approximately 18740 traditional midwives were registered with the Mexican government and it is possible that there are around another 9000 who were unregistered (Mills & Davis-Floyd, 2009).

The position taken by the Mexican Ministry of Health towards the practice of traditional midwives is complex: on the one hand they have tried to control their practice, and on the other hand they have tried to improve their practices through up-skilling courses⁵. The attitude of the state regarding traditional midwives can thus be described as being one of *dejar hacer* or “leave them to do it” (CASA, 2003, p. 8). This is in part a pragmatic response to the difficulty in providing complete healthcare coverage around the country. Even with the increase in university trained medical professionals numbers have not been sufficient to cover the maternal health demands of the country, especially in rural and marginalised areas as health professionals often decide to remain and work in urban centres where they have access to professional development and can better their social and economic status. As long as the *parteras* attend the up-skilling courses they are legally permitted to work. For many Mexicans, traditional midwives remain the only option for birth attendants. As Maricruz explains,

They [the Ministry of Health] accept them, because they can't get rid of them, and because they are there because people need them, it is not that the Ministry of Health wants them. If the Ministry of Health could decide, there wouldn't be any. They are there because women need them. In fact there are many *parteras* who don't want to be *parteras*. For example, here in Guanajuato there is a girl whose mother-in-law was a *partera* and the mother-in-law died and I told her “study to become a *partera* because they are going to come looking for you”, and I was right, women came looking for her mother-in-law, and she tells me that she has to let them in as she

⁴ This is still the number that is most often still cited in current literature, although CASA writes that traditional midwives attend between 25 and 30% of all births in the country, and up to 100% in some rural communities (CASA, 2007, p. 429).

⁵ These courses tend to be run by government institutions of health such as the IMSS and the Ministry of Health. The length of the courses can range from two to four weeks long. These courses are taught by doctors and nurses, and tend to be mainly theoretical (CASA, 2007, pp. 430-431).

can't just leave them there. She doesn't want to be a *partera* but here she is attending births. Thus, traditional midwives exist because the communities need them, it is not necessarily that they themselves want to be *parteras* but that there are no other options. That is how it is. The Ministry of Health accepts them, and they are part of the health system even though they don't get paid, they are there under the general health law. They are legal. (Interview with Maricruz)

The role of the traditional midwife has not changed greatly over the centuries. The majority of *parteras* are women over the age of sixty (Davis-Floyd, 2001). For the most part they have learned their profession by assisting other *parteras*, often their own mother, grandmother or mother-in-law. Sometimes they find themselves being given the role of *partera* after being called on to help with the labours of friends or family members. Historically many *parteras* came to the role as a result of a 'divine calling'. This is no longer the case. By the 1980s it had already been noted that fewer midwives were giving this as a reasons for becoming *parteras* (Ferrari ,1982, p. 48).

Changing ideas in communities about how to best treat and cure health problems has resulted in gradual changes in the practices of *parteras*. It is important to recognise that 'cultures' are always changing and that when cultures come into contact ideas and practices do not flow just in the one direction; i.e. from the 'dominant' culture to the 'subaltern' culture, rather they flow both ways.⁶ Communities adopt the healthcare practices that most meet their needs and beliefs. When traditional midwifery/medicine comes into contact with modern midwifery/medicine it does not necessarily close itself off to incorporating foreign elements into its practice. A good example of this combining of traditional and modern midwifery practices is the high use of oxytocin by *parteras*, and the widespread adoption of good hygiene practices. At the same time, a community's cultural beliefs may hardly be affected by these changes, so a *partera* who employs many aspects of modern midwifery in her practices may at the same time continue, for example, her role as an intermediary between the natural and supernatural worlds. While the degree to which traditional versus western approaches varies in dominance by regions, both can and do coexist

⁶ The idea that a dominant culture and a subaltern culture influence each other in situations of prolonged contact was emphasized by Fernando Ortiz in his coinage and definition of the term *transculturation*. See Arnedo-Gomez, 2006, pp. 65-85.

in differing amounts. It appears that traditional practices are perhaps only completely conserved in a few isolated indigenous communities.

As has been discussed, there are a variety of reasons why *parteras* continue to attend such a high percentage of births in some parts of the country. Two key factors are those of financial cost and the accessibility of healthcare services. There is a general belief in Mexico that giving birth with a *partera* is seen as something that you do only if you are poor or live in a rural area. It is seen as ‘backwards’ and there is a perception that even if you have only a little bit of money it is better to give birth with a doctor at a hospital. Marianne Dietiker Amsler (1995) captures this when she writes about a conversation that she had with women in Mexico City when she was looking for *parteras* for her research:

“Excuse me, do you know of any *parteras* around here?”. They replied: “There aren’t any *parteras* around here. You should look in the provincial towns, there they believe in *parteras*. Here in the city, there aren’t any anymore, here we go to the doctor at the hospital and not with *parteras*. Here we are modern and not like the Indigenous who have their children any which way they come”.⁷ (p. 68)

However, there is clear evidence to indicate that many women still opt to have a traditional midwife as their birth attendant even when free maternal healthcare is available thus there are factors other than cost, accessibility and the perception of lesser quality of care that are taken into consideration when choosing to have a traditional midwife. For many women the idea of giving birth in a hospital or health clinic away from their homes and families is an entirely foreign concept, especially because when a woman gives birth in a public assistance hospital she does not know beforehand who will attend her and there is also the worry of the use of birthing interventions which are common place in hospitals in Mexico. Moreover, outside health professionals often lack an understanding of local cultural traditions and beliefs. Thus, births in a health care facility may be attended by someone who, while technically qualified, does not necessarily cover all of the woman’s spiritual and cultural needs. Because of this, some women prefer to risk dying in their own homes than to go to a healthcare facility. Giving birth with a *partera* often means that women receive a much more respectful treatment, one which is in accordance with their beliefs. This is because the *partera* is usually from the same community as the

⁷ My translation from the Spanish.

women she attends. *Parteras* take care of both the physical and spiritual needs of the pregnant woman. Many conserve the value of dedicating time to women; believe in the importance of touch; and believe and trust in the natural process and the capabilities of women's bodies to do it in a safe way. All these are aspects which have been devalued with the medicalisation of childbirth (Romero, 1994). Dietiker Amsler (1995) writes that women *necesitan de la partera por las carencias y deficiencias de la medicina hegemónica* ['need midwives because of the gaps and deficiencies of hegemonic medicine'] (p.128). Furthermore, CASA believes that *parteras* are also still needed because 'every woman has the right to decide where, how and with whom she is going to give birth'⁸ (CASA, 2007, p. 431).

However, despite the continued need for *parteras* and their focus on the cultural, spiritual and physical needs of the mother, traditional midwifery in Mexico is facing some major changes. The average age of traditional midwives is rising and with little interest shown by young people to continue on the vocation, this is resulting in a diminishing number of *parteras* in some communities. Additionally, some state governments, working on the understanding that the only way to reduce the MMR is with the attendance of SBAs at birth, have recently begun paying traditional midwives to take pregnant women to hospitals to deliver rather than the traditional midwives attending the births themselves. All this could have serious impacts for women in communities without other options for maternal health care.

Summary

The slow progress worldwide so far at achieving MDG5 has once again brought the issue of maternal health in developing countries to the forefront. It is now recognized that there are a multitude of factors that contribute to poor maternal health outcomes, so while having a SBA present during pregnancy and birth is considered key to improving maternal health it has also been acknowledged that merely improving access to health care services will not solve the 'problem'. With this in mind, many health practitioners and scholars are now pushing for the increased involvement of communities in maternal health initiatives.

⁸ My translation from the Spanish

The Maternal Mortality Ratio for Mexico of 85 per 100 000 live births is consistent with that of other developing Latin American and Caribbean countries and the 8% reduction in the ratio from 93 to 85 over the period 1990 to 2008 while positive is still grounds for concern. The MMR varies across states in Mexico and is higher in marginalised rural and indigenous communities

The overview of the history of birth attendants in Mexico and a description of the current maternal health situation in the country provides the context in which the CASA School of Professional Midwifery finds itself as the only professional midwifery school in the country. Many of the aspects touched upon in this chapter will be revisited in the following chapters. The large section on traditional midwives was included for an important reason; by understanding why women are still choosing to deliver with *parteras*, the failings of the present formal maternal health services are highlighted. If women prefer to risk death giving birth in their own homes than go to a healthcare facility we seriously need to be asking how to make formal healthcare services more acceptable, accessible, and affordable, and one way to do this is to look at traditional midwifery practices.

The Relationship Between Community Participation and Maternal Health Outcomes

Introduction

The United Nations Millennium Goal 5: Improve Maternal Health (MDG5) sets two targets to be achieved by the year 2015; a 75% reduction in the global maternal mortality ratio and universal access to reproductive health. As has already been noted there have been international attempts to reduce the incidence of maternal mortality that precede MDG5, in particular the Safe Motherhood Initiative (SMI) which has been in place for over 24 years. While both MDG5 and the SMI incorporate the philosophy of participation within their projects there is increasing concern that the reduction in the MMR to date, although substantial, has remained slow and geographically varied (United Nations, 2008; Hogan et al., 2010).

A well established theme in the development discourse on maternal health is that this failure to improve the incidence of maternal mortality may well be due to the fact that the type of participation that has been engaged in has either not incorporated community participation in initiatives designed to improve maternal health or that the type of participation engaged in has not resulted in ‘community uptake and ownership’ (Rosato et al., 2008, p. 962). This is consistent with the ongoing debate as to how to define participation and how to distinguish between “genuine” and “pseudo” participation (Deshler & Sock, 1985; Michener, 1998). Central to understanding whether or not participation is genuine is an examination of power relationships particularly the extent to which the recipients of development have control, delegated authority and true partnership (Deshler & Sock, 1985). Community participation involves the direct participation and contribution of ordinary people in their communities of interest, and appears to hold great promise for ensuring genuine participation (Midgley, et al., 1986). However the whole construct of participation, regardless of it being at a popular or community level remains a complicated and ambiguous concept.

This chapter covers a basic understanding of participation and presents a number of classification systems which highlight the complexity of the concept. It alerts us to the need to always reflect on who participates in a project and how. There is a discussion of the idea of participation as “a means to an end” versus participation as an “end” in itself, and an examination of the difference between genuine participation versus pseudo participation. The chapter then goes on to highlight some of the criticisms surrounding the concept, and lastly discusses current literature on community participation in the field of health. In order to look at the concept of community participation, we first need to focus on what is meant by ‘community’ as this is a central term used in this research project.

Community

There is no one standard definition for ‘community’ and a whole chapter alone could be dedicated to discussing the term. The term community was formerly used to describe groups of people in mainly geographical terms but it is now widely accepted that people living close to each other do not automatically represent a community (Tindan et al., 2007). This is because the social concept of community places more emphasis on cultural characteristics and shared value systems than just physical proximity (Tindan et al., 2007). This study has adopted the definition of community as ‘groups of people affiliated by geographical proximity, special interests, or similar situations’ as means of defining the community participating in the training of midwives at the CASA School of Professional Midwifery (CDC/ATSDR, 1997).

Conceptualising Participation

Participation is a construct that has become so embedded in development discourse over the last four decades that it is almost an indispensable condition to have it included in some form within development, whether it be in projects, research or theory development (Parfitt, 2004). Michener (1998) considers it to be one of the most widely used concepts in development. It is so widely used within NGOs, governmental agencies and development organisations that its use acts as a hallmark of respectable research and development (White et al., 1994, cited in Michener, 1998, p. 2105). Its popularity with agencies and governments notwithstanding, cautions have been sounded against seeing participation as a panacea for all

problems within development (Michener, 1998; Rifkin & Kangere, 2001; Rifkin, 1996). While there is widely held agreement that participation is a crucial component of development programmes, there remains a lack of clear definition as to what it is and no consensus as to how it should be implemented (Rifkin, 1996). It remains a concept filled with many ambiguities and has come under increasing scrutiny and criticism over the last two decades from both academics and development practitioners (Parfitt, 2004; Cooke & Kothari, 2001; Neef, 2003).

The difficulty with defining participation reflects the fact that constructs of participation can take on numerous different forms which can vary in both purpose and context. This is further complicated by the existence of a number of closely related- but also poorly defined- terms such as *community engagement* and *community involvement*. It is not uncommon for these terms to be used interchangeably in the literature leading to a blurring of meanings. Additionally, Jennings (2000) argues that the meanings given to participation are often an interpretation of the organisational culture defining it. While these challenges are considerable there have been a range of discourses developed that have sought to clarify if not resolve these issues. Some of the earliest approaches were to look at participation in relation to power and control.

Participation in Relation to Power

The concept of participatory development in relation to power was first articulated during the 1970s where it grew out of the concern for reaching and meeting the needs of the “poorest of the poor” (Michener, 1998, p. 2105). Paulo Freire is regarded as one of the pioneers in this discourse. His seminal work *Pedagogy of the Oppressed* (Freire, 1970) introduced the notion of ‘conscientization’ a process whereby literacy education provides the means to give people the knowledge, skills and attitudes to organise themselves to change their social realities. Freire was an activist working to increase awareness and emancipation of disempowered and marginalised groups within society. Conscientization and its focus on bringing about political change meant that for governments the word participation had a very subversive connotation (Rahema, 2003). However, after the failures of numerous development projects to produce the expected results, a number of major aid organisations, on the advice of

experts, agreed that local people had to be involved in projects so as to increase the likelihood of success. This brought about a big change in relationships between the various development stakeholders, and a change in the way that the word participation was perceived. Nowadays participation is no longer seen as a threat by governments and development agencies. In fact, Rahnama writes that it has become a 'politically attractive slogan' (Rahema, 2003, p. 118). However, as will be discussed, this does not mean that power issues are not still at play.

Participatory approaches to development have been seen as a way to challenge the Eurocentric, paternalistic, dependency-creating, top-downist approaches that had characterised development thinking in the past (Chambers, 1997). A central concept is the recognition and acceptance that local people have knowledge, skills and the capability of enhancing their own well-being. In this way, participatory development has seen a shift in focus from being on the interests of development professionals to those of the beneficiaries. In fact, Robert Chambers a leading theorist in participatory development thinking proclaimed as far back as the early 1980s that rural development could *only* be achieved by 'putting the last first' (Chambers, 1983). In other words, the interests and views of those being subject to "development" need to come first.

Participation as a Continuum

Because of the widely varying definitions as to what constitutes participation and the recognition that not all participation is the same, with some forms of participation being more participative than others (Smith, 1998), it has been suggested that rather than seeing the varying definitions as mutually exclusive they could be considered as points on a continuum (Rifkin & Kangere, 2001). The advantage of this approach is that it provides a framework that allows a range of views to be accommodated (Rifkin & Kangere 2001). Figure 1 below presents a simple example of this with information sharing at one end and empowerment at the other.

Figure 1. Basic participatory continuum

Source: Rifkin & Kangere (2001)

Howard-Grabman (2007) has proposed a more complex continuum of community participation (Figure 2) with the upwards arrow indicating increasing levels of community participation

Figure 2. Degrees of Community Participation

	Collective Action	local people set their own agenda and mobilize to carry it out, in the absence of outside initiators and facilitation.
	Co-Learning	local people and outsiders share their knowledge to directing the process create new understanding and working together to form action plans with outsider facilitation
	Co-operation	local people work together with outsiders to determine priorities; responsibility remains with outsiders for
	Consultation	local opinions are asked; outsiders analyse and decide on a course of action
	Compliance	tasks are assigned, with incentives; outsiders decide agenda and direct the process.
	Co-option	token involvement of local people; representatives are chosen, but have no real input or power.

Source: Howard-Grabman (2007)

Early conceptions of the term *participation* did not distinguish between active and passive community involvement. Current conceptions are along the lines of a continuum. At its lowest level participation can consist of little more than communities being told what to do. Low level participation can refer to co-option where local people have no authority to implement change and are a minority within the power structure. At the other end of the continuum is collective action, where there are high levels of participation, empowerment and the mobilisation of the community.

There has been much written on the broad distinction between participation as a ‘means’ and as an ‘end’ (Michener, 1998). Here the word ‘means’ denotes an ‘input’ into a development programme (i.e. participation being incorporated as an intervention) while participation as an ‘end’ refers to a process with the outcome of meaningful participation. The two types of participation are quite distinct, and their differences stand out further when we look at the various benefits of participation.

Michener (1998) talks about *planner-centred* and *people-centred* participation as a way to look at the relationships among those involved in development initiatives. *Planner-centred* participation, which is development professionals-centred, is participation implemented as “a means”. The reasons for incorporating this type of participation is planner driven in that it, for example, brings about administrative and financial efficiency, and is a way of increasing the success of the initiative. This success could be through better uptake of the project by way of using local people to gain the acceptance of new policies being promoted by outsiders (i.e. development workers and organisations). Success may also be measured in terms of reduced costs as the incorporation of local labour, knowledge and resources can also lower expenses for outsiders. Scholars describe this type of participation as being a *means*.

By way of contrast people-centred participation is both a means to meet local needs and an end in itself, in that it empowers people. This means that not only is participation a ‘means’ (or ‘input’) to help meet locals needs and interests, it is also valuable within itself as a process which can empower people through capacity building, management skills, and the raising of collective consciousness (Michener

1998). This is participation as both a means and an end. Both types of participation imply the possibility of involvement within the power relationship however the extent of empowerment and involvement on the part of the community differs dramatically between the more limited means participation than it is in participation as a means and an end approach.

Focusing on or specifying classifications and degrees of participation is one of the ways researchers have addressed the issue of multiple definitions and perspectives of the term (Deshler & Sock, 1985; White, 1996). Although some of the systems we will include within this chapter were designed more than two decades ago they remain relevant in helping us to acquire a better understanding of the dynamics and complexities of the concept for it is through a careful examination and delineation of these that a distinction can be made between genuine participation and pseudo participation.

As can be clearly seen from Figure 2, there are differing levels of participation. Collective action and community co-option both come under the label of participation even though they are at opposite ends of the participatory continuum and vary widely in levels of actual 'genuine' participation. This tells us that merely having communities participate does not necessarily guarantee that their concerns are really being heard. This problem has been conceptualised as pseudo-participation whereby development professionals manipulate the beneficiaries so as to meet their own interests and needs and not those of the people, as opposed to genuine-participation where participants are empowered through the participation process (White, 1996).

Deshler and Sock's (1985) widely used classification system, underlines the importance of the relative levels of power held by outsiders and beneficiaries as a key characteristic in defining participation. Their system shows the differences in control and power found along the participatory continuum from pseudo participation, where participation is at its lowest level, to genuine participation where we find high levels of participation.

