A bridge over troubled water: Insights from aid workers seeking to reduce maternal mortality in the developing world

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Abstract

Each year, hundreds of thousands of women are dying needlessly in their efforts to bring a child into the world. It is a continuing tragedy on an international scale, and is at the forefront of the world's global health agenda. Yet, despite maternal mortality reduction being the outcome of one of the United Nations Millennium Development Goals (MDG5), and the sustained target of aid and research advocates for decades, women continue to die at unprecedented rates in many developing nations. So why is reducing maternal mortality such a complex goal to achieve; and what of those charged with providing the robust maternal-child health services needed to save these women's lives?

Many of the issues focused on maternal mortality to-date have been addressed in the quantitative paradigm and largely by men. By way of contrast, this critical hermeneutic research illuminates the voices of those who have been essentially unheard—expatriate health professionals who work in the aid sector—gaining insight into what it is like to be actively involved in striving to reduce maternal mortality in much of the developing world. Such a topic is politically sensitive, emotionally charged, and logistically challenging. Thus, to protect the identity of the 28 participants, and to avoid critique of any one country, this is a global study related to no one place. Its participants reside and work in all parts of the world. This thesis forefronts women's health rights and reveals the tensions inherent in striving to reduce maternal mortality. By showing the worldviews that shape 'what matters' to the various players and, therefore, 'what happens,' the huge complexity becomes apparent. There is no quick fix. However, a way forward, post the Millennium Goal era, in an environment where there are no easy answers despite the global mandate for change, is proposed. Aid workers, those people who live within the communities they serve must be valued as the bridge between global health agendas and 'what happens to the child-birthing woman'; for it is an aid worker, who is most likely to grasp what could work in 'this' situation.

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Glossary of Health-Related Terms

Abortion - the termination of a pregnancy resulting in, or closely followed by, the death of an embryo or foetus.

Ambiguous genitalia - a condition in which the external genital organs do not have the appearance typical of a female or male.

Ambu bag - a manual bag used for resuscitation.

Anaemia - a condition in which the blood is deficient in red blood cells, in haemoglobin, or in total volume.

Antenatal - occurring or performed prior to birth during a woman's pregnancy.

Angioedema - a disorder that affects the mucous membranes and deepest layers of skin resulting in rapid swelling, large welts and pain.

Bandl's ring - an abnormal retraction ring that occurs in obstructed labour at the juncture of the upper and lower segments of the uterus. It is a sign of impending rupture of the lower segment of the uterus.

Breech birth - presentation of the baby where the buttocks or feet are born first.

Caesarean section - a surgical procedure involving incision through the abdominal wall and uterus for delivery of the baby.

Cleft palate - a congenital fissure of the roof of the mouth.

Deep transverse arrest - a condition of vaginal delivery that occurs when the baby's head fails to rotate despite steady descent and the baby is unable to birth without assistance.

Deflexed - a position of the baby during the labour and delivery process where the baby's back is straight, the head position is deflexed and upright on the spine.

Disseminated intravascular coagulation - a rare and serious condition affecting the blood's ability to clot and stop bleeding.

Doppler - an imaging test that uses sound waves to blood moving through blood vessels of the uterus. It can also present as a handheld device to locate and record a baby's heartbeat throughout pregnancy and labour.

Eclampsia - a condition in which one or more convulsions occur in a pregnant woman suffering from high blood pressure, often followed by coma and posing a threat to the health of mother and baby.

Episiotomy - an episiotomy is a cut (incision) through the area between your vaginal opening and your anus. This area is called the perineum. This procedure is done to make your vaginal opening larger for childbirth.

Fetascope - a stethoscope placed on the pregnant woman's abdomen to listen for the fetal heartbeat.

Fistula - a rectovaginal fistula can occur after childbirth associated with a large vaginal tear that occurs between the rectum and vagina. It can lead to faecal incontinence or leakage of faeces into the vagina.

Fundal pressure - manually applying pressure or pushing downward at the top of the mother's uterus.

Gestation - the period of time between conception and birth

Hypertensive disorders - a common condition in which the long-term force of the blood against the artery walls is high enough that it may eventually cause health problems.

Hypertension is the most common medical problem encountered in pregnancy and is a leading cause of perinatal and maternal morbidity and mortality.

Hysterectomy - a surgical operation to remove all or part of the uterus.

Instrumental delivery - is when forceps or a ventouse suction cup are used to help deliver the baby.

IUD (Intrauterine Death) - a clinical term for stillbirth used to describe the death of a baby in the uterus. The term is usually applied to losses at or after the 20th week of gestation.

Magnesium sulfate - is a medication used in pregnancy to prevent seizures due to worsening preeclampsia, to slow or stop preterm labour, and to prevent injuries to a preterm baby's brain.

Malaria - a serious and sometimes fatal disease caused by a parasite that commonly infects a certain type of mosquito which feeds on humans.

Misoprostol - a synthetic medication used to prevent and treat stomach and duodenal ulcers, induce labour, cause an abortion, and treat postpartum bleeding due to poor contraction of the uterus.

Moro reflex - the *Moro reflex*, or *startle reflex*, refers to an involuntary motor response that infants develop shortly after birth.

Neonatal - relating to, or affecting the newborn and infant during the first month after birth.

Obstetrician - an *obstetrician* is a doctor who is specially trained to deal with pregnant women and with women who are giving birth.

Obstructed labour - the failure of the baby to descend through the birth canal, because there is an impossible barrier (obstruction) preventing its descent.

Oedematous cervix - inflammation of the cervix, the lower, narrow end of the uterus that opens into the vagina.

Oxytocin - is a hormone and a neurotransmitter that is involved in childbirth and breast-feeding.

Postpartum haemorrhage (PPH) - heavy bleeding after a baby is born and is a complication of pregnancy that has the potential to be very serious, even resulting in death in rare cases.

Preeclampsia - a pregnancy complication characterized by high blood pressure and signs of damage to another organ system, most often the liver and kidneys. Preeclampsia usually begins after 20 weeks of pregnancy in women whose blood pressure had been normal.

Puerperal sepsis - an infective condition in the mother following childbirth. It is the third most common cause of maternal death worldwide.

Sage-femme - *a midwife.*

Syntocinon - a man-made chemical that is identical to a natural hormone called oxytocin. It works by stimulating the muscles of the uterus (womb) to produce rhythmic contractions. Syntocinon can be used to bring on (induce) labour. It can also be used during and immediately after delivery to help the birth and to prevent or treat excessive bleeding.

Tracheostomy - a medical procedure — either temporary or permanent — that involves creating an opening in the neck in order to place a tube into a person's windpipe to assist them to breathe.

Traditional birth attendant - a traditional, independent (of the health system), non-formally trained and community-based provider of care during pregnancy, childbirth and the postnatal period.

Vertex - the *vertex* position of the baby (head facing down)is the most appropriate and favourable position to achieve a vaginal *birth. The vertex refers to the top of the baby's head.*

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Date: 10 May 2021

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Lastly, to the millions of mothers whose lives were lost as they fought in vain to bring their children into this world. I hope this thesis in some way illuminates and lends voice to your bravery and ultimate sacrifice. May you rest in eternal peace.

Chapter One: Introduction

Would the world stand by if it were men who were dying just for completing their reproductive functions?

Asha-Rose Migiro, UN Deputy Secretary General (cited in Kristoff & WuDunn, 2009, p. 109)

The 'Something' of this Research

It is a continuing tragedy on a global scale—hundreds of thousands of women dying needlessly each year in their efforts to bring a child into the world. It is also a crisis at the forefront of the world's global health agenda. Yet, despite reducing maternal mortality being the outcome of one of the United Nations (UN) Millennium Development Goals (MDGs; specifically MDG5), and the sustained target of aid and research advocates for the past 30 years, women are still dying at an alarming rate in many of the world's developing nations. So why is reducing maternal mortality such a complex goal to achieve; and what of those charged with providing the robust maternal-child health services needed to save these women's lives?

Many of the issues focused on maternal mortality, to-date, have been addressed in the quantitative paradigm and largely by men. By way of contrast, this critical hermeneutic research aims to illuminate the voices of those who have been essentially unheard—health professionals who work in the aid sector. Thus, my research question: 'What is the lived experience of aid workers actively involved in seeking to reduce maternal mortality in the developing world?', strives to bring to light the areas that are working well in reducing maternal mortality, and to highlight the areas that are not. Its primary objective is to uncover what is shaping why some areas are able to reduce maternal mortality and others cannot. Such a topic is politically sensitive, emotionally charged, and logistically challenging; and, as such, this global study is related to no one place. Its participants reside and have worked in all four corners of the world.

The Status Quo

Seventy years after its inception, the UN reported on the success of its MDGs; that is, eight international development goals adopted in 2000, by 189 member countries, and at least 23 international organisations. These goals committed to significantly improving global

health, eradicating poverty, and endorsing gender equality by 2015. With the timeline passed, the consensus among many commentators, outside of the UN, is that progress in some areas has been nothing short of apathetic, and debate is rife as to the effectiveness of the MDGs, in particular in eradicating extreme hunger and poverty, promoting gender equality and the empowerment of women, and in reducing child and maternal mortality. The UN, however, marches ahead with a new set of goals and targets to be quantified by 2030. The Sustainable Development Goals (SDGs), a list of 17 goals with 169 targets, have been met with scathing criticism from commentators such as the *Economist*, and Pope Francis himself. This research was conducted during the final five years of the MDGs and, as such, the SDGs will only be reviewed in the discussion section of this thesis.

Research Aim

While scholarship critiquing all of the MDGs from the perspective of those on the ground trying to implement the policies and initiatives handed down by the UN agencies and partner organisations would be ideal, it is beyond the scope of this document. It is, therefore, the purpose of this thesis to focus on what is arguably the most important goal to the success of all other MDGs; that of reducing maternal mortality and those charged with such a burden. This research seeks to reveal the tensions inherent in striving to reduce maternal mortality, with women's health rights at the forefront, and proposes a way forward post-MDGs in an environment where there are no easy answers despite the global mandate for change.

Selecting the Methodology

The vision of this thesis is to uncover what is shaping why women are still dying in childbirth at such alarming numbers in many of the world's developing countries. This is a complex question and an even more difficult task to unpack. Due to ethics and language constraints, I was unable to interview the women most affected—the women in developing countries who watch their mothers, sisters, daughters, and friends die almost daily in their struggle to bear a child. Instead, it was the voices of 28 aid workers who I challenged to bring to light the circumstances that these childbearing women face. Initially, a hermeneutic approach, informed by Hans Georg Gadamer, was sought.

The stories the aid workers told were so powerful and gut-wrenching that to begin with a hermeneutic interpretation felt sufficient. Yet, as I explored the data further, I found myself

with more questions than answers. What was shaping why women were dying in such circumstances? What invisible influences were at play; and what, if anything, could be done to improve their chances of survival? To answer these questions, I needed to turn a critical eye to the data. However, I was conscious that I did not want to be critical of the women, nor their beliefs and traditions; as a white Western woman, that was certainly not my place. The critique, instead, had to become an act of unearthing, a revealing of what influenced crucial decision-making that ultimately led to these women's deaths. This research is not about apportioning blame or critiquing cultural and/or other practices; rather, about opening the world's eyes to the influences that shape practice and understanding in relation to caring for women in childbirth in developing nations.

Hans Kögler is a philosopher who marries a critical heart with a hermeneutic soul. He proposed that to view a research question through a hermeneutic and critical lens opens up the possibility not only of coming to an understanding of the phenomenon itself, but recognising what and by whom the phenomenon is being shaped (Kögler, 1999). Kögler's method of critical interpretation enables a "hermeneutical thematic analysis of that which is shaped (worldviews) and a critical structural analysis (discursive orders, social practices, relationships of power and structures of domination) of the shaping and shapers of practice and understanding" (McAra-Couper et al., 2010, p. 161). This thesis is indeed an act of uncovering that which has been hidden or overlooked, to reach a deeper understanding of what is shaping why many developing countries are struggling to significantly reduce the numbers of women dying in childbirth. Furthermore, Kögler's (1999) exploration of reflexivity provides a useful framework to ask important questions about the critical hermeneutic context of decision-making for those working in the area of maternal health in developing nations. Kögler is firm in his sentiment that a structural-self reflexivity materialises only when a person is in a dialogic relationship with someone whose own interpretive understanding differs or is outside the bounds of their own understanding (Lynch, 2006). His reasoning seemingly provides justification and permission for myself, as a white Western woman, to explore the taken-for-granted understandings of the practice world of the aid workers working in developing nations, as I do so from outside of their horizon or worldview.

Of note, within the writing of this thesis, is my use of quotation marks to draw attention to a word to show that its meaning is open to question. For example, I came to understand that 'care' in a New Zealand midwifery context is vastly different from what might be

called care in a developing country. From a hermeneutic perspective it is important not to assume that language comes with a fixed, shared meaning (Gadamer 1989). Also of note is my previous career as a journalist. It pervades my style of writing. When I am passionate, angry, disturbed, as I have been many times through this thesis journey, I feel a strong need to ensure the reader feels the strength of my emotions. This research is both mind-work and heart-work. One cannot be divorced from the other.

Research Context

This thesis represents a global study, with a focus on no one place. To have reduced the scope of this study to one country or one region of the world would have risked exposing the very voices that wanted to be heard—yet, were vulnerable to those in power. The aid community is relatively small and close-knit. Participants were more forthcoming once they were assured that their identity would be protected, in the main, by not identifying the area/s with which they worked. Thirty participants were interviewed, with two discounted due to not fully meeting the criteria. The 28 remaining participants were English-speaking maternal health aid workers who were working, or had worked, as expatriates in developing nations in all four corners of the globe. The roles they operated in were as varied and diverse as the countries from which they originated. Twenty-four of the participants were women and four were men. Many were interviewed in-person whilst actively working in a developing country setting; others in conflict settings were interviewed via satellite phone or Skype.

What is an Aid Worker in the Context of this Research?

For the purposes of this research, I have used the term *aid worker* to describe the participants in this study. Whilst I acknowledge that there are many different titles bestowed upon people who conduct such work, *aid worker* seems the best fit for these participants. The term has been defined as the "employees or associated personnel of not-for-profit aid agencies (both national and international) that provide material and technical assistance in humanitarian relief contexts" (Stoddard et al., 2017, p. 1). Aid workers are active in emergency relief and development organisations, such as the many UN agencies (e.g., Food and Agriculture Organisation of the United Nations [FAO], Office for the Coordination of Humanitarian Affairs [OCHA], United Nations Development Programme [UNDP], United Nations Population Fund [UNFPA], United Nations High Commissioner for Refugees [UNHCR], United Nations Children's Fund [UNICEF], World Food

Programme [WFP], World Health Organization [WHO], International Organisation for Migration [IOM]and United Nations Relief and Works Agency for Palestine Refugees in the Near East [UNRWA], Non-Governmental Organisations (NGOs), and donor agencies. Aid workers, however, are not UN peacekeepers, nor are they human rights workers or those working in purely advocacy or political agencies. The term *aid worker* can include local staff; however, this research is focused solely on expatriate aid workers' experiences of working in a foreign environment that is outside of their usual horizon (Stoddard et al., 2017, p. 1). These environments include areas that have been imperilled to war, natural disasters, or other issues in relation to the environment or development of a country. Aid workers can typically be found operating on the frontline of any given disaster or humanitarian crisis. It is dangerous, often life-threatening work, as the aid worker works directly within communities giving hands-on support and life-saving treatment to the world's most vulnerable populations (GradIreland, 2017).

What is a Developing Country?

When data collection began for this thesis, the term used for the grouping of nations that my intended participants were working in was "developing countries". Previously, and sometimes simultaneously, they were dubbed the 'Third World'. At the time, and widely used until 2016, a "developing" country was one that was deemed to have a low Human Development Index (HDI). This means that economically the country's Gross Domestic Product (GDP) was extremely low, the government's level of debt was unsustainable, there was an unequal distribution of income, and unemployment was rife (United Nations Development Programme [UNDP], 2014; World Bank Group, 2017). Socially, the impact of such poverty inducing circumstances was keenly felt with high levels of illiteracy, substandard housing, communication, transportation, and medical facilities. Overall, living conditions for the majority of the population were extremely poor. Its inhabitants did not enjoy a safe and healthy environment, leading to increasing levels of malnutrition and a high rate of mortality (UNDP, 2014; World Bank Group, 2017). A "developed" nation was considered to be everything a developing nation was not. The UN did not offer an official designation for the terms "developed" or "developing" nations; yet, it attached the latter label to 159 nations (Fernholz, 2016). The UN stated that the terms were used purely for statistical purposes and "do not necessarily express a judgement about the stage by a particular country or area in the development process" (United Nations Statistics Division, 2014, p. 4).

In 2016, the World Bank made a stand. It declared its data would no longer show a distinction between "developed" and "developing" countries (Fernholz, 2016). With the end of the UN MDGs, created in 1990 as a means for "developed" countries to help lift "developing" countries out of poverty, there has been a mood change within the UN to steer away from such divisive language. Instead there is a move to implement a set of universal goals, the SDGs, intended for every country, prosperous or not, to attain (Fernholz, 2016). It is important to note, however, that this thesis reflects the time and mood of the MDGs era, and hence the term "developing country" will still be used.

What is an Aid Agency?

Throughout this thesis the term 'aid agencies' is used to generically describe the international health organisations that actively support developing nations in their quest to combat maternal mortality. These agencies can predominantly be divided into three main groups multilateral agencies, bilateral agencies and non-government organisations (NGOs).

Multilateral agencies receive funding from multiple governments and their funds are dispersed widely across many different nations (IMVA, 20200. The predominant multilateral organisations belong to the United Nations such as the World Health Organisation (WHO), the United Nations Development Programme (UNDP), The United Nations Children's Fund (UNICEF) and the World Bank. Their level of financial assistance extends into the hundreds of millions of dollars each year (IMVA, 2020)

Bilateral agencies are those attached to the government of one single country. The largest such agency is the United States Agency for International Development (USAID). Many nations in the developed or industrialised world have similar agencies. New Zealand's own bilateral agency is the New Zealand Ministry of Foreign Affairs and Trade (MFAT). Who these agencies give donations to is largely determined by historical or political alliances. Some countries prefer to give aid to their former colonies, while others choose neighbouring countries within their own continent (IMVA, 2020).

Non-governmental agencies (NGOs) are primarily private, church-based and voluntary organisations such as World Vision, Oxfam, the Red Cross and Médecins Sans Frontières (MSF). NGOs provide nearly a quarter of all external health assistance to developing nations and are clearly visible on the frontline of many of the world's largest health crises. Once given permission to work in a country, they probably have the most freedom to work

directly with local community in identifying needs and determining how funds are invested (IMVA, 2020).

While the idea of aid donation seems simple enough, there is a real tension that these agencies and aid workers must deal with daily. All multilateral and bilateral agencies are working to an international agenda. Throughout the tenure of this thesis that international mandate was primarily the United Nations Millennium Development Goals (MDGs). It is worthy of note that these agencies are only able to carry out their mandates at the invitation of the developing nation they are choosing to assist. At no time can one government interfere in the domestic affairs of another. Just how that donated money is spent is also of great consternation. Donors from smaller nations such as New Zealand often combine with other nations to create a pool of aid that is then disepersed to support particular projects. Alternatively aid dollars are given directly to a developing nation's budget for them to use as they see fit. There is however, as you will read throughout this thesis, often much duplication amongst the various agencies, and often times a lack of coherence and accountability in terms of what is happening on the frontline of a health crisis. This can look like much is being done but very little is being achieved, particularly in relation to reducing maternal mortality in developing countries.

What is Maternal Mortality?

For childbearing women, pregnancy and childbirth can bring with it complications that may result in death. Complications such as postpartum haemorrhage, obstructed labour, unsafe abortion, sepsis, and indirect conditions such as anaemia and malaria, are the leading causes of death and disability for women of reproductive age in developing nations (WHO, 2016).

A maternal death is categorised as any death of a childbearing woman while pregnant or within 42 days of termination of that pregnancy, irrespective of the length of the pregnancy, from any cause that is pregnancy related or occurs as a direct result of that pregnancy (WHO, 2016). The maternal mortality ratio is categorised as the risk associated with each pregnancy and is significant for this research in that it was used as a UN MDG indicator. The goal of MDG5a aimed to "Reduce by three quarters, between 1990 and 2015, the maternal mortality ratio" (UN, 2000).

It has been widely acknowledged that measuring maternal mortality accurately is difficult, at best, in many developing nations where comprehensive registration of deaths, and of causes of death, is not readily available. In such circumstances, various methods, such as census, surveys, or verbal autopsies, are used to estimate maternal mortality numbers (Alkema et al., 2016).

Personal Horizon with Which I Entered this Research

> We are not just stamped by our "genes" but also by the socialisation through which we are in a position to gain access to our world and to the traditions in which we exist. These characteristics imprinted on our minds open up our horizons, and of course also limit them. But it is only through them that we have a horizon at all and are able to encounter something that broadens our horizon. (Gadamer, 2001, p. 43)

In November 2003, I was rushed to hospital for the birth of my first child. I was 35 weeks pregnant and under threat of losing both my own and my baby's life. Had I, at the time, been an impoverished woman in one of the world's developing nations, neither of us would have survived. We are both here today because of an exceptional midwife trained to see the illness (pre-eclampsia), that which hints at the deadly fate that may have awaited us. Our chance at life is one not afforded to many who live outside a developed nation, rich in skilled health professionals and facilities that honour the sanctity of life. I did not have to wait for life-saving treatment, nor did I stare death directly in the face. As a woman, I was prioritised; and as a girl child, my daughter received the best available care. At the time, I was not aware that childbirth held such fragility—I never doubted we would survive it. The experience was to change the course of my life. With my daughter just 14 months of age, I re-entered university in an endeavour to become a midwife, a far cry from the profession I had spent the previous 15 years devoted to as a journalist. I did not just want to tell people's stories anymore, I wanted to journey with them as they navigated their many triumphs and tribulations.