Figure 3. Participation levels

I. Genuine Participation	A. Empowerment	i. Citizen Control
	B. Cooperation	i. Delegated Power ii. Partnership
II. Pseudo-Participation	A. Assistencialism	i. Placation ii. Consultation
	B. Domestication	i. Informing
		ii. Therapy iii. Manipulation

Source: Deshler and Sock (1985)

The abuse of participatory approaches by development agencies and institutions has led to many of them taking on the ‘label’ of participation while only really involving the community in pseudo or passive participation. There are a number of reasons for why they may do this, i.e. to meet the agency’s own interests, to remain in control of the management of the project, and because the word participation is so important nowadays for attracting funding (Michener, 1998). In fact, Michener writes that agency documents suggest that the policy level is often more concerned with participation as an efficiency device (Michener, 1998, p. 2115).

This leads us lastly onto the idea that not everyone involved within a project or programme, i.e. ‘stakeholders’, share the same expectations of participation (Michener 1998, p. 2107; White, 1996, p. 7). White (1996) explores this aspect in her classification system which describes four types of participation: nominal, instrumental, representative, and transformative; and the characteristics of each (White, 1996, p. 7). These are shown in Table 3. Each row embodies the differing interests of the stakeholders. The first column describes the different forms of participation. The second column indicates what the interest is from the ‘top-down’, in other words, the interests of those who design and implement development programmes in the participation of others. The third column presents the point of view from the ‘bottom-up’, how the participants see participation and what they expect to get out of it. The end column describes the function of these different types of participation.

Figure 4. Interests in Participation

Form	Top-Down	Bottom-up	Function
Nominal	Legitimation	Inclusion	Display
Instrumental	Efficiency	Cost	Means
Representative	Sustainability	Leverage	Voice
Transformative	Empowerment	Empowerment	Means / End

Source: White 1996

Each of these classification systems highlight the complexity of the concept of participation, and alert us to the need to always reflect on who participates in a project and how.

Because of its promises of empowerment and the increase in a programme's chance of success, there is pressure on development planners to standardise participation (Rifkin et al., 1998). A number of different context-specific methodologies and techniques for designing, implementing and evaluating participatory programmes have been developed (Morgan, 2001, p.224). These include conscientization and praxi, and rapid and participatory rural appraisal (RRA and PRA) among others (Jennings, 2000). However, many scholars point out that a 'blueprint model' of participation does not often work and that any participatory initiative must be adapted to take into account the context of the local situation. Morgan (2001) writes,

Experience has shown that, even in the case of 'successful' projects, there is no guarantee that what worked in one situation will work in another, or will work in the future. The uniqueness of each participatory project resists the systematizing requirements of operationalization and evaluation. (p. 225)

However, in saying this, there are certain characteristics and features that are important to participation, these include: meeting the concerns of the community, capacity-building, the involvement of all stakeholders in a development initiative, and the recognition and incorporation of local knowledge and skills. High levels of participation should include all of these categories.

Criticisms of Participation

The publication in 2002 of the book *Participation: The New Tyranny ?* (Cooke & Kothari, 2001) made visible many theorists' discomfort with some of the ideas of participation that had long been considered positive. The majority of criticism focuses on the method of Participatory Rural Appraisal (PRA) as championed by Robert Chambers (Parfitt, 2004). This criticism can be grouped into two main categories: criticism of the technical limitations of participation when put into practice, and criticism of the theoretical and conceptual limitations of participation (Parfitt, 2004; Cooke & Kothari, 2001). A full review of these criticisms is beyond the scope of this thesis; instead, here we will focus on briefly outlining just three of these, namely: the complexity of power relations, the exaltation and myth of 'the community' and the problem of local knowledge (Neef, 2003).

In terms of this first criticism, the complexity of power relations, we have already seen how participatory approaches to development inherently bring up the questions of *who* participates, and the *level* of their participation (White, 1996, p. 7). Both these questions recognise that participation is the site of political and power conflicts; because the interests from the 'top down' and 'bottom up' are not often the same (Figure 4), power is involved in the negotiation to determine which interests are favoured over others (White, 1996). A criticism of participation is that these power relations are not always acknowledged in participatory processes. White writes more about this aspect in the following passage:

Participation must be seen as political. There are always tensions underlying issues such as who is involved, how, and on whose terms. While participation has the potential to challenge patterns of dominance, it may also be the means through which existing power relations are entrenched and reproduced. The arenas in which people perceive their interests and judge whether they can express them are not neutral. Participation may take place for a whole range of un-free reasons. It is important to see participation as a dynamic process, and to understand that its own form and function can become a focus for struggle. (p. 6)

It is important to recognise that issues of power are present in all participatory approaches, and that this must always be taken into consideration.

A second major criticism of participatory approaches to development is what is known as the exaltation or myth of 'the community'. With their emphasis on enabling the local community to take control over their own development, participatory approaches rest upon the idea that there is unity or cohesion within communities, and that for example communities have shared aims and interests (Kapoor, 2002). This idea of community, however, is very problematic with many development theorists contending that the exaltation of this *united* vision of community may in fact mask the unequal distribution of power found within communities, and in doing so conceals the different needs and interests amongst community members (i.e reflecting differences in gender, age, class, and so on) (Cooke & Kothari, 2001, p.6). Communities, as Cleaver points out, need to be recognised as sites of 'solidarity and conflict, shifting alliances, power and social structures' (2001, p.45). Participatory approaches to development have often ignored these differences.

Lastly, there is the issue of the reliance of participatory approaches on 'local knowledge', something which is key within my own research. Traditionally, the use of local knowledge in development planning has been regarded as a way of handing over the control of decision making to the community. However, Kothari (2001) points out that it needs to be recognised that 'local knowledge' is not a fixed commodity, rather it is, 'culturally, socially and politically structured' (p.141). This means that what is deemed to be 'local knowledge' is actually regulated and normalised by power structures (Kothari, 2001, p.152). In other words 'local knowledge can reflect local power' (Mosse, 2001, p. 19). Along with this, Mohan and Stokke (2000) argue that putting local knowledge first can also result in the romanticising and essentialising of 'the local', which in itself can prevent people from questioning the assumption that 'local knowledge' is naturally non-maleficent (p. 249). Kapor (2002) questions the idea that 'patriarchal community institutions, which prohibit women from inheritance and land rights, or parochialisms such as xenophobia' are naturally non-maleficent (p.112). These criticisms make a strong case for re-evaluating participatory development. However, as Cooke and Kothari (2001) conclude, although many of the critics of participatory approaches believe that further discussion and reflection is needed, they do not necessarily want to get rid of these approaches.

This was certainly the message put forward by scholars and practitioners in the 2004 book *Participation: From Tyranny to Transformation? Exploring New Approaches to Participation in Development* (Hickey & Mohan 2004). While recognising and addressing the issues raised in the first book, these authors believe that the concept of participation can – given certain circumstances – lead to transformative processes and outcomes for marginalized communities. Participation in development remains as big as ever, with new approaches and strategies coming out of communities themselves in developing countries that are finding new ways to answer to the critiques.

Because of this, and because of the focus in literature on participation being essential for improving maternal health, the concept of community participation will be reflected upon in this case study of what appears to be a unique and very promising model of professional midwifery training aimed at meeting the maternal health needs of rural communities.

Literature on Community Participation and Health

The concept of community participation in health improvement is not new; it emerged in the early 1970s as it became clear that health needs in developing countries could only be met with the involvement of communities' themselves (Zakus & Lysack, 1998). Promoted by the WHO and the United Nations Children Fund (UNICEF), community participation was formally expressed as a key principle of primary health care (PHC), the health policy put forward in the Alma-Ata Declaration in 1978 (Rosato et al., 2008; Rifkin, 1996). Rifkin cites the following as the reasons given for the inclusion of community participation in PHC:

1. The health services argument: the services provided are underutilised and misused, because the people for whom they were designed are not involved in their development;
2. The economic argument: there exists in all communities, financial, material and human resources that could and should be mobilised to improve local health and environmental conditions;
3. The health promotion argument: the greatest improvement in peoples' health is a result of what they do to and for themselves. It is not the result of medical interventions;

4. The social justice argument: all people, especially the poor and disadvantaged, have both the right and duty to be involved in decisions that affect their daily lives (Rifkin, 1990 as cited in Rifkin & Kangere, 2001, p.38)

Community participation in health was thus adopted first by WHO member states and then by many other countries.

It has now been over 30 years since the concept was formally included in international health policy. However, the evident ineffectiveness of some existing programmes to improve health, particularly maternal health, in poor, rural areas in developing countries has once again renewed this focus on community participation with many health scholars arguing that it is an essential prerequisite for better health outcomes. In fact, the literature on maternal health highlights the failures of numerous programmes that were all designed without the involvement of the community they were aiming to serve (Howard-Grabman, 2000). Donnay (2000) goes as far as to write that ‘interventions that do not incorporate active involvement by communities are destined to fail’ (p. 96).

Underpinning the promotion of community participation in health nowadays is the idea of participation as a transformative process which can lead to the empowerment of communities. This is considered critical for health improvements, as it has been recognised that when communities are empowered, motivated and informed, they can plan, analyse and evaluate their own solutions to health problems. Thus, perhaps the most important benefits are as Zakus and Lysack (1998) identify, the ‘heightened sense of responsibility and conscientiousness regarding health and the concomitant gain in power achieved through the acquisition of new skills and control over resources’ (p. 2). They go on to write that through community participation

Participants have the opportunity to educate themselves to the possibilities of controlling their own destiny, often resulting in a more equitable relationship between the so-called clients or recipients of health services and the providers. (Zakus & Lysack, 1998. p. 2)

High levels of participation allow communities to articulate their needs, access services confidently and without delay, make informed choices, and seek

accountability from service providers and managers (Roth & Mbizvo, 2001; Barnett et al., 2005).

Community participation approaches can also be very positive for those providing the healthcare programmes and services. It can aid in improving the organisation, coverage and delivery of the services. It can also produce a better understanding of what the need is for health facilities, their location and size, employment practices, the number and types of staff needed, and the hours that they are open (Zakus & Lysack, 1998). Through community participation, health programmes can seek to understand and to take into account the local cultural context around maternal health and the use of health services, and social and gender roles (Rosato et al., 2008). This knowledge can help to strengthen links between health services and the community. On this last point, Howard-Grabman (2000) writes about the importance and absolute necessity of what she calls ‘bridging the gap’ (p. 92) between communities and health care providers. She argues that the best way to achieve this is through high levels of community participation such as found in community mobilisation. As she puts it, community mobilisation approaches invite ‘community members and service providers to enter into an ongoing, respectful dialogue about what constitutes quality services and how they can improve health and the quality of health services’ (Howard-Grabman, 2000, p. 92). This idea of ‘bridging the gap’ is of the utmost importance for improving maternal health especially as receiving care from a SBA during delivery has been identified as the most important intervention for making motherhood safer (Moran et al., 2006; Starrs, 1997). It is only through strengthening the links between health services and the community that women can be encouraged to access culturally acceptable maternal healthcare services (Roth & Mbizvo, 2001).

While it is clear that community participation is considered by many as essential to improving maternal health, Rifkin & Kangere (2001) write that ‘planners and managers cannot agree upon the contribution of community participation to health improvements’ (p. 38). This is because, as Zakus and Lysack (1998) point out, the ‘reputed benefits’ of community participation remain exactly that - ‘reputed’ (p. 3). Although the benefits of community participation are widely accepted through personal experience and along theoretical grounds, health literature is ‘seriously lacking in empirical studies that specifically demonstrate these benefits’ (Zakus &

Lysack, 1998, pp. 2-3). There is a lack of empirical data in health literature that shows that the ideals of community participation can be realized.

One of the biggest challenges to evaluating the effectiveness of community participation in health is the matter of how to measure something that is so hard to define. There is no one universal definition for either community or community participation. Nor is there a universally accepted conceptual framework for community participation. All of this means that it is very difficult to compare and analyse projects and evaluations. For example, how do you determine what effects or contributions come from community participation, and which are the result of other aspects such as the context in which the programme takes place? This is not to say, however, that there is *no* evidence that community participatory approaches work. There have been many projects published in the literature that point towards the effectiveness of community participatory interventions in improving maternal health, however, as Howard-Grabman (2007) notes very few 'have had the necessary resources to measure their effect on mortality reduction' (p. 5). Successful projects in terms of reducing maternal and neonatal mortality include: the Makwanpur Project in Nepal (Manandhar, 2004), the Shivgarh Project in India (Darmstadt, 2006), and the Warmi Project in Bolivia (O'Rourke, 1998; Gonzales, 1998). Nevertheless, because of the importance of the local contexts of the programmes there is no guarantee that what worked in one place will work in another. Case studies of these individual initiatives, however, can provide important information about 'the range of factors that might influence participation' and allow people designing programmes to 'anticipate problems and implement procedures that worked elsewhere' (Morgan, 2001, p. 226). For this reason, my own research has been conducted as a single case study of the CASA School of Professional Midwifery.

The Adoption of Community Participation in This Study

While the concept of community participation has proved difficult to define (Jennings, 2000) its utility is widely recognised (Parfitt, 2004, Michener, 1998). It provides a means of addressing the issue of power (Michener, 1998) and many of the concerns about the lack of clear definitions can be addressed if community participation is viewed as a continuum (Rifkin & Kangere, 2001). The adoption of

community participation also allows the researcher to address issues such as active versus passive involvement (Michener, 1998), the degree and levels of participation (Deshler & Sock, 1985; Howard-Grabman, 2007) and whether participation is genuine and in the interests of those to whom it is being offered (White, 1996). Finally, like Rifken et al. (1998) and Hickey and Mohan (2004) I firmly believe that the adoption of community participation holds the promise of empowerment and successful uptake and will lead to a transformation of the lives of the participants. For these reasons I have taken this approach in my research.

Summary

The suggestion that MDG5 is not being reached due to the failure to incorporate community participation into maternal health initiatives, places this key development concept well within the maternal health discourse. While it remains a complicated concept and has faced criticism, it appears to offer the possibility of transformative development for communities. It is context specific and there is no guarantee that what worked in one situation will work in a similar one in a different context. However, case studies of initiatives involving community participation are able to provide us with important insights into levels of participation and genuineness, who participates, what the benefits are, and whose interests are being met

For the purpose of this study, the concept of participation is presented as a continuum from the very weakest variations, such as participation simply being the act of contributing, to the strongest variation, namely participation as empowerment. Case studies of initiatives involving community participation can provide us with important information for us to predict and reflect on the challenges of integrating community participation into maternal health care services.

Methodology

Introduction

This thesis looks at the model of professional midwifery training employed at the CASA School of Professional Midwifery. In this chapter we will discuss the qualitative methodology used in the research, beginning with the research inquiry, and a brief outline of the theoretical framework of the research methodology. It then goes on to discuss the different research methods realised in the study, and touches on the idea of triangulation. However, more than just laying out the theory behind the methodology, this chapter presents the story of the process that was involved in bringing the study into the field. Finally, it concludes with a reflection on the ethical issues that had to be considered when undertaking this research.

The Research Inquiry

The study's research question is: *How does the model of midwifery training employed at the Casa School of Professional Midwifery reflect the concept of community participation?* The study sets out to gain an understanding of how one model of professional midwifery training is attempting to improve the cultural acceptability of professional midwifery services in rural communities. In particular, it looks at the involvement of traditional midwives as a way to achieve this.

My interest in this topic has arisen from growing up with a mother who is a midwife in Aotearoa/New Zealand, and from a year spent studying Social Anthropology in Mexico as part of my undergraduate Anthropology degree. It was while studying in Xalapa in 2005 that I first truly became aware of the poor maternal health situations in developing countries. I was shocked at the high levels of maternity mortality in rural and indigenous communities in Mexico, especially knowing that the overwhelming majority of these deaths were preventable. Now, as a student in Development Studies, I am interested at looking at how the incorporation of the key development concept of community participation within professional midwifery

training may help in the process of making professional midwifery services more acceptable to rural communities. To address this complex social phenomenon I selected a qualitative case study approach, which emphasizes in-depth inquiry rather than mere quantification (Stark & Torrance, 2005).

Qualitative Case Study Methodology

Qualitative research draws upon what is broadly known as an interpretivist paradigm. Interpretivism is concerned with the meanings and experiences of human beings (Williamson, 2006, p.85). It is centered around the idea that people are constantly involved in interpreting their ever changing world. Distinct from the world of nature the social world is seen as being constructed by people and thus research within this paradigm emphasizes qualitative rather than quantitative data (Williamson, 2002 as cited in Williamson, 2006, p. 84). Qualitative research is used to understand a given research problem or topic from the perspectives of the population it involves. It seeks out the *why* and *how* of phenomena, not just the what, when, and where (Yin, 2009). The following excerpt outlines some of this methodology's strengths:

The strength of qualitative research is its ability to provide complex textual descriptions of how people experience a given research issue. It provides information about the "human" side of an issue – that is, the often contradictory behaviours, beliefs, opinions, emotions, and relationships of individuals. Qualitative methods are also effective in identifying intangible factors, such as social norms, socioeconomic status, gender roles, ethnicity, and religion, whose role in the research issue may not be readily apparent. (Family Health International, 2005, pp. 1-2)

Given the area of study that I am interested in, I decided to conduct this research as a qualitative case study. This is because qualitative case studies allow us to understand a phenomenon, such as participation, within a real-life context; in this case, in the real-life context of the CASA School of Professional Midwifery. The case study approach I have used here is one proposed by Robert Yin (2009) who believes that in order to gain a deeper understanding of any concept, it is essential for there to be an understanding of the context in which it is found. Baxter and Jack (2008) write that according to Yin qualitative case study design is a good option for research when:

(a) the focus of the study is to answer "how" and "why" questions; (b) you cannot manipulate the behaviour of those involved in the study; (c) you want to cover contextual conditions because you believe they are relevant to

the phenomenon under study; or (d) the boundaries are not clear between the phenomenon and context. (p. 545)

Yin (2009) classifies three specific types of case studies, these are: explanatory, exploratory, and descriptive. This research is in the form of a descriptive case study. This means that to look at community participation in the CASA model we need to consider the social, historical, cultural, political, and gendered context in which the School and teaching model are situated. I decided to conduct the research as a single case study because these provide the researcher with an opportunity to produce a depth of understanding that is often richer than if they were looking at a number of different cases. Furthermore, in terms of the knowledge produced, single cases can be used to confirm or challenge a theory, or to represent a unique or extreme case (Yin, 2009). In this instance, we are looking at community participation in CASA's unique training model.

Like all methodologies, case studies have strengths and weaknesses. The weaknesses of this approach include the difficulty of knowing where to draw boundaries (what to include and exclude), and an increased demand on participants (particularly in the case of a single case study where there may be a fewer number of participants). Additionally, there have been widespread misunderstandings about the scientific value of case study research, such as the idea that the intense exposure to the study may cause biases in the findings. However, the most frequent criticism of case study research has to do with the issue of generalisation. Because single case studies are location and context bound, it has been widely said that this makes them incapable of providing a generalizing conclusion. However, this is not so. In his refutation of this, Yin (2009) explains the difference between 'analytic generalisation and statistical generalisation' (p. 43). He argues that rather than relying on statistical generalisation as quantitative methodologies tend to do, case studies rely on analytical generalisation, which allows the researcher to attempt to generalise a particular set of results to some broader theory. It is important to note here, as Tellis (1997) points out, that this generalisation of results is 'made to theory and not to populations'.

Research Methods

Qualitative methods are often described as being more sensitive to the complexities of social phenomena than quantitative methods. They are also considered more flexible, in that they allow for greater spontaneity between the researcher and the study participant (Family Health International, 2005). For example, open-ended questions let participants answer in their own words rather than them having to choose from fixed responses. Consequently, the responses given tend to be more complex than just 'yes' and 'no' answers, and hence offer greater detail (Family Health International, 2005, p. 4). The flexibility of qualitative methods also allows the researcher to respond straight away to what the participants are saying; giving the researcher the opportunity to modify questions or research plans in response to 'novel or unanticipated findings' (Bryman, 1984, p. 78).

In qualitative case study research, much emphasis is placed on the use of multiple data sources. There are two main reasons for this. First, it helps facilitate a holistic, inside view of the phenomena. Baxter and Jack (2008) liken each data source to 'one piece of the puzzle, with each piece contributing to the researcher's understanding of the whole phenomenon' (p. 554). The second, and principle, rationale for using multiple sources of data is for the triangulation of evidence. Triangulation involves the combination of 'two or more theoretical perspectives, methodological approaches, data sources, investigators, or data analysis methods' (Thurmond, 2001, p. 253). The reason for using triangulation is that it increases the reliability of a study's data by corroborating the data gathered from other sources. With this in mind, and knowing that all research methods have their strengths and weaknesses (see Figure 5 below), my research design has included a number of diverse data sources so as to contribute to a full understanding of the CASA model. The four qualitative research methods I have employed are: semi-structured interviews, focus groups, participant observation; and document analysis.

Figure 5: Strengths and Weaknesses of the data sources used in this research

Source of Evidence	Strengths	Weaknesses
Semi-structured Interviews	Flexibility Insightful - provides perceived causal inferences Positive rapport between interviewer and interviewee Detail and depth	Bias due to poor questions response bias Incomplete recollection Reflexivity - interviewee expresses what interviewer wants to hear
Focus Group	Participants are able to bring to the fore issues relating to topics they deem to be important Participants can often feel more confident talking about issues when they are in a group with others In-depth information Useful for exploring ideas and concepts Can examine how participants react to each other Identifying group norms Discovering variety within a group Group dynamic stimulates conversation	Issues of power and authority within the group Can be difficult to generalise results May include large amount of extra or unnecessary information
Participant observation	Allows for insight into contexts, relationships, behavior reality - covers events in real time Can provide information previously unknown to researchers	Time-consuming Selectivity - might miss facts Reflexivity - observer's presence might cause change The main concern is bias due to investigator's actions Requires conscious effort at objectivity because method is inherently subjective
Document analysis	Stable - repeated review unobtrusive - exist prior to case study Exact - names etc. Broad coverage - extended time span	Retrievability - difficult Biased selectivity Reporting bias - reflects author bias The potential for over-reliance on documents Access - may be blocked

(Yin, 2009; Family Health International, 2005)

The principal data collection method for my case study was the semi-structured interview. Mason (2002) describes this type of interview as a ‘conversation with a purpose’ (p.62). Semi-structured interviews use a thematic-centred approach. This means that rather than being in a question-answer format, they cover a set of points

(Mason, 2002). This also allows the researcher to explore themes as they come up during the interview. For this research, semi-structured interviews were carried out with four CASA staff members: Antonia Córdova Morales, traditional midwife and teacher of the traditional midwifery classes; Débora Clavé, director of the midwifery school and teacher of the classes of continuing education; Maribel Garcia Hernández, the School's administrative director; and Maricruz Coronado Saldierna, the director of all CASA programmes.

While the majority of the interviews took place at the hospital, two were held in a central location and one at a staff member's house. Likewise, the interviews with the director took place at her office at the Santa Julia campus. The time and place of the interviews were decided upon by the participants, and consequently some of the interviews were conducted after working hours. Key areas of questioning included the aims of the Midwifery School, its history and funding, and the development of its specific training model with a particular focus placed on the traditional midwifery practices included in the course. Interviews were voice recorded with permission, and later transcribed. In total, nine semi-structured interviews were conducted.

As a way of bringing in another perspective to the research, a focus group was conducted with students. Focus groups are a form of semi-structured interview in which there are a number of participants. The focus group I conducted was with six students in their final semester of training, all those who were not working the afternoon at the maternity hospital on that specific day. The group took place in a small conference room in the hospital. It covered topics such as the students' reasons for studying at the school, their take on the combining of modern and traditional midwifery practices within the training, issues that they felt were of importance, and the challenges that they face as students. At the beginning students were a little shy about speaking, but as the group got going they became a lot more confident and relaxed. I found that the focus group was extremely useful in understanding what issues the students felt were of importance. Additionally, they brought up some issues that I had not previously considered or that they presented a different perspective on.

A further method used in this study was participant observation, which is one of the most favoured techniques of qualitative research in the social sciences. Tellis (1997) describes participant observation as a 'unique mode of observation in which the researcher may actually participate in the events being studied' (p. 2). The attraction of this technique is that the researcher can get close to her subjects, and thus, see the world from their perspective. It also produces data which has a great deal of depth (Bryman, 1984). At the CASA School I was invited to attend the classes of traditional midwifery and the continuing education classes, both held on Friday mornings at CASA's Santa Julia campus. As well as observing the content of these classes and the way in which they were taught, I was also able to participate in group activities and discussions. This involved the sharing of stories and experiences, and included the opportunity to go with the class to make a herbal salve round at one of CASA's student houses. It was through these classes, and the time spent at the campus before and after class - talking, sharing food and laughter - that relationships of trust and friendship were developed with both staff and students, and this was fundamental in terms of carrying out the research. Participant observation also allowed me to observe firsthand the passion and enthusiasm of the teaching staff; the incorporation of traditional midwifery into the students' training; and the interactions between students. Due to the School's midterm break occurring part way through my time in San Miguel de Allende, and with the occasional irregularity and cancelling of classes, I attended and participated in around 9 classes. Throughout all this time I kept a field journal which included observations from these classes. It was also used to record impressions, reflections, and interactions, and has been very useful for my thesis writing upon returning to New Zealand.

While in San Miguel de Allende I had access to School documents. These included the old plan of studies (curriculum), the new plan of studies, the CASA educator's manual (*Manual para promotores*), a short documentary about the School (which is used to promote the midwifery school), and pamphlets describing each of the CASA programmes. Included in the old plan of studies were copies of the posters advertising the school, and a list of the questions included in the application form for prospective students. These all gave me an in-depth understanding of the training and entry process, the aims of CASA and the midwifery school, and the skills and knowledge acquired during the three years of training.

Lastly, a literature review was carried out throughout the whole research project. Resources were 'reviewed' from books, journals, websites and presentations. During my time in San Miguel de Allende I had access to the CASA library. The library was a good source for texts about traditional midwifery practices in Mexico, and also contained government maternal health reports, and old research studies undertaken in the country. Some of this data would have either been impossible or a major challenge to have got hold of otherwise, especially the information and studies on traditional midwifery in Mexico, all of which helped me understand the context in which the School works. However, even with access to the CASA library one of the big challenges of this study has been obtaining current data on midwifery and maternal health in Mexico, either because it has not been undertaken or it has not been published. As has been mentioned, much of the Mexican data sources used for this research are unfortunately already a decade old. In terms of other resources for the literature review, University libraries from all round New Zealand were used to access books. Online journal databases were widely used, and internet searches were also completed to access web based resources.

Each of these research methods have helped me form an in-depth understanding of the CASA School's model of midwifery teaching and the context from which it has arisen. At the same time triangulation has allowed me to corroborate the data gathered, increasing its reliability, and unexpectedly also highlighting some of the contradictions or differences in opinions.

Reflexivity in Qualitative Research

Right from the beginning I have been conscious about coming into this study with my own positionality formed by my worldview and western university education. Positionality is the recognition that knowledge and practice are shaped by our own perspectives and that therefore, the way we think and view the world around us is not neutral. As a Western researcher with a Western academic background, it is important that I am aware of, and take into account, how this may shape the way I view the world and the ideas that I have, for example, about development, research processes, and traditional knowledge. This 'active reflexivity' on the part of the

researcher is now widely recognized as being essential in any research. Morgan (2002) reflects on this idea below:

Qualitative research should involve critical self-scrutiny by the researcher, or active reflexivity. This means that researchers should constantly take stock of their actions and their role in the research process, and subject these to the same critical scrutiny as the rest of their 'data'. This is based on the belief that a researcher cannot be neutral, or objective, or detached, from the knowledge and evidence they are generating. Instead, they should seek to understand their role in that process. (p. 7)

Throughout the research process I have checked and rechecked my understandings with both staff and students to try and minimise presenting my own take on the situation. I have also consciously tried to counter this by including in the text numerous excerpts from the semi-structured interviews and focus group so that the issues are expressed in the participants' own words. This follows the idea expressed by Douglas (1976) that it is harder to 'lie' when 'extensive quotes are presented in context' (p. 115). Likewise, this inclusion of numerous quotes follows the suggestion that qualitative research should provide the reader with 'material upon which they can judge it' (Mason, 2002, p. 7).

The Research Procedure

I first came across the CASA School of Professional Midwifery while reading up on the internet about maternal health training in Latin America. My competency in the Spanish language, and background in Latin American cultural studies, meant that I was interested in undertaking research in this region. The aims and objectives of the CASA School – particularly the focus on maternal health in rural communities and the emphasis on culturally acceptable services - fitted in neatly with what I was interested in looking at. In terms of the location, it was very useful that I had previously lived in Mexico and so was familiar with the language, geography, and social practices.

My first contact with CASA was in September 2009 through email with Maricruz Coronado y Maribel Hernández, the director of CASA programmes and the School's administrative director respectively. In the email I explained who I was and why I

was interested in looking at the School as a case study. They responded very warmly to my email and invited me to come and carry out my research with them.

I arrived in San Miguel de Allende in March 2010. The first few weeks were spent getting to know San Miguel de Allende, visiting the CASA maternity hospital and School, and discussing the research plans with staff members. It was through these early discussions with staff that we agreed on what were appropriate research methods for the study. We also discussed about with whom I should meet, what topics were of importance for the school, and any ethical issues that needed to be taken into consideration.

Upon attending my first class with the students, Débora Clavé, the School's director of midwifery and teacher of continuing education classes, got me to stand up and introduce myself and explain a little about my research. I found this opened up channels of communication with the students who upon knowing what I was doing there became accustomed and at ease with my presence. I also felt that having a mother who is a midwife also helped my acceptance into the group, and students were very interested in finding out about midwifery in New Zealand.

Through talking with staff and students, and observing and participating in the Friday classes, I soon began to get an idea of how the School was run, and the challenges faced by the school, the students, and midwifery in Mexico. A substantial period of time was spent at the beginning translating consent forms and information sheets into Spanish. I also used this time to familiarize myself with the texts in the CASA library. The semi-structured interviews began in the last five weeks in San Miguel de Allende once relationships of trust had been formed. The focus group with the students in sixth semester took place in the second to last week.

Ethical Considerations

Ethical issues arise from any research undertaken with communities, and need to be considered throughout the whole research process. Prior to undertaking the field research, I had to apply for ethics approval from the Victoria University of Wellington's Human Ethics Committee. They raised two issues requiring special

consideration. These concerned Mexico being considered a dangerous country, and whether this was likely to impact on the project in any way, particularly with respect to the public disclosure of names. The ethics application was approved at the end of March 2010 and given the reference number 17261.

The first ethical issues that had to be considered for this study were informed consent, confidentiality and anonymity, and the right for participants to withdraw from the study. These issues were all discussed with CASA staff and shaped the final versions of the consent forms. Before any semi-structured interviews took place, each respondent was provided with information sheets and consent forms translated into Spanish. They were also given the opportunity to ask any questions that they may have had about the research or the research process. It was important that participants had a full understanding of what the research was about because it is only with complete knowledge that participants can freely agree to be part of a project and give informed consent. This included understanding the purpose of the research, knowing who would have access to the data and what would happen to the outcomes and knowledge produced from the study. Participants were made aware that they were free to withdraw from the research at any time, without any repercussion, and were assured that in the case of withdrawal before 24 June 2010 any information they had already given would not be used.

The issues of confidentiality, anonymity and the precautions that would be taken to ensure privacy were also widely discussed with all the participants. Each of the staff members involved in the semi-structured interviews was asked permission for their names to be included in the thesis and in any ensuing articles. This was decided on the logic that as their names and roles within the School and CASA were readily available on the internet they would be easily identifiable. Moreover, some staff members had already been named and quoted in two earlier articles published about midwifery in Mexico and the CASA School. It was agreed that any direct quotes from the interviews needed the respondent's approval before being included in the thesis. The students taking part in the focus group understood that they would not be named in the thesis and that the information discussed during the group was confidential. Collected data has been stored in a locked cabinet and in password

protected computer files. It is understood that this data will be destroyed after five years.

My thinking about the ethical aspects of research has been greatly influenced by readings on indigenous research methodologies. Writings by Smith (1999), Gegeo (1998), and Hereniko (2000), have all helped to frame my ideas about indigenous knowledge, epistemologies, research and methodologies. The main aim of indigenous methodologies is to ensure that research can be more 'respectful, ethical, sympathetic, and useful' for the peoples involved (Smith, 1999, p. 9). At the centre of the methodologies must be indigenous peoples' interests, experiences and knowledge. Furthermore, Indigenous methodologies require researchers to think critically about their research processes and outcomes. With my case study I have been guided by indigenous principles of research, these include the following five ethical principles that must be considered when undertaking research within a community:

Beneficence (an interruption to people's lives should only occur if the research is beneficial to the community)

Non-malevolence (do no harm)

Justice (fairness to how we conduct ourselves)

Autonomy (people are free-agents when they participate)

It contributes to knowledge (necessary knowledge)

(Course notes PASI 401: Theory and Method in Pacific Studies, Victoria University of Wellington 2009)

In the past, research has not always followed these principles. In fact, research has done much harm to communities (Smith, 1999). As a result of this Smith writes that anyone planning to do research in indigenous communities needs to 'clarify their research aims and think more seriously about effective and ethical ways of carrying out research with indigenous people' (p. 2). This is even more important when we recognise that research is not 'an innocent or distant academic exercise but an activity that has something at stake and that occurs in a set of political and social conditions' (Smith, 1999, p. 3). Among the critical issues that I discussed with the

participants before undertaking any research were the following questions posed by Smith (1999):

Whose research is it? Who owns it? Whose interest does it serve? Who will benefit from it? Who has designed its questions and framed its scope? Who will carry it out? Who will write it up? How will its results be disseminated?
(p. 10)

Reporting back to the community and the sharing of knowledge is one of the most important imperatives of indigenous research (Smith, 1999, p. 15). Thus, the key objective of my research is to give the knowledge produced back to CASA, the school, and participants. Through discussion with CASA Staff we came up with what the best forms of disseminating this knowledge back to the School and participants are; this includes translated summaries, translated results and discussions as well as a full copy of the finished thesis.

Summary

My decision to conduct this research as a single qualitative case study was due to two main factors:

1. Qualitative research methodology allows us to understand the topic from the perspectives of the people involved, and as we have seen, poor maternal health is a social issue; and
2. In order to gain a deeper understanding of any concept, it is essential for there to be an understanding of the context in which it is found.

Community participation within maternal health initiatives is very much context specific, and there is a need for more information on the relationship between community participation and contextual conditions. Case studies of individual initiatives provide information about what may influence participation, what has worked in other places, and predict and anticipate any problems. Furthermore, conducting this research as a single qualitative case study has allowed me to look at this unique case and the context in which it finds itself in great depth. Because all research methods have strengths and weaknesses, my research design has included a

number of diverse data sources so as to contribute to my overall understanding of the CASA model, and to allow for the triangulation of evidence.

My awareness of my own positionality has led to my active reflexivity on my own role in the research process. To try and counter my own positionality not only have I checked and rechecked my understandings with participants, I have also made sure to include extensive excerpts from the semi-structured interviews and focus group so that the issues are expressed in the participants' own words. Lastly, research ethics have had to be considered right throughout the whole research process, and my thinking in this area has been greatly influenced by readings on indigenous research methodologies and has been guided by indigenous principles of research.

Description of the CASA School of Professional Midwifery

Introduction

This research is a case study of the model of midwifery teaching employed at the *Escuela de Partería Profesional de CASA* (CASA School of Professional Midwifery) in San Miguel de Allende, Mexico. This chapter provides an overall description of the CASA Midwifery School and its teaching model. The first section describes San Miguel de Allende, where the School is located, and about my interactions with students and staff members. The second section presents an introduction to the CASA organisation and a description of the CASA School, including how it was set up. The third section focuses specifically on the students and enrolment in the programme and describes aspects such as educational entry requirements and the selection process. The fourth section describes the School's curriculum, with a particular focus on the classes of traditional midwifery and the *prácticas comunitarias* [community field experiences]. The last section explores some of the challenges for the School and students that arise from the implementation of this unique teaching model.

Research Stay in San Miguel de Allende

At the start of March 2010 I arrived in Mexico to begin what has been one of the most challenging and rewarding experiences of my life; the opportunity to undertake field research at the CASA School of Professional Midwifery in San Miguel de Allende. This town, in the State of Guanajuato, is located a three and a half hour bus drive north of Mexico City. In 2008, San Miguel de Allende's town centre was declared a World Heritage site. However, it is not only the heritage status that draws thousands of visitors to the town each year. Since as early as the 1930s, San Miguel de Allende has attracted numerous North American artists and writers. In fact, it has long been known as an American enclave in Mexico, attracting large numbers of

foreign retirees, artists, writers and tourists. At the time of my research, there were around 10,000 Ex-patriot Americans living in the area giving it a very different feel to other parts of Mexico, for example in terms of overall prosperity and lower crime rates.