As a child, I had always felt a need to "save" the world. While not educated in the Catholic school system, I was certainly, as a young child, conditioned to the Catholic "tradition". My maternal grandparents ensured that I made helping and praying for people less fortunate than me, a priority. As a teenager, the "save the world" discourse remained firmly entrenched. I became a child sponsor at the age of 14 and was active in volunteer work. As

soon as I could earn my own money, I was drawn deeper into "gifting" to charities; often a bigger priority for me than paying the bills.

I naively considered myself well-versed in terms of developing countries and their issues. Inspired by the stories of others, I visited a number of developing countries as an adult. While I had often felt drawn to the need to stay and "help", I was not quite sure in what capacity. As my midwifery degree headed towards completion, an opportunity in Senegal, Africa presented itself that seemed to just "fit", and I seized upon it before the ink was even dry on my newly obtained practising certificate.

The offer of a chance to immerse myself in the Senegalese culture; to live, eat, and breathe with the local people, while working with and imparting my well-constructed Western midwifery knowledge on the village birth attendants, seemed a dream come true. I was under no illusion that it was going to be easy, but neither was I aware just how much of a challenge I was about to face.

Professional Horizon with which I Entered this Research

> I was a privileged stranger and it was necessary for me to understand the rights of people to their full humanity and to learn… that I had the power and the proper use of that power should be a negotiated process. (Ramsden, 2002, p. 67)

My faith in all that is fair and true was tested on that trip to West Africa. A newly graduated midwife full of bravado with my beautifully constructed knowledge of pregnancy and childbirth and being "with women", I set forth to impart such knowledge on the midwives and childbearing women of Senegal. The following are excerpts from my Senegal diary, and subsequent reflective journal, around a woman's labour and birth and the resuscitation of her baby. Names have been changed, and all attempts have been made to ensure those who were present and most vulnerable, are kept safe. I would like to stress that while there were many people involved on that day, these reflections are mine alone; my interpretation of what took place. I have no doubt that others who were present may see the events through a different lens.

> *A bead of sweat trickled across her brow, she stirred, her body gently swaying to a rhythm only she could hear. Her face contorted; the momentum increasing. And then she was still. I wanted to run to her, to comfort her as she lay alone on the stained and broken mattress, but I sat unmoving, eyes*

lowered, hardly daring to breathe. "Masa", I whispered, the only word of comfort I knew. And we waited.

A week earlier it had been so different. My head wrapped, dressed in my newly starched lab coat, and with my handful of Wolof phrases, I entered the clinic full of well-meaning bravado. Like many in the district, the clinic housed one *sage-femme*, a university-trained midwife responsible for upwards of 30,000 women. Assisting her were a handful of *matrons*, women who had received six months on-the-job training. The sage-femme held overall responsibility, conducted the antenatal clinics, and lived on the premises. The matrons attended to the majority of the women who came to the clinic to birth, each covering alternate 24 hour shifts. It was these women with whom I was to spend the majority of my time. From day one I learned there was a very clear protocol. A labouring woman arriving in clinic was given a vaginal examination and sent through to the Salle de Travaille (literally the place-of-work). The women in her family, had they accompanied her, were left to care for the woman until she was ready to birth—this included providing food and water. If no one had travelled with her then she was on her own. Birthing was a different story. Strictly no family were allowed. Women were expected to carry their own cloths on which to birth, to use as sanitary pads, and to wrap their baby in after the birth. Women were not touched with empathy nor were they comforted during the entire birthing experience. They were not used to our "kindness", nor was it entirely welcome.

It was time. Stiff from two hours perched motionless on a bed with an unforgiving mattress I made my way quietly to Sali's cot. She knew why I had come and "assumed the position". Shielding her face from view, she braced herself. I fought back tears as I dutifully went about my business.

Birth, I observed, is a very clinical matter in Senegal. Once in the Salle de Travaille, the only contact women have with a matron is courtesy of an aggressive vaginal examination, every 1-2 hours. I shuddered every time I observed or was required to perform such practice, especially with reused gloves. Partnership was non-existent and I was deafened by the women's silence. I had attempted, in the early days, to "labour" a woman as I would in New Zealand. I would suggest mobilising, position changes, and would attempt to provide some gentle massage as pain relief; yet I found most women uncommunicative, unresponsive, and ultimately unwilling. I felt lost, alone, and completely "foreign". I had no idea how to help these women and, after all, was not that what I was here to do? While the other interns retreated, my own midwifery construction made it difficult for me to leave a labouring woman alone. Sali was one such woman with whom I tried a change of tact.

Instead of forcing my horizon on Sali I hoped that we might attempt to fuse the two. Not willing to leave Sali on her own I sat on the mattress across from her as she laboured. I was acutely aware that for women to show weakness in front of a "toubarb" or foreigner was frowned upon. I wanted Sali to feel like she was not on her own, yet I did not want to cause her any angst, so I sat very still and lowered my eyes, so she did not feel watched. But as the hours ticked by, I knew the 'task' of the required vaginal examination was looming. As much as it pained me to do so, I knew that if I did not perform it then the Senegalese matrons would. These women were very skilled and efficient at their work, but a gentle disposition was not a prerequisite. That is not how midwifery is taught in Senegal.

> *The door flew open. "Neuf", I replied to the unuttered question, hoping God would forgive me. Sali was fully dilated, but then she knew that. As her body picked up its rhythm again, I turned towards my cot. Suddenly, Sali's hand grabbed my arm. I sat back down beside her; my hand trembling as I tentatively moved it towards her lower back. "Masa", I whispered. And we waited.*

It was the breakthrough I had been hoping for, the trust moment that had seemed unattainable just a few short hours before. My "white lie" to the matron was intended to hand the power back to Sali and, as she reached out to me, it seemed our horizons fused and a new understanding between us was born. Yet I was cautious. Nothing was that straightforward in Senegal.

> *It was time. Suddenly Sali stood up, wandered gingerly out of the Salle de Travaille, and knocked on the birthing room door. Once opened, and without a word, she climbed onto the plinth, lay flat on her back waiting for confirmation of what we already knew. I kept my distance. Sali began to push.*

The labour room, no bigger than the average New Zealand bathroom, was full. Three interns, two matrons, and a cleaning lady all crowded in. A tall woman, Sali could barely fit on the half-length plinth. Her head was jammed against the wall while, her knees bent up, she grabbed at her ankles to keep them slipping off the bed. The talisman, given to pregnant women to ward off evil spirits, was cut from Sali's waist, as a large bed pan was shoved under her hips. The matron reached for the two fingered glove and proceeded to ensure Sali was "ready". Women, I had been told by one matron, were not to be trusted. While I witnessed adequate care of the women in Senegal, it was far from the women-centred care I had grown accustomed to.

> *Minutes stretched into hours and still not a peep of vertex on view. Flat on her back, Sali's staunch resolve wavered. Dehydrated and exhausted she cried out to Allah to come to her aid. "Inshallah", I whispered. And we waited.*

At that moment I saw why Sali had remained so strong. Her one sign of weakness was pounced upon. As the matron's hand whipped across Sali's face, she quickly regained her composure. The matron was not intending to be cruel; this was her tradition, her preunderstanding of what was now needed. The matron was just doing what she had been taught. I stood still at Sali's head, every inch of me fighting the urge to intervene. While another vaginal examination was performed, the matron announced to the room that Sali was being disobedient, and it was time for the sage-femme to be called. I felt Sali stiffen. I whispered words of comfort in her ear and joined her in a prayer that I had heard many times previously. The sage-femme entered the room and yet another vigorous examination was performed. Sali remained motionless. Her examination over, the sage-femme slapped Sali's thighs open and yelled at her to "poussée". Urged on by all of us, Sali pushed with everything she had.

> *It was time. Nervously I approached the sage-femme. "Peut-être l'oxytocine (perhaps oxytocin)?" I suggested. She glanced across at the matron rolling her eyes. Laughing they left the room. I nodded to the interns for water. We didn't have much time and we knew it. We poured the forbidden fluid into Sali's foaming mouth. She gasped as the cool water hit her parched throat. I called Sali's brother from outside, thrust money and a note into his hand. "Rapidement," I replied to his bewildered stare. He sensed my urgency and ran.*

I could not take it any longer. I knew when I had conducted my vaginal examination earlier in the day that that while Sali had been fully dilated, the head was high, deflexed, and the baby was lying in a difficult spine to spine position As I drew up the meagre amount of syntocinon, the interns offered Sali the first sip of water she had been allowed all day. In Senegal, water, I had been told, is seen as detrimental in labour. At this point, in New Zealand, I would have consulted and transferred, but the Senegalese midwives do not have the luxury of a "scope of practice". Their job is about getting the baby out and keeping the mother alive—pure and simple. I did not envy them at all. It was, however, excruciating to stand aside and watch. My rapport with Sali was such that, in a moment of weakness, I let my heart rule my head. But at what cost to Sali and her baby?

> *Two hours turned to four and still no baby. My trusty Doppler showed that the little life was clinging on but I sensed it wouldn't for much longer. As the more "highly trained" of the three, the interns turned to me for answers. My repertoire exhausted, I had none. Sali's eyes too were pleading as her body was wracked by yet another futile contraction. I wanted to scream, to really scream, not just for the hopelessness of it all but for my ignorance and incapability. As the other interns called for the sage-femme, I slumped defeated at Sali's side. "Masa", I whispered. "Am nga doole (you have strength)", and we waited.*

It was here that my traditions and socialisations were truly challenged. With a modern ambulance outside, and a hospital an hour away I willed them to transfer but I knew it was a lost cause. Only the extremely sick were given that privilege and only then if they had money. The sage-femme and matrons knew they could "deliver" Sali's baby; they had been here many times before. My intervention, my bravado, had just delayed the inevitable, prolonged Sali's suffering and endangered that little life further. What seemed "right" in New Zealand was just not appropriate in Senegal.

> *It was time. Thump, thump. My body flinched with every sickening blow. The others retreated; horrified at what they were witnessing. I couldn't leave. Mesmerised I watched as Sali's baby was forcefully inched out of her. She remained calm and dignified as her body was violated on so many levels. I had much to learn; I knew that now. Bravado stepped aside for bravery and I was left humbled.*

It was the bravest thing I had witnessed in my limited midwifery experience and it was also the most barbaric. The use of extreme fundal pressure goes against all of my constructed principles of midwifery; yet, as a skill used as a last resort, I witnessed its lifesaving properties. Could I do it myself? I do not really know; it is such a violent act to perform on someone. I saw for the sage-femme too it was an evil, yet a necessary one; a decision not made lightly. It was at this moment I came to a new understanding as to why women were "harassed" so much in labour. While I could never condone it, rather than abuse, I now saw it as a desperate willingness to avoid the horror of what was coming next. I saw no joy or malice on the sage-femme's face as she struggled to save Sali and her baby, but instead sensed a bravery.

> *70bpm, 64bpm… I stopped listening. Feeling helpless and hopeless I prayed silently for the two souls I believed were now at God's mercy. It was brutality beyond anything I could ever have imagined; I couldn't look. Cradling Sali's*

head in my arms I fought back the tears of my own inadequacy. Suddenly, her eyes wild, Sali let out a primal scream. And then there was silence.

I had brought technology to Senegal in the form of my Doppler. It had caused great excitement amongst the matrons, and I was ready to gift it to them. Surely it would be an asset to their practice. But I found myself using it less and less as the weeks wore on. The Doppler is a method of checking the rate and rhythm of the fetal heartbeat. The fetal heart rate may change as the fetus responds to conditions in the uterus, and as such an abnormal fetal heart rate or pattern may mean that the fetus has become distressed. An abnormal pattern may also mean that an emergency delivery is needed. Yet, at that clinic, in that one moment, with a caesarean section or instrumental delivery not considered an option, the Doppler and indeed the fetascope became redundant. So, it begged the question, not being able to listen to the fetal heart and unable to deliver Sali's baby – what sort of midwife was I?

It was time. I raced to the end of the delivery table as the sage-femme, rusty scissors poised, prepared to cut the cord. "Stop", I cried as I reached for the ambu bag. She sighed and walked out of the room. I held the tiny lifeless head against my abdomen and called for help. "Breathe" I pleaded to the half open eyes staring up at me, "Breathe damn it". I reached for the base of the cord. The pulse was faint – barely a beat per second. "Oompapa, oompapa", I muttered as I called on all I had been trained to do.

At last I could help. While there was a heartbeat there was hope. Neonatal resuscitation is an important skill of which New Zealand midwives are required to update annually. We are entrenched in the first world socialisation of the 'save at all costs' mentality. More often than not, these decisions are made with little disregard for the long-term consequences. It is the norm in New Zealand to resuscitate babies born over 24 weeks gestation, and in some Western countries babies as young as 22 weeks are being considered. It is this socialisation, this prejudice, which I brought with me in that moment. As the sage-femme and the matrons turned their backs I, without hesitation, reached for the ambu bag. With no oxygen available, I left the umbilical cord attached hoping it would buy me a few precious minutes.

The little life slowly struggled against me as I rhythmically willed it to live. Twelve minutes passed but it could have been an hour. When it came – the faint but heart-warming cry – I was elated. I had "saved" my first baby. I removed the ambu bag and we waited.

Performing successfully what I had been trained to do, I was thrilled. It is one of my biggest fears as a midwife to lose a baby, and I was reassured to know that I had "mastered" the skill. But what exactly is the "saving" all about and who really does it benefit? At that moment I did not care. I had discovered my reason for being here; I could "save" the babies of Senegal.

> *It was time. As I separated the baby from its exhausted and beaten mother I saw it. So desperate to save this baby I had not noticed what the sage-femme had seen. As the baby became more vigorous I noticed the legs flailing at an awkward angle. The lower half of the baby's legs had formed back-to-front. But that was not all. "Do we have a boy or a girl?" I asked one of the interns. She looked at me. "I'm not sure", she replied hesitantly. As I proceeded through the neonatal check my heart sank. Oh God what have I done.*

With the baby limp and lifeless, I had not seen the severe deformities that were now so clearly evident. They were devastating. As I proceeded through the neonatal check, I noticed skin tags on the ears, a cleft palate, no Moro reflex, ambiguous genitalia and legs that had formed completely back to front. The abnormalities were beyond repair, especially in a developing country such as Senegal. I felt sick as I contemplated my condemning this baby to a life of suffering; yet, at the same time, would I have done anything differently? Before this encounter, I readily condemned people who did not take action, did not attempt to save a life. Yet, in this moment, I realised that to "not do" takes more courage than to act. What I did know was that "damaged" babies had very little chance of a future in Senegal. To this end I learned there is a fate worse than death.

> *With the baby carefully wrapped I showed it to Sali. She smiled weakly then turned her head away. I knew better than to force it. Skin to skin is not an option here. The sage-femme returned to suture Sali, although much I assumed, most specifically the fistula, would be beyond her skill to repair. Her eyes bore through mine; I couldn't hold her gaze. Instead I cradled the damaged and forgotten baby in my arms and headed outside. As I sank into the sand the tears that had threatened all day finally came. Welcome to Senegal - no - welcome to midwifery.*

Many may consider Senegal a country with little in common with New Zealand. However, while the two midwifery models are polarised, they are not opposing; with both countries' ultimate goal to ensure the best possible outcome for their women and children. In three short weeks did I come to understand the sage-femmes' horizon – no I did not, that would have been impossible. Would a longer term spent in Senegal have made a difference? I

remain unconvinced. Perhaps it would only serve to "adapt" me to my new horizon. What I did know was that I was curious to hear from those Western health professionals, whose life's work is dedicated to working alongside the sage-femmes or local midwives in developing countries. I was curious as to the tensions and challenges they faced in an attempt to save these women's lives, whilst grappling with their own personal horizons and a global mandate for change.

Justification for the Study

On my return home to New Zealand I perused literature to see what had been written about such tensions of midwifery practice, and the world of expatriate health professionals who worked on the frontline trying to save the lives of childbearing women in developing countries. Not only was there very little related literature, but there was also a distinct lack of scholarship, particularly qualitative research. Most of the information that I found was by way of narratives on aid agency websites, the occasional magazine article, and anecdotes at international maternal health conferences. It was at these health conferences that I was most disillusioned. The information I came away with was about what could be statistically 'measured' or 'upscaled' in an attempt to improve the maternal mortality ratio, but not what it felt like to a health professional, expatriate or otherwise, working on the frontline trying to save these women and children. My experience in Senegal, and from visiting other countries such as Bangladesh and India and various health professionals working in them, was that it was heart-breaking, and interventions from aid agencies towards reducing the maternal mortality ratio did not seem to be working. Whilst there was undoubtedly a problem, I wanted to know was it one that could be truly measured and eventually be solved.

This thesis allows, perhaps for the first time, these health professionals to tell their stories in a way that they are kept safe and unidentifiable. It is raw, unnerving, and at times disturbing reading. Yet, the challenges these aid workers voiced need to be heard and added to the body of knowledge if we are ever to significantly reduce the number of women dying in their bid to bring about new life.

Preunderstandings

Hans-Georg Gadamer talked about there being a polarised relationship between familiarity and foreignness in hermeneutics. One's own pre-understanding or prejudice is the old

horizon, and this is the horizon with which one meets a strange new horizon in new cultures (Gadamer, 2004). Certainly, the New Zealand midwifery discourse and the discourse of the participants within this research work could not have been more disparate. The midwifery model that underpins the New Zealand maternity services is one of partnership between the midwife and the woman (Guilliland & Pairman, 1995). The ideal is that this is a relationship of equity to which both make equally valuable contributions (Pairman, 1998). The midwife brings her knowledge, skills, and experience and the woman brings her knowledge of herself and her family, and her needs and wishes for her pregnancy and birth. Fundamental to the partnership is communication and negotiation (Pairman, 1998). Also inherent in midwifery practice in New Zealand is the concept of cultural safety, a model founded on the socio-political definition of culture that acknowledges the principles of partnership, protection, and participation central to the Treaty of Waitangi (Ramsden, 1990; Spence, 2003). The Treaty of Waitangi (Te Tiriti o Waitangi) is considered the founding document of New Zealand. It is an agreement that was signed by representatives of the British Crown and the indigenous Māori people of New Zealand in 1840, to enable the British settlers and Māori to live peacefully together under a common set of laws (White, 1887/2011).

The Nursing Council of New Zealand (NCNZ, 2005) defined cultural safety as:

> The effective nursing or midwifery practice of a person or family from another culture and is determined by that person or family… Unsafe cultural practice comprises any action that diminishes, demeans, or disempowers the cultural identity and well-being of an individual. (p. 4)

The NCNZ (2005) also stated that a culturally safe midwife is one who can reflect on her "own cultural identity and will recognise the impact that her personal culture has on her professional practice" (p. 4). While this is a uniquely New Zealand concept, intended for the bicultural population of the country, it is an important factor in understanding the professional and cultural horizon upon which I stood prior to embarking on this research journey.

During the interview process, there were times I was an active observer of the aid worker in action. Where possible, I would accompany a participant as they went about their maternal health duties. The aid worker's interviews were often harrowing, and it was important for me to observe their frustrations and triumphs first-hand to build a clearer

picture of the complexity of aid work. During a visit to a tea garden in the depths of an Asian country, this complexity was brought home. Within a six-kilometre radius lived three communities, all employed by the tea garden. These communities represented three different religions and their conflicting ideas around pregnancy, childbirth, and the value of women in society. One expatriate maternal health aid worker served them all. The aid worker's role was complex. In one community she was celebrated and supported by local health professionals. They listened to her recommendations and, as such, this community had a low number of maternal deaths. The second community were somewhat cautious. They had ways of being where the husband made the decisions but were mostly open to negotiation. They could be educated about the reasons and signs for transferring a woman if she became unwell, and largely they followed through. For the third community however, discussing birth was an abhorrent idea. Women either survived or they did not. They were either 'strong' or they were not. Her worth was in how she survived childbirth and bore sons, largely on her own and without intervention. This observation, while not conventional for a hermeneutic study, is within its scope and certainly opened my mind to the horizon of my participants during that interview phase. Such complexity helped me to begin to set aside my judgments or prejudices when conducting what were, at times, gut-wrenching interviews.

Structure of the Thesis

I have chosen to present this study in 10 chapters. They are as follows:

Chapter One: **Introduction** has discussed what is called for in the question of this study and the purpose for why such research is being undertaken. In this chapter I have declared both my personal and professional horizons, acknowledged my preunderstandings, and placed this study within its global context. I have discussed why hermeneutic phenomenology was selected as my methodology and research method.

Chapter Two: **Historical Context** situates the global effort to address maternal mortality within a historical context beginning from the conclusion of World War Two until the year 2000 when the UN announced a global reduction in maternal mortality as one of its MDGs.

Chapter Three: **Literature Review** builds on the literature presented in Chapter Two pertaining to the UN MDGs era from 2000 to 2015, and the resulting publications by leading medical journal THE LANCET during that time.

Chapter Four: **Philosophical Underpinnings** describes the philosophical ideas that have provided the foundation and guidance of this study. Drawing on the work of Hans-Georg Gadamer and Hans-Herbert Kögler, this chapter describes how the philosophical writings of these philosophers have informed the study.

Chapter Five: **Method** clarifies the conditions by which understanding in this study has taken place. This chapter shows the congruence between the philosophical underpinnings and the steps taken to answer the research question.

Chapter Six: **No Woman, No Cry** situates the heart of this research, and introduces the complexity and paradoxes at play through the stories of women dying in childbirth.