The foreign presence in the town has done much in terms of maintaining the historic centre, providing jobs for locals, and seeing the founding of numerous NGOs and charities in the area; the CASA organisation being one of these. It has also meant that in the past the town has not been affected so much by Mexico's unpredictable economy. However, 2011 has seen large numbers of foreigners selling-up their properties in San Miguel de Allende, and a sharp decline in the numbers of North American tourists visiting the area. These events are seen to result from the worldwide economic recession, as well as from the nation-wide rise in drug-related violence in Mexico, and the consequent warnings from the United States of America's government to its citizens about the dangers of travelling in the country. San Miguel de Allende is one of the areas in Mexico most affected in terms of this decline in foreign visitor numbers.

During my stay in San Miguel de Allende I rented a place just two blocks away from *el jardin*, the tree-lined plaza in the centre of town. Most of my research was conducted in walking distance at the CASA maternity hospital and family health centre, as well as at the CASA organisation's Santa Julia campus. The CASA maternity hospital and family health centre (which I will refer to from now on simply as the maternity hospital) where the midwifery students carry out their practical learning, is a twenty minute walk from the centre of town. While it is not far in walking distance, the hospital is situated well outside the tourist area. It is a newish two storied building with tiled floors and an open central patio. On most days when I entered the building, women and their families would be sitting on chairs along the sunlit corridors while they waited to be seen.

The Santa Julia campus, which is home to the CASA director's office, library, childcare and counselling services, classrooms and student residence, is a further 15-20 minute walk from the maternity hospital towards the outskirts of town. It is a pretty collection of buildings, with pathways winding between small gardens. The

tilled floor classrooms are all very clean and simple, containing tables, chairs, benches and whiteboards and/or blackboards. During my time in San Miguel de Allende I spent a large part of my research stay at the CASA library located on campus. The library is small but is well stocked with books and has a good section for maternal health, including a number of Master theses focusing on traditional midwives and traditionally midwifery practices in Mexico. All of these were written in Spanish; the majority focusing on aspects of traditional midwifery practices. The library is open to the public and books can be issued out and taken home. It is also visited daily by the children at CASA's child day-care services.

During the three months I spent living in San Miguel de Allende, the walk along the dusty roads to both the maternity hospital and the Santa Julia campus became an enjoyable part of my day. As I became more familiar with the students I would often run into them as they made their way between the campus and the hospital. We would walk together and chat. Along the road we would pass many small shops or stalls where they would buy *tamales* and drinks between classes.

From my very first visit to the CASA maternity hospital I was warmly welcomed into the school community by both students and staff members. I was invited along to observe classes and to participate in hospital celebrations. Early on I was also invited to participate in a weekly study group organised by a small group of students, and through them I was invited along to many social occasions including student celebrations of the international day of the midwife. On first meeting the midwifery students I was surprised at how young they were. While I knew that the students needed to be at least 18 years old to be accepted into the programme I still had images in my head of the midwives I knew back in Dunedin, most of whom are around my mother's age (in their 40s and 50s). At CASA, the majority of midwifery students are 18-22 years old. While their young age was sometimes apparent in the giggling and joking taking place during class, they would mention experiences that surprised me as being well beyond their years, for example having already witnessed complicated pregnancies and stillbirths back in their communities.

CASA and the School of Professional Midwifery

The CASA School of Professional Midwifery is the only government recognised professional midwifery school in Mexico. The School is unique in its aims to improve maternal health by training professional midwives who will provide culturally appropriate, professional maternal health care in rural communities. Its unique model of training includes the teaching of both traditional and modern midwifery practices and the chance for students to undertake community field experience working with traditional midwives in the community. To understand how the school has come to develop this model it is important to understand about both the CASA organisation that runs the School, and the series of events that led to the midwifery school being set-up.

The midwifery school is run by CASA (*Centro para los Adolescentes de San Miguel de Allende* / Centre for the Adolescents of San Miguel de Allende), a non-profit health and social service organisation. It was founded in San Miguel de Allende in 1981 by Nadine Goodman, a New York social worker and public health specialist, and her husband Alejandro Gonzalez, a local of the San Miguel de Allende area (Mills & Davis-Floyd, 2009, p. 305). The organisation was set up in response to the high rates of teenage pregnancies in the area, and the absence of family planning, health education and reproductive health services. The organisation's principles are set out in the mission statement seen below:

To contribute with quality and warmth in improving the living conditions of the most vulnerable populations, through actions in health, education and culture, promoting sustainable development and respect for human rights with a gender perspective.⁹ (CASA 2007)

Today CASA reaches out to adolescents, rural women and their families, through a number of health, social service, education, and environmental outreach programmes. These include: the maternity hospital and family health centre; professional midwifery school; child development and day-care centre; CASA (public) library; adolescent peer counsellors; sexual education (PESANE: Promoters of Sexual Education and Advocacy at the State Level); theatre groups (TEATRO: Theatre Education on Topics of Reproduction and Orientation); violence prevention,

⁹ My translation from the Spanish

and a radio programme. The organisation has approximately 100 paid staff, and around 300 volunteers (Mills & Davis-Floyd, 2009).

History of the CASA School

The CASA School of Professional Midwifery developed out of the relationship the organisation had with traditional midwives in the San Miguel de Allende area. In 1981 CASA began offering sexual health education and family planning to local youth and women (Mills & Davis-Floyd, 2009). In 1985, the organisation was approached by a group of local *parteras* [traditional midwives] wanting to learn how to better meet the needs of women in their communities. In response to this request, CASA held a series of informal lectures for traditional midwives in 1990 in which they discussed topics such as ‘sexuality, family planning, physiology and anatomy’ (Mills & Davis-Floyd, 2009, p. 307). At the conclusion of these lectures, a number of the midwives, in particular Antonia Córdova Morales, expressed their desire to continue learning. Antonia asked if CASA could find them a teacher. In 1991 Patricia Kay, an American direct-entry midwife living in Mexico, began teaching a three year training course for the *parteras*. The idea was to create a course shaped to the *parteras*’ needs, taking the midwives’ existing knowledge as its starting point and building on from there (Mills & Davis-Floyd, 2009, pp. 307-308). Three traditional midwives, including Antonia, finished Patricia’s course.

During this time CASA decided to build a maternity hospital. The organisation saw the hospital not only as a training site for midwifery students and a way of helping local women but also as a way to help legitimate midwives as health professionals. The idea was that in the future the maternity hospital would be staffed on the greater part by midwives (Mills & Davis-Floyd, 2009).

Upon completing Patricia’s course, Doña¹⁰ Antonia Córdova returned to practice midwifery at the CASA maternity hospital and began teaching her own three-year course for local *parteras*. From November 1994 to April 1997, she taught a further

¹⁰ *Doña* is a courtesy title placed before the first name of an older or more senior woman in Spanish as a way of showing them your respect when talking to them or about them. Both staff and students at CASA refer to the School’s traditional midwife as Doña Antonia.

seven traditional midwives. Her course was a mixture of what she herself had learned as a *partera* and what she had learnt from Patricia (Mills & Davis-Floyd, 2009). Two of the seven midwives later joined her to work at the hospital.

Although the programme with the traditional midwives had been considered a success, it was decided that, in terms of significantly improving rural maternal health, it was more realistic to educate new midwives rather than traditional midwives (CASA, 2007). This was because during the previous courses it had been noted that the cultural gap between the two systems of midwifery was in many cases ‘too wide to be effectively bridged’ (Davis-Floyd, 2001, p.19). This included aspects such as the illiteracy of some of the traditional midwives. It was decided that the group who could most benefit from the training were the daughters of traditional midwives who while having grown up with traditional midwifery would also be of ‘a generation that is accustomed to receiving formal education’ (Davis-Floyd, 2001). In 1997, the School’s curriculum was formally accredited by the Ministry of Education of the State of Guanajuato and the School was approved as a government-accredited vocational programme below university level.

The first generation of professional midwives graduated from CASA in July 2000 with the title of *parteras profesionales al nivel técnica* [professional midwives at a technical level]. Three of the four graduates stayed on to practice for a number of years at the CASA maternity hospital (Mills & Davis-Floyd, 2009). In this group was the *partera* Maricruz Coronado, who has since gone on to serve twice as the educational director of the CASA School, and currently holds the position as the director of all CASA programmes. Since 2001, upon completing the programme and a year of *servicio social* [social service], graduates have received a *cedula profesional* [federal professional license], the same as all other professionals in Mexico.

Right from the beginning the School’s focus has been on helping those communities who most need it. The curriculum lists the socio-economic characteristics of these communities as those who:

- live in rural and marginalised areas
- are of low economic resources
- have had low or inexistent schooling
- have a large youth population
- do not have adequate health services
- Have high rates of risk factors: poor nutrition, unwanted pregnancies, early sexual activity, high rate of births, teenage pregnancies and pregnancies in women over 35 years old, domestic violence, repetitive abortions, and live in deficient sanitary conditions.¹¹ (CASA, 2003, p. 13)

In other words, communities where there are scarce or non-existent health, education and economic resources. Working in these communities comes with its own challenges as these areas often see much higher rates of complications in pregnancy and childbirth than in the cities. This is due to problems such as malnutrition. CASA's aim is to work in these communities because, as Maricruz reflects, 'it is our job as an NGO, to help the most vulnerable people'. CASA strongly believes that the training of professional midwives is the best way to meet the maternal health needs of these communities. As Maricruz (2010) goes on to explain:

Why does CASA believe that this is the way to do things? Firstly because it [professional midwifery] is a model that has been proven all around the world; it works. Our own model has been evaluated by the *Instituto de salud pública* [Institute of Public Health] here in Mexico. And we have shown that our model covers 93% of the skills and abilities that the WHO recommends for attending births. The doctors [in Mexico] have been shown to cover 70% and the *licenciadas en enfermería y obstetricia* [graduates in the degree of Nursing and Obstetrics] cover 56%... Additionally, Mexico covers a very large geographical area and there are many areas where doctors do not want to go. For this reason we believe that our model is a good strategy for reducing maternal deaths. And just as traditional midwives are needed, I believe that we are also needed. (Interview with Maricruz)

This belief in the importance of professional midwifery for meeting the maternal health needs of communities is also something echoed by the students. When asked during the focus group about why they had decided to become professional midwives a common reason given by students was so as to provide better maternal health care for their families and communities. This can be seen in the responses from three students below:

I am planning to work in my community. This is because in the area where I live there are many people, many women, with very little resources. I feel that I can work closely with them and maybe if I can help with their

¹¹ My translation from the Spanish

maternal care then things will be easier for them. This is what I hope I can do.

I am from a community, *un rancho* [a ranch] which has around 600 inhabitants. I have decided to do this course because I was already a traditional midwife and I wanted to up skill myself further so as to better attend to women.

I like the model of care. I like that it is woman-focused. I know that one day I will probably be in this situation, and the truth is I wouldn't like to go to a hospital, especially now that I have experienced them. Apart from this, I also have sisters and I don't want them to have to go through something like that. I want them to have another option, and doing this, more than anything, is how I can help them.

The failings of Mexico's biomedical system of health when it comes to the maternal health care offered to women, is a theme that is repeatedly brought up by both staff and students at the School. We will come back to look at this in more depth towards the end of the chapter.

What we can see from the responses above is that many of the students who apply to study at CASA do so with the desire to change the poor maternal health situations present in their communities. This explains why so many of the students at the school are from rural communities.

Students and Enrolment in the Programme

CASA understands just how crucial it is that the services offered by professional midwives be culturally and socially acceptable in the communities where they work. They have come to the conclusion that 'women value the help of other women who share similar characteristics in terms of gender, and both cultural and social beliefs'¹² (CASA, 2003, p. 24). For this reason, preference is given to the training of the daughters and relatives of traditional midwives and to students from rural areas (CASA, 2003). In fact, CASA has organized its midwifery programme to cater especially for these students. It does this in three key ways:

1. the prior level of education required for entry into the programme;
 2. the provision of scholarships that cover the cost of fees and accommodation;
- and

¹² My translation from the Spanish.

3. by providing a residency where students from outside of San Miguel de Allende can live.

The entry requirements for the CASA midwifery programme necessitate that prospective students be eighteen years old or above and have completed *la secundaria* [junior high school] with an average grade of 8 (out of a possible 10). In Mexico, basic education is divided into three steps: *primaria* [primary school], comprising New Zealand Years 2-7; *secundaria*, comprising New Zealand Years 8-10; and *preparatoria* [high school], comprising NZ years 11-13. In Mexico attendance of *primaria* and *secundaria* is compulsory by law but not so *preparatoria*. The majority of the country's population complete only primary school. This is particularly so in rural areas where access to higher education is often not available. CASA has set the School's entry requirement as the completion of *secundaria* understanding that the majority of young people in rural communities do not continue their education past this. Débora Clavé comments further on this:

When we formed this idea of the school, and when we started to look at who would be the students enrolling and what would be the enrolment requirements for students, it was established that we would follow the WHO's norms of the minimum age being eighteen years old, but that the minimum education level completed had to be *secundaria* so that the communities in which there are the most traditional midwives wouldn't be excluded. It is in these communities where there are the greatest numbers of daughters of traditional midwives that could study and continue on the profession. (Interview with Débora)

Because of this lower education entry requirement the CASA School is only able to offer midwifery at a 'technical' level, rather than at a 'degree' level.

The selection process for prospective midwifery students starts in February each year. From February to May applications are received from women all over Mexico interested in studying at CASA. If it is possible, the women come to San Miguel de Allende to hand in their application in person and to be interviewed. Of course, for many prospective students, travel to San Miguel is not possible due to cost and distance. In this case, the School sends an interview for them to fill in and email back. On average the School receives around 67 applications each year. In June the school's revision group go over each application and interview to determine which

30 applicants are the most apt to welcome into the school and to provide scholarships to.

The school attracts prospective students from all around the country through announcements on the radio, advertisements on television, posters and flyers. CASA also has a website which describes the organisation and the midwifery school. Along with this, staff and midwifery students visit schools to talk to students and show them a short video about the School. They also sometimes visit busy areas such as shopping centres or health campaigns to talk to people and to hand out flyers. This is how they promote the school and get information about professional midwives out into the community. Additionally, CASA also has contacts with universities and associations in both Mexico and Guatemala.

The majority of students studying at the CASA School come from families with scarce resources. This means that they often do not have the financial resources to pay for the three years of study and accommodation costs. For this reason, CASA offers scholarships covering the school fees and the costs of living at the student residency. Although the majority of students have scholarships that cover 100% of these costs, it is not always financially possible for CASA to offer full scholarships to every student. For those students who it is not possible to fully fund, the School asks that they pay only upwards of 14% of what the training actually costs the organisation. This is with the condition that the student maintains an average grade of 8.5.

Recognising that most of their students come to San Miguel de Allende from other parts of Mexico, CASA has a student residency at their Santa Julia Campus. The residency is designed to accommodate 24 students, with each bedroom being shared between two. However, the school now has more students than the residency can hold so at the time I was there they were renting another house two blocks away. The organisation was also looking for an additional house to rent so that there would be sufficient living space for the new generation of students that were to start in August.

At the time of my research (March-June 2010), there were 35 students studying at the School. These were spread out over the six semesters that make up the three-year

course: fifteen students in the second semester, eleven students in the fourth semester, and nine in the sixth. The students were from all over Mexico, not just from the state of Guanajuato where the school is based. There were a number of students from San Luis Potosi and from Coahuila, as well as from the states of Chiapas, Guerrero and Veracruz. There were also three students from Guatemala. On a whole, about 60% of the students at the time were from rural or small communities and about 40% from cities (estimation made by Maribel Hernandez during interview).

The CASA Model of Midwifery Education

The School's particular focus is on training professional midwives who will go on to provide culturally appropriate, professional maternal health care in rural communities. The students are trained in both technical and holistic skills with the idea that upon graduating they will be able to provide comprehensive care to meet all the needs of their clients. But more than simply training health professionals, the course provides students with a wider understanding of the socio-economic aspects and politics of maternal health provision, and thus creates social spokespeople. The organisation writes that the training of these midwives is designed so that they will:

Recognise, respect and be familiar with the care given by traditional midwives in Mexico.

Have an understanding of the social, economic and political panorama of Mexico.

Serve as human rights lawyers, especially in terms of the health rights of women. These services will include dedicating part of their own professional practice as midwives attending people with scarce resources.

Base their practice on the needs of the mother and the infant and not on the needs of the carer or provider.

Provide a competent service of health care for the woman throughout her reproductive cycle.

Facilitate complete, independent maternal care to low risk clients in various settings such as at home, in maternity clinics and in hospitals.

Respond to the psychological and educational needs of the woman and her family.

Maintain levels of competency of practice through continuous further education

Work with other Mexican midwives so as to define themselves and their professional ethics

Practice in accordance with the laws, regulations and professional ethics agreed upon between midwives and the Mexican government.

Comply with the requirements of the CASA School of Professional midwifery¹³.

(CASA, 2003, p. 14)

The *plan de estudios* [curriculum] was developed by the School's initial co-directors, Anne Davenport, an American nurse who later became a direct entry midwife, and Gloria Metcalfe, a Chilean midwife and former government director of Chilean Midwifery (Mills & Davis-Floyd, 2009). Both women were experienced in international maternal-child health projects. The curriculum was designed around an international definition of 'midwife' and includes the woman-centred philosophy known internationally as the 'midwifery model of care'¹⁴ (Davis-Floyd, 2001, p. 9). The CASA curriculum covers the core midwifery competencies set out by MANA (Midwives' Alliance of North America), and meets the requirements and standards of both NARM (North American Registry of Midwives) and the International Confederation of Midwives (IMC). The school has also adopted certain parts of the curriculum criteria in practice at other midwifery schools and implemented in its teaching methodology the University of Georgetown's (Catholic University of Washington D.C.) five pillars of education plan aimed at developing holistic and humanitarian visions of the taught subjects (CASA, 2003).

Although formally accredited by the Ministry of Education of the State of Guanajuato in 1997, the Mexican government requires that the curriculum be updated every five years. CASA is presently working on getting their new curriculum accepted. This has been written with the guidance of la ENEO (the *Escuela Nacional de Enfermería y Obstetricia*/ National School of Nursing and Obstetrics). The new curriculum includes some suggestions made by the *Secretaría de Educación* [Ministry of Education], including changes in the number of hours required for different subjects. More than anything, however, the main difference between the old and new curriculums is that the old curriculum was revised and

¹³ My translation from the Spanish

¹⁴ For more information on the midwifery model of care see Rothman (1982).

authorised in Guanajuato; the new one is being revised and authorised at the federal level in Mexico City. The curriculum format is set by the Ministry of Education and not by the School itself.

The three years of training are divided into 6 semesters, during which the students are trained in subjects such as biology, anatomy, physiology, pharmacology, nutrition, obstetrics, neonatology, gynaecology, family planning, homeopathy, psychology, anthropology and sociology (CASA, 2007). Mornings are for clinical experience at the hospital, and theoretical classes take place in the afternoon.

From their very first semester at the school, CASA midwifery students begin undertaking clinical experience with women in the maternity hospital. The type of practices they participate in depend on what point they are at in their studies. At first this may just involve simple observation, but later on includes conducting prenatal consultations and carrying out examinations of women and newborns (CASA, 2007). In the sixth semester, students spend half a year as interns in the CASA hospital, during which time they attend women in all stages of the reproductive cycle with the support of the staff midwives. The main objective of *el internado* [the internship], as Débora explained to me, is that students establish an interrelationship between theory and practice (Interview with Débora). CASA also provides a homebirth service for women living in San Miguel de Allende so this means that students also have the opportunity to experience births attended outside the hospital setting (Mills & Davis-Floyd, 2009).

At the end of the three years of study, students are required to undertake a further year of social service working in a hospital under the supervision of doctors before they can receive the professional license. This is a requirement of both the Ministry of Education and CASA. Starting from 2010 the School now has field clinics in Guanajuato where this can be carried out. While the Ministry of Education only requires the students to do six months of social service, the school asks them to do a whole year. This is because CASA believes that the more experience students have, the better prepared they will be to work as midwives, particularly because they want students to graduate with all the skills that they will need for working in rural communities (Interview with Débora).

Combining Traditional and Professional Midwifery

CASA recognises that to improve maternal health in rural communities midwifery graduates need to be able to provide comprehensive and culturally acceptable maternal healthcare services for the women in their communities (CASA, 2003). CASA hopes to achieve this by including traditional midwifery practices within its professional midwifery training. This is done in two key ways: through the weekly classes of traditional midwifery taught by a traditional midwife; and with *las prácticas comunitarias* [community field experiences] where students live and work with traditional midwives in the community. The importance of having access to culturally acceptable health services is a matter of life and death, and is highlighted in the following excerpt from an interview with Maricruz:

Our experience of going to communities is that Mexican women prefer to die in their homes rather than go to a hospital. This is in communities. As our students come from the community and we come from the community, we understand this. You can have a hospital right opposite your house, but you don't go there because they don't respect your traditions, your customs. For example, in Huasteca Potosina, women plant their placentas. Thus, because they do not give you your placenta you don't go to the hospital. And you prefer to die in your house with a haemorrhage, but you don't leave your house. (Interview with Maricruz)

CASA believes that professional midwives can combine the best of traditional and professional midwifery; i.e. respecting the rights and traditions of women while at the same time providing a qualified service (CASA, 2007). Maricruz reflects on this:

Our idea was to complement these two things. On the one hand students need to be prepared for obstetric emergencies and know about oxytocin and how to put in a IV, and about the use of other drugs... These things they need to know. But they also need to respect the beliefs and customs of the people, whenever these do not put women's health at risk. If the *Señora* wants a ribbon tied to her, and the ribbon doesn't do any harm well then tie the ribbon on her... this is where we complement the beliefs, culture, and customs. I feel that the definition for sexual and reproductive health has to include this part to it, to involve the environment and the future, so that it takes into account the complete well being of the women – psychologically, mentally, and physically – that it also includes cultural and social well being. And this was the idea - to share this strength and to complement it. I feel that this is a very important part of our school. (Interview with Maricruz)

The students also see the combining of the two types of midwifery as very important. During the focus group students spent a long time discussing this aspect of the course. What was recognised, in particular, was the importance of the inclusion of cultural practices of traditional midwifery for increasing the number of women accessing professional maternal health services. This can be seen in the responses below:

I think it is important because one of the objectives [of the school] is also to reduce maternal mortality, right. For this to happen, it is important to combine these two.

In terms of for the women in the communities, it is very important us knowing aspects of traditional midwifery because it makes them have more confidence, and feel more secure.

One of the great challenges for CASA is how to teach traditional midwifery within a school setting. While some of the students have grown up aware of traditions and cultural practices surrounding pregnancy and birth, for others it is completely new to them. Débora acknowledges this as a challenge for the school:

We can't directly include all the traditions but we at the school aim that the students understand and are aware of this information through activities such as the community field experiences, where we travel to communities to live with traditional midwives so as to enrich our knowledge of this, and through the classes taught by a traditional midwife. (Interview with Débora)

The Traditional Midwifery Classes

Las clases de partería tradicional [traditional midwifery classes] are taught by Doña Antonia every Friday morning at the Santa Julia campus. The 2-3 hour long weekly class is attended by all the midwifery students. The students crowd into one classroom with the students in 6th semester sitting on benches along the far wall, the 4th semester students on chairs alongside the opposite wall, and the second semester students around the big table in the middle. The content of the classes is decided by Doña Antonia in collaboration with other staff members. When asked about what is covered in the classes, Maricruz responds:

Who decides what we are going to cover in these classes? The students decide, the teachers decide, the directors decide. There is a programme but this programme changes and always complements with the opinions of the girls themselves, in accordance with the needs that are presented by the

students. Maybe one of the students has an interest like “I want to know more about the placenta, about why they eat it in a certain area of the country”. So that’s when they’d look at that. Or, “I want to know more about how you rotate the baby”. And they look at that. A lot of it comes from the suggestions of the students, and also from what we live through during the *prácticas comunitarias*. Thus, in accordance with what they experience there, there are sometimes changes made, and this is how it complements the programme. (Interview with Maricruz)

The traditional midwifery classes I attended were focused on various aspects of traditional midwifery practice, particularly on non-medical treatments for common problems. For example, to help with mastitis the students are taught that they can use warm wet cloths, cabbage leaves or water massages. The classes also looked at how to make curative soaps, syrups and salves, and the use of different plants for skin infection, wounds and rashes. Doña Antonia would follow the teaching of each method with an example of when she herself had used this in practice.

When asked about what she wants students to learn in her classes Doña Antonia replied: ‘I have decided to teach things in the class that they won’t find in books’ (Interview with Doña Antonia). This includes what she calls the *espiritualidad* [spirituality] - the spirit of the woman and the midwife; also respect for women and recognition of women’s knowledge and power, and the ‘wisdom’ of their bodies. For the students, many express the ideas of respecting the women that they are caring for, the importance of communication, and the need to be humble as the key ideas learnt in these classes. As one student told me, ‘they teach us about the humanistic side of the *partera*, and the patience and respect they show women.’

Lastly, the classes of traditional midwifery are an important site for community and solidarity building among the students. At the end of every class the students and Doña Antonia stand together holding hands in a circle, and sing the following song:

*Somos hermanas caminando
Cantando como una
Recobrando el poder
De nuestra sabiduría
Somos las mujeres.*¹⁵

We are sisters walking together

¹⁵ Dona Antonia learnt this song from other *parteras*

Singing as one
Recovering the power
Of our wisdom
We are women.

Community Field Experience

As part of their three years of training, CASA midwifery students undertake *las prácticas comunitarias* [community field experiences] at the end of each semester. This involves the students living and working with traditional midwives in different communities around the country for periods of 2-3 weeks at a time. The aim of *las prácticas comunitarias* is to provide the students with the cultural and social understanding required for practice in such communities; it is an opportunity for students to experience the reality of the work of midwives in rural communities. Débora reflects on this below:

Basically, the idea of *las prácticas comunitarias* is to live with traditional midwives, see how she works, see the role she plays in the community, how the community recognises her, look at what some of the difficulties are, what are the benefits of being a midwife and working in these communities, what are the obstacles that they encounter, and what are the conditions that women in the communities live in. All this is important because, for us, in the books, we are given the ideal of how women physiologically experience birth. But if the woman is malnourished in a community with no resources it will be difficult to keep her healthy, and as a midwife you need to know these things. So in this way we see what some of the difficulties are that are found in real life. (Interview with Débora)

But more than this, Débora describes the community field experiences as being an interchange between CASA students and traditional midwives in which both groups are enriched.

The *prácticas comunitarias* are organised by CASA with the assistance of different state institutions such as the IMS or the Ministry of Health, who arrange for the students to be put up in a community where there are a high number of traditional midwives. The first three days see the students and traditional midwives living together at provided accommodation. The students, who have been divided into mixed-semester groups, carry out workshops and activities with the traditional midwives. Each group is given their own topic to teach about, these normally

include: haemorrhages, attention for low-risk birth, resuscitation, newborn care, and complications during pregnancy and childbirth. Occasionally there have been times when a topic has had to be omitted because another one is of more importance for that particular group of *paretras*. Students communicate the information through three main methods: through talks, role-play practice with the midwives, and skits where they act out situations between pregnant women and midwives.

These first three days of the community field experiences are really important for the students and *parteras* to get to know each other and to start to form relationships. Débora explains how after the first day the traditional midwives will often start to bring little gifts for the students such as *tortillas*. At the end of these three days the students then accompany back to their communities those traditional midwives who are willing to accommodate them. Débora notes that “by the third day there aren’t even any students left for me to share out because everyone wants to take them”. She says that it is *alucinante* [amazing] the response that they get from the traditional midwives (Interview with Débora). Débora notes that the response given to the students by both traditional midwives and the communities have always been very positive and welcoming:

In the communities the students are more than just recognised and more than just appreciated. The traditional midwives themselves who are working in the communities approach them for their knowledge, and if it is a professional midwife then this is even more so. (Interview with Débora)

During their stay with the *parteras*, the students have a list of activities that they need to carry out, these include giving talks and advice to pregnant women and adolescents, taking part in prenatal consultations with the traditional midwives and, when possible, also attending births. Of course, sometimes this happens and sometimes it does not. A lot of the experience is about seeing the midwives’ interactions and roles within their community.

The students in the focus group talked a lot about the positive nature of the community field experiences and how important they are in terms of their training. Their stories are of the students and traditional midwives learning from each other.

As one student told me: “The *parteras* teach us and we teach them; it is a combination of the two.”

Importance of Professional Midwifery Skills

Throughout the training programme while an emphasis is placed on the importance of knowing traditional midwifery practices, staff and students also clearly express the importance of returning back to their communities with the professional knowledge and skills for detecting and responding appropriately to any complications a woman may have. Doña Antonia reflects on this point:

I believe that it is very important for the communities that they have returned to them a person with more skills, someone who combines traditional midwifery with the professional. The traditional midwives don't have the knowledge of how to take someone's pressure, or to check the pulse and temperature, or listen to the baby's heartbeat. All of which are very important. Thus, this is what the students can learn here, and the traditional midwives do not have this knowledge. Therefore, this other knowledge is good for the community. (Interview with Doña Antonia)

This was also expressed by Débora and the students, who pointed out numerous times that having knowledge of professional midwifery is essential for saving women's lives. As one student explained to me:

It's very important the professional part of our studies. Why? Because if we have a complicated birth we need to know what to do. Natural things and everything are very good but we also need to know when and where to take a woman or her baby in these cases.

The CASA model of professional midwifery teaching is thus very much about preparing students to work in rural communities, with an emphasis placed on them providing comprehensive and culturally acceptable services. As Débora explains the model of midwifery that the school teaches is ‘professional midwifery based on traditional midwifery but with the fundamentals of modern medicine’ (Interview with Débora). Students also learn and understand where and when to seek help when complications arise. In this way they see themselves as part of a larger maternal health team alongside *parteras* and doctors. As one student reflected during the focus group: ‘there's the importance of having all three: the doctor, the traditional midwife and us’. In fact, a number of the students talked about their desire of going back to

work in their communities but with the support or backup of a doctor for when complications arise.

Challenges for the CASA School's Model of Midwifery Education

Thus far I have discussed the aims of the CASA School of Professional Midwifery and focused on how their model of midwifery teaching specifically focuses on providing culturally acceptable, skilled, professional midwives in rural communities. This is the theoretical basis of the school. The question is how does this model work in reality? The following section will explore some of the key challenges faced by this teaching model, both from the point of view of the students and the School. These challenges include: professional midwives being formally and socially recognised in Mexico; finding sufficient funding; the high rate of student withdrawal from the programme; students' prior education levels; and combining traditional and modern midwifery. Lastly, we will look at the challenges involved with working under the biomedical system.

Formal Recognition of Professional Midwifery

In a country with a population of over 110 million inhabitants, the CASA School, at the time of my research had produced only 43 graduates. This highlights the immensity of the challenges that this one small organisation and school faces when it comes to challenging the health politics in Mexico, fighting for the legitimacy of profession midwives within the public health system, and increasing public awareness of the existence and services of professional midwives. One of the biggest challenges for CASA's model of midwifery has been in becoming formally recognised. As Mills and Davis-Floyd (2009) write: "it took almost 10 years and much hard work and political networking to ensure that the CASA graduates would obtain the federal professional seal (*cedula profesional*)" (p. 324). This is because there is a widespread belief among many of the country's health professionals and state officials that there is no need for professional midwives, and in fact, many see the training of any kind of midwives as 'a step backwards' in terms of skilled healthcare. This is clearly expressed in the excerpt from a Wall Street Journal article that Mills and Davis-Floyd (2009) include in their chapter:

Carlos Tena, the Minister of health of Guanajuato state, where both the school and hospital are located, says that while he is all for giving existing midwives the training necessary to do their jobs better; he sees no point in creating new ones. “I don’t think Nadine’s vision is workable”, says Dr Tena, a cardiologist. “And I will continue fighting with her as long as she demands that parteras be recognised as professionals...” Robert Uribe, a professor at the National Autonomous University of Mexico and officer of the National Federation of Gynecologists and Obstetricians, says the idea of reviving the partera, even with clinical training, “is a tremendous step backward.” “It doesn’t matter if the parteras all die off,” Dr. Uribe says. “The real issue is: How do you get rural women to the hospital on time?” (Friedland 2000, p. 1 cited in Mills & Davis-Floyd, 2009 pp. 324-325)

This widespread disregard for professional midwifery in fact nearly brought about the closure of the CASA maternity hospital. In 1999, the doctor run State Ministry of Health threatened that they were not going to renew the maternity hospital’s license unless the midwives were removed. CASA and its supporters collected more than 10,000 signatures in support of the hospital, and the license was shortly afterwards renewed (Mills & Davis-Floyd, 2009).

As part of its struggle to be formally recognised, CASA has had to make compromises in many areas, including having to adapt and omit parts of the school’s formal curriculum so as to meet national requirements. In terms of the points system and accreditation of the programme, the curriculum is set out in accordance to the requirements of the Ministry of Education. Being at *el nivel técnico* (a technical level) means that the programme has to meet a set of specific characteristics. These include, for example, how many teaching hours must be spent on certain subjects. Too many teaching hours and the course would be at a degree level; too few hours and it would not qualify as being at a technical level. Because of the restrictions of the number of hours and credits allowed, the School’s traditional midwifery classes are not formally included in the curriculum; as such they are an extracurricular activity. Maricruz Coronado explains this:

Why did it not stay in the study plan? Well, it did not remain in the study plan because it was going to go over the hours required. Right? To legally do the study plan for a course at ‘technical level’ means that we can’t go over a certain number of hours or credits. Like everything traditional, or everything that is not scientific, they are not accepted by the [health and education] institutions; therefore I did not put it in there. But here we are seeing it, practicing it, demonstrating it... Thus, the only thing that we are lacking is to have this part of the course written down; it exists, but we cannot legalize it because it would mean we would go over the credits, but it

exists and it is taught and the girls are trained like that. (Interview with Maricruz)

There is of course the risk that by not being formally included in the curriculum the inclusion of the traditional midwifery part of the course may be put in jeopardy in the future.

As mentioned earlier, since 2001 graduates have received a *cedula profesional* (professional license) that allows them to work as independent health professionals, whether this be in hospitals, clinics, or in the community, anywhere in Mexico (CASA, 2007, p. 439). However, while professional midwives may be formally recognised by the government, the actual ‘midwifery model of care’ itself is still not widely recognised in Mexico. Both students and staff say that this presents a number of challenges for the school and students, especially when it comes to clinical placements at hospitals, and the graduates’ later employment within the Mexican health system. As Maricruz explains:

It is legal [to work as a professional midwife] but it is a right that hasn’t been implemented... We as a school went to the government, we presented them with a plan of studies, and the Ministry of education said “very good, open the school” but when we opened it and asked for spaces in the hospitals this was when they realised “Oh no. What do we do?”; “Where do we put them?”; “Who knows about midwives?” and this is when the problems started for us. Although we are legal because the government have authorised us, the government didn’t know what it had authorised, and there is not a space for us where our model is respected. (Interview with Maricruz)

This lack of recognition for the midwifery model of care means that during clinical placements at hospitals, CASA students often find themselves in situations where they are told to do something in a way that does not fit in with their model. As Maricruz reflects:

The biggest challenge is to be able to find a balance, and to be able to comply with the midwifery model in the hospitals under their rules. Because, for example, the hospital regulations say that you must do an episiotomy for all first time mothers, and they say that you have to give them oxytocin, and for us as midwives, our model isn’t like that. We do not want to do this. Thus, we don’t do it. So what happens? This is where we find opposition. The students go, and they don’t do it and they get told off. (Interview with Maricruz)

The lack of recognition for the midwifery model also means that there are few employment opportunities currently available to CASA graduates in the Mexican public health system. Of the 43 students that had graduated from the CASA School, Maricruz informed me that only one at the time of this research held a position in a hospital, however, she was not employed under the title of ‘midwife’. She goes on to explain:

They [CASA graduates] aren’t contracted because they don’t have a profile within the professional programme. They go along asking for employment but it’s not there in the staff personnel. They don’t know where to put them. (Interview with Maricruz)

Much of the School’s energy continues to be aimed at fighting for the legitimacy of professional midwives and their model inside the health system. CASA is currently moving to change health legislation. They have proposed a change to the general health law, which would incorporate professional midwives into the law and mean that they could be a part of the health system.