Chapter Seven: **Bearing Witness** gives voice to the participants and sheds light as to why they are a crucial voice to be heard surrounding this topic.

Chapter Eight: **Maternal Mortality – A Human Rights Violation** focuses on women's reproductive health as a human right, and what is shaping how and why human rights abuses continue against childbearing women in developing countries.

Chapter Nine: **Politics & Aid – Help or Hindrance?** focuses on the role politics and aid play in the maternal mortality discourse. What is and is not working well is discussed, as well as how crucial politics and aid are in shaping the future direction of this crisis.

Chapter Ten: **Discussion** brings the meanings uncovered in this research back to the whole. The chapter considers the implications of this study for practice, education, and future research. Limitations are offered as a means for further discussion and research.

Chapter Two: Literature Review - Historical Context

All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood.
Universal Declaration of Human Rights 1948 (UN, 1948)

Introduction

This thesis does not stand in isolation; rather, it is greatly influenced by the traditions and preunderstandings of what has gone before in the field of global maternal health. Gadamer (1989) reminded us that as a hermeneutic researcher, we approach understanding in a historically affected consciousness that is, in turn, aroused as we juggle current understandings with the tradition of the past. Tradition, Gadamer believed, is a gift that challenges us with prejudices, questions, and issues that provoke knowledge. Engaging with historical literature and traditionary texts is essential in a hermeneutic study—both to provide context, and to link the past with current understanding and interpretation. This research, however, does not solely look through a hermeneutic lens. It also engenders a critical interpretation; the underpinnings of which identify those prejudices that are deeply rooted in the social, cultural, and political practices of a community or society, and, indeed, shape the everyday life of its members.

The aim of this literature review is to situate the current research in the traditional context of what has already been published in relation to the global maternal health discourse; in particular, maternal mortality. As well as establishing a timeline and providing background knowledge, reviewing historical literature helped shape the questions asked of the aid workers during the interview process, and identified gaps in understanding. Part one of this literature review looks at the origins of the global maternal health discourse and the resulting women's rights movement. Such a topic is related to an abundance of literature; therefore, only those most closely aligned with the intention of this research have been included.

Maternal Mortality – Setting the Scene

At the beginning of the 21st century, dying during childbirth was a rarity amongst women living in the more developed regions of the world; yet, the same cannot be said for women in developing nations where bringing new life into the world remained precarious at best

(De Brouwere et al., 1998; Gruskin et al., 2008). Such imbalance was not always the case. History shows that in the late 1900s, maternal mortality in the so called 'industrialised nations' was greater than 600 per 100,000, with only Sweden showing any signs of a decline (AbouZahr, 2003; De Brouwere et al., 1998). As early as midway through the 18th century, the Swedish Health Commission observed that two-thirds of the women who succumbed could have been saved, had they been attended by a midwife rather than a traditional birth attendant (Högberg et al., 1986). Supported by a powerful political will, Sweden set about training scores of midwives; and by the turn of the 20th century, three-quarters of women had a certified midwife attend their birth, with traditional birth attendants assisting less than 20 percent of all births conducted (De Brouwere et al., 1998). The result was a reduction in Sweden's maternal mortality ratio by more than half to 250 per 100,000 (De Brouwere et al., 1998). Few knew that Sweden's acknowledgement of the critical role skilled midwives played would be largely ignored, except by its Scandinavian neighbours, for close to a century; and so too, the importance political will would play in determining the fate of the world's childbearing women.

England and Wales were less successful in reducing their maternal mortality ratios, with numbers remaining well above that of the less industrialised Sweden at the turn of the 20th century. Apart from a Ministry of Health special committee established in 1928, it was not until the 1930s, most notably the 1938 'Mothers' Charter Conference, that the problem of women dying in childbirth found a secure place on the health agenda (AbouZahr, 2003; De Brouwere et al., 1998). Mandatory certification and regulation of midwives did not begin until 1902, substantially later than Sweden, with a clear reduction in the number of maternal deaths not being seen until the 1930s (De Brouwere et al., 1998).

The United States (US) fared no better than Britain, with reliable numbers related to maternal mortality not available prior to 1918 where the ratio was discovered to be a staggering 885 per 100,000 (De Brouwere et al., 1998). As a point of comparison, Sweden had not seen numbers this high for a century. Straying away from Sweden and Britain's lead, the US health authorities believed that to see a reduction in maternal mortality it was deemed necessary for all women to have obstetric-led births in a hospital setting, denouncing midwife-assisted homebirths, despite nurse-midwife pioneer Mary Breckinridge casting doubt on that theory (De Brouwere et al., Dye, 1983). In 1925, Breckinridge proved that a community of highly skilled, well-trained, and consistently available midwives in the rural area of Kentucky, where she resided, could provide a

quality service that resulted in a maternal mortality ratio of just 68 births per 100,000. By way of contrast, in the nearby town of Leamington, the rate was in excess of 800 deaths per 100,000. The difference was that in Leamington all births were doctor-led (De Brouwere et al., 1998). Despite Breckinridge's efforts, medical lobbyists hindered the advancement of midwifery-led care outside of the hospital setting. To this day, the US has the highest rate of maternal mortality amongst all developed nations, with the numbers continuing to rise from 12 per 100,000 in 2000 to 19 per 100,000 in 2017 (WHO, 2019). Of note, is that a mere 1.6 percent of births occur outside of the hospital setting in the US (Grodzinsky et al., 2019; MacDorman & Declercq, 2019). So why, when this thesis focuses on maternal mortality in developing nations, are the maternal mortality ratios in developed nations, and their subsequent histories, significant?

Right to Life

It has been suggested that "no single threat to men aged 15 to 44 approaches the enormity of maternal death and disability" (Cabal & Stoffregen, 2009, p. 1). It is not just gender inequity that Cabal and Stoffregen (2009) bring to the fore, but the issue of disparity between developed and developing countries, with maternal mortality ratios exposing a cavernous gap between the rich and the poor—the greatest separation seen amongst all health indicators (Cabal & Stoffregen, 2009). How, in the 21st century, can this be? And why is there so little progress, despite major international human rights treaties requiring governments to uphold the rights of their most vulnerable population—women? The remainder of this chapter looks at the cooperation, or lack thereof, of the international community as a whole in bringing to attention the plight of childbearing women. It highlights the measures put in place throughout the remainder of the 20th century—what worked well and what ultimately failed—in an attempt to address the imbalance.

Maternal Mortality – 1930s to 1950s

Concerns about women dying in childbirth were first raised by the League of Nations Health Section in 1930, with colonial powers keen to reduce maternal mortality rates in the colonies through the introduction of the medical care model practised in industrialised countries (AbouZhar, 2003). Very little, however, was acted upon due to the advent of World War II, with the global focus largely on protecting the populations of the colonies (Roseboom, 2005). The human rights movement was largely borne out of the World War II with sovereign states obliged to recognise the rights of those within their borders.

However, a more cosmopolitan approach has developed over the years, with stronger emphasis on shared international responsibility (Hammonds & Ooms, 2014; Reilly, 2011). At the San Francisco Conference in 1945, a "Declaration on the Essential Rights of Man" was touted, leading to the establishment of the UN in October of that year. It was to be a further three years before the UN Declaration of Human Rights was born (UN General Assembly, 1948); and, so too, the UNs own health agency—the WHO, idealised as an intergovernmental organisation charged with protecting the health of all global citizens (O. M. Campbell, 2001). In its constitution, the WHO (1948) decreed "to promote maternal and child health and welfare and to foster the ability to live harmoniously in a changing total environment" (p. 3). Yet, while maternal health became visible on the world health agenda, those leading the charge were somewhat misguided, categorising maternal health, a normal life event, under a list of diseases (O. M. Campbell, 2001).

The 1950s saw the WHO stay true to its agenda. At its core, the WHO offered administrative support to countries to ensure they could include maternal and child health in their national health programmes (O. M. Campbell, 2001; WHO, 1952). In addition, the WHO also provided technical support in the form of training health workers in an attempt to improve the standard of care given to childbearing women, particularly for the majority who chose to birth at home (O. M. Campbell, 2001). Yet, during the 1950s, maternal health was not prioritised on the global health agenda as a significant public health concern. Maternal health programmes received little to no funding, nor received global attention to their plight; that honour going instead to the more politically favoured programmes aimed at reducing the world's population (Hammond & Ooms, 2014). A glimmer of hope was sparked in 1954 by way of a proposed multilateral treaty, namely the International Covenant on Economic, Social and Cultural Rights (IEESCR); however, it would take 12 years before it was adopted by the UN General Assembly and a further decade to come into force (Hammonds & Ooms, 2014). It was not until 1958 that women's health was identified as a key area of concern, when the WHO conducted a report into its first decade of practice. The report identified maternal health as a 'disease' requiring action (WHO, 1958).

Maternal Mortality – 1960s

Concern for maternal healthcare was to be further diluted in the 1960s, with the emphasis placed primarily on population control in the form of contraception. Pitched as a means to empower women; it came with an underlying eugenic political agenda (De Brouwere et al., 1998; Gruskin et al., 2008). During this decade, maternal health also became synonymous

with infant and child health. Children, it was believed, were at substantially higher risk of dying than their mothers and were, therefore, prioritised by policymakers (O. M. Campbell, 2001; Gruskin et al., 2008). Maternal and child health programmes began to appear, with international cooperation amongst donors and agencies funding and implementing multiple maternal and child health initiatives; yet, the 'M' (maternal) component was often difficult to find in the ensuing reports, remaining hidden amongst child and infant health initiatives such as universal immunisation and addressing nutrition (O. M. Campbell, 2001).

The 1960s also saw the advent of the first set of 'global development goals' by the UN. These initial goals did not specifically address maternal or child health. Instead, they were predominantly centred on increasing staff to patient ratios, clean water, communicable disease prevention, and control and national health planning (O. M. Campbell, 2001).

Maternal Mortality – 1970s

The 1970s saw a surge in visibility from feminist and human rights lobbyists around the globe. Their call to action centred on the right of women to secure control over their own bodies and to venture beyond the stereotypical horizon that saw women limited to childbearing and household related duties (Campbell, 2001; Gruskin et al., 2008). As a result, a renewed emphasis on reproductive health was brought to the fore, bringing the issue of maternal mortality squarely back on the agenda (Campbell, 2001).

By the mid-1970s, the WHO was committed to implementing family planning strategies, including the introduction of contraception, in an attempt to improve maternal health outcomes (Campbell, 2001; Sen et al., 2007). Much of what they implemented was founded in developed nations with strategies most suited to those populations and well-supported health systems. Those strategies, however, failed to translate across developing nations in terms of improving maternal health outcomes; prompting a move away from hospital-based initiatives, and with it an emphasis on promoting primary or community care (Van Lerberge & De Brouwere, 2001). Antenatal care became the renewed focus in the fight against maternal mortality, bringing with it what would later become a hotly debated practice, the training of community-based Traditional Birth Attendants or TBAs (De Brouwere et al., 1998).

The WHO (1992) defines a TBA as, "a person who assists a mother during childbirth and who initially acquired her skills by delivering babies herself or through apprenticeship to

other traditional birth attendants" (p. 18). This apprenticeship was usually as a result of either a family or local community member who was a practicing TBA (Aziato & Omenyo, 2018). The 'knowledge' that informed their practice was largely informed by the spiritual realm, through dreams and spiritual artefacts, and traditional beliefs and medicines (Aziato & Omenyo, 2018).

While both the idea and practice of training TBAs was not new—Sudan began training TBAs as early as 1921, and Thailand, India, and the Philippines in the 1950s—it was during the 1970s that the notion of training TBAs gained significant traction (De Brouwere et al., 1998). In 1970, at a WHO-led seminar in Malaysia, an international research study was endorsed that recommended the implementation of a guide for all relevant countries around the training and subsequent utilisation of TBAs in their communities (De Brouwere et al., 1998). While TBAs were already in existence and birthing childbearing women, it was widely acknowledged that their technical skills were not adequate. However, they were recognised as a valuable asset to communities in that they were wholly accessible, culturally acceptable and, at times, actively encouraged women to seek medical care (De Brouwere et al., 1998).

TBAs were largely introduced to plug a widening gap in maternal services due to an acute shortage of health professionals, a gap the WHO could not foresee closing any time soon (De Brouwere et al., 1998). Added to this widening gap, was an acute shortage of hospital beds and workforce, should every childbearing woman birth in hospital (Dissevelt, 1978). Such was the uptake, that many organisations supported the training of TBAs ahead of maternal child-health nurses (Pfeiffer, 2003). From 1972 to the mid-1990s, the training of TBAs was initiated by 85 percent of countries directed to do so (Fleming, 1994); yet, the results were disappointing, with an abundance of literature demonstrating that TBAs had little to no impact in reducing the large number of women dying in childbirth (Bergström & Goodburn, 2001; De Brouwere et al., 1998; Fauveau & Chakraborty, 1994; Goodburn et al., 2000; Greenwood et al., 1990; Rosenfield & Maine, 1985; Sibley et al., 2004; Türmen & AbouZahr, 1994).

Studies also suggested that most TBAs had had insufficient training to integrate into the wider health system, and those that had been exposed to a higher level of TBA education, still needed a great deal of support from skilled practitioners (Bergström & Goodburn, 2001; Ganle, 2015; Nyanzi et al., 2007). While it is acknowledged that TBAs were better

able to give culturally safe care and support to women (Bergström & Goodburn, 2001), deeply rooted cultural and social ties also proved a barrier, as some TBAs actually stalled women seeking vital medical care and hindered transfer to hospital when it was needed (De Brouwere et al., 1998). Davis-Floyd (2001) even suggested that TBAs are an obsolete workforce that only exists due to the extreme shortage of skilled health workforce.

Meanwhile, as the experiment that was TBAs was being undertaken, the UN was busy becoming a vocal advocate for women's health rights, declaring the UN Decade for Women commencing in 1976 (AbouZahr, 2003; De Brouwere et al., 1998; Hammonds & Ooms, 2014). The UN General Assembly also shone the spotlight on women's health adopting the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) in December 1979. Often referred to as the Women's Bill of Rights, it is, to this day, one of the world's most widely endorsed human rights treaties, having been ratified or acceded by 188 countries (Freedman, 2001). Vital to the success of the document is the ideal that all nation states work in harmony and cooperation, with the both the 'right to life' and the 'right to the highest standard of health' at the forefront of each nation's actions (Hammond & Ooms, 2014). The Treaty's only downside was that just one article pertained to healthcare and its focus remained on the decade's main priority—family planning (Davies, 2010).

Maternal Mortality – 1980s

Little was to change in the 1980s, with a continuing sustained focus on educating developing nations with skills and knowledge brought in from the more developed nations (AbouZahr, 2003; De Brouwere et al, 1998; Hammonds & Ooms, 2014). The voices and opinions of those on the ground in the developing nations—the policymakers, the health workers, and the women themselves—were to be of no consequence. Attendance at antenatal clinics, the education of mothers, and continued upskilling of TBAs were to lead the primary health care strategy during this time (De Brouwere et al, 1998; Gruskin et al., 2008).

As the new decade dawned, the health factions of the international women's movement met to push the agenda for childbearing women, particularly in developing nations, across the globe (Garcia-Moreno & Claro cited in Sen et al., 1994; Gruskin et al., 2008). Of most concern were three key actions: access to safe health care from antenatal services to birthing care; the need for affordable contraceptives; and the desire for a ban on population

control, particularly by way of coercive sterilisation, imposed by a number of governments during this time (Gruskin et al., 2008). There was no doubt that global activism by women's groups had a sustained impact on the UN Decade for Women (1976-1985), in terms of keeping the health needs of women, particularly those in their childbearing years, firmly at the forefront of the agenda (Gruskin et al., 2008). Yet, in 1987, the women's health movement retained a healthy scepticism about the true commitment of the UN and its partner organisations, launching the International Day of Action for Women's Health with a focus on 'Preventing Maternal Mortality' and highlighting the lack of autonomy women had over their childbearing decisions (Gruskin et al., 2008).

The global economic crisis of the 1980s was, however, to ensure that the struggle for women to claw their way to the top of the health agenda was further thwarted for much of the decade (AbouZahr, 2003). The World Bank, together with the International Monetary Fund (IMF), led the charge, with programmes elevating privatisation and liberalisation at the top of the agenda, while slashing spending by the governments under its eye (Elzinga, 2005; Kickbusch, 2000). As a consequence, donor and aid agencies ignored human capital investments, preferring instead to prioritise vertical health programmes targeting select health conditions over strengthening the current status quo (Elzinga, 2005; Kickbusch, 2000).

It was not to be until midway through the decade that the 'true' impact of such approaches on the world's childbearing women was to be highlighted. A report published by the WHO in 1986, in conjunction with the UN Population Fund, uncovered the previously underestimated magnitude and scale of maternal mortality across the globe (AbouZahr, 2003; Hammonds & Ooms, 2014). New figures suggested that more than half a million women were dying of maternal health related causes each year, with all bar one percent of those women living in a developing world setting (Hammond & Ooms, 2014). Coincidentally, in the very same year, a piece of scholarship by Rosenfield and Maine, in the leading medical journal *The Lancet*, entitled 'Where is the 'M' in MCH (Maternal Child Health)', also highlighted the neglect of childbearing women in favour of prioritising the healthcare of infants and children (Rosenfield & Maine, 1985). The pair challenged the validity of the sustained focus on antenatal screening and the use of TBAs, pressing for more attention to be placed on the mother's wellbeing and not just the child's (Rosenfield & Maine, 1985).

In February 1987, with mounting pressure from women's lobby groups, the World Bank, the UN Family Planning Association (UNFPA), and the WHO came together in Nairobi to present the first ever international conference dedicated to addressing the issue of maternal mortality (Hammonds & Ooms, 2014). Here, women's reproductive health was finally at the top of a global health agenda and clearly underlined as a fundamental human right (Davies, 2010; Starrs, 2007). The result was a call for the reduction of maternal mortality by 50% by the year 2000, as the Global Safe Motherhood Initiative was formed (Starrs, 1987). The lasting message from this global conference was the inherent need to improve the status of women in the world through educating and strengthening communities on the core competencies of maternal health care (Starrs, 2007).

While many nations heeded the call and committed to improving and protecting the lives of childbearing women, some questioned the necessity of a specific focus on maternal health. Their argument was that their nation's health systems already included targeted maternal and child programmes (Starrs, 2007). Criticism was also pitted at the highest level with UN and donor agencies ignoring the reasoning of Rosenfield and Maine, and favouring only two, arguably the most cost-effective, strategies—the antenatal screening of women for risk factors and the continued training of community based TBAs (Starrs, 2007).

Maternal Mortality – 1990s

While the Nairobi conference failed to make an impact, it did prove a catalyst for many advocacy and research initiatives, and spawned a plethora of international conferences in the 1990s. Most notable was the International Conference on Population and Development (ICPD) held in Cairo, Egypt in 1994, and its subsequent 'Program of Action' (AbouZahr, 2003; De Brouwere et al., 1998; Hammond & Ooms, 2014). Human rights and gender equity were central to the conference's messaging with particular emphasis placed on the wellbeing, health, and rights of women in their reproductive years (Corrêa, 1999; Hammonds & Ooms, 2014). Of most significance, was the ICPD acknowledging the crucial link between the legal and social status of women in society, and greater sustainable development at all levels from the grassroots to national level in those communities (Sai, 1997). After years of campaigning, women were finally acknowledged for their basic human right to safely deliver their children.

The ICPD's Program of Action withstood the test of time, being upheld across the global community throughout the 1990s for its goal of reducing maternal mortality and its focus on dismantling long held social structures and gender ideals (Haslegrave, 2004; Sai, 1997). It also proved a defining moment in the use of language regarding women's sexual health. The term 'family planning' made way for the phrase 'reproductive health', and with it a more comprehensive acknowledgement of a woman's social, physical, and mental wellbeing and not just the absence of disease (Haslegrave, 2004).

The WHO acknowledged the worth of the ICPD, announcing its own upgraded maternal health policies based around four pillars: family planning (still named as such by the WHO), antenatal care, clean safe birth practices, and access to emergency obstetric care (WHO, Maternal Health, & Safe Mothering Programme, 1996). This was in light of the abundant scholarship that revealed that the previous model of antenatal care and the upskilling of TBAs was not stemming the rate of maternal deaths which remained excessively high (Bergström & Goodburn, 2001; De Brouwere et al., 998; Fauveau & Chakraborty, 1994; Goodburn et al., 2000; Gruskin et al., 2008). Alongside the continued provision of contraception and the treatment of sexually transmitted infections, abortion services and attention to gender-based violence practices were also to be prioritised (Rosenfield & Min, 2009).

Maternal mortality was also high on the agenda the following year at the Fourth World Health Conference in Beijing, China, as the world's health leaders once again acknowledged the historical "reprehensible neglect of women's health" (Starrs, 1998 p. 2). The ensuing Beijing Declaration and Platform for Action proposed to ensure women would remain highly visible on the health agenda and become active participants in deciding their future (Gruskin et al., 2008). It reiterated that women's rights are human rights and endeavoured to "intensify efforts and actions to achieve the goals of the Nairobi Forward-looking Strategies for the Advancement of Women" (Beijing Declaration, 1995, p. 4)—the goal being the end of the century. Despite the rhetoric, women continued to die in unprecedented numbers in the ensuing decade, with maternal death rates declining a mere 2.5% per year in many of the poorest nations, with some nations recording no decline at all (Hill, 2005).

By 1997, it was clear that more needed to be done. Policy and decision-makers from around the world were asked to convene in Colombo, Sri Lanka to review many of the lessons

learned from the first decade of the Safe Motherhood Initiative. It was debated that maternal deaths cannot be categorised as just another death, in that pregnancy is not a disease, rather a "normal physiological process that women must engage in for the sake of humanity" (AbouZahr, 2003, p. 18). It was also acknowledged that maternal mortality could not be eradicated like that of a notifiable disease. Slowly, the perception of maternal mortality changed and those governments at the helm began to view maternal mortality politically and legally in terms of a social injustice or health disadvantage (AbouZahr, 2003). There were detractors, however, who believed that the key messaging from the meeting was too broad and not focused enough on initiatives that would see the numbers of childbearing women dying in childbirth decrease substantially enough to make a marked difference (Rosenfield & Min, 2009). One message that drew consensus amongst those attending the technical conference was the need for a skilled attendant with 'midwifery skills' to attend every birth (Rosenfield & Min, 2009; Starrs, 1998). While in some developing nations, there had been a concerted effort to address this issue, nearly half of all births failed to have a skilled attendant present. In some countries the numbers of women birthing with a skilled health worker was less than 20 percent (AbouZahr, 2003). So what does a skilled attendant caring for childbearing women look like?

It was to be a further two years before the WHO, in conjunction with UNPD, UNICEF, and the World Bank, clearly defined a skilled birth attendant as, essentially, a midwife—a person trained with adequate midwifery knowledge and skills who is proficient at managing normal labour and birth, can recognise when complications arise and refer immediately (WHO, 1999). The WHO released a modified statement, five years on, in conjunction with the International Federation of Gynaecology and Obstetrics and the International College of Midwives, stating that a skilled attendant must now be an accredited health professional (doctor, nurse, or midwife) who has undertaken formalised training to proficiency level (WHO, 2004). There is much scholarship that lends itself to the other side of the debate, with Prata et al. (2011) stating that such skilled attendants are not a realistic option for the 45 million in rural communities who do not have easy access to a birth centre or hospital and rely on their local TBAs for assistance. They state that denying TBAs necessary training and not valuing them as a workforce can only lead to more disastrous outcomes (Prata et al., 2011). While Stanton et al. (2007) shared Prata and colleague's sentiment, they believed that the advantages of pushing the skilled attendant agenda overrode the negative consequences.

The 1990s concluded with Safe Motherhood once again prioritised by the WHO, when World Health Day in 1998 was dedicated to the health and wellbeing of childbearing women. Leading with the tagline, 'Pregnancy is special: let's make it safe', the day was celebrated with much hoopla around the world by politicians, media, and even the First Lady of the United States of America (AbouZahr, 2003).

The Millennium Declaration – The Year 2000

As a result of sustained focus and ensuing consensus amongst maternal health technical advisors during the 1990s, reducing maternal mortality was touted to become one of the key health priorities of the new millennium (AbourZahr, 2003). The UN Millennium Declaration was drafted and signed in December 2000, with 189 countries in agreeance. From there, the eight MDGs were born, with MDG-5 solely committed to maternal health (AbouZahr, 2003). There was an obvious nod to the Safe Motherhood movement, with the initial focus of MDG-5 on the reduction of maternal mortality and an increase in skilled attendants at birth (AbouZahr, 2013). The targets were set high with the goal of MDG5.A to reduce the global maternal mortality ratio by three quarters between 1990 and 2015, and the aim of MDG5.B to ensure universal access to reproductive health by 2015 (UN, 2015).

However, despite the hype, not everyone saw MDG5 as the panacea for the survival of childbearing women. Anti-abortionists' were among the biggest critics, believing the Safe Motherhood movement, and the ensuing MDGs, to be the "Trojan horse for the introduction of legal abortion" (AbourZahr, 2003, p. 18). Others weighed into the debate from a human rights perspective, with Yamin and Boulanger (2014) arguing that focusing on maternal health alone was too narrow and failed to address the root cause of maternal mortality—that of women's status in the world and the power influences that engender and sustain the continued inequality.

The following literature review focuses solely on the MDG era from 2000 to 2015.

Chapter Three: Literature Review – Millennium Development Goal Era

If they (women) become tired or even die, that does not matter. Let them die in childbirth, that's why they are there.

Religious reformer Martin Luther (cited in Mongan, 2005, p. 46)

Introduction

The United Nations Millennium Declaration, with its 8 goals and 18 targets, was to stimulate the health research industry. Over the ensuing 15-year period after its adoption, hundreds of researchers were to publish thousands of articles in most, if not all, of the world's leading health publications such as *The Lancet*, *The British Medical Journal*, *The New England Journal of Medicine*, and those related specifically to maternal health issues such as *Women's Health Issues, International Journal of Women's Health* and *Midwifery*. Over the many years spent conducting this research, I collated and read close to one thousand articles related specifically to maternal mortality around the world. At times it felt overwhelming with the sheer amount of literature taking over my office. I struggled, at first, to work through how to best represent this abundance of rich literature into my research. To review what was printed regarding maternal mortality in its entirety would require a standalone thesis itself. A decision needed to be made as how best to represent all that I had read, and yet would fit within the constraints of this thesis.

I have, therefore, chosen to follow only scholarship published in one of the world's most highly regarded health journals, *The Lancet*, during the MDG era from 2000 to 2015. *The Lancet* sits as one of the oldest and best-known medical journals in the world. Founded by English surgeon Thomas Wakley in 1823, the peer reviewed journal publishes original research, case studies, conference/seminar reviews, as well as book reviews and editorials. Its long-standing editor, Richard Horton, has been a visible presence at some of the world's leading maternal health conferences over this period. Key search terms used were, maternal death, maternal mortality and Millennium Development Goal 5. Of the 163 pieces of scholarship (2000-2015) deemed relevant, only those considered closest to the research question will be discussed. While most literature reviews would follow a theme, I felt a chronological review would help with understanding the level of priority, or not, placed on maternal health during the MDG period.

2000 to 2003

For the first three years after the inception of the MDGs, there was a dearth of literature regarding maternal health published in The Lancet; this, despite one of those goals, MDG5, being explicitly focused on the reduction of maternal mortality. Not one article could be found during these years that, in any way, centred on the health of childbearing women during that period.

Maternal Health Research Priorities – 2004

It was January 2004 before the first articles to address maternal mortality appeared in the journal. Two were led by Professor Wendy Graham, a Professor of Obstetric Epidemiology with a commitment to reducing maternal mortality in developing nations. In the most poignant, Graham and Hussein (2004) alerted us to a potential drawback of MDG5A, stating that while it aids in increasing the profile of maternal deaths, reducing deaths alone is not enough to diminish the suffering of childbearing women. For every woman who dies in childbirth, there are many more who live with complications caused by pregnancy and childbirth for which there remains increased burden on both their families and the community in which they live (Graham & Hussein, 2004). The article also addresses a fundamental issue regarding MDG5A—that the UN mandate assumes that every woman's death is counted. It is reported that up to 63 percent of maternal deaths are underreported, for reasons ranging from direct omission to misclassification (Graham & Hussein, 2004).

It is also the first time we see an article linking human rights and the fate of childbearing women. Adrienne Germain (2004), from the International Women's Health Coalition, reminded us of the disparity between the rich and poor. Nowhere was it more evident than when comparing the risk of dying in childbirth, where women had a 1 in 16 chance of dying in sub-Saharan Africa, whereas for women in western Europe that risk was 1 in 4000 (Germain, 2004). Germain lamented that the numerous world health organisations had prioritised communicable diseases, whereas diseases associated with sexual and reproductive health had largely been ignored. She acknowledged, however, the complexity of addressing maternal mortality and the myriad of underlying causes that contribute to the issue (Germain, 2004).

September saw the publication of an article by Manandhur et al. (2004) looking at the effect of facilitated community women's groups on neonatal outcomes. A surprising secondary outcome of the research was a substantial reduction in the maternal mortality ratio with 69

deaths per 100,000 births in the intervention groups, compared with 341 deaths per 100,000 births in the control groups. Manandhur et al. concluded that this was most likely due to a better uptake of the use of skilled health professionals antenatally and during delivery, as well as better hygiene practices.

It was also the first time we see publication in The Lancet of the use of Misoprostol being used to treat postpartum haemorrhage (PPH), arguably the most prolific cause of death amongst childbearing women in the world (Potts & Campbell, 2004). In the article, Potts and Campbell (2004) highlighted the common use of the drug by TBAs to treat women in Indonesia and Tanzania, and the urgency of other nations pushing for the drug to be available for all childbearing women. All of this despite the pharmaceutical company (Pfizer), who manufacture the drug for the purpose of treating gastric ulcers, not wishing to endorse the use of Misoprostol as a treatment for PPH (Potts & Campbell, 2004).

Maternal Health Research Priorities – 2005

Just two articles focused on maternal health were to appear in 2005. In their article, *Taking action to improve women's health through gender equality and women's empowerment*, Grown et al. (2005), lamented the fact that women's health outcomes were invariably tied to women's status. They proclaimed that more commitment at the highest political levels was needed to break down the attitudinal and societal gender bias that was deeply entrenched in many countries around the world; deeming it a necessity before women's health and, therefore, maternal mortality, would see any substantial change.

In June, Costello and Osrin (2005) reminded us that a summit of many of the world's leaders would gather in September to review any progress made towards the MDGs. They stated that the likelihood of any reduction in the maternal mortality rate would be very slim at best (Costello & Osrin, 2005). They believed that while the WHO has produced outstanding guidelines for the management of the childbearing woman through her pregnancy, birth, and the postpartum period, the priorities of the health sector have often been misguided (Costello & Osrin, 2005). They believed too much focus had been placed on the provision of doctors and drugs, to the detriment of any community involvement in the health and wellbeing of its childbearing women (Costello & Osrin, 2005).

Maternal Health Research Priorities – 2006

The September 2005 meeting of world leaders sparked a plethora of scholarship, with The Lancet publishing in excess of 20 articles in 2006 related to childbearing women. These included a Maternal Survival series in September/October, and a further series focused on Sexual and Reproductive Health in November/December.

Dominating the Maternal Survival series was the notion that the solution for reducing maternal mortality, globally, was for women to give birth in a medical facility with a skilled health professional, more specifically a trained midwife in attendance, despite birth not being specifically deemed a medical condition (Campbell & Graham, 2006; Horton, 2006; Lawn et al., 2006; Filippi et al., 2006). Ronsmans and Graham (2006), commenting on behalf of The Lancet maternal survival series steering group, as well as advising of the chances of surviving childbirth globally (1 in 6 in the poorest areas of the world and 1 in 30,000 in North Europe), seemed to contradict the above writers, highlighting that a substantial number of maternal deaths did actually occur in a hospital setting. Rosenfeld et al. (2006) were the first to acknowledge that MDG5 could in fact be an impossible dream, while Starrs (2006) provided a rather sobering update of the Safe Motherhood initiative 20 years since its inception. Starrs' appeal was that more emphasis was needed on viewing maternal health as a human right, and that there were social and economic benefits and advantages of saving childbearing women's lives. She also highlighted the need for more collaboration of local government agencies and NGOs in the field (Starrs, 2006).

The Sexual and Reproductive Health series presented papers highlighting many of the direct and indirect reasons as to why childbearing women die each year, such as unintended pregnancies, unsafe abortion, and lack of access to contraception (Cleland et al., 2006; Glasier & Gulmezoglu, 2006; Greer, 2006; Shaw, 2006). This series came a month after the UN General Assembly added universal access to sexual and reproductive health care to the MDG targets (MDG5B), to try and encourage a more global mandate for action after years of neglect (Glasier & Glumezoglu, 2006; Greer, 2006). Glasier et al. (2006) stated that around 80 million women were burdened with unintended pregnancies each year. Over half of those (45 million) resulted in an abortion; 19 million of which were deemed unsafe and resulted in the death of 70,000 women each year (Glasier et al., 2006). Shaw (2006) supported these findings and stated that if these statistics related to any other social demographic in the world, it would be deemed intolerable. Power and politics appear to be the drivers for the lack of progress in ensuring universal access to contraception. For instance, the US, by far the largest donor, appeared to have the ultimate say in whether the

money was spent on contraception depending on which leader was in power and their personal and political beliefs (Buse et al., 2006; Fathalla et al., 2006).

Other months saw a smattering of articles related to the reduction of maternal mortality including Khan et al.'s (2006) review of an analysis done by the WHO into the main causes of maternal mortality; while Stephens et al. (2006) called for an increased focus on indigenous health with a sobering analysis that the goal for the MDGs could be met despite entire indigenous populations vanishing. Ronsmans et al. (2006) highlighted the huge gap between the rich and the poor in regard to access to life-saving caesarean sections, while Chatterjee (2006) introduced the dichotomy that is India and its health care system, a world leader with its state-of-the-art facilities, health tourism, and the manufacture of pharmaceuticals; yet a country whose inequities mean that it has some of the worst outcomes for childbearing women in the world, particularly among the rural poor.

Maternal Health Research Priorities – 2007

The focus of maternal health research published in The Lancet in 2007 was the frustration over the inability to obtain any clear and accurate data from many of the developing world settings. Setel et al. (2007), in their paper *A scandal of invisibility: Making everyone count by counting everyone*, highlighted the fact that most people born in Asia or Africa are not registered when they are born, nor when they die. With no legal form of recognition, these populations were simply invisible. How then, could there be any accuracy in maternal mortality data when large numbers of those who succumb in childbirth were not seen and not counted (Setel et al., 2007)? Setel et al. called on the international community to prioritise civil registration so that all who are born, or die, are counted. Gill et al. (2007) added weight to the argument believing that maternal health should be viewed not just as a health issue but as a development issue. They stated that when women are ill or die, it has huge flow on effects for their family, community, and, ultimately, the economy of the country in which they live (Gill et al., 2007). Freedman et al. (2007) went one step further, adding that now was the time that, "the focus of the global maternal health community needs to shift. Instead of energy spent on… generic packages, we now need to address the health system that must deliver them" (p. 1383).

Articles of interest in 2007 included Starrs (2007) who commented that women in some of the neediest areas of the world had a 1 in 20 risk and were 500 times more likely to die during their pregnancy and childbearing journey than women in more developed nations.

This, she reasoned, was due to the status of women in their country and community, substandard and inaccessible health systems and services, and a high fertility rate (Starrs, 2007). Obaid (2007) agreed with Starrs, adding that countries with a lack of skilled health professionals at birth, coupled with poor uptake of contraception and ineffective health systems, had a higher occurrence of maternal death. Paul (2007) believed one answer may lie in a monetised incentive scheme being undertaken in India, but only if the infrastructure could support it. Here women were incentivised monetarily if they delivered in a hospital setting. Those that facilitated the women to do so, such as health workers, were also rewarded with a cash bonus. Such practice, however, posed an ethical question which Paul does not answer.

The most interesting piece of research that year appeared to be out of Matlab, Bangladesh. Chowdhury et al. (2007) conducted a 30 year cohort study to best determine what worked when it came to the reduction of maternal mortality. They looked at interventions, such as skilled health workers at birth, to ascertain whether they made a difference to the number of maternal deaths in that area. Maternal mortality fell as much as 68% in Matlab during that time. Chowdhury et al. stated that while there was low uptake from women of skilled support during birth overall, the fall in deaths resulted from fewer unsafe abortions, plus greater access to emergency care that was most likely facilitated by midwives. Thus, skilled attendants contributed to the decline in maternal deaths.

Maternal Health Research Priorities – 2008

A series focused on Alma Ata was to dominate publications in 2008. In September of 1978, *The Declaration of Alma Ata* was pledged at an international primary health care conference in Kazakhstan (Rosato et al., 2008). The declaration called for action to promote and protect the health of all people around the globe. It was the first of its kind to underscore the value of primary health care. The series focused on the importance of primary health care, specifically community based initiatives, in trying to combat maternal mortality (Ekman et al., 2008; Rohde et al., 2008; Rosato et al., 2008; Zulfiqar et al., 2008). The authors of this series made a plea to the governments of developing nations to ensure they prioritised cost effective primary health care initiatives, such as community mobilisation and home-based care by skilled attendants, to ensure that meeting MDG5 becomes a reality (Ekman et al., 2008; Rohde et al., 2008; Rosato et al., 2008; Bhutta et al., 2008). Such initiatives were the village based midwife programme in Indonesia where every village has a skilled birth attendant to provide primary health care services such as antenatal care,

perinatal care, immunisation, family planning, and advice on nutrition; and which was proving successful at reducing the high number of maternal deaths in that country (Fauveau et al., 2008).

At the halfway mark towards the meeting of MDG5 by 2015, Horton (2008) reported that South Africa and Tanzania were stepping forward and producing the most comprehensive sets of data to date. Fraser (2008) reported that Peru, by adapting their health care environment to suit the cultural preferences of its population in rural areas, had made astonishing progress in reducing maternal deaths, with the area studied reporting no maternal deaths since the initiative began. They also provided a solution to ensure staff retention by incentivising health workers who remained in the area through pay rises and access to free advanced training programmes (Fraser, 2008).

Other priorities raised during 2008 in The Lancet regarding maternal mortality were a call to track donor assistance to ensure greater accountability (Greco et al., 2008); Mavalankar et al. (2018) presented the idea of public-private partnership to help reduce maternal mortality in India; and Langer et al. (2008) discussed the WHO's initiative to utilise magnesium sulfate for the treatment of severe preeclampsia and eclampsia. The Countdown 2008 Equity Analysis Group (2008) concluded, however, that despite the range of initiatives in place, with just seven years left to achieve MDG5, the rate of global decline needed to more than double if those targets were to be met.

Maternal Health Research Priorities – 2009

In 2009, the UN issued a report card on the advancement of MGD5 (Horton, 2009). The news was far from heartening, with the document showing little progress had been made, particularly in areas such as Sub-Saharan Africa (Horton, 2009). South Africa also appeared to be failing in its commitment to reduce maternal and child mortality, with child mortality actually increasing since MDG data gathering began (Chopra et al., 2009). The continuing after effects of apartheid, particularly for women and children, and the prevalence of the HIV/AIDs epidemic, coupled with a poorly run, overburdened health system, added to the problem of trying to stem the numbers of women dying in childbirth (Chopra et al, 2009).

Unsafe abortions were still a major contributor to maternal mortality numbers (The Lancet, 2009a). It was estimated that as many as eight women died each and every hour, with some

20 million women dying annually due to a lack of family planning options and without safe access to abortion services (The Lancet, 2009b). Child marriage was proving a barrier to reducing the number of maternal deaths in India (Raj et al., 2009). One of the dangers of child marriage was a lack of fertility control. These young women had no access to contraception before giving birth to their first child, possessed high fertility rates including birthing a second child within two years of the first, and faced the issue of subsequent multiple unwanted pregnancies (Raj et al., 2009). Raj et al. (2009) reported that close to 45 percent of young women in their research cohort were married before the age of 18, nearly 23 percent were married before they were 16 years of age, and just over 2.5 percent were married prior to becoming a teenager. These children and young women were at much greater risk of dying from pregnancy complications and during childbirth. Raj et al. believed greater enforcement of already existing policies for the prevention and abolition of child marriage was urgently needed.

Positive research had come out of Bolivia with a reduction in maternal deaths, in part, due to a government initiative that gave financial incentives to childbearing women (Moloney et al., 2009). To receive the money, women must have attended compulsory antenatal check-ups and birthed in a hospital setting. The incentive was lucrative, amounting to almost US$250 (Moloney et al., 2009). Despite this initiative, Bolivia still had far to go if it was to meet its MDG5 obligations prior to 2015 (Moloney et al., 2009). A mathematical model by Pagel et al. (2009) predicted that the use of Misoprostol and antibiotics in the primary community setting would be advantageous in reducing the number of women dying in childbirth. By way of contrast, both drugs were required to be administered in a secondary, rather than primary, setting in developed countries during labour and delivery.

The most uplifting news from 2009 for women was surely the news that the UN Human Rights Council passed, in June, a landmark decision that, “recognises preventable maternal mortality and morbidity as a pressing human-rights issue that violates a woman’s rights to health, life, education, dignity and information” (The Lancet, 2009a, p. 1400). The decision was an important step forward for the human rights community in recognising lack of health care as just as important to campaign against as the death penalty and torture (The Lancet, 2009b).

Maternal Health Research Priorities – 2010

With just five years left to meet the MDGs, a plethora of papers were submitted for publication in The Lancet related to MDG5; of which 22 articles were published, the largest number in any one year to date. One particular piece of scholarship funded by the Bill and Melinda Gates Foundation exploring maternal mortality in 181 countries, was to dominate the coming years and became the most cited piece of research as evidence to an estimated sizeable reduction in maternal mortality globally; a drop to an estimated 342,000 women dying in childbirth in 2008, down from 526,300 in 1980 (Hogan et al., 2010). This article was to prove contentious, however, with many who believed there was marked difference between what they were seeing on the ground and what was being published as 'true fact' (Althabe et al., 2010; Meda et al., 2010; Qomariyah & Anggondowati, 2010). These critics published contrasting articles showing much confusion at the disparity between Hogan and colleagues' modelling of the maternal mortality ratio, and in-country figures endorsed by the governments of Indonesia, Argentina, and Burkina Faso (Althabe et al., 2010; Meda et al., 2010; Qomariyah & Anggondowati, 2010). McKee et al. (2010), on the contrary, were full of praise for Hogan and her fellow researchers but did share some concerns, namely that unsafe abortion—a major contributor of maternal deaths—was omitted. Once again, discrepancies in data between the estimates of Hogan et al. (2010) and some Asian and Eastern European country data were highlighted; but, overall, McKee and colleagues gave high praise to their work. Yet, Hogan et al. did not paint an altogether perfect picture in their research report, stating that only 23 countries were on track to meet MDG5 by 2015, and more than half of maternal deaths were occurring in just six countries—India, Pakistan, Ethiopia, Afghanistan, Nigeria, and the Democratic Republic of Congo.