In terms of social recognition it does not help that there is very little social awareness in Mexico of professional midwives and their services. As Débora puts it:

Here you say *partera* and this is directly related to traditional midwives that live in the community and age-wise are more than 50 years old. And well, obviously this isn’t so in the majority of cases. (Interview with Débora)

CASA finds that an important way of promoting professional midwifery throughout the country is to train students from all the different states in Mexico. After graduating the majority of these students return to their communities to work. In this way CASA sees the students as little *semillas* (seeds) spreading the awareness of professional midwives.

Funding

Finding sufficient funding is another one of the School’s biggest challenges. CASA does not receive any funding from the Mexican Government. Instead, the School’s money largely comes from foreign donations, the majority found through Nadine Goodman in North America. It also receives money from some Mexican foundations.

Additionally, a small amount of money comes from fee paying students but as mentioned earlier, those who do not have full scholarships often pay as low as 14% of what their training actually costs the School. Each midwifery student costs CASA 3700 pesos a month (equivalent to NZ\$395 at the time of this research). This covers the school fees and the accommodation costs of living at the student residency. CASA and the school are totally financed by donations; this covers staff salaries, amenities, the cost of equipment, and the expenses generated by the community field experiences, just to name a few. In fact, Débora notes that the biggest challenges for the community field experience are not practical but financial:

What we have the most difficulty with, and above all because we have gone to different states around the country, is this: it is obtaining the resources for this. We have to pay for transport. At this moment I have thirty-five students. At the beginning when there were eight, it was simply just a combi van that could carry us all – but now we have thirty-five. Where do we fit them all? Well, in a bus. Then, transport, the travelling expenses of everyone that goes, food and we give an ‘allowance’ to each group that are staying with a traditional midwife. (Interview with Débora)

Finding sufficient funding is critical for a model in which the importance of culturally acceptable midwifery services is emphasised and where the majority of students come from poorer backgrounds.

Student Withdrawal Rates

The CASA School of Professional Midwifery sees 30 new students enrolling in the first semester of the course each August. However, it can be seen from the student numbers that the School experiences a high rate of student withdrawal from the programme. Up until the time I left San Miguel de Allende the student withdrawal rate for 2010 had lowered to 16.77 from the 2009 rate of 44.14. While there are a number of reasons why students may decide to withdraw from the programme, two main causes stand out; the first is economic difficulties, and the second has to do with students living away from their families.

Because many of the students studying at CASA come from families with scarce resources, some have real difficulties in covering the study costs and living expenses of the three years of study. While the majority of students are studying on fully paid

scholarships, covering school fees and accommodation costs, many still struggle to find sufficient money to cover food costs and private expenses. As classes and clinical experience take up the whole day there is no time for students to work while they study, as one student pointed out: 'We would like to be able to study and work but there isn't the time; it just can't be done'. For some, the financial struggle is too much.

The principal cause, however, of this high rate of student withdrawal comes down to the fact that the midwifery course involves the majority of students having to live away from their families and communities for a number of years. As Débora explains:

As you know we are the only school in the country, this means that the student, whatever part of the country she is in, if she wants to come to study at the school has to move, leave all her family and everything to come here for four years (three years of study plus a year of social service) to become a professional midwife. (Interview with Débora)

Time and time again, when asked about the reasons why so many of their classmates withdraw from the course, students answer: '*Muchas de las chicas se van porque están lejos de su familia y se desesperen y quieren estar con su familia*' ['Lots of the girls leave because they are far away from their families and they despair of this and want to be with their families']. For many of the students, this is their first time living away from home and it is too difficult, especially for those students who have left young children or newborns behind with family members.

Furthermore, students face the reality of having to take on a number of new challenges and responsibilities in their first year of study, these include: getting into a routine of sitting down and studying, cooking and taking care of themselves, and studying a career which is completely new to them. So while they may come to San Miguel de Allende with the desire to study midwifery at CASA many students find that they are unable to cope with these challenges. As Débora notes, students 'might really want to study but come here for only 6 months as they cannot cope with the rhythm or the distance' (Interview with Débora).

Education Levels

The low level of prior education with which some students enrol in the midwifery programme also presents a number of challenges for both the School and the students. CASA requires that prospective students have completed junior high school. Not only has the School's low educational entry requirement produced a number of complications at the Ministry of Education level it has also meant that the qualification which students receive upon graduating is at a 'technical level' rather than at a 'degree level'. In this way, the school has had to 'sacrifice' a midwifery degree so as to widen the enrolment possibilities for women in rural communities. This, as we will see in a moment, presents some challenges of its own in terms of the acceptance and recognition of midwives as health professionals.

Some of the students' lower level of prior education is evident to the School's teaching staff. They describe the main difficulty for such students as being one of adapting. This is because for many of the students the course involves a whole new way of learning, one where they have to be able to inter-relate all the information being taught throughout the various subjects.

Teachers also face the challenge of teaching classes of varying educational abilities. Within the one class they may have some students who have degrees and others who have already worked in their profession alongside students who have only completed junior high school. The teacher first has to get everyone up to a certain level before they can start teaching the material. The School has found that these varying education levels are most evident during the students' first year of study. Débora elaborates on this:

Interestingly, what I have discovered in the nearly two and a half years that I have worked at the school is that in spite of this occurring, the time that it is most notable and is at its toughest is in the first year. After the first year they all catch up to each other, and they then all go at the same speed, but yes, it is tough for them, and the hardest part is for them to sit down and study, and have the routine of sitting down and studying. (Interview with Débora)

The differences in the students' prior education levels also explain the different expectations that many have of the course and of the type of employment they hope

to find upon graduating. For some students it is a point of disillusionment that the course is not at a degree level. This means that the professional license with which they graduate is only recognised within Mexico. This restricts them from working as qualified midwives in other countries. The lack of a degree may also affect how other health professionals in the country view the expertise and qualifications of professional midwives. As one student noted during the focus group, ‘as professionals, the rest of the health professionals don’t recognise midwives because it’s still not a recognised career in Mexico; and because nobody recognises it, it is very difficult’ (Focus group response).

Challenges Combining Traditional and Modern Midwifery

The CASA midwifery model also faces challenges in its aim to integrate traditional midwifery practices within the students’ professional midwifery training. Both Doña Antonia and Maricruz emphasise the real difficulty of teaching traditional midwifery in a school setting. Challenges include what is taught, who teaches it, and how students’ put these skills into real-life practice. Maricruz and Doña Antonia recognise that a number of these difficulties have to do with particular aspects of traditional midwifery, which are generally felt, not learnt. Spirituality is one such aspect. As Maricruz points out ‘it is very difficult to teach traditional midwifery because it is very difficult to teach spirituality’. Along similar lines, Doña Antonia reflects on the feelings and emotions of traditional midwifery:

I think the most important thing of all is feelings, the humbleness or humility of what it is to be a midwife, and I believe that this humility is not something that can be taught in a school. What other way can they learn this apart from watching and observing the humility of traditional midwives? How is the humility?... or the simplicity or sensibility that midwives have with talking to the women. These things you cannot teach in a school, they can only be learnt from one *partera* to another. (Interview with Doña Antonia)

Nor is it easy to bring together two very different practices. In fact, Maricruz admits that occasionally it can be like sending ‘double messages’ to the students. This idea was reiterated by two students who mentioned that what they learn in the traditional midwifery classes is occasionally contradicted in the classes of anatomy, biology and physiology; the topics generally taught to them by doctors. This ‘double message’ is

even more noticeable in the different practices that students observe when working with traditional midwives and doctors. As one student notes:

We can listen in class when they say that you shouldn't do this or that, but you will always see it done in practice... it is always a bit more complicated because you always have to be aware of this, and you always have to be questioning nearly everything. (Student focus group)

Maricruz acknowledges this as a challenge for the students:

Everything, everything is a challenge... When the paediatrician tells us "it has been three minutes... cut the umbilical cord" and you don't cut it, or you have seen with a traditional midwife in the community that they don't ever cut it until after the placenta has come out and everything, and that nothing bad happens, well then, of course you question the doctor "why must you cut it if we have already seen that nothing bad will happen?" (Interview with Maricruz)

The school also faces the challenge of trying to meet the different expectations that students have of the traditional midwifery side of the course. For some students the programme presents the right mix of traditional and professional midwifery, for others it is much more medical than they would have liked. For example, one student reflected upon having to do rotations with doctors at different hospitals even though she had never wanted to be in the medicalised setting of a hospital. Other students felt that the traditional midwifery being taught did not always cover every topic. In this instance the students gave the example of not being shown how to deal with obstetric emergencies using traditional methods. Maricruz recognises the challenge involved with trying to meet the expectations of students while also having to comply with the outside requirements placed on the school:

There have been many girls that come with a certain idea of the school and upon not fulfilling them in the way they thought, or the way that they wanted it to, they leave. And there are many who are here but who complain "Ay, why did they give the saline solution? Why did they do this or that?" and I always tell them "Girls, this is the only place we have to prepare ourselves. We don't have the history of other schools. We don't have years of experience. So then, learn all these skills. When you graduate from the school, you can do what you like with your women - what your women want." (Interview with Maricruz)

The CASA School believes that ultimately it is up to the students themselves to decide what traditional practices they will or will not employ in their work. For some

students this will mean that they will incorporate a lot of traditional midwifery into their practice, for others, not so much. As Débora reflects

The challenge is their own, I would say. We don't confront this. I can't for example, not let a student graduate because they have a more structured or more interventionist way of thinking than traditional. Simply, we don't want it to get lost.... What I value is the capacity that this student has to develop their own objectivity. And obviously, we don't want to be creating mini-doctors. We don't want to create people that after leaving here are going to intervene, intervene, intervene with the women. No. This is not our role. But, sincerely, that everyone does with the information what they want: how they learn it, how they process it, and how they later act on it. We simply want to plant a seed in everyone. (Interview with Débora)

The difficulty of finding a middle point between the two types of practices was something mentioned by the students. For some of them it is a process of constantly having to question the actions and techniques employed by both sides. As one student commented; 'It is difficult to combine two very different things; it is difficult to stay in the middle of them'. Débora ultimately sees it as something that comes down to how the individual students assimilate the information and what methods they decide to employ in their practice. She explains that when students find themselves in a dilemma about this they usually come to discuss it with the staff. The staff's response is to outline the risks and benefits of the different options and it is up to the student to make their own decision.

Lastly, it is important to mention here one further challenge to the traditional part of the course which is increasingly being faced by the CASA teaching model. This is the continuous decrease in the numbers of traditional midwives still practicing in some communities. One of the factors for this decrease in numbers is the aging of current *parteras* who do not have young apprentices to continue on their profession. Another reason, which became apparent during the School's community field experience in the state of Veracruz, is that in some parts of the country traditional midwives are now being paid by the government to take women to deliver in hospitals with doctors. Débora elaborates on this:

One of the governments' strategies is to pay the *parteras* to find women and to bring them to give birth in the hospitals because one of the situations that generate obstetric emergencies and, obviously, maternal deaths, is women not having maternal health care... it is cheaper for them to pay the traditional midwives to bring the women [to the hospital] than to up-skill all of the midwives. (Interview with Débora)

This questions the future possibility of the school being able to carry out the current type of *práctias comunitarias*.

CASA Professional Midwives and Mexico's Biomedical Model of Health

The failings of Mexico's biomedical health system when it comes to the care offered to pregnant women, is a theme that was repeatedly expressed by both staff and students. For some students, as mentioned at the beginning of this chapter, it is the reason why they feel so strongly about becoming professional midwives. The failings, as they see it, come down to three main issues: 1) the lack of respect shown by doctors (including respect for the woman and for her traditions and beliefs); 2) the uneven power relations between doctors and women; 3) and the overuse and misuse of birthing technologies.

These all come down to the different models under which midwives and doctors are trained: the biomedical model and the midwifery model of care. It is the values, attitudes and assumptions associated with these models that shape the practices. Under the biomedical model, doctors are the *unquestionable* authority on health. Pregnancy and childbirth are viewed as a pathological problem that requires the expertise of doctors and medical interventions. As Davis-Floyd (2001) writes:

As Marcia Good Maust (2000) has shown, many Mexican physicians genuinely believe that birth is a dangerous process that can cause harm to mothers and babies; that technological interventions like caesarean sections are the best way to ensure the safety and well-being of mother and child; and that midwives, a hangover from the undeveloped past, are a temporary evil that must be replaced as quickly as possible with the vanguard of the future - modern health care. (p. 6)

The differences between the models explain the different ways doctors and midwives view their roles as maternal health professionals. Doctors 'deliver' babies, whereas midwives support women while women's bodies 'give birth' to babies. This straight away alerts us to the different power relations present between doctors and women. This is something that Doña Antonia expresses in the following interview excerpt,

The power of women is being lost. A woman gets pregnant and she now thinks that she needs to be in the hands of a doctor, and the doctor is the only one that can decide what is going to happen during childbirth, without

letting her body do the work, or letting her give birth to her child through normal labour. (Interview with Doña Antonia)

The dominance of the biomedical model of maternal health in Mexico, with its emphasis on doctors and births taking place in hospitals, also sees the routine overuse and misuse of birthing technologies such as episiotomies and caesarean sections. This is actually changing the very nature of childbirth in the country. All this explains why the CASA School continues to face such a big challenge when it comes to making a space in the Mexican health system where the midwifery model of care is recognized and accepted. The difficulties faced by any group who tries to challenge the biomedical model is something that we will reflect on in greater depth in the next chapter.

Summary

CASA's unique model of professional midwifery training focuses on meeting the maternal health needs of communities with scarce or nonexistent health, education and economic resources. The model came about from the special relationship that CASA had with traditional midwives in the San Miguel de Allende area. As a result of this relationship the school emphasises the importance of learning traditional midwifery within the professional midwifery training. This is seen in the School's traditional midwifery classes and in the community field experiences. The aim of meeting communities' needs has also been carried over to the structure of the school and consequently to the shaping of entry requirements, selection process and the provision of scholarships and accommodation for students. The implementation of this unique model has also resulted in a number of challenges faced by the school and students. These challenges remain far from over.

CASA and Community Participation

Introduction

The CASA School of Professional Midwifery is the story of how one community decided to confront the problem of poor maternal health in their area. While the School has arisen out of its own unique local context, an analysis of its teaching model and the challenges it faces can help us to reflect on the overall concept of community participation and its incorporation into the training of maternal health professionals.

There are two main communities actively involved in the shaping of the CASA model of midwifery teaching. The first of these are the communities where the students come from. This is because the students' local knowledge plays a role in shaping their studies. The second community is that of the traditional midwives involved in the School and training process, for example the traditional midwives in rural communities where CASA students live and work during the school's *prácticas comunitarias*. Although the first outlined community is in itself an interesting subject for future research, this study focuses on the latter.

While not all traditional midwives in rural Mexico share the same beliefs and/or practices, they can be considered a community because of a number of shared cultural and social aspects.¹⁶ Above all, traditional midwives are frequently the principal providers of maternity support and opinion in their communities. They are also community leaders and are often involved in community politics (CASA, 2007). The *parteras* themselves are usually from the community where they work. Therefore, they often subscribe to the same cultural and traditional beliefs about pregnancy and birth as the women they attend. This is reflected in their midwifery practices and explains why many women continue to choose the services of

¹⁶ Howard-Grabman (2007) writes that a community is comprised of those most affected and interested in one particular issue' (Howard-Grabman, 2007, p. 9). In this case, traditional midwives are the group most involved with and concerned about improving maternal health in their area. Moreover, traditional midwives as a 'community' fits in with the CDCP definition of 'communities' as 'groups of people affiliated by geographical proximity, special interests, or similar situations' (CDC/ATSDR, 1997).

traditional midwives even when formal maternal healthcare services are available and accessible. More importantly, these traditional midwives are the link between communities and formal health care systems. Through their involvement in the training of CASA midwifery students they are helping to produce professional midwives to, in the words of Howard-Grabman (2000), ‘bridge the gap’ between two very different health paradigms.

This chapter is divided into four sections. The first section describes how community participation is reflected within the CASA School’s model of professional midwifery training. The second section explores what the findings of this study tell us further about the concept of community participation in development namely about the difference between the concept of community participation being purposely implemented in a project (as a separate notion), and community participation as an emerged outcome of a community’s own solution to a development problem. The third section arises out of CASA’s experience of trying to have their alternative health model recognised within the Mexican biomedical system of health. It looks at the dominant Western biomedical paradigm which shapes the biomedical model of health, and asks whether high levels of community participation are even possible within this paradigm. This is because there are fundamental differences between the biomedical and development paradigms. Finally, the fourth section reflects on the research process.

CASA and Community Participation

Although the CASA School was not founded on the basis of the development concept of community participation, several of the notions that are central to the concept are present in the School’s model of midwifery. There are three key features of the School that most directly reflect such ideas. These are a) the School’s history and development, b) the subjects included in its training programme and the community field experiences, and c) the structure of the School. It is through these three key features that the CASA model aligns itself with the concerns of the community, emphasizes local knowledge and skills, and facilitates capacity building.

The history and development of the School strongly reflects a process of community participation. It was local traditional midwives who identified a concern for poor maternal health, and who took deliberate action to change this. Their idea in approaching the CASA organisation was to further educate themselves on the topic of maternal health, and to explore how modern midwifery knowledge could be added to their own so as to save lives. In this way traditional midwives were the ones to initiate the process which the CASA organisation then facilitated. CASA's two initial courses for traditional midwives saw the beginning of a process of capacity-building and up-skilling of traditional midwives. In fact, this resulted in trained traditional midwives taking on work and leadership roles within the CASA organisation, midwifery school, and maternity hospital. This is clearly seen in the case of two such traditional midwives: Antonia Córdova and Maricruz Coronado, the School's teacher of traditional midwifery classes, and the current director of all CASA programmes, respectively. They are just two of a number of local traditional midwives who completed their training and then went on to participate in the training of new generations of midwives. This cycle of learning and teaching is a very strong and important aspect of the school.

Another key feature that strongly reflects community participation are the subjects included in the professional midwifery training programme. The programme was designed by taking the universal concept of professional midwifery training and shaping it so as to better meet the needs of women in rural communities in Mexico. So while the programme follows the international midwifery model of care and covers the core competencies, requirements and standards as set out and defined by MANA, NARM, and the ICM, it also sees the incorporation of traditional midwifery classes and the carrying out of *prácticas comunitarias* with traditional midwives in the community. This enhancing of international midwifery training models to meet local needs mirrors Howard-Grabman's identification of high levels of community participation (i.e. as seen in community mobilization) as when 'community members identify and implement strategies and approaches that will improve maternal health in their communities' (Howard-Grabman, 2007, p. 8). The design of the CASA programme takes into account the social and cultural norms which hinder or help communities in accessing maternal healthcare. It recognises and incorporates local knowledge and skills. The aim of the school is thus not to replace traditional

midwifery with professional midwifery practices, rather it seeks to combine the two so as to overall 'better' local maternal healthcare.