Editor of The Lancet, Richard Horton (2010a), also weighed in on the state of maternal mortality in 2010 and wrote a scathing piece of prose that pointed the finger at world leaders' ultimate failure in protecting childbearing women over the past 20 years of the Safe Motherhood initiative. Horton (2010b) stated, "[the] striking lack of progress, despite maternal mortality reduction being awarded its own Millennium Development Goal (MDG-5) in 2000, has been a source of puzzlement and embarrassment to global health leaders" (p. 1581). While he contended there was wide uncertainty about the numbers reported in the research presented by Hogan et al. (2010), he did believe that it clearly showed that programmes involving the education of childbearing women, increasing skilled attendants at their births and increasing the average income of individuals, had resulted in a reduction of maternal deaths. Wakabi (2010) concurred with Horton (2010a)

in regard to a lack of accountability by world leaders, stating that African leaders had much to answer for when it came to the dearth of progress in many African nations towards reducing maternal mortality.

Other notable reports included Bhutta et al. (2010) who, in their *Countdown to 2015* report, stated that progress in reducing maternal mortality in most countries was gradual and varied, with inequalities both within and between developing nations. Potts et al. (2010a) believed that progress regarding the goal of a skilled attendant at each birth was also slow, with an estimated 45 million women still birthing without trained health professionals every year. There were articles praising the effectiveness of participatory women's groups in reducing maternal mortality (Azad et al. 2010; Tripathy et al. 2010) and others supporting more research on community-based interventions as a way to help reduce the number of maternal deaths (Bhutta & Lassi, 2010; Gülmezoglu & Souza, 2010). However, it was to be an article published mid-year by Abdool-Karim et al. (2010) that was to highlight yet another prevalent and underreported addition to the risk of dying in childbirth, those women infected with HIV/AIDS. Abdool-Karim and colleagues reported that the two most prolific causes of death amongst women of childbearing age were HIV/AIDs and complications associated with pregnancy, labour and birth, and that HIV infection rates amongst young women were steadily rising in many countries throughout the developing world.

There was further discussion around the use of Misoprostol to prevent PPH. Potts et al. (2010b) called for more accurate guidance on the best use of the drug in the community. They described the WHO's statement that, "Although WHO does not condemn community distribution of Misoprostol during pregnancy, WHO does not recommend such practice", as irresponsible at best, and called on the World Bank and the International Federation of Gynaecology and Obstetrics (FIGO) to produce clear and undisputed evidence-based guidelines on the best way to care for the estimated 45 million childbearing women who give birth unattended (Potts et. al., 2010b).

Papers published by Ronsmans et al. (2010) and Yusuf and Atrash (2010) highlighted the flow on effect of maternal death and the subsequent survival chances of the children left behind. Ronsmans et al. (2010) proved the most powerful, indicating that the chance of a child surviving to their 10th birthday was just 24 percent if their mother died during that period. The contrast was staggering with that statistic changing to 89 percent if their mother

survived her childbearing years (Ronsmans et al., 2010). The most crucial age appeared to be children aged 2 to 5 months who likely were at most risk due to no longer being able to access their mother's milk (Ronsmans et al., 2010). Of note, was the effect of a father's death on children which was considered negligible (Ronsmans et al., 2010).

Maternal Health Research Priorities – 2011

After a year in which The Lancet heavily focused on maternal health research, 2011 resulted in just seven related published articles. Acuin et al. (2011) introduced a paper looking at the state of maternal and child health in Southeast Asia. They suggested that while much of Southeast Asia has managed a sustainable reduction in maternal deaths since 1990, progress had been uneven both within and between countries (Acuin et al., 2011). While many countries in the region including Singapore, Malaysia, and Brunei were on target to meet MDG5, others such as Laos, Cambodia, Indonesia, and the Philippines were lagging far behind (Acuin et al., 2011). Acuin et al. proposed greater cooperation between countries if Southeast Asia was to meet MDG5.

Victora et al. (2011) reported that Brazil, while on target to meet the child related MDG targets, was not likely to achieve MDG5 by 2015. While there was much good news in the form of a national health system that had been unified and the targeting of primary health services for those in geographical complex areas, key problems were still proving challenging (Victora et al., 2011). Those included the need to reduce the prevalence of illegal abortion, preterm births, and unnecessary caesarean sections (Victora et al., 2011).

India was also facing challenges meeting its MDG targets (Chatterjee, 2011). The pervasiveness of child marriage was a contributor to the country's high maternal mortality ratio, with both morbidity and mortality extremely high amongst young teenage girls. Danger in giving birth was largely due to the immaturity of their reproductive organs (Chatterjee, 2011). Chatterjee (2011) reported that recent steps to take a stand against child marriage had proven highly successful in areas such as Andhra Pradesh.

An article by Thapa and Koirala (2011), highlighted the issue of insufficient skilled health workers in India, the Caribbean, and Sub-Saharan Africa, with many leaving for lucrative positions in the US, Britain, Canada, and Australia; and proposed the idea of paramedics taking the place of doctors in the interim. Another paper by Frøen et al. (2011) looked at the close link between stillbirths and maternal mortality, citing that mothers who deliver

stillborn babies often face unbearable shame and may be ostracised from their communities. Frøen et al. (2011) called for more education at community level to reduce the stigma associated with stillbirth and to denounce the theory that a woman produces a stillborn baby because she has either sinned or is possessed by evil spirits. They stated that more education is required for health professionals around key health initiatives that aid in the prevention of stillbirths (Frøen et al., 2011).

Maternal Health Research Priorities – 2012

Research presented in The Lancet in 2012 on maternal health, centred predominantly on how maternal deaths could best be averted. Ahmed et al. (2012), and Gilmore and Gebreyesus (2012), suggested that the use of contraception was key to cutting the number of maternal deaths by half. Carr et al. (2012) agreed, believing that many lives could be saved by allowing women the choice to plan and space their pregnancies, whilst also being given the opportunity to place a limit on the number of children they birthed. Such a proposal was not without political and traditional/religious complications in terms of its implementation, but strong political will had been seen in countries such as Rwanda, Ethiopia, and Indonesia (Carr et al., 2012). It has been estimated that making voluntary contraception accessible to all in developing nations could reduce the costs associated with maternal health care by many millions of dollars (The Lancet, 2012).

As 2015 and the deadline for the MDGs neared, concerns around the number of developing nations expected to reach the targets of MDG5 was growing. Bhutta and Chopra (2012) reflected on a recently released Countdown report that estimated only 9 of the 75 countries were expected to meet the maternal mortality target. Hsu et al. (2012) added to the sobering news with their research findings detecting a marked slowdown in aid funding. Both Hsu et al. (2012) and Bhutta and Chopra (2012), asked for more accountability in donor tracking to ensure aid was reaching those that needed it the most. Presern et al. (2012) added weight to voiced concerns, calling for an independent Commission on Information and Accountability to assess whether donor commitments were being carried through and actual progress was being made on the ground.

Other papers of interest include Chiu's (2012) report on the Philippines where there was groundswell of support for a bill on reproductive health to allow contraceptives to be widely distributed throughout the country. Rather than decreasing, the maternal mortality ratio in the Philippines was tracking upwards (Chiu, 2012). While there was strong

government support for the bill, the Catholic Church, a dominant voice in the Philippines, registered its extreme disapproval (Chiu, 2012). It was an altogether different picture in Indonesia, a predominantly Muslim country, with its President Susilo Bambang Yudhoyono an international advocate for women's health and the MDGs (Webster, 2012). He appointed a Director of Maternal Health to fast track initiatives in a final push towards meeting its MDG5 obligations by 2015 (Webster, 2012). As a side note, Yudhoyono had been tasked, alongside the UK's David Cameron and Liberia's Ellen Johnson Sirleaf, with, "forging a new global development roadmap to replace the Millennium Development Goals (MDGs) when they expire in 2015" (Webster, 2012, p. 1981). This is the first we hear of active planning post the MDG era and a quiet reluctance to admit that many developing nations were unlikely to meet the lofty goals of MDG5.

Maternal Health Research Priorities – 2013

The main theme running through the scholarship presented in The Lancet in 2013 is the failure of most developing countries to meet MDG5 by 2015 and what to do next. An abundant group of maternal health advocates held meetings throughout the year, most notably in Tanzania and Kuala Lumpur (Langer et al., 2013; The Lancet, 2013). In Tanzania, the message was that individual countries, not donors, should take ownership and lead the way forward in setting a new maternal health framework for the post 2015 era. Any new framework must have women's rights and their voices at its forefront, and focus on tackling maternal morbidity as well as the mortality of childbearing women (Langer et al., 2013). There was no coincidence about Kuala Lumpur being awarded the chance to host the third global Women Deliver Conference in May of 2013. Malaysia had been one of the few success stories of the MDG era with a 65 percent reduction in maternal deaths reported (The Lancet, 2013). UNICEF also released its 'Surviving the First Day' State of the World's Mothers report in 2013. Predominantly infant focused, the report looked at the fate of one million children who died the day they were born, indicating, once again, that when women's health is not prioritised, their children will not likely survive (The Lancet, 2013).

Articles focused on the state of maternal mortality in Pakistan and Sub Saharan Africa make for grim reading (Myer, 2013; Bhutta et al., 2013), highlighting a comprehensive dearth of progress as many women continued to die in childbirth in record numbers despite interventions. The common denominator appeared to be a lack of women's agency in both areas, a fact also raised by Grépin and Klugman (2013) as a common reason for a stalling

in the reduction of maternal deaths. By way of contrast, Chowdhury et al. (2013) presented the paradox that is Bangladesh. Held in high regard as a leading performer in the reduction of maternal mortality, it still retained a high ratio of maternal morbidity, maternal malnutrition, and low uptake of maternal health services (Chowdhury et al. 2013).

What appeared to be proving successful across multiple settings in many developing countries was the addition of women's groups (Chowdhury et al., 2013; Kirkwood & Bahl, 2013; Lewycka et al., 2013; Prost et al., 2013). Countries such as Malawi, Bangladesh, India, and Nepal all trialled the use of women's groups to actively work in their communities to educate and support childbearing women with a home-based approach (Prost et al., 2013). The results were encouraging. An uptake in maternal health care services in those communities lead to the hope that women's groups could be a cost effective solution in helping to reduce maternal deaths, particularly in settings where resources are scarce.

2013 also saw the introduction of articles focusing on the state of maternal health in conflict settings. Webster (2013) highlighted the difficulty facing childbearing women in post-war Iraq. Sectarian violence was still rife with health professionals an easy target. As a result, 70 percent of specialist health professionals who practiced in Iraq, prior to the war beginning, had since left, with those remaining, working in constant fear for their lives (Webster, 2013). As a result, maternal health had been neglected and the maternal mortality rate remained stagnant.

Maternal Health Research Priorities – 2014

With just one year remaining until the MDG5 goal of reducing maternal mortality by 75 percent needed to be achieved, 2014 saw more high praise for Bangladesh and its efforts in reducing maternal deaths—being one of only nine countries on track to meet MDG5 (El Arifeen et al., 2014). Also receiving high praise was China, who had already met the target of MDG4 and was certain to meet MDG5 (Xi et al., 2014). While the dramatic results in both maternal and child mortality should be applauded, You et al. (2014) asked for that excitement to be tempered. They questioned the level of underreporting of maternal deaths, and the substantial financial inducement given to women who birth in a hospital setting (You et al., 2014). Caesarean section rates were also on the rise in a country where meeting targets set by the government around the MMR was met with either punishment or reward (You et al., 2014).

It seems confusion around the exact number of maternal deaths was not restricted to China alone. WHO and the Global Burden of Disease (GBD) more or less agreed on the estimation of maternal mortality globally in 2013; yet, the numbers of maternal deaths of their over 20,000 collaborations differed by as much as 20 percent that year and, hence, led to differing narratives about progress made toward MDG5 (Kassebaum et al., 2014). Kassebaum et al. (2014) condemned the WHO for their misclassification of deaths and wide underreporting, which they believed showed a lack of accountability. Gerland et al. (2014) challenged Kassebaum and colleagues and disputed the scholars' suggestion that in the 20 years between 1990 and 2010, maternal deaths had fallen far less precipitously than the UN agencies had been reporting. These authors stated the UN had done its best with data gathering under very trying circumstances (Gerland et al., 2014).

There were articles touching on subjects such as the demand for more blood banks and obstetric services to be made available in future maternal health frameworks (Dare et al., 2014); the role of private providers to accelerate the reduction in maternal mortality (Agrawal et al., 2014); and the need to "apply a social lens to assessing improvements in health outcomes" (Graham & Witter, 2014, p. 933). Garcia-Moreno et al. (2015), in their paper *Addressing violence against women: A call to action*, implored those developing the post MDG agenda to prioritise actions that ensure the safety of women and girls, and to deconstruct political and social systems that "subordinate women" (p. 1685). But it was to be the introduction of a series in The Lancet specifically related to midwifery that was to prove most interesting. It was the first time in five years since the MDGs called for more skilled health professionals with midwifery skills, that midwifery leaders were given a voice in The Lancet.

The first paper in the series, by Renfrew et al. (2014), supported a shift in focus from the medical causes of maternal mortality to that of skilled care for childbearing women. They firmly believed that such skilled care should initially come from midwives, with access to emergency obstetric care when required (Renfrew et al., 2014). Such interdisciplinary cooperation was vital across all settings, be that in the community or within health facilities (Renfrew et al., 2014). In the second paper of the series, Homer et al. (2014) discussed the important place midwifery holds in the chain of survival for childbearing women. They stated that good midwifery care on its own could improve the global survival rate of childbearing by as much as 30 percent, with a further 30 percent reduction in maternal

deaths if midwives had the ability to refer to specialist care when needed (Homer et al., 2014).

The third paper in the Midwifery Series, was presented by Van Lerberghe et al. (2014), who focused on the experience of low and middle income countries that used a midwifery model in an attempt to improve maternal health outcomes. Such benefits included an increased uptake of women birthing in facilities and increase in the number of the midwives being trained (Lerberghe et al., 2014). ten Hoope-Bender et al. (2014) lead the final paper with recognition of the cost-effective and sustainable nature of midwifery, and how they should be prioritised in all national health plans moving forward. Also touted was the notion that midwives welcome consultation with both women and their communities as to how best to serve them moving forward (ten Hoope-Bender et al., 2014).

The last word was given to The Lancet editor Richard Horton and his colleague Olaya Astudillo who stated:

> Midwifery is commonly misunderstood… the evidence presented in this Series could avert more than 80% of maternal and newborn deaths… Midwifery therefore has a pivotal, yet widely neglected, part to play in accelerating progress to end preventable mortality of women and children. (Horton & Astudillo, 2014, p. 1075)

Maternal Health Research Priorities – 2015

2015 was the year of the MDGs post-mortem, although much regarding MDG5 had already been dissected in previous years when it was clear the targets were not going to be met. In its place, the UN Sustainable Development Goals (SDGs) were created; with their 17 goals, 169 targets and 230 indicators all needing to be met by 2030 (Maternal Health Task Force, n.d.). The WHO published a report in February 2015 titled *Strategies toward ending preventable maternal mortality (EPMM),* with the intention of using a human rights based methodology to the SDG targets and goals in an attempt to eradicate any inequities that prevent access to quality health care for childbearing women (Maternal Health Task Force, n.d.). The EPMM targets include the global target of reducing the MMR to less than 70 maternal deaths per 100,000 live births; national targets encouraging countries to reduce their MMR, from 2010, by a minimum of two thirds; and the ultimate goal of no country having an MMR more than 140 maternal deaths per 100,000 live births by 2030 (Maternal Health Task Force, n.d.).

The leading maternal health article to appear in The Lancet that year was by Alkema et al. (2016), who were the first to declare defeat, stating that the global maternal mortality ratio fell well short of the MDG declared 75 percent reduction. Their data stemmed from 171 of the 183 countries targeted and resulted in a mere 43.9 percent decline in the maternal mortality ratio (Alkema et al., 2016). Alkema et al. (2016) projected that progress would need to be greatly accelerated if the SDG targets are to be met.

Victora et al. (2016) reminded us that the majority of the 75 high priority countries failed to meet MDG5; while Powell-Jackson et al. (2015), once again, heaped praise on China, believing that while there is variation in the reduction of the MMR between provinces, China is to be commended for their overall drop in the MMR from 66 deaths per 100,000 in 1996 to 14 deaths per 100, 000 in 2013. Melinda Gates (2015) reminded the world that for a global sustainable agenda to be effective, more women have to become agents of change; while Langer et al. (2015) agreed, calling for more recognition of women by ensuring their basic human rights around maternal health and gender equality are met.

Conclusion

The journal articles presented in this literature review were a small snapshot of the thousands of journal articles published during the MDG era. The purpose of this chapter, and the one preceding, was to provide historical evidence to set the scene for the data analysis to come. It is important to remember that the participants in this thesis were active in seeking to reduce maternal mortality during the period 1990 to 2013 when interviews concluded. This was the horizon with which they entered the discussion and, as such, contributed to the lens through which they viewed maternal health and their efforts in trying to reduce the numbers of women dying in childbirth. As the literature reveals, while there were noble intentions, significantly reducing maternal mortality proved an ongoing and complex challenge.

In preparing these two literature reviews I was reminded of how, as words on paper, maternal mortality when reduced to academic accounts of statistics, policies, commentary and medical facts succumbs to losing its human edge. Somehow, through academic and political prose the true horror of women dying in childbirth, appears to wash from the page. Everything becomes matter-of-fact. Therein lies the dilemma for an academic researcher as to how best present this research so that those who read it can position themselves, both as an academic and as a human, in the environment that the participants are working in, as

well as truly ‘seeing’ the invisible faces of the women whose lives will be told in the stories relayed in the data chapters that follow.

Prior to reading Chapter Four, that introduces the philosophical underpinnings and methodology of this thesis, I invite you to visit the work of Lynsey Addario (2010), a photographer who travelled to Sierra Leone (one of the countries with the worst maternal mortality ratio in the world) to photograph women and their childbearing journeys. Her photo/video story—*The Story of Mamma Seesay*—reminded me of own similar experience in Senegal, and further sparked my desire to write this thesis. To watch *The Story of Mamma Seesay* visit https://time.com/3774896/the-story-of-mamma/

Chapter Four: Philosophical Underpinnings and Methodology

Unlike seeing, where one can look away, one cannot 'hear away' but must listen... hearing implies already belonging together in such a manner that one is claimed by what is being said.

Hans-Georg Gadamer (1994 p. 35)

Introduction

Stumbling through a methodological maze of theoretical perspectives and epistemological stances, the world of philosophy can appear somewhat daunting for a neophyte researcher. Equally challenging, is locating a philosophical paradigm that can ensure that the previously unheard voices of the participants are truly articulated; and, in so doing, illuminate the plight of the women for whom they care. At the heart of this research lies the many childbearing women who die trying to bring new life into the world. With intention, this research seeks to gain richer understanding of maternal mortality across a breadth of developing nations, in an attempt to bring to light the areas that are working well in reducing maternal mortality, and to highlight the areas that are not. Through the lived experience of the participants, this research also seeks to uncover what is shaping why some communities are successful at reducing maternal mortality and others are not.

Hermeneutics – Uncovering the Lived Experience

Phenomenology is both a philosophy and a research method that explores and describes everyday experiences in order to generate and enhance the meaning of what it is to be human (Caelli, 2001; Koch, 1999; Smythe 1997). Hermeneutics umbrellas that approach. As Crowe (2006) explained, "Hermeneutics is the lived experience of the lived experience" (p. 26). It is a process by which we attempt to render something clear that appears unclear (Crowe, 2006). While there are many philosophers who are informed by hermeneutics, I have been influenced, most particularly, by the work of Hans-Georg Gadamer. His writings appeal because he is determined to ensure that thinking remains practical (Phillips, 2007). To address all of Gadamer's philosophical notions would be an enormous task—one outside the scope of this thesis. It is, therefore, those notions that I feel are most pertinent to helping uncover or make sense of my participants' experiences that I have chosen to discuss.

Tradition

As I ponder the adoption of Gadamerian hermeneutics to assist me in understanding my participants' challenging experiences, I am alerted to his concept of tradition. Hermeneutical experience, according to Gadamer (1989), "is concerned with tradition" (p. 358). It is Gadamer's idea that understanding is always influenced by the tradition in which we are historically located or, rather, the existing history, language, and culture that we are thrown into (Phillips, 2007). For Gadamer, the idea that we can set aside our own cultural 'way-of-being' to embrace a timeless truth is pure modernist fiction (Lawn, 2006). New understanding, Gadamer (2004) suggested, is always tinged with the past or tradition that we bring forth with us, and we would be naive to assume that we can fully embrace another's culture without drawing from our prior experiences. Gadamer takes tradition to be a part of the background to our engagement with the world. It can never find a point outside it to test its validity (Lawn, 2006). Gadamer (1976) also adhered to the fact that tradition does not exist of its own volition, it needs to be "affirmed, embraced and cultivated" (p. 250).

Understanding is brought to the fore when we are attracted to something or it interests us (Gadamer, 2004). It is tradition that influences our attitudes towards this 'thing', and it must be taken as a legacy which does not necessarily need to be analysed in advance, but just 'is' (Roy & Starosta, 2001). Gadamer also believed we would be wrong to look on tradition as being in stasis as we have the ability to change it regularly (Roy & Starosta, 2001). It is not, therefore, a question of being fixed content in the tradition; rather, content which changes meaning over generations (Gadamer, 2004; Grondin, 2003). It is here, Gadamer (2004) added, that understanding is not grounded in tradition, but what he viewed as the basis of all understanding, prejudice.

Prejudice

There is no doubting that the expatriate aid workers in this study began their work in developing countries with a mind full of prejudice. The media's portrayal of the countries in which they were to work, the various cultures and ethnicities that dominate the population in their chosen destination, their experience as health workers in their home country, and their constructed knowledge of that health profession, all situated them within a certain pre-judgement of what they were going to face. Add to that their many personal

and professional traditions, and a constructed pre-understanding emerged of what preparing for, and carrying through with, their aid work was going to be like. But Gadamer's priority is not to see prejudice wholly as a negative term; instead, he asked us to differentiate between the 'false prejudices' that preclude us from discovering new and different understandings, and the 'true prejudices' that encourage us to expand our horizon and further develop our understanding of a situation (Spence, 2001). Indeed, it is Gadamer's (1996) wish that we remain open to the "hidden prejudices that make us deaf to what speaks [through] tradition" (p. 270). Not only does he ask us to explore the origin of our prejudices, but he also encourages us to consider other concealed prejudices, and the potential for our understanding to grow and change. Doing so, Gadamer believed will bring to light the nature by which prejudice informs our practice (Spence, 2001).

Pondering the scholarship of Spence (2001), further cemented my desire to use Gadamer to help unpack my participants' individual journeys as she, in her writings, makes his theories relevant to health care practice. She alerted me to the many 'true' prejudices inherent in the practice of a health professional such as the philosophies of "caring, respect and justice for others, 'being there' or advocating for and 'coming to know' the [woman and her whanau]" (Spence, 2001, p. 626), as well as those that may hinder the development of new understanding such as, "stereotypical expectations of cultural groups, belief in the superiority of Western medicine and a lack of willingness to question existing beliefs and practices" (Spence, 2001, p. 626). But in embracing our many prejudices, Gadamer sounded a warning. He strongly suggested that we not make the mistake of trying to place ourselves in the lifeworld of 'other' (Lampert, 1997). Gadamer (2004) explained, "The person to my left can see further to the left horizon than I can see, but I can see further to the right. At no point do I step into her shoes and see what she sees" (p. 303). Rather than assimilating to the point of view of the 'other', Gadamer suggested that by interpreting what they say, I will extend my horizon further which will lead me to a greater understanding of the world we both share. It is here, that Gadamer's hermeneutic circle and fusion of horizons notions come into play, "Like any experience, cultural experience is a directed movement towards expanding interpretation, a 'fusion of horizons' that meets others interpretations as partners in an interpenetrating dialogue" (Lampert, 1997, p. 356).

Fusion of Horizons

So, if I was to look back toward the beginning of my research journey through Gadamer's eyes, I would see a temporal being situated in a historical horizon influenced by the tradition of my past (Phillips, 2007; Spence, 2001; Walsh, 1996). 'Horizon' is a metaphor used by Gadamer (1976) to represent "the range of vision that includes everything that can be seen from a particular vantage point" (p. 232). Although the beginning and end points may not be clear, one's horizon is never static. Bound by history, horizons are fluid and move with us as our circumstances change (Koch, 1996; Spence, 2005). It is in this shifting of perspectives and reflexive engagement through language and conversation that we can begin to understand things differently (Spence, 2001). A 'fusion of horizons' occurs when one's own horizon is expanded by opening oneself up to the horizon of the 'other'—indeed, the coming together of the differing vantage points (Koch, 1996). Although, as Gadamer is quick to point out, fusion does not result in us ever truly knowing the situation of the 'other'. To do so would be to assimilate to their worldview and thus abandon our own (Gadamer, 2004). Rather, what Gadamer asks of us is to intentionally challenge ourselves by the different or unfamiliar horizon (Koch, 1996). As we open ourselves to this new horizon Gadamer warned us that we must not deny our own historical reality by bracketing out prejudices, standing outside of our horizon or indeed adapting to the worldview of the other, instead we must consciously and steadfastly stand in our own horizon (Phillips, 2007). To be successful, Gadamer (1976) suggested that we adopt a hermeneutic attitude:

> The fusion of horizons is more like a posture, a style, a way of living, or a way of conducting oneself other than it is a way of knowing... [and it] usually results in greater self-understanding, a greater moral awareness, and an appreciation of other vantage points (p. 235).

It is this process of understanding that takes place within a circle that is defined by our horizons (Walsh, 1996).

Hermeneutic Circle

The circle Walsh (1996) alluded to is Gadamer's 'hermeneutic circle'. The idea of the circle refers to the constantly turning movement between one part of a text and its total meaning (Lawn, 2006). In making sense of a fragment of the text, one is always simultaneously interpreting the whole (Lawn, 2006; Walsh 1996). The beauty of the circle is that there is no beginning and no end, meaning that the interpretation inside the circle is always dynamic (Walsh, 1996). Because interpretation is an active process involving the fusion of

horizons, the subject-object distinction commonly found in positivist research becomes meaningless (Walsh, 1996). In the hermeneutic circle one does not remain in the same place, but constantly acquires new knowledge (Gadamer, 1976). As such, the circle is an opportunity for gaining new knowledge. Gadamer (2004) asked that we understand the hermeneutic circle as the context with which we must interpret and reason. Understanding takes place when the prejudices that lead to misunderstanding are filtered through the interplay of the whole and the parts in the hermeneutic circle (Gadamer, 2004). It is not, however, the case that we understand better; rather, that 'we understand in a different way, if we understand at all' (Gadamer, 2004, p. 296).

Dialogic Question and Answer

Thus, as we embrace this new understanding in a circular motion, whilst standing in our tradition and acknowledging our prejudices, Gadamer (1986) said we do so in a dialogical manner of question and answer. He suggested that it is through this dialogue that our preconceptions are at most risk of change. If we do not take the risk, indeed ask the questions, our learning will cease (Gadamer, 1986; Kögler 2014). The two-way dialogical nature of Gadamer's conceptualisation of understanding allows the possibility for both participants to change through the process (Phillips, 2007). It is not just the physical act of a conversation between two parties sharing a common interest or understanding that characterises the term 'dialogue' for Gadamer; rather, "the foundational phenomenon within which objects and themes, subjects and perspectives, and common interest and shared understanding are grounded" (Kögler, 2014, p. 47). Gadamer argued we only really engage in the true act of interpretation when we approach a text or discussion in such a way that we are trying to comprehend or make sense of it (Kögler, 2014). However, to fully acknowledge the other's thinking or beliefs, Gadamer is adamant that our own assumptions must come into play. Only by assessing, appraising, and refining those beliefs will we be better able to understand and acknowledge others (Kögler, 2014). Interpretation is, therefore, this to-and-fro movement, a purposeful rather than random act, that encompasses both what we, as the interpreter feels, coupled with what we sense the other is trying to impart about something important to them (Gadamer, 1989; Kögler, 2014). Here, during the to-and-fro movement, understanding takes shape and the 'truth' is disclosed. It is then that self-transformation, through this uncovering of meaning, can happen. This revelation of meaning can only be brought to light by dialogue; a hermeneutic circle in which prejudices and tradition both influence and become influenced, by subsequent

understanding (Gadamer, 1989). Essentially, Gadamer (1989) highlighted that this is, indeed, a hermeneutic process—what was hidden is brought to light and what was unknown becomes known.

As I entered into this research journey, I was aware that as a New Zealand European midwife, I was seeking to understand the horizons of the many aid workers from around the world, as well as the childbearing women for whom they care. At the same time, as participants in the process, they too were seeking to understand circumstances from their own horizon. Gadamer (1986) suggested that it is the unexpected, the experience of differentness, that leads us to question and, in turn, brings about new understanding. Through this process of dialogue, our preconceptions are challenged and are at risk of being rejected or changed. However, it is crucial that we remain open to hearing the words and meanings of others. To do so, is to become an active participant in the fusion of horizons (Gadamer, 1989).

Overview of Gadamer

Selecting Gadamerian hermeneutic inquiry to unpack this complex cross-cultural journey is highly appropriate, as the philosopher is firm in his view that the fusion of horizons cannot be done through knowledge but, rather, through encounter (Koch, 1999). It is in this participatory aspect of understanding that Gadamer suggested understanding others is inseparable from understanding ourselves (Phillips, 2007). The mystery and gift of Gadamer's fusion theory informs me that everyone is changed by engaging with difference, whether we want to be or not. He professes that we can never presume to know that level of engagement or change that this fusion has on the 'other', all we can know is what happened to us; but, if we do not put our preconceptions, our ideas at risk, we limit our understanding of others and ultimately of ourselves (Gadamer, 2004).

However, while Gadamer's ruminations can ensure a deep understanding of what it means to live as an aid worker actively involved in seeking to reduce maternal mortality, only by simultaneously 'dancing' with the critical paradigm is it possible to uncover how that understanding is being shaped and by whom. The critical paradigm appeals, as its fundamental motive is beyond merely understanding the day-to-day realities and worldviews of the participants in this research, but also to provoke change.

The Critical Potential of Hermeneutics

While Gadamer underscores hermeneutic philosophical thinking, he is no stranger to debate or, as he prefers to call them, 'conversations', with critical theorists, most notably the German philosopher Jürgen Habermas and his French counterpart Jacques Derrida (Kinsella, 2006). The mid-20th century polemics between Gadamerian hermeneutics and the critical theory of Habermas were considered "a landmark in contemporary philosophy of human sciences" (Roberge, 2011, p. 7). To fully illustrate the diatribe between these great philosophers is beyond the scope of this thesis; suffice to say, at the heart of the debate was Habermas' criticism of Gadamer's absolute blind faith in tradition, and Gadamer's defence of his position, claiming that Habermas' ideas "lead to imagining an Archimedean point for both knowledge and critique that cannot rightfully exist" (Roberge, 2011, p. 7). Yet, despite Gadamer and Habermas's ruminations on their differences, there are philosophers whose work is centred on a marriage between hermeneutics and critical theory, believing that whilst looking at the world differently, the two can "interpenetrate each other to form multiple points of convergence" (Roberge, 2011, p. 7). Theorists such as Caputo, Derrida, Gardiner, and Ricoeur looked to broaden what they believed were the constraining confines of hermeneutics (Kinsella, 2006). Gardiner (1992) critiqued Gadamer, believing his hermeneutic theory to be lacking critical acknowledgement of power, most particularly how it can often distort or change the discourse at hand. Caputo (1987) introduced his ideal of a 'radical' hermeneutics', which attempts to blend Heideggerian hermeneutics and Derrida's deconstructionist writing. Here he debated with the critics that believe his approach is somewhat negative and pessimistic, arguing that radical hermeneutics instead holds us accountable for the mess we find ourselves in. Ricoeur (1981) also supported the notion of a critical hermeneutics stating that if you simply tear hermeneutics and critique apart from one another, they will "be no more than ideologies" (p. 307). While these philosophers all gave me pause for thought, it is, above all else, the scholarship of Hans Herbert Kögler and his project of *critical interpretation* that best resonated with me, and whose work I have drawn on to enhance this research.

Kögler's critical hermeneutics

Kögler's project of critical hermeneutics strives to overcome the polarised debate between Gadamer and Habermas. Of utmost importance to Kögler (1999) is the ability to recapture the critical promise that reflexivity holds for practice in the modern world. In his book, *The Power of Dialogue: Critical Hermeneutics after Gadamer and Foucault*, Kögler begs the

question, “How can we take up a critical or reflexive stance toward contexts of meaning and power while acknowledging our own situatedness in those contexts” (Hendrickson, 2004, p. 384)? For Kögler to accept that critical theory is a both a practical and sustainable option, he believed it must first disavow its adversarial conflict between hermeneutic theory based on the self-understanding of agents, and the distanciating approach of discourse analysis (Hendrickson, 2004). Kögler then set about amalgamating the two methodologies—critical theory and hermeneutics—under the title ‘critical hermeneutics’.

He did so firstly by marrying the first-person hermeneutic narrative of the participant with the distanciating viewpoint of the third-person researcher. Kögler’s intention here is to legitimise Gadamer’s stance that a participatory viewpoint is necessary to interpret or uncover meaning, and to lend weight to Michel Foucault’s vision that “speakers are often unaware of how symbolic orders and power practices structure meaning” (Hendrickson, 2004, p. 384). By fusing these hermeneutic and distanciating perspectives, Kögler introduced a fresh approach to reflexivity (Hendrickson, 2004). Kögler (1999) also asserted that it is only by means of a “methodologically undogmatic amalgam of interpretively gleaned insights and conclusions, phenomenological observations and analytically conceived results and arguments” (p. 11), that he believed the “underlying premises of interpretive praxis” (p. 11) can be unearthed and brought forth into our consciousness. This act of unearthing and bringing forth into the light of what would otherwise remain hidden, can best be described in this research as the shaping of understanding and practice in relation to why women are continuing to die in childbirth in unprecedented numbers in developing nations. Kögler proposed that these participants’ stories capture a deep, interpretively garnered and thorough insight into their worldview and, by way of phenomenological reflection, illuminates the worldviews of the childbearing women for whom they are charged with caring. This act of hermeneutic interpretation is further enhanced by a critical analysis that bring forth into consciousness the concealed influences (social practices, power relationships, and structures of domination) that are often times accepted without question yet shape understanding and practice (Kögler, 1999; Lynch, 2006; McAra-Couper, 2007). In other words, while Gadamer gave me the platform to truly hear my participants’ voices and interpret their lived experiences, Kögler has allowed me the space to uncover what was shaping those experiences and, in doing so, better understand the lives of the women those participants are trying to save.

As an additional interpreter of these childbearing women's lives, Kögler (1999) questioned how it is conceivable to adopt a "critical or reflexive space toward contexts of meaning and power while acknowledging our own situatedness in those contexts" (Hendrickson, 2004, p. 384). Indeed, Kögler seeks to make clear how one can be situated in a certain context and lifeworld; yet, simultaneously, be critically observing the fundamental inferences of that context. His answer is situated in the premise that we are only ever able to reflect upon or attain an appreciation of our own background through effective communication with someone with whom we do not share that past (Kögler, 1999; Lynch, 2006).

Kögler's hermeneutic circle

In his project towards critical interpretation, Kögler (1999) pursued a hermeneutic ideal that strives for a distance from that which can be understood, as well as a description of that understanding. At the heart of his critical hermeneutic circle is recognition that, as a researcher, I can gain a reflexive distance from my personal assumptions simply by being open to viewing the ways in which other humans link their everyday encounters in the world to the social norms that represent those experiences (Kögler, 1999). It is indeed a somewhat radical reflection of oneself that encompasses a thorough disentanglement from deeply entrenched ideological systems (Kögler, 1999). It is, as Kögler explained, this act of being able to "lose ourselves in the other's context that enables us to gain distance from our own customary assumptions which is truly necessary for radical self-criticism" (p. 172). Figure 1 assists in illustrating the dialogical interplay between the researcher and the interviewee.

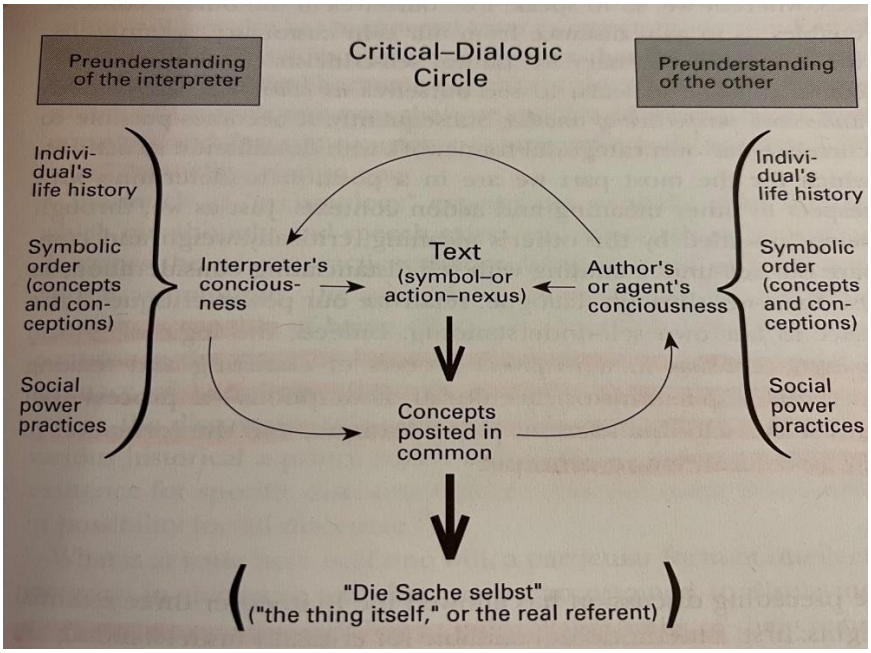

Figure 1. Kögler's Critical-Dialogic Circle (Kögler, 1999, p. 171)

Through this visual representation of his critical-dialogic circle, Kögler (1999) ensured we comprehend that "the logic of critical dialogue consists in a reciprocal process of clarifying and making conscious implicit historical-cultural assumptions – a process that can lead to self-distanciation, power critique, and the formation of new, reflectively aware concepts" (p. 172). To cover all prose written by Kögler with regards to his project of critical interpretation is outside the necessary bounds for this thesis. What I would like to further expand on, however, is his critical hermeneutic discussion with respect to power and domination.

Power

Research that leans towards a critical stance dances with the idea of power. Kögler (1999) is one such philosopher who acknowledged that within our social world, power relationships are numerous and diverse. He described such a society as one that unveils itself via a "multithreaded interpretive framework into which power structures are tightly woven" (Kögler, 1999, p. 232). According to Kögler, a hallmark of critical theory is the complex ways with which power can shape and even dominate our conscious minds. Kögler strongly believed that before any critical analysis can take place, a researcher must familiarise themselves with the deep-rooted relationship between the notions of dominance, power, and freedom.

Affirming the work of Michel Foucault before him, Kögler (1999) stated that power can only ever be exerted over a person who is 'free'. He reiterated that power and domination are separate entities, and those who do not enjoy freedom are, in turn, dominated (Kögler, 1999). For a power relationship to be free from dominance, it must be able to be reversed and possess a natural fluidity (Kögler, 1999). Kögler asserted that power, rather than being the property of one person, faction, or societal entity, instead flows existentially between them all. The nature of this research is such that a dialogical relationship between the participant and the researcher needed to ensure that equity of power. As the interviewer, I needed to feel free to question the participant about any aspect in relation to their experience of working for an aid agency and with childbearing women in a developing world setting. Equally, it was important that the participant was situated in a way that they held equitable power to answer such questions (or not), free from any form of coercion or domination. Had the questions been asked in a room with the head of their aid agency or the leader of the community they were working with present, Kögler's writing suggests that it would be difficult for both myself and the participant to be truly free from dominant influence.

In an attempt to distinguish between power, domination, and freedom, Kögler (1999) suggested a space where "a hermeneutic critique of power situates itself with respect to social contexts" (p. 235). It is here that Kögler presents the notion of resistance. He indicated that resistance is acquired when dominating power practices lead to a battle for freedom (Kögler, 1999). Kögler informed us that to truly understand how an individual's self-understanding is shaped, we must first acknowledge the influences and conditions that constrain them, leading them to become unfilled and stagnant.

It is here that Kögler (1999) expressed that critique, in a hermeneutic framework, is not merely about the analysis of power influences at play, but allows for understanding and the holding of space for another agent, whilst recognising that agent as being "ontologically equal" (p. 108). By doing so, Kögler recognised that any given society comprises scores of agents with differing and often times conflicting realities; yet, each should be regarded as important as the other. He suggested that by creating an "archaeology of their self-understandings and a genealogy of their related power practices", symbolic orders influencing an agent either by social or cultural means can be uncovered allowing for the potential of "a space for reflection and action over against established interpretations and structures of domination" (Kögler, 1999, p. 239). It is only then, as agents engage in this

new and unfamiliar pathway of self-discovery, that critical hermeneutics can assist them in combating the structures of power that have effectively held them hostage until now. It is worthy to note that Kögler (1999) does not view power as altogether negative, but noted that, "power prevents human existence from corresponding to its own self-understanding" (p. 244).

Relationship of power

Kögler (1999) rendered power relationships as fractious confrontations between two agents with opposing points of view, each vying for their interests to be prioritised. These power relationships have the potential to be reversible insofar that they do not possess "a priori fixed structure of causality" (Kögler, 1999, p. 235). However, it is wholly possible that an agent within that relationship views their reality as ontologically impossible to change, when in fact their way of being in the world has been influenced by "symbolic world disclosures that paradoxically attempt to do away with the dimension of reversibility… by establishing a firmly united world picture that joins together reality and social hierarchy" (Kögler, 1999, p. 236). For Kögler, it is crucial that any research method that seeks to uncover what is shaping the practice and understanding of its participants, does so from a place that belies any irreversible power practices. Therefore, it is the implicit intention of Kögler's critical interpretation, which begins from a place of conflict between structures of power and the agent's understanding of self, to encourage the deconstruction of their power-ridden identity and to allow an "opening up of possibilities for reflexive self-determination and self-empowerment (p. 243). This is the precise instant when that which is shaped, and those involved in the shaping, are laid bare to expose the power relationships influencing understanding.

For the participants to feel free to speak their truth during the research process, all possible structures of power that could interfere with that freedom of speech needed to be identified and counteracted. All participants in this research remained anonymous, both to the reader and to each other. My presence in-country was predominantly under the guise of a volunteer, or as a conference attendee, so as not to draw wider attention to my purpose as an asker of questions that certain structures of power may not wish answered.