The influence of notions of community participation in the School's teaching model is perhaps at its most visible in the community field experiences, which offer students and traditional midwives the opportunity to learn and benefit from each other's knowledge. In this way, they are a reciprocal learning process with knowledge and skills being shared in both directions. In terms of the capacity building for traditional midwives, the knowledge, strategies and practices shared by the students during the *prácticas comunitarias* complement local knowledge, a process which according to Howard-Grabman (2007) generally leads to 'better informed decision making' (p. 8). This empowers traditional midwives and their communities, and leads to the better maternal health of their women.

Lastly, CASA has arranged and designed the teaching model so as to make community involvement possible within the training programme, ie the structure of the programme. This idea clearly informs the School's selection process, the educational entry requirements for students, and the provision of student scholarships and accommodation. It also sees the employment of trained traditional midwives within the teaching staff and at the maternity hospital. To confront the problem of poor maternal health CASA has had to identify itself with the realities of life and maternal health in rural communities. This has shaped what is taught, how things are taught, and who is accepted into the midwifery programme. In identifying itself with rural communities CASA has had to focus not only on the content of the course but also on the way in which the school is run. Thus, the CASA School offers a programme which emphasises community entry and community dialogue; differing from the standard model of higher education in Mexico.

Because the aim of the school is to improve maternal health in rural communities, preference is given to students who are the daughters or relatives of traditional midwives and/or students from rural communities. This in turn has determined what prior educational levels are required for entry into the programme and how course and accommodation costs are covered. The relatively low educational requirement of completing *secundaria* opens up the opportunity for study to those from rural

communities. As a result of this, the school has had to develop effective ways of teaching these students. The mode of teaching and testing thus is not solely based around the written word; other ways of learning are valued. This includes an approach orientated toward practice, discussion and reflection.

The Process of Community Participation as Reflected in the CASA model

In this section we will look at what the findings of this study suggest about community participation processes in global health development initiatives. This study has brought to my attention the very different ways in which outsiders (development workers, academics, development policy advisers etc.) and insiders (members of the community) may arrive at implementing community participation-type processes in development initiatives. While both parties may come to solutions that involve the participation of communities in programmes, they may arrive at this through very different processes. In fact, these processes can fundamentally differ in terms of the ideas held about what is meant by ‘development’, and what ‘good development’ incorporates.

In the chapter *The Relationship between Community Participation and Maternal Health Outcomes*, we looked at the distinction between community participation as a means or/and end. I want to now take this one step further and explore the difference between the concept of community participation being purposely implemented in a project (as a separate notion), and community participation as an emerged outcome of a community’s own solution to a development problem. The first is what we see in standard development practice; the second emerges organically out of a specific context. It is now considered standard practice for ‘outsiders’ to go into a development project with the idea of implementing community participation. Often the *concept* of participation is worked into a development project as an essential yet separate (‘standalone’) notion to that of ‘development’. However, in many non-Western communities ideas of ‘development’ inherently entail community involvement, and the incorporation of local and traditional knowledge and perspectives. In the latter case, community participation, as a concept, is not deliberately incorporated into a development project; rather it emerges organically out of the community’s own idea of development and development solutions. The

differences between the two perspectives are obvious when we look at the following processes of a hypothetical maternal health initiative:

Figure 6: Comparison of “Outsider” versus “Insider” Approaches

The fundamental difference between these two processes is in the steps identifying the solution to a problem. Outsiders arrive in the community to incorporate already ‘known’ solutions into a project and use community participation as a way to validate the implementation of this external knowledge into community initiatives. In the second case, a community’s solutions arise from their own understandings, skills and knowledge. This can lead to processes which may *reflect* community participation but which, through emerging organically out of a community’s own perspectives, are very different to the theoretical concept of community participation. In fact, thought about in this way, this second community participation seems to point away from the development concept of community participation, and moves perhaps more towards indigenous or alternative development.

Relating this back to the case study, when CASA staff and traditional midwives were discussing the maternal health needs of their communities and how these needs could best be met, they did not identify what they were doing as incorporating community participation. Their fundamental concern was with meeting the maternal health needs of communities as decided on by communities themselves. The CASA model is therefore an inversion of the way participation has been used in the past. Consequently, rather than thinking of the School’s model as a community participation model of professional midwifery education, perhaps a more adequate alternative term would be that of a *community* model of professional midwifery education. This idea persists when we later briefly explore the implications of the way Western paradigms are often imposed on development countries when there are in fact indigenous or alternative models already taking place there. Moreover, rather than being a process of community participation within the current Mexican health system, the model created by CASA and the *parteras* has actually been a much more political process challenging the Mexican biomedical model of health.

Community Participation under the Dominant Western Biomedical Model of Health

One of the major themes highlighted by this case study is the uphill battle faced by anyone who challenges the dominant Western biomedical model of health. Throughout the research, staff and students have talked about the failings of the

Mexican biomedical health system in caring for women, its reluctance to recognise and accept the midwifery model of care; and its dismissal of traditional practices. As Maricruz explained: '*Como todo lo tradicional, o todo lo que no es científico, las instituciones no lo aceptan*' [everything that is traditional, or everything that is not scientific, is not accepted by [health and education] institutions] (Interview with Maricruz).

The problem is that the biomedical paradigm that shapes the biomedical model (on which current medical practice is based) delegitimizes any other way of thinking about health. This raises many questions when it comes to the idea of incorporating community participation into maternal health initiatives and the setting of health development policies. This section will highlight the fundamental differences between the biomedical and development paradigms and in doing so puts into question the very way we do health development.

The Biomedical Paradigm and Model of Health

The biomedical paradigm describes the underlying philosophy or way of thinking about modern medicine. Its focus is very much on the body's biological processes and the idea that sickness and disease can be cured and controlled through the use of medication and medical procedures (Hasan Kasule, 2007). As such, it likens the patient to a machine with an illness, where the illness must be treated and 'fixed' (Hasan Kasule 2007; Cohen 1998; Longino, 1997). Modern medicine follows this idea and can be said to focus more on treating the disease and its symptoms rather than on treating the person (Hasan Kasule, 2007).

The biomedical paradigm was first introduced into Western medicine in the late 19th century and by the mid-20th century it became the dominant paradigm of health not only in Western countries but in all economically advanced countries (Thomas, 2011; Cohen, 1998). The paradigm is firmly rooted in the field of science which states that experimentally proven 'true' knowledge exists. Thus, modern medicine, bases itself on what is claimed to be ascertainable fact, knowledge which is expounded as being both universal and innately objective (Wolffers, 2000, p. 269;

Thomas, 2011; Kasule, 2007; Longino, 1997). However, despite these claims we know that “subjectivity cannot be avoided in diagnostic and treatment decisions” (Hasan Kasule, 2007, p. 5).

It is the biomedical paradigm that shapes the biomedical model of health with its emphasis on medical professionals and hospitals. The biomedical model's association with the words ‘modern’ and ‘technology’ have become synonymous in peoples’ minds with ‘best’ and ‘safest’. Moreover, the biomedical paradigm asserts that the challenges of health are effectively and completely addressed by the objective methods of biomedical science. As a consequence of this deeply-ingrained belief, the worldwide reform in healthcare has followed what are mostly biomedically-dominated assumptions (Lukere, 2002).

Nowadays the majority of health professionals and health policy advisers in both developed and developing countries have been trained in the biomedical model. This further legitimises and guarantees its replication in national and international health development policies. At the same time the biomedical model actually delegitimizes and replaces any other concepts of health (Lopez, 2010). It does this in two main ways, through the medical specialty's control over health discourse and through government-approved and/or sponsored health services. Both of these strongly legitimise the ‘one way’ to think about health. Lopez, in his doctorate thesis about the changes in health concepts in a Mexican village, explores the issues of power and Michel Foucault's idea of the creation of ‘docile’ bodies:

Michel Foucault, in *The Birth of the Clinic*, analyzes how powerful entities such as medical academies and military hospitals establish and enforce new ways of thinking about health. The discourse on a certain issue can be controlled by these entities, which in turn dictate, and limit, how the issue is conceptualized by the general population... In Zapata, the biomedical paradigm is reinforced through the way illness is talked about by the M.D. and the *promotoras*. By negating any alternative realities to illness and illness treatment, the M.D. is perpetuating the idea that biomedicine holds the ultimate truth—creating docile bodies that do not question health aetiologies or treatments but only react to the epistemological axioms produced by the clinic. (Lopez, 2010, pp. 27-28)

Any health views differing to those of the biomedical model are thus rejected. Furthermore, the biomedical model of training is constantly being enforced. For health training programmes to be formally recognized within a country they need government approval. Thus programmes must comply with the regulations set out by both the Ministries of Health and Education. These regulations at once reflect and enforce the dominant health paradigm.

This self-assertion that the biomedical approach is the *only* valid approach to health is of great concern when we recognise its many failings. From the 1960s onwards many scholars, such as sociologists and advocates of alternative epistemologies, have raised concerns and questioned the widespread belief in the appropriateness of the biomedical model. There are four main objections to the biomedical model. The first is that the model is reductionist in that it reduces the body to the status of a machine (Leah Fow, 2008). Another is that it is curative, which means that it is more focused on ‘curing rather than on preventing disease’ (Thomas, 2011). It is also criticised for being individualistic and for not giving enough attention to the social, cultural, emotional and spiritual aspects of health (Hasan Kasule 2007; Cohen 1998). Lastly it is criticised for being interventionist, with a belief in the always beneficial nature of technological intervention resulting in interventions being overused as well as misused. So while the biomedical model of health may be good for curing diseases, it has its limitations when it comes to creating health and addressing health improvements (Rifkin, 2009, p. 34). These limitations are highlighted in the 2008 WHO World Health Report:

Biomedical science is, and should be, at the heart of modern medicine. Yet, as William Osler, one of its founders, pointed out, “it is much more important to know what sort of patient has a disease than what sort of disease a patient has”. Insufficient recognition of the human dimension in health and of the need to tailor the health service’s response to the specificity of each community and individual situation represent major shortcomings in contemporary health care, resulting not only in inequity and poor social outcomes, but also diminishing the health outcome returns on the investment in health services. Health workers have to care for people throughout the course of their lives, as individuals and as members of a family and a community whose health must be protected and enhanced, and not merely as body parts with symptoms or disorders that require treating.” (p. 41)

Yet it is under this biomedical model with its many limitations that we are seeing the widespread inclusion of ‘community participation’ into health initiatives. While

many health development initiatives advocate the inclusion of community participation, Rifkin notes that having the ‘bio-medical paradigm as the main planning tool for programmes, leads to the view of community participation as an intervention rather than as a process’ (Rifkin, 2009, p. 31). This takes us back to the idea of participation as a means. Community participation, in this case, is seen as a way to achieve the universal acceptance and implementation of the biomedical model of health; the ‘pinnacle’ of all health models. Consequently, the belief in the model’s unfailing appropriateness shapes how community participation is employed in health initiatives. As Rifkin points out, ‘there is a tendency in both theory and practice to see a community as a target group for a health intervention, and participation as the response of the group to take up advice and activities that have been proven to deliver better health’ (Rifkin, 2009, p. 32). This promotes the idea that the solutions to all communities’ health problems are already *known* through biomedical health research and thus can be delivered to communities as ‘known remedies for cures’ (Rifkin, 2009, p. 34).

In terms of development theory, there is an interesting parallel between the biomedical model of health and the modernisation model of development. However, development has since moved on from a modernisation model towards participatory development. What does this change mean for the relationship between the biomedical and development paradigms?

The Biomedical and Development Paradigms

A big challenge facing global maternal health improvement is in the fundamental differences between the biomedical and development paradigms. Wolffers (2000) lays out these differences in his article *Biomedical and development paradigms in AIDs prevention*. According to him, the biomedical paradigm is characterised by the idea of ‘individualisation’ and by the concept of ‘risk’ (Wolffers, 2000, p. 267). Here, health is visualised within the concept of the market, and is viewed not only as a ‘product of services’ but as ‘a series of new discoveries that can be marketed’ (Wolffers, 2000, p. 267). Under this paradigm, greater importance is given to the biology of the individual than to his or her social, environmental, and cultural context and thus results in the ‘decontextualisation’ of health (Wolffers, 2000, p. 269).

In contrast, the participatory development paradigm emphasises the participation of all stakeholders. Here the importance is on solidarity and empowerment, and improving the conditions in which people live. The development paradigm talks about the idea of ‘vulnerability’ rather than ‘risk’. Reducing this vulnerability is considered essential for good health (Wolffers, 2000). The idea of ‘vulnerability’ rather than ‘risk’ acknowledges the existence of social constructs and systems of power and control. Therefore, to improve health under the participatory development paradigm it is essential that the social constructions under which people live are recognised.

The fundamental differences between the biomedical and development paradigms are substantial. In fact, the biomedical paradigm appears to actually *impede* processes of empowerment and participation - two of the primary ideas of participatory development. Consequently, we have got to ask whether it is even possible for these two paradigms to work together to meet the healthcare needs of communities? This brings us back to the question of whether high levels of community participation can take place under the biomedical paradigm, and what this means for maternal health in developing countries. On reflection, the answer to this question appears to be in the negative. In reality it appears that communities may only be permitted to participate in the maternal healthcare services sanctioned by the state. In the case of Mexico, this refers to a government-backed biomedical health system controlled by doctors.

Community participation should not mean merely being able to choose from a limited selection of options put forward by those who have control over childbirth. High levels of community participation should mean that communities themselves are able to come up with their own solutions to maternal health problems by employing local, traditional and modern knowledge and skills, independent of any official State recognised medical paradigm or model.

The negation of high levels of community participation in the biomedical model has a significant impact on how we think about and implement health development. It dramatically restricts the number of choices women are presented with in terms of

maternal healthcare services. This impacts the number of women accessing these services in developing countries. One of the risks of this in terms of maternal healthcare is that the biomedicalisation of birth and the normalization of the overuse of birthing technologies will put women at risk at the same time as resulting in the knowledge of what is normal/natural childbirth being virtually lost to both medical professionals and to women (Donnison, 1988). This is not a fantastic exaggeration. Globally we are already beginning to witness this with the increase in non-emergency caesarean sections. In Brazil there is now a real fear of substandard care for vaginal births because many doctors are now more experienced at operating than dealing with any complications with vaginal birth (Song, 2004, p. 58). Mexico is not far behind; now having one of the highest caesarean section rates in Latin America and the World. Furthermore, the biomedical model alone struggles to get more women accessing services and the problem remains of the acceptability, accessibility and affordability of healthcare services.

Where to From Here?

The failings of the biomedical paradigm are clearly seen in the maternal health services in developing countries. It adds to the questions of the very relevance of implementing Western paradigms in non-western realities, something which has been explored in the literature coming out of Cultural studies and Sociology. Scholars in these fields have expressed their concerns about what they see as the ‘uncritical adoption’ of Western social science practices in developing countries¹⁷. These concerns arise from what they see as ‘a lack of fit between the Western social sciences and non-western realities’ (Alatas, 1999, p. 1). Furthermore, they refute that the Western model is the neutral and universal discourse that it presents itself to be. The same can be said of the dominant Western biomedical model (Wesley-Smith 1995, p. 125).

¹⁷For criticism of the implementation of Western social sciences in non-western realities, see: theories of Orientalism (Said, 1979, 1993), theories of Eurocentrism (Amin, 1989), postcolonial criticism, rhetorical theories of social science (S. F. Alatas, 1998), the theory of mental captivity (S. H. Alatas, 1972, 1974), and academic dependency theory (Altbach, 1977; Garreau, 1985).

There have been a number of suggested responses to this problem in the social sciences, including the call to create universal forms of scholarship. The universalising of the social sciences includes the selective and critical adaption of Western models of social sciences so as to meet the needs and circumstances of non-Western societies and cultures. The question thus is, can universal forms of health scholarship exist? We only need to look at the CASA model of professional midwifery to know that it is possible to take steps in this direction.

Reflection on the Research Process

The shape that this research has taken is due more to the involvement of the research participants than any ideas of community participation that I arrived in Mexico with. It was through discussions and the semi-structured interviews and focus group with staff and students that I was able to focus on and shape my research towards what they considered the most important issues. It was through them that I became aware of the widespread unacceptability of current formal maternal healthcare services in Mexico. Likewise, they alerted me to the significant constraints put on both the School and students by working under Mexico's biomedical model of health.

As my first time undertaking any field research, this experience has been very much a process of learning. Initially I had the idea that I would arrive in Mexico and be easily able to identify how community participation was incorporated into the CASA model of midwifery training. What I found was, of course, so much more complex. To understand about the school and its model the context in which it is situated had to be thoroughly understood. This meant having to take into account aspects such as culture, history, gender issues, and politics. The research thus ends up bringing together various ideas from indigenous knowledge and development, cultural studies, subaltern studies, gender studies, anthropology, and development studies. Thus, it does not fit tidily into one discipline, or the one neat category that perhaps at first I was thinking it would.

Furthermore, throughout the study a wide range of differing perspectives about the model were revealed. On arriving at the school I was initially surprised at first coming across conflicting perspectives amongst the students about their thoughts on

the CASA midwifery training programme. While the majority of students had very positive things to say about the school, there were a few who expressed some frustration and disillusionment with their studies. This at the time confused me as to what the 'truth' of the situation was, how conflicting views could surround the same reality, and how I would be able to consolidate these differing views into this one study. The conflictive perspectives were mainly about the different expectations students had had on enrolment as to the traditional midwifery side of the programme. While for many students the training offered the right mix of traditional and modern midwifery, for a small few it was not nearly traditional enough. At first I wondered whether this frustration and disillusionment expressed by a few students put into question the overall success of the CASA School model. However, as the interviews progressed and I became more aware of CASA's situation I realised that rather than questioning the success of the School's training model these conflicting perspectives further highlighted the challenges faced by the School, and the compromises it has had to make. In other words, how can CASA meet every students' demands when: a) it is the only midwifery school in the country, b) there are specific educational requirements it has to cover so as to be formally recognised, and c) it is working under a national biomedical health system. Rather than there being a need to consolidate the differing perspectives, I realised that these clearly show the reality of the challenges the school faces.