Domination

Kögler (1999) explained that an agent may not always be aware that they are in a dominant power relationship. He stated that often agents are shaped by certain rituals, beliefs, or practices that serve the interests of a specific faction (Kögler, 1999). When those rules, beliefs, or practices have a detrimental or constricting effect on the agent, they are no longer deemed to be in a free or fluid power relationship (Kögler, 1999). These structures of domination are, in the main, socially constructed so as to "reproduce themselves through social interactions inasmuch as they turn the individuals through socialization processes, into bearers and producers of these structures" (Kögler, 1999, p. 238). Such shaping by these structures of domination can be rendered subtle, "an authorized understanding of reality which allows them to be seen as legitimate and to appear to correspond to the natural order" (Kögler, 1999, p. 237).

An interesting paradox is that the very hallmark of these dominant power relationships, the influencing and moulding, is the very thing that renders these relationships to have the potential to be reversible (Kögler, 1999). As such, agents can never be fully and completely socialised to any structure of domination that is wholly absolute and cannot be transformed (Kögler, 1999).

This research is two-fold in that it seeks to ensure a safe space, free from dominating influences for the participants to express their reality; yet, it also seeks to uncover, through that truth, what is shaping why so many women are still dying in childbirth in developing countries. It is expected that Kögler's (1999) critical interpretation will allow the shaping of habitualised practice and understanding of what leads to unacceptable rates of maternal mortality in the developing world to be revealed, and assist in unveiling the shapers themselves. This would not otherwise be possible through a purely hermeneutic interpretation alone. Instead, Kögler suggested that when bound within a critical theory context, hermeneutic analysis has as its intention to foster a form of critique that exposes power within both cultural and social milieus. Kögler contended that it is indeed the task of critical hermeneutics to reveal "the conceptual and methodological space in which an interpretive practice of critical self-reflection can be most completely and productively achieved" (p. 254). He reminded us that we must accept that no interpretation is unflawed because, as researchers, we are bound by the social context and theoretical construction of our own lifeworld (Kögler, 1999).

Conclusion

This study holds at its core the phenomenological learnings of Hans-Georg Gadamer, and at times dances with Hans-Herbert Kögler's critical interpretation. This marriage of two philosophical powerhouses, one a student of the other, is done so as to best answer the research question that seeks to uncover what is shaping why women are continuing to die in childbirth in developing countries in such unprecedented numbers. As explained previously, much has been researched on the topic from the quantitative paradigm, but very little of the experience and understanding of what was happening to these women has been addressed in the qualitative realm. This research seeks to put that to right with the hermeneutic guidance of Gadamer and through the critical hermeneutic insights of Kögler.

The following chapter outlines the process by which new insights and fresh understandings were obtained.

Chapter Five: Methods

A phenomenological description is always one interpretation, and no single interpretation of human experience will ever exhaust the possibility of yet another complementary, or even richer or deeper description.

van Manen (1990, p. 31)

Introduction

Hermeneutic phenomenology provides the philosophical underpinnings for a research method that explores and describes everyday experiences in order to generate and enhance the understanding of what it means to be human (Caelli, 2001; Grant & Giddings, 202; Koch 1999; Smythe, 1997). Hermeneutic phenomenology offers us a way of viewing ourselves, others, and everything else that comes in contact with our lives. It provides an approach in which experience, reflection, and ideas can come together and make sense to the individual (Caelli, 2001; Smythe, 1997). There are those who refrain from using the term 'method' when discussing hermeneutic phenomenology, preferring to see such an approach as nothing more or less than a considered attentiveness to what it is to be human in the lived world (Heidegger, 1962; van Manen, 1990). Gadamer (1989) also preferred to avoid the structure and procedure that 'method' presupposes; viewing hermeneutic phenomenology as a vehicle which illuminates the circumstances in which understanding occurs. Gadamer stopped short of declaring the term 'method' invalid. Instead, he asked that when using hermeneutic phenomenology, it remains congruent to the philosophical underpinnings of the study. Van Manen (2006) agreed, adding that "genuine phenomenological method consists in creating one's path, not following a path" (p. 720).

Gadamer (1989) inferred that hermeneutic phenomenology generates a prose from our experience of *being-in-the-world*. This experience of 'being-in-the-world' brings forth our research question and the desire to express and explore it hermeneutically. Part of my *being-in-the-world,* prior to undertaking this research, involved my experience as a short-term midwifery intern in a developing country, experiencing the complexities involved in providing a robust maternal-child health service, and trying to ensure the safety and well-being of the women in my care. It also involved my daily life as a midwife in New Zealand with similar expectations. Throughout this research journey I had the privilege of accompanying a handful of study participants during their daily routine in some of the most

challenging environments. These experiences furthered my own horizon as to what it is to bear witness to childbearing women in the most precarious of circumstances, and illuminated the aid workers' words, assisting in a more profound interpretation of being in *their* world.

As discussed in the previous chapter, I chose the work of Hans Herbert Kögler and his theory of critical interpretation, most particularly because Kögler's work builds on Gadamer's hermeneutics, marrying it with Michel Foucault's work on the relationship between power and knowledge and how they are used as a form of social control (Kögler, 1999). Kögler (1999) presented the case for a middle ground between Gadamer's concept of interpretation as dialogue, and Foucault's theory of the structure of discourse and the practices of power. I felt that Kögler's critical interpretation offered an insightful perspective on the influence of prejudice and cultural background on systematic interpretation, and the importance of understanding the 'other' without assimilating their otherness. Kögler focused on the conditions through which meaning is constructed so that those things that unconsciously shape the participants' understanding and practice are revealed or made visible.

Thus said, I was strongly committed to first letting the stories be heard in the manner that the participants themselves chose to tell them; therefore, the dominant guiding approach is hermeneutic rather than explicitly critical. There is, however, movement within the process of data analysis between the two philosophical approaches when deemed justified.

Ethical Considerations

Ethics in research can be considered as the degree to which the research conforms to moral standards, including issues related to professional, legal, and social accountability. Any participant involved in research is entitled to confidentiality, voluntary participation, informed consent, and protection against harm (Cluett & Bluff, 2006).

It is acknowledged that many of the developing countries pertinent to this research do not have robust ethics committees such as that of New Zealand; therefore, it was important that this research met the stringent standards held by the AUT University's Ethics Committee (AUTEC) both for best practice and the protection of the participants. Obtaining ethics approval proved challenging with the AUTEC Committee wanting further clarification as to how the participants, and the childbearing women whose stories they were telling, would

best be protected throughout the interviewing and writing up process. I met with AUTEC's Kaitohutohu Matatika Rangahau (Research Ethics Advisor) to seek further guidance. Consultation with one current and one former New Zealand aid worker active in the field of maternal health also took place prior to, and during, the design phase of this study. There was an unanimous desire by both to protect the aid workers and any individual country within this research. Thus, it was decided that participants should be expatriate to the countries they were discussing, and that involving a wide range of countries and aid organisations would provide greater protection from what could be insights of a political nature. It was also strongly suggested by the aid workers, that better representation across aid agencies would be obtained if the aid workers were guaranteed anonymity and all reference to their location was kept confidential. Having satisfied this criteria, ethics approval was granted (Appendix A).

It is important to understand that the analysis of this study does not focus on specific countries; rather, issues generic to the developing world. Many of the participants have worked in multiple countries and drew on their experiences of working in the maternal-child health field in several different countries. This is, therefore, a global study related to no one place.

Voluntary participation and informed consent

Both the design and practice of this research process is consistent with the principles of Aotearoa New Zealand's te Tiriti O Waitangi, namely the principles of partnership, participation, and protection. Participants were invited to partake in the study via an information sheet (Appendix B) that contained adequate information about the study, its risks and benefits, and what the participant's involvement would require. Participants were then made aware of the purpose and aims of the study, and how the data were to be collected. Those participants had the opportunity to ask questions prior to signing the consent form (Appendix C), and were informed that they had the right to withdraw from the study at any time prior to the completion of data collection.

Minimisation of harm

Participants in this research were asked to open up about their experiences of working in the developing world as an aid worker in the field of maternal-child health care, with a particular focus on the issue of maternal mortality. It was acknowledged that, due to the subject content of this research, much of the material would be of an extremely sensitive

nature, especially pertaining to the topic of women dying as a result of pregnancy or childbirth and could be potentially distressing for the participant. Counselling support was made available to participants during and after the interview process. It was also recognised that an aid worker put forward by their organisation may have felt uncomfortable discussing political or organisational complexities of their work, due to the perception that they could potentially be identified by their employer. All efforts were made to ensure their privacy was protected at all times.

Confidentiality

Due to the sensitive nature of this study, confidentiality was a priority. To protect their identity, participants were assigned a number only. While assigning pseudonyms for participants is more congruent to qualitative research, to ensure each participant was provided the highest level of confidentiality in this research, it was important that they could not be identified by gender or ethnicity. A participant number was, therefore, the safest option. While I would have liked to have promised the participants the possibility of anonymity, there are questions about the likelihood of keeping a participant truly anonymous as Saunders et al. (2015) explained,

> Anonymity cannot be completely guaranteed. It can be subverted from different directions, not least because of the major challenges to anonymity linked to the rapid changes we are seeing in the data available on the world wide web, and associated practices. Particular challenges are posed especially through the increasing use of social media (both by research participants and researchers) and open access publishing of academic work. (p. 629)

Information about each participant was stored in a locked filing cabinet with the information only linked electronically by their participant number. No information that could identify an individual participant has been used in any research reports. It is acknowledged, however, that despite the high level of confidentiality given, the participant may be recognised by a reader who is personally known to the participant.

Whilst conducting the interview, the researcher made it clear that the information being imparted was confidential and that the participant did not have to divulge information with which they were uncomfortable. In addition, the participant was offered the opportunity to

debrief at a later date. The study was monitored by the researcher and supervisors for any significant harm that may be experienced by the participants.

Participants

Participants who have the lived experience being investigated are a key source of data for the phenomenological researcher. It is their verbal, written, and artistic expression of the phenomenon that forms the basis of that data (Baker et al., 1992; Wrathall, 2005). The 28 participants selected for this study were English-speaking aid workers who were currently working, or had worked, in the field of maternal health care in the developing world, with a particular focus on reducing maternal mortality. Participants were expatriates and, therefore, not a national of the country to which their interview data refer. All were, or had been, practising health professionals caring for childbearing women in developing country settings, although some were now in administrative roles. Participants spoke freely on the clear understanding that their contribution to this research would remain anonymous with no identifiable factors i.e. gender, country of origin, agencies worked for nor population that they were working with be released. Participants reiterated that any one of those factors could lead to their identity being exposed.

Hermeneutic phenomenology is well-suited to the purposive sampling used in this study to identify suitable participants. This type of sampling permits the selection of interviewees whose qualities or experiences permit an understanding of the phenomenon in question and is, therefore, invaluable (Cluett & Bluff, 2006). Some participants were already known to the researcher through professional and collegial connections and their contact details were readily accessible. Other recruitment was done via snowballing sampling technique.

Snowball sampling is an effective method of recruiting participants who can often be difficult to locate by more common methods, such as advertising (Noy, 2008). In this technique, participants, once interviewed, suggest other possible participants who may fit the criteria or who they believe would be a crucial voice to be heard in the research data. It is, in effect, a type of chain referral system (Morgan, 1996; Valdez & Kaplan, 1999). Snowball sampling formed a crucial part of this research. It enabled participation of aid workers who were not working for large organisations and, therefore, not so easy to locate by the researcher. Their voices leant a whole new perspective to the issue that had not previously been heard by aid workers working for some of the larger more recognisable agencies.

When conducting phenomenological research, sample size is less important to the researcher than the quality of the data being collected. The phenomenological researcher, instead of reaching saturation, continues until they feel that sufficient stories have been heard (Cluett & Bluff, 2006). As this was a global study, that feeling of 'enough' did not occur until the participant numbers reached close to 30. It is acknowledged that this is a larger number than usual for a PhD study, but to have included fewer participants would have compromised the depth of the global voice.

Data Collection

The phenomenological method embraces a unique approach to data collection because the researcher is the primary study instrument (Fain, 2004). Phenomenology directs the researcher toward an understanding of the self as a person, as well as toward the study participant as a person (Cluett & Bluff, 2006). The data collection issue in phenomenological studies is that it needs to be open to the possible preconceived notions, expectations, and frameworks that could influence the data in any way (Schneider et al., 2007). As a result, questions are broad, open-ended, and designed to avoid influencing the respondents' answers (Baker et al., 1992).

Data for this study were collected via semi-structured interviews conducted either face-to-face, or via Skype. As an experienced journalist, I felt the need to observe the participants' faces and body language throughout the interview. Many participants began the interview often very nervous or untrusting. I felt the importance of being able to engage face-to-face with them so that they were able to gain a truer perception of who I was and feel more at ease. By reading their facial cues, I felt that I could watch for when the participant was relaxed or looked stressed during the interviews which assisted in directing the questions. I witnessed when I could push further and when I needed to pull back. The interviews focused on achieving a full description of the lived experience and continued until there was a sense that any more data would overwhelm the analysis process.

To elicit the stories pertinent to this study, the questions asked were focused on 'lived experience' but moved to a more critical hermeneutic stance of inviting critique. The following were the first-line prompts for the participants:

- Tell me what it is like to be an expatriate aid worker in a developing country in the area of maternal-child health care.
- Focusing on that experience, what is it like to be working on the front-line in the fight to reduce maternal mortality?
- Tell me a story that best illustrates that experience.
- How have you seen the 'aid and political efforts' affect the lives of the people you are caring for?
- Tell me a story that best illustrates that experience.
- Drawing from your experience, what has, in your view, been the impact of 'aid and political efforts' in terms of providing a robust maternal-child health service in the communities you have worked in?
- What are the areas or interventions, from your perspective, that have worked well?
- What are the areas or interventions, from your perspective, that haven't worked well?
- From your experience, what gets in the way of making things work well?
- From your experience, what supports aid and political initiatives to make them effective?

These questions were used primarily as core prompts for discussion; but, as each interview progressed, the questioning became led more by the participant's answers. Each participant had individualised situations and stories that necessitated a more open approach to questioning. Interviews lasted anywhere from 60-90 minutes in duration, with some limitations such as one interviewee being in a very remote location with constrained satellite time available for the Skype interview.

Transcription Process

The gathering of data for this research was prolonged in that it was conducted over a period of 15 months. This was due to both the availability of myself, as researcher, to travel internationally to conduct interviews, and also the availability of the participants to be interviewed due to the nature of their work. To ensure confidentiality, I decided to transcribe the interviews myself. All data were transcribed verbatim to ensure the whole of the interview was captured. All interview scripts were double-checked against the audio to ensure accuracy.

Due to the time difference between data collection, transcription, and the crafting of data, it was often difficult to locate some of the participants to return transcripts. This was also, in part, due to the transient nature of aid work. Having perused the scholarship of Crowther et al. (2017), Morse (2015), and Sandelowski (1993), a decision was made not to return any scripts, if not all participants could be located. There was also the issue of not quite trusting that the returned transcript would remain only in the participant's hands. However, all participants were encouraged to contact me after the interview if they had second thoughts about what they had said. No participants during the tenure of this thesis, have indicated that they wish to retract any information they supplied during the interview process.

Sandelowski (1993) was the first to challenge the practice of member checking as a form of enhancing rigour in qualitative research. While she acknowledged that such a practice may enhance the idea that checking the reliability of a researcher's interpretation of data is paramount for the validity of said data; paradoxically, she also stated that member checking can undermine the trustworthiness of that data and, indeed, actually prove a threat to its validity (Sandelowski, 1993). Morse (2015) agreed with Sandelowski, stating that "it is not clear why one should provide the participant with such an opportunity to change his or her mind; it is not required in other types of research" (p. 1216). Crowther et al. (2017) further emphasised upon Sandelowski's claim:

> Stories, phrases, words, manners of speech and meanings are not static, they all continue on their own trajectory. What is shared in a conversational interview style may be forgotten or reinterpreted when read later in typed transcripts. Thus, member checking to ensure rigour is not congruent with hermeneutic phenomenology. (p. 16)

While participants were made aware during the interview process that they could request their transcript prior to the publication of this thesis, none chose to do so.

Data Analysis

Working with hermeneutic phenomenological data is more likened to that of an 'event' than a process (Smythe et al., 2007). Rather than reducing the data into a packaged articulate 'product', Heidegger invites us to use it as a tool to enrich our 'thinking' (Smythe et al., 2007). I therefore used his, and other philosophical, writings as a tool to enhance my

ruminating around what it is to be an aid worker in a developing country working in the area of maternal-child health charged with helping reduce maternal mortality.

Gadamer (1989) also reminded us that we "play along" in our process of thinking. Smythe et al. (2007) explained: "To play along is to go with the thoughts that excite, confuse, perplex. It is to let thinking find its own way, to await the insights that emerge" (p. 1392). While van Manen (1990) encouraged the emergence of themes in the data, he asked that themes not be used as a formula for understanding or objectifying experience (Harman, 2007); rather, as "a free act of seeing meaning" (van Manen, 1990, p. 79). To extract a theme from the data in this study is to discover something of meaning, of significance, that can be shared with the reader (Smythe et al., 2007). Rather than subtracting concrete findings, we are encouraged to see the 'finding' in the data as an invitation to the reader to join in playing with the 'thinking' of what such data provokes. It is Smythe et al. (2007) who alerted us to Heidegger's vision that: "The calling [to think] is not a call that has gone by, but one that has gone out and as such is still calling and inviting; it calls even if it makes no sound" (p. 1393). So, in the restless 'toing and froing' movement of the data, we are encouraged to offer up our whole selves in the reading, writing, talking, mulling, re-reading, re-writing of the data and keeping new insights in play; and in dwelling in the data we must trust that new understandings will come.

Crafting Stories

As I continued to work with the data, such was its richness that I struggled long and hard to contain it. It became clear that over 700 pages of raw transcript would not fit into the limited constraints of a PhD thesis; yet, the stories emanating from the data were so powerful and meaningful that I felt them pulling me deeper into their vice each time I revisited the transcripts. It was here I turned to Gadamer and his work on aesthetics to help me discern a clearer way forward.

Gadamer's hermeneutical aesthetics is deeply embedded in the *experience of or encounter with* art, rather than with concept or theory (Palmer, 2001). He believed art is a medium through which *real* subject matters are able to reveal themselves. For Gadamer, any creditable work of art, such as literary work, brings with it a power that can profoundly affect us and do so without warning. His claim that "art has something to say to us, either through the question it awakens or the question it answers" (Palmer, 2001, p. 70), is backed

up by the often surprise and disbelief we feel after an encounter with such a work. We are, therefore, challenged to reflect deeply on its claim; hence, evoking a keener understanding for ourselves and for others who choose to become caught up in its midst. Gadamer also holds in high regard the ability of art to challenge customary and cultural expectations and its blatant provocation of the observer to embrace the 'other' and the 'different' (Palmer, 2001).

In his dialogue of the characteristics that are intrinsic to the nature of aesthetic experience Gadamer stressed the importance of participation, absorption, and perception to understanding the various truths in a work of art. By actively participating in or 'playing' with the aesthetic experience, the observer becomes drawn in, mesmerised and transformed, seeing something of themselves that makes sense, appears true and in turn they come to understand the whole.

> the power of the work of art suddenly tears the person experiencing it out of the context of his life, and yet relates him back to the whole of his existence. In the experience of art is a fullness of meaning that belongs not only to this particular content or object but rather stands for the meaningful whole of life. (Gadamer, 1989, p. 70)

It is through such hermeneutic reflection that a 'fusion of horizons' takes place; our preunderstandings and traditions blending with the new knowledge obtained through our aesthetic experience, eventuating in a new understanding.

By crafting the data into stories or literary art, I was able to ensure a deeper meaning of the aid worker's narrative was illuminated throughout the thesis, while concurrently acknowledging that there is always tension between the idea of 'story' in comparison with the presentation of verbatim data (Crowther et al., 2016). It is this tension, though, that Crowther et al. (2016) argued underpins hermeneutic phenomenology. They remind us that as hermeneutic researchers our intention is to "illuminate essential, yet often forgotten dimensions of human experience in ways that compel attention and provoke further thinking" (Crowther et al., 2016, p. 3). When analysing with such intention, the researcher not only sits delicately within the data to uncover the phenomena, but through the crafting of that data into story form can bring to light ways of being or thinking that may otherwise have remained hidden (Crowther et al., 2016). Such a hermeneutic stance brings with it a fusing of horizons between the participant and the researcher.

Far from tightening up verbatim transcripts, the art of story crafting is to shine a light on what the researcher is experiencing whilst deeply immersed in the data; to offer insights into the human condition and incite deeper thinking (Crowther et al., 2016). As Crowther et al. (2016) so eloquently explained, "the stories do not belong to an individual, once spoken they are shared" (p. 23). This is important to reflect on whilst delving into the rigour of this hermeneutic study.

At first I read the data through a purely hermeneutic lens. I wanted to soak in the lived experience of these aid workers to really get a sense of their worldview. My first reading gave me a clear insight into what the chapters needed to be. Initially I had planned just the three—one purely sharing the stories of women dying through the eyes of the aid worker, one unpacking maternal mortality as a human rights issue, and one looking at the part politics and aid are playing in maintaining the status quo. The more I sat with what I had read, the more I felt a chapter was missing. While I had wanted this thesis to focus on the childbearing women, I was struck by the severity of vicarious trauma that the aid workers faced daily. I had been unaware of just how much stress they dealt with bearing witness to women dying on a daily basis and felt that a chapter honouring that was called for.

It was also clear after that first reading, that a critical eye should be cast over the data. I gave myself a few months break and came back to the crafted data with a fresh approach. I wanted to uncover what was shaping why these women were still dying. As I was unable to speak to women and their families, I had to use the aid worker as the conduit. I set about interpreting the worldview of the aid worker and the woman through the dialogue of the aid worker. Sometimes it was what was unsaid, but that which hinted at an unspoken way-of-being, that spoke the loudest during this process. Using Kögler (2014) and his empathetic critical interpretation, I formulated tables (see Chapter Ten, Discussion), to illuminate the differing worldviews and the key importance of the aid worker in bridging the Western worldview shaped by law and horizon of the childbearing woman fully immersed within her family, culture, religion, and her community; examples of how these tables came into being are located in Appendices E, F, G, and H.