Summary

In this chapter we have looked at how community participation is reflected in the CASA model of professional midwifery training. The community that we have focused on in this study is that of the traditional midwives involved in the School and training process. While the school was not formed on the basis of the development concept of community participation, it does include many notions of participation in its model. This can be seen particularly well in the school's history, in the traditional midwifery classes and community field experiences, as well as in the School's structure and the mode of teaching used. Through these key features the CASA model aligns itself with the concerns of the community, emphasises local knowledge and skills, and facilitates capacity building; all of which are essential characteristics of community participation.

By focusing on the forming and shaping of the school I have become aware of the very different ways in which outsiders and insiders may arrive at implementing community participation-type processes. Where outsiders often view participation as a separate ('stand alone') notion to that of 'development', for many non-Western communities ideas of 'development' inherently entail community involvement, and the incorporation of local and traditional knowledge and perspectives. Thus, as is with the case of the CASA School, community participation as a concept is not deliberately incorporated into a development project; rather it emerges organically out of the community's own idea of development and development solutions.

In this way the CASA model is an inversion of the way participation has been used in the past. For this reason I have suggested that the School be seen as a *community* model of midwifery education rather than a participatory model of midwifery education. Especially because more than merely being a process of community participation within the current Mexican health system, the model created by CASA and the *parteras* actually challenges the biomedical model of health in Mexico.

This led us to look at the fundamental differences between the biomedical and development paradigms and to question whether high levels of community participation can even take place under the biomedical paradigm. The answer to which appears to be no. In reality it appears that communities may only be permitted to participate in the maternal healthcare services/paradigms sanctioned by the state. This led us to look at what has been written in the social sciences about the application of Western paradigms in non-western realities and the idea of creating universal forms of scholarship as a response to this problem.

Conclusion

Discussion of Research Question

This study explored the way that community participation is reflected in the model of training at the CASA School of Professional Midwifery. As many health researchers and practitioners now believe, for maternal healthcare initiatives to be successful communities need to be actively involved throughout the whole process. A growing body of literature points towards the need for more community involvement in global maternal health initiatives, however, there are few concrete examples published of community participation in the training of skilled birth attendants (SBAs).

This study aimed to further this knowledge of incorporating community participation in the training of maternal health professions with a focus on what specific aspects of professional midwifery training might help in the process of making midwives' services more acceptable to rural communities.

It was found that, while the school was not formed on the basis of the development concept of community participation, it included many notions of participation within its model. This is particularly evident in the school's history, in the traditional midwifery classes and community field experiences, as well as in the School's structure and the mode of teaching used. Through these key features the CASA model aligns itself with the concerns of the community, emphasises local knowledge and skills, and facilitates capacity building; all of which are essential characteristics of community participation.

By focusing on the forming and shaping of the school I became aware of the very different ways in which outsiders and insiders may arrive at implementing community participation-type processes. Where outsiders often view participation as a separate ('stand alone') notion to that of 'development', for many non-Western communities ideas of 'development' inherently entail community involvement, and the incorporation of local and traditional knowledge and perspectives. In the first

case, outsiders arrive in the community to incorporate already ‘known’ solutions into a project and use community participation as a way to validate the implementation of this external knowledge into community initiatives. In the second case, a community’s solutions arise from their own understandings, skills and knowledge. This can lead to processes which may *reflect* community participation but which, through emerging organically out of a community’s own perspectives, are very different to the theoretical concept of community participation. In fact, thought about in this way, this second community participation seems to point away from the development concept of community participation, and moves perhaps more towards indigenous or alternative development.

The CASA model is an inversion of the way participation has been used in the past. So rather than thinking of the School’s model as a community participation model of midwifery education, these findings suggest that perhaps a more adequate alternative term would be that of a *community* model of midwifery education. This led us to consider the way that Western paradigms, such as the biomedical paradigm, are often imposed on non-western realities.

We looked at the fundamental differences between the biomedical and development paradigms and questioned whether high levels of community participation can even take place under the biomedical paradigm. The answer to which appears to be no. In reality it appears that communities may only be permitted to participate in the maternal healthcare paradigms and models sanctioned by the state. This questions the very way we think about health development, and introduces the need for universal forms of health scholarship.

Findings

This study arose from the recognition that poor maternal health is a social issue, rather than just a medical problem. This means that any initiative to improve this needs the involvement of the communities themselves. The literature also tells us that to improve maternal health in developing countries formal maternal health services need to be made affordable, accessible, and acceptable. What this particular study provides is a concrete example of a bottom-up, community-centred approach to the

training of professional midwives, an approach which successfully sees maternal health professionals returning to work in rural communities.

The CASA School of Professional Midwifery is a bright spark of hope offering a new way of thinking about the relationship between maternal health professionals and the community. The School breaks away from a purely biomedical tradition in order to identify itself with the realities of rural communities, thus integrating communities back into the maternal health discourse. The CASA model questions and challenges the idea that the biomedical model can meet all health needs. At the same time, it selectively and critically adapts the knowledge that is useful, thus enhancing international midwifery training models to meet local needs. With its focus on meeting the needs of rural communities and the teaching of both traditional and professional midwifery the CASA model is a big step towards creating universal forms of health scholarship.

The CASA model aims to produce graduates who are skilled maternal health professionals and can also work as human rights advocates who can spread awareness of women's rights to accessing acceptable maternal healthcare services. In doing this they challenge the many unnecessary and unacceptable birthing practices continuing to be carried out in hospitals, such as routine episiotomies for all first time mothers. They challenge this at both local and federal levels both amongst health professionals through social awareness building. It is perhaps in this area – in challenging the country's health policies and unnecessary biomedical practices - that CASA offers the greatest potential.

That CASA has graduates working in rural communities around Mexico is in itself a testimony to the impact of this innovative training approach. It is a real initiative, providing real solutions. Their model presents tremendous potential in terms of building similar schools in Mexico and around the world, and provides a means for governments to adopt parts of the model into their own health training programmes. With this in mind it is important to consider what the key characteristics of this model are.

To implement the CASA model in other locations, a core alternative curriculum needs to be set which can help schools identify with the realities of what is a predominantly rural problem.

Following the CASA model, there needs to be three key components to any such programme:

1. Schools should have a pro-rural and/or pro-poor communities focus
2. The majority of students should be from rural areas or be the daughters or relatives of traditional midwives. Subsequently, the Schools' admissions policy needs to take into consideration the prior educational entry requirements so as to broaden the scope of students accepted into the school
3. The inclusion of community field experiences ensures that students and staff work closely with communities and traditional midwives as an integrated part of the curriculum.

However, the CASA story shows that this model does not come without challenges. One of the core challenges that the model faces is the availability of resources both financial and human – to run such a programme. This research clearly shows that finding sufficient funding is a constant struggle, particularly in the case of schools being run by NGOs with no government funding. In terms of the challenges of human resources, the model may find itself implemented in locations with very different maternal healthcare cultures where traditional midwives may be few or non-existent. There may also be no previous culture of midwifery in the area with the need for foreign professional midwives to be brought in to implement the initial training. All these will affect the way that rural communities view and uptake professional midwifery services.

Moreover, there are challenges in terms of changing national health policies. To do this requires strong committed leadership. CASA itself has experienced the hostile reception new models can face from government structures, the educational establishment, and professional bodies. Their model also shows the need for the re-orientation of local maternal health professionals many of whom will have been trained in models that do not innately incorporate the community or traditional

practices. They have demonstrated how essential it is for the leadership of any such schools to have strong connections with the maternal health concerns of rural communities, as this is where the strength of the model lies.

It is important point to note that wherever the model is implemented it will need to be modified to take into account the local context. The CASA model implemented in a different context will never be the innately organic process it was in San Miguel de Allende. To try and counter this being another case of implementing an outside initiative into a community, the design and development of the curriculum, while being based on the CASA model, would need as wide as possible consultation from the community and all stakeholders. It needs to be shaped to its own context as one curriculum cannot possibly reflect the realities of all communities.

Conclusion

Mexico has not seen a big reduction in maternal mortality over the last two decades. In fact, the 8% reduction in the ratio from 93 to 85 over the period 1990 to 2008 while positive is still grounds for concern, especially when we consider how the MMR varies across states and is higher in marginalised rural and indigenous communities. Clearly the current national strategy for reducing maternal mortality has not proved as effective as hoped. Increasing the number of formal maternal health services available has not provided a decrease in the MMR and there is the need to consider other options.

The CASA School of Professional Midwifery provides a model of maternal health training that offers hope for communities. However, it has had to overcome numerous challenges, and these are far from over. The financial constraints alone could potentially bring the training programme to a halt and there is an urgent need to make it financially secure. With the changing circumstances of traditional midwifery in Mexico the model may have to start to change but it will remain the source of midwifery in Mexico; where midwifery drew breath. It tells us that bottom-up community approaches can work, and it is an alternative response to the many failings of the current dominant Western biomedical model of health.

Recommendations for Further Action and Research

This study strongly points out that many biomedical practices and services do not meet the needs of communities. Consequently a shift in maternal health training towards greater relevance to communities is needed. Governments and organisations need to fund, support and work with maternal health solutions that work for communities.

In terms of the CASA model of midwifery training, the main recommendation is that this model be adopted, adapted, and tested in other locations. Not only could this lead to the setting up of individual schools in Mexico and worldwide but also provides the potential for Ministries of Health to incorporate many of the model's ideas into state-funded obstetric nursing, and medical schools. Even if it is not possible to replicate the whole model, parts of it could be adopted, for example training women from rural communities as maternal health professionals.

The principle suggestion for further research is the need for studies focusing on how the CASA model can be replicated in other locations and contexts. While the adoption of the CASA model in a different context will never be the innately organic process it was in San Miguel de Allende, the inclusion of as wide as possible consultation from the community can mean that it is not just another case of imposing an outside initiative on a community.

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Appendices

Appendix A: Information Sheet for Semi-Structured Interviews

VICTORIA UNIVERSITY OF WELLINGTON

INFORMATION SHEET FOR SEMI-STRUCTURED INTERVIEWS

Title of project: The CASA Model of Midwifery: Increasing Formal Maternal Health Care in Rural Communities.

Researcher: Jenny Woodley Higgins: School of Geography, Environment and Earth Sciences, Victoria University of Wellington, New Zealand.

I am a Masters student in Development Studies at Victoria University of Wellington, New Zealand. As part of this degree I am undertaking a research project leading to a thesis. The project I am undertaking is a case study of the midwifery teaching model employed at the CASA School of Professional Midwives in San Miguel de Allende, Mexico. This research sets out to explore how the CASA model of midwifery training aims to increase formal maternal health care services in rural communities in Mexico. By focusing on one case study this research project will add to our understanding of how different midwifery training models can contribute to reducing maternal mortality. This will bring to light new ways of improving access to skilled birth attendants, not only in Mexico, but in other developing countries around the world.

Responses collected will form the basis of my research project. All material collected will be kept confidential. As we have discussed, the CASA School and staff will be named in the research reports and publications, any opinions attributed to you will be checked for your approval prior to final inclusion. No other person beside me and my supervisor, Dr Joan Skinner, will listen to the tape recording of the interviews or have access to the transcripts. The thesis will be submitted for marking to the School of Geography, Environment and Earth Sciences and deposited in the University Library. It is intended that one or more articles will be submitted for publication in scholarly journals.

Ethics approval for this research has been granted by the Human Ethics Committee of Victoria University of Wellington. The approval number is 17361.

What is involved?

- The interviews are designed to take 30-40 minutes and can take place at a mutually agreed time and place. You will be interviewed by Jenny Woodley Higgins. You will be required to sign the attached consent form prior to the semi-structured interviews.
- Your participation is entirely voluntary. If you agree to take part in the interviews you are free to withdraw at any time without having to give a reason and without penalty of any sort. You are free to withdraw any information you have provided before 10th June 2010 after which withdrawal

will not be possible due to data collection having been completed.

- You will be asked several semi-structured questions in each interview regarding the CASA model of midwifery training. You do not have to answer all questions.
- The interviews will be tape-recorded and transcribed. The recording will be used to complement the notes taken during the interview.
- Opinions attributed to you in any written reports will be checked for your approval prior to final inclusion.
- All raw data collected during the interviews will be accessed by the principal investigator and research supervisor only. These will be stored in a locked filing cabinet or as password protected electronic documents and destroyed after 5 years

Please feel free to contact the researcher or research supervisor if you have any questions or would like to receive further information about this study.

Principal Investigator:

Jenny Woodley Higgins

Masters of Development Studies student – Victoria University of Wellington

jenwoodhig@hotmail.com

Phone number in San Miguel de Allende: 415 149 6332

Phone number in New Zealand: (0064) 4 476 3634

Research Supervisor:

Dr Joan Skinner

Senior Lecture at Graduate School of Nursing, Midwifery and Health – Victoria University of Wellington

Joan.skinner@vuw.ac.nz

Phone number in New Zealand: (0064) 4 463 6654

Appendix B: Consent Form for Semi-Structured Interviews

VICTORIA UNIVERSITY OF WELLINGTON

CONSENT FORM FOR SEMI-STRUCTURED INTERVIEWS

Title of project: The CASA Model of Midwifery: Increasing Formal Maternal Health Care in Rural Communities.

- I have read and understood the attached 'Information sheet for semi-structured interviews'. I have had an opportunity to ask any questions I may have about the study and about participating in the interview and have had them answered to my satisfaction.
- I agree to participate in these semi-structured interviews and understand that I may withdraw myself (or any information I have provided) from this project before 10th June 2010 without having to give reasons or without penalty of any sort.
- I understand that the interviews will be tape recorded and transcribed, and that only the researcher and her supervisor will have access to this material. Any information I provide will be kept confidential to the researcher and her Supervisor.
- I understand that my name will be included in the written report and that any opinions attributed to me in written reports will be checked for my approval prior to final inclusion.
- I understand that all written material and taped interviews will be stored in a locked filing cabinet or as password protected electronic documents and then destroyed after 5 years.
- I understand that the data I provide will not be used for any other purpose or released to others without my written consent.

I _____ (full name) hereby consent to take part in this study by being interviewed.

Signature: _____ Date: _____

Interview conducted by: _____

Signature: _____ Date: _____

☐ I would like to receive a summary of the research findings **Yes / No** (Please circle)

Appendix C.: Information for Focus Group

VICTORIA UNIVERSITY OF WELLINGTON

INFORMATION SHEET FOR FOCUS GROUP

Title of project: The CASA Model of Midwifery: Increasing Formal Maternal Health Care in Rural Communities.

Researcher: Jenny Woodley Higgins: School of Geography, Environment and Earth Sciences, Victoria University of Wellington, New Zealand.

I am a Masters student in Development Studies at Victoria University of Wellington, New Zealand. As part of this degree I am undertaking a research project leading to a thesis. The project I am undertaking is a case study of the midwifery teaching model employed at the CASA School of Professional Midwives in San Miguel de Allende, Mexico. This research sets out to explore how the CASA model of midwifery training aims to increase formal maternal health care services in rural communities in Mexico. By focusing on one case study this research project will add to our understanding of how different midwifery training models can contribute to reducing maternal mortality. This will bring to light new ways of improving access to skilled birth attendants, not only in Mexico, but in other developing countries around the world.

Responses collected will form the basis of my research project and will be put into a written report on an anonymous basis. It will not be possible for you to be identified personally. All material collected will be kept confidential. No other person beside me and my supervisor, Dr Joan Skinner, will listen to the tape recording of the focus group or have access to the transcript. The thesis will be submitted for marking to the School of Geography, Environment and Earth Sciences and deposited in the University Library. It is intended that one or more articles will be submitted for publication in scholarly journals.

Ethics approval for this research has been granted by the Human Ethics Committee of Victoria University of Wellington. The approval number is 17361.

What is involved?

- The focus group is designed to take 60-120 minutes at a specified time and venue. It will be facilitated by Jenny Woodley Higgins. You will be required to sign the attached consent form prior to participating in the focus group.
- Your participation is entirely voluntary. If you agree to take part in the focus group you are free to withdraw at any time without having to give a reason and without penalty of any sort. You are free to withdraw any information you have provided before 10th June 2010 after which withdrawal will not be possible due to data collection having been completed.

- The group will be asked several semi-structured questions. You do not have to answer all questions.
- Common courtesy towards other participants needs to be exhibited at all times and the confidentiality of other participants must be maintained.
- The focus group discussion will be tape-recorded and transcribed. The recording will be used to complement the notes taken during the focus group by the investigator.
- All raw data collected during the focus groups will be accessed by the principal investigator and research supervisor only. These will be stored in a locked filing cabinet or as password protected electronic documents and destroyed after 5 years.
- As a thank you for your time you will be provided with refreshments during the focus group.

Please feel free to contact the researcher or research supervisor if you have any questions or would like to receive further information about this study

Principal Investigator:

Jenny Woodley Higgins

Masters of Development Studies student – Victoria University of Wellington

jenwoodhig@hotmail.com

Phone number in San Miguel de Allende: 415 149 6332

Phone number in New Zealand: (0064) 4 476 3634

Research Supervisor:

Dr Joan Skinner

Senior Lecture at Graduate School of Nursing, Midwifery and Health – Victoria University of Wellington

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Appendix D: Consent Form for Focus Group

VICTORIA UNIVERSITY OF WELLINGTON

CONSENT FORM FOR FOCUS GROUP

Title of project: The CASA Model of Midwifery: Increasing Formal Maternal Health Care in Rural Communities.

- I have read and understood the attached 'Information sheet for Focus Group'. I have had an opportunity to ask questions any questions I have about the research project and my participation in the focus group, and have them answered to my satisfaction.
- I agree to participate in this focus group and understand that I may withdraw myself (or any information I have provided) from this project before 10th June 2010 without having to give reasons or without penalty of any sort.
- I agree to exhibit common courtesy towards others at all times and to maintain the confidentiality of other participants.
- I understand that the focus group will be tape recorded and transcribed, and that only the researcher and her supervisor will have access to this material.
- I understand that all written material and taped interviews will be stored in a locked filing cabinet or as password protected electronic documents and then destroyed after 5 years.
- I understand that no individual from the focus groups will be named in any written reports.

I _____ (full name) hereby consent to take part in this study by participating in this focus group.

Signature: _____ Date: _____

Focus Group conducted by: _____

Signature: _____ Date: _____

☐ I would like to receive a summary of the research findings **Yes / No** (Please circle)