Rigour

What are the hallmarks of a "good" research study and how do we know that what is presented to us is truly "valid"? These and many other challenging questions are

continually debated among seasoned researchers, especially in terms of what constitutes rigour in qualitative research (Davies & Dodd, 2002; Koch, 1996; Sandelowski, 1993; Rolfe, 2006). For the researcher these questions pose quite a dilemma; can qualitative research really be trusted; and, if so, just who is to be believed? In focusing on how the issue of rigour is addressed in terms of this hermeneutic phenomenological research study, I have drawn from the writings of Guba and Lincoln (1989), Koch (1996), Sandelowski (1993), and Davies and Dodd (2002).

While the researchers named above wish to remain faithful to the spirit of qualitative research, they vary in how they evaluate the processes and findings of such research (McAra-Couper, 2007). Guba and Lincoln (1989) offer up the criteria of credibility, transferability, dependability, and confirmability to assess rigour. Koch's (1996) stance is that rigour, or trustworthiness as she prefers to label it, can be established through providing an audit trail of methodological, philosophical, and theoretical decisions; while Sandelowski (1993) believed that 'artfulness' has a place in ensuring sound qualitative research. Davies and Dodd (2002) also presented challenges in relation to rigour, especially in terms of being attentive to the research process. While their opinions may be diverse and confusing for the researcher, what these scholars capture is the complexity of what constitutes a rigorous qualitative research study (McAra-Couper, 2007). The following are key ideas pertinent to establishing rigour in this hermeneutic phenomenological research.

Trustworthiness

In understanding the concept of trustworthiness in hermeneutic research, an idea presented by Koch (1993), I looked first towards home and the writings of Smythe et al. (2007). They believed that it is indeed the researcher who is first to discover the trustworthiness of their study by engaging in discussion with those who share or 'live' their common interest. Smythe et al. claimed that resonance is the hallmark of trustworthiness in a hermeneutic study, and they contested the idea of pre-established criteria. Instead, they invite the reader to arrive at their "own understanding of meaning" and decide themselves on the "accuracy of the phenomenological description" (Smythe et al., 2007, p. 8).

Credibility

Guba and Lincoln (1989) used the term credibility as one of four criteria on which to judge the trustworthiness of this study. The word refers to the 'fit' between the experiences of

the researched and the researcher's representation of them (Bradbury-Jones, 2007). It is the moment when the reader discovers a familiarity in the interpretations of the experience that is presented before them (Koch, 1996). Van Manen (2007) referred to this as 'concreteness' or 'living-thoroughness'; the moment when the "interpretations resonate with the reader's understandings of an embedded lived world" (Water, 2008, p. 106). It has also been described as the moment when the reader identifies the effect such interpretations have on the 'truth' of their own life (Frank, 1995). Such 'truthfulness,' said Heidegger (1962), can unite the researcher and the reader as they come together in seeing things "as they are" (Water, 2008, p. 106); while van Manen (1990) referred to this as the optimal phenomenological nod. It is in seeking this "ah-ha" moment for both the researcher and reader that underlies the intention of this study. Yet, van Manen (1990) asked us to be mindful that ours is only one interpretation and that "full or final descriptions are unattainable" (p. 18).

Audit trail

Sandelowski (1996), Koch (1994), and Rolfe (2006) subscribed to the belief that credibility can be enhanced through the implementation of an audit trail; more specifically, by tracking the many decisions made through the research study. While some researchers dismiss audit trails by stating that simply recording a decision does not identify its quality (Morse et al., 2002), Koch, Rolfe, and Sandelowski stand by their beliefs, stating that if researchers hold up their decisions and interpretations for scrutiny, the reader can then make a 'true' judgement in relation to the quality of the study. A feature of this study was the extensive journal that I kept throughout the process of this research. All decision points, thought processes, actions and influences were thoroughly documented (Appendices E, F, G, H, & I).

Reflexivity

While an audit trail can advance the credibility of a hermeneutical phenomenological study, Davies and Dodd (2002) argued that rigour is simply about being attentive to the research process and making visible the process of research undertaken through "reflection and reflexivity". Herein lays another debate. While some researchers advocate the use of bracketing, or setting aside the researchers own prejudgements, others argue that far from getting in the way of the research, the position, and preunderstandings of the researcher, in

fact, makes it more meaningful (Koch, 1996; McAra-Couper, 2007). After perusing the scholarship, I deemed bracketing as inappropriate for a hermeneutic research approach.

Koch (2006) argued that rigour and reflexivity are synonymous, and that reflective writing develops new ways of thinking, enables creativity or Sandelowski's (1993) "artfulness", and that researchers will learn much from critically analysing their journaled thoughts. Koch comes from the philosophical viewpoint that interpretation is at the heart of all research practices and advocates that the entire research process is a matter for critical reflection. She argued that "if research is well signposted with reflective notes, readers will be able to travel easily through the world of the maker of the story, and decide for themselves whether the research is rigorous" (Koch, 2006, p. 101).

Researchers who adopt such a hermeneutic phenomenological philosophy acknowledge the creative interpretation that they bring to their study and the incorporation of personal prejudice and understanding into the hermeneutic endeavour (Bradbury-Jones, 2007; Maggs-Rapport, 2001). Bradbury-Jones (2007) believed a researcher's subjectivity is "like a garment that cannot be removed and is always present in both our research and non-research life" (p. 203). Davis and Dodd (2002) agreed, in part, with Peskin, in that reflexivity involves reflective self-examination and interrogation of ourselves regarding how the prejudices and paradoxes of our lives are reflected in our research.

Summary

This chapter has captured the 'methods' by which this hermeneutic study was carried out to uncover what is shaping why women are still dying in childbirth at such alarming numbers in many of the world's developing countries. It is simply the 'thinking' and the 'doing' of this research. Throughout this chapter I have explained the methods used and shown their congruence with the methodological and philosophical underpinnings of hermeneutic phenomenology. In the following chapters, I present the many and varied stories of childbearing women from around the globe, as told by the aid workers who care for them. The stories make for powerful and confronting reading, as they seek to reveal the true shapers of this phenomenon.

Chapter Six: No Woman, No Cry

Whatever the very real benefits of investing in women, the most important fact remains: women themselves have the right to live in dignity, in freedom from want and freedom from fear… let us rededicate ourselves to making that a reality.
Kofi Annan, UN Secretary General, 8 March 2005 (UN, 2005)

The heart of this research lies firmly in the stories of women; women who have by their own hand, by the hands of others, or through fate alone, given their lives in the quest to bring new life into the world. Their stories are told by those who fought in vain to save these women's lives—the participants—women and men who are dedicated in their quest to help others. It is essential, therefore, that in the quest to uncover what is shaping why women are dying in childbirth, the lived experiences of those who walked alongside these women, as they took their last breath, are heard. In the sharing of these stories, all attempts have been made to ensure those who were present and most vulnerable are kept safe. These reflections are the participants' alone; their interpretation of what took place. There is no doubt others who were present at these women's deaths will see the events through a different lens; their paths and horizons with which they have encountered these comparable phenomena are diverse. It is my intention, however, that by sharing the participants' stories, and discerning meaning from their insight, it will further engage others in a hermeneutic conversation around their own experiences.

This chapter serves as a precursor of what is to come as the thesis evolves. It serves as a stark introduction into the lives of the participants and the childbearing women for whom they provide care. Its aim is to alert the reader to the problem at hand, as the participant declares it; and, for me, standing in my own preunderstandings centred in my Western and white privileged bias, to document the many questions raised to be answered as this thesis progresses. There is, therefore, little methodological or supporting literature weaved throughout this chapter. It was felt that the stories, by way of introduction, stand alone in their own power.

The Preventable Causes of Death

It has been well documented over the past 30 years, and highlighted in the earlier literature review, that there are known direct physical causes, such as haemorrhage, sepsis, and

hypertensive disorders, with which women are dying needlessly in under-resourced countries. These causes account for over half of all maternal deaths in developing countries to date, and have been the subject of many research projects and foreign interventions (Kongnyuy et al., 2009; Say et al., 2014). One participant highlighted why such disorders may be so prevalent and equally difficult to avoid:

> *Women are coming in and they're dying, and they're dying for reasons we could prevent. They're dying because they've stayed at home too long; they're dying because there's not access close enough for them to get to that first health centre, it's still a day's walk; they're dying because they don't have the right diet and their iron levels are low, and they haven't had antenatal care; or they've had a malaria infection and they haven't been anywhere close to get treatment or bed nets. It's very frustrating and it still touches me deeply that they die. I am frustrated by this job sometimes because I don't know how much difference I can make.* (Participant 4)

The anguish of this participant can be clearly heard. In her experience, women are dying of causes that could, given the necessary material resources and manpower, be easily fixed. For many years, better access to health centres, better nutrition, and malaria prevention have been the priority of aid organisations and maternal health policymakers alike; yet this participant alerts us to a potential gaping hole on the ground. Another participant shares such concerns.

> *A woman came to us, she was five centimetres dilated with unusual contractions so we decided to augment to see if that might help as we prepared to transport her to a place where she could get a caesarean if need be. Augmentation worked, and she delivered her baby about two hours later, still while we were trying to get the transportation to the hospital. We were all excited because the baby came out... and then she haemorrhaged and wouldn't stop haemorrhaging. Through a ton of questions, and giving her IV fluids and medication, we finally pinpoint that she has some kind of bleeding disorder. It wasn't the potentially fatal disseminated intravascular coagulation [DIC], but it was strange... she just wouldn't stop bleeding. We referred her for a blood transfusion, but she wasn't likely to get it in time – the hospital was a good four hours away with no blood bank. Her family all needed to be tested and that takes three days. I am sure she didn't have that long.* (Participant 22)

Even if well-resourced and with skilled health professionals in attendance, this participant alludes to the fact that there is no guarantee of survival for women in these settings. They suggest that if one link in the chain of survival is missing or broken, then the women will more than likely die.

> *A woman we knew well showed up to the clinic in labour—she was already eight centimetres dilated, and she came in the middle of the night, in the middle of a rainstorm, which made it impossible for us to transport her. I had been telling her for months, 'You need to prepare for a caesarean. We will try to help you, we will give you a trial of labour, but if you are not progressing, you have to be ready.' And she kept saying 'I'm not going to the city, I'm not going to have another caesarean.' I was like, 'listen, use your brain, do you want to live?' We pleaded with her, both midwives, but she came in in labour. We said, 'Okay we can help you, we're not going to send you away, but there's only a limit to what we can do. If your baby doesn't come tonight, then you have to leave first thing in the morning for a caesarean.' The baby was deep transverse arrest, it wouldn't come, and there was absolutely no progress. We said, 'We need to stop your contractions, we need to prepare you to go to the city. We'll get you going first thing in the morning.' She had already been trying to push for hours, and there was no progress, and she was showing all the signs that she needed a caesarean. But her family ran away with her in the middle of the night, 2:30 in the morning, they took her home. And we can't track her down; we don't know where she is. And they know that she needs a caesarean... I don't know what they were thinking.* (Participant 22)

The frustration felt by this participant is audible. She and her colleague had prepared this woman, to the best of their abilities, for the eventuality of a caesarean section, yet they could not convince the woman of the seriousness of her situation and the inevitable happened. The woman's stance was also very clear, she would not be going to the city nor would she be having a caesarean section. True to her word, once in labour, she came to the clinic at a time where she knew a transfer would be impossible. Why did this woman choose to go against the advice of the health professionals she trusted? Did she not fear death? Or, did she not believe death would come? What could possibly be shaping her mindset? Could it be fear of the big city, lack of money, family pressure, or the stigma of caesarean section in her community?

> *They brought her back to me 14 hours later; Bandl's ring had developed, and her baby was showing signs of a slowing heart rate and was definitely on the way out. I asked her, 'Where did you go, and why did you go?' She says, 'My family made the decision; I had no choice.' She didn't – the grandmother figure in her family was the one that said, 'I'm done here, let's take her home.' And so she really actually had no choice. She went home and the baby didn't come and eventually her contractions stopped. I've never seen Bandl's ring in my life. She was in crazy, crazy amounts of pain, the baby was on the way out, and I'm looking at her going, 'Are you ready*

> *to go to the city now?' She said, 'Yes, I'm ready now, we have the money, can you help us with the ambulance?'* (Participant 22)

Here we learn that the childbearing woman was not the decision-maker in her labour and birth journey. An older female family member was making the life and death choices on her behalf. We are also left to ponder the word 'choice.' What makes a person, a woman who herself could have had such decisions made for her years earlier, choose such a treacherous path for her grandchild? Did she really appreciate that death was a probable outcome? In a country where birth and death are so tightly bound together how could she not? There is so much, from a Western perspective, that we do not understand about what constitutes the sanctity of life in this setting.

> *By the time she arrived – it's a two and a half hour drive – the baby was already dead, and she was semi-comatose. The doctors in hospital were irate with us, thinking that we had kept her for so long, which we didn't – we would have sent her 14 hours earlier if she had not gone home in the middle of the night. She was so unstable that they wouldn't do anaesthesia. She died two days later, baby still inside of her – never having had the caesarean. They refused to give it to her because 1) she wasn't stable, and 2) they had no blood.* (Participant 22)

The midwife's predictions came true. The frustration can be heard as she is berated by the health professionals who believe it is *her* lack of care and urgency that has led to this woman's death. However, she transferred the woman at the first possible moment she could and the woman arrived in hospital still alive. As the literature around causes of maternal death eludes, timely transfer is paramount to these women's survival. What could this midwife have done differently to change the outcome? Was it not also the lack of hospital resources and a casual attitude by the doctors that contributed to this woman's death? In a Western setting, having more adequate resources on hand, it is likely that they would have done the caesarean to attempt to save this woman at all costs; but here, in this country, it was as though she was left to die.

> *When I transport these women, I don't know what's going to happen to them; they get there, and they need blood transfusions, but there's not a blood bank. And so, you have to show up with your whole family, test everybody, and cross match and whatnot, and then get your blood. That takes days – days! And then by that point it's too late and they're dead. I'm sick, sick, SICK of watching them die.* (Participant 22)

This story begs the question about the place and value of a woman's life. When life-saving resources are scarce and only those most likely to survive are given that opportunity, how must it be to make the decision as to who lives and who dies? Could it be that the woman who has been seen to not take life-saving precautions is disadvantaged? Once the baby has died, does this woman's life no longer become a priority?

> *One of the huge problems was that our women were ethnic minorities, and our staff was the predominant ethnicity and they did not care. They just didn't – and I'm not sure that it was even because they were ethnic minorities; it was the fact that they weren't a part of them.* (Participant 20)

This participant highlights that women are not only disadvantaged in childbirth by their gender, but also by ethnicity, and, worse still, indifference by the very health professionals charged with saving their lives. They talk of the complex societal relationships that can play out in such a healthcare setting where a woman becomes worse than a mere number, she becomes invisible.

> *[Her death] didn't show in their statistics because no one in this country would move a dead body. So if the family knew the woman was going to die they would take them home, because once they were dead no one would transport them so there was no mortality in the hospital at all. It's all about window dressing in this country; if it looks okay, then that's fine. It is an incredibly frustrating place to work.* (Participant 20)

Once again, the question is posed by this participant's story: is care in these settings only afforded to those most likely to survive? And for what reason? Could countries, as this participant suggests, be denying women access to critical care in an effort to improve their maternal mortality statistics? What pressure are these health professionals and governments under to resort to such extreme health care practices, and from whom? This participant is not alone in highlighting the extreme conditions with which health professionals are expected to work under in an attempt to save women's lives.

> *It was about four in the morning and this woman had been in labour forever. It was her fourth baby. I examined her and said, 'This is an obstructive labour… let's prepare for caesarean section.' The female obstetrician, who'd not been paid for six months, said, 'We don't have any anaesthetics. I had to sell them to pay the staff.' So I took a deep breath and said, 'Right, we need to transfer to the tertiary unit.' The local midwife and the obstetrician got really embarrassed. A year before an NGO had bought them an ambulance. The ambulance had been sold to pay salaries in the hospital. Where did the money go to? To the male surgeon and the male*

> *physician… the female obstetrician and a handful of midwives, none of them had been paid for six months.* (Participant 3)

The scenario shared in the above story is, unfortunately, all too common among the participants in this study, with the consistent thread that binds them being the undervaluing of women in these societies. What is different here is the role of NGOs. Could it be that gifts/aid from these organisations are a double-edged sword for these communities? While the ambulance, in a Western sense, seemed crucial to providing emergency transfer for life-saving care, the birth centre did in fact have an obstetrician who could have provided that care on site. The 'tools' to save a life, however, were not available for her. Whose responsibility is it to provide such equipment? More than saving a life, the health professionals in this centre also faced the challenge of their *own* survival. If they stopped work how could they ensure the health and well-being of their own families? If they continued working without being paid, what pressure then would there be on authorities to reimburse them? While on the outside this birth centre looked 'healthy' with midwives, obstetricians, and an ambulance in attendance, it was, itself, haemorrhaging due to a lack of money to ensure that these services could be accessed. In hindsight, was the NGO misguided in 'helping' to ensure the childbearing women in this community survived? Could their 'gift' have had the opposite effect of absolving the local health services of their responsibility? Did the NGO consult the community or did their western conditioning inform them that an ambulance was the critical need for this health centre? Who decides what is most important—the community or those who were are gifting?

Their Own Worst Enemy?

While those giving aid were often under question by the participants, so too were the women themselves. What part did women play in engendering their own fate? And what influences were *in* play, as Gadamer (1989) suggested, that led women to make these often life-ending decisions?

> *Where I have worked the women usually know that the hospital is there, but they'll only come if they think it's safe to leave the village. In one country I worked in, even though the war had ended probably two years before, women wouldn't travel out of their own area for safety reasons because they feared attack. Women were always fearful that if they were alone, that they might be attacked and raped. Conflict affects a woman's access to healthcare.* (Participant 19)

Here we learn that women are true casualties of unstable communities. This participant alerts us to the unenviable choices that women face daily in seeking medical treatment, particularly in areas of war or conflict. Whether to stay at home and risk death through unaccompanied childbirth or face attack on the road to the hospital. What must it be like to live in such a state of fear?

> *If the husband doesn't give permission for them to travel also, then they can't go anywhere. I've had women dragged out of the hospital by their husbands. One woman came in with an incomplete abortion, bleeding quite a lot, and was put on a drip and various things. But her husband found her and dragged her out with the drip and all – she hadn't had permission to be at the hospital or for the abortion. She would have been badly beaten at the very least for what she did. It is not unusual for a woman in that situation to be killed.* (Participant 19)

And what too when access to life-saving care, or lack of it, is not of their own choosing; when paternal influences determine their fate?

> *We had just finished antenatal care for a group of women, and a neighbour came and said, 'Please will you come and look at my daughter, she is pregnant and she is very, very sick.' We found this young woman about 16, around five months pregnant and extremely ill. We had walked through a room to get to her, and in there were at least six men drinking their home brew. I went back in and said, 'Please can you help me, I want to take this woman to the hospital, she is very sick, she needs medication.' And the men looked at me and laughed, and said, 'We will not take you anywhere; we're busy, we're spending time together.' And I said, 'Please will you help us, this woman is very ill.' And they said, 'She can wait until her husband comes home.' Now it was going to be another few hours before her husband came home so I managed to get transport through another means and got her to the hospital, where she was treated.* (Participant 7)

This participant alerts us to the status of women in some societies, where social influence and paternal power determines a woman's fate irrespective of whether they live or die. This woman was not family, she had no connection to these men, and, therefore, as highlighted by an earlier participant, they felt no responsibility for her fate. In Western society such negligence would be voiced as abhorrent, not only by women but by many men in society. Yet, was the decision by these men made out of malice, ignorance, or a deep-rooted tradition that forbade them to interfere in another man's 'business?' What then becomes of this 'high risk' woman when labour begins?

> *The woman recovered and gave birth at home a few months later. She gave birth on her own – which is not that uncommon in this particular area – and began bleeding a few hours later. They eventually found transport for her, but she died at the gates of the hospital.* (Participant 7)

We are unable to delineate whether this woman died due to the apathy of those charged with caring for her, or whether she would have died even if her transfer was expedited. What we do know, through this participant's voice, is that this woman had no choice or voice in deciding what became of her situation. This young woman's life, and the life of her unborn child, was not hers to determine; a fate not uncommon to many women in developing countries.

> *A lady was brought in with undiagnosed twins, which were to be her 10th and 11th children. She was very typical of what we saw, no ability to have clean running water, no ability to access care, hence she'd got chronic anaemia and malaria. She delivered the first twin and then labour stopped. We gave her some synto (syntocinon – a drug to augment labour) to get her started again; she delivered the second twin but immediately began haemorrhaging. She lost 1500mls, but that was enough to severely compromise her, because she only had an Hb (haemoglobin) of 4. We tested her husband and he was the same blood group so we made him give up some blood for her. I showed him the condition of his wife and how poorly she was, and told him she needed a hysterectomy. Not even seeing her like that, nor the fact that his wife had nearly died, would he in any sense give up what he considered to be his property—her uterus and her capacity to have children. He took her back to the settlement still bleeding heavily. We never saw her again after that.* (Participant 16)

What 'prize' is a woman's uterus if she does not have her life? How many children is 'enough?' Both are relevant questions generated from this participant's story. When we skim through this story we are initially horrified and our Western view of the sanctity of marriage is tested. However, we could ask ourselves what did this man fear? What did he stand to lose amongst his community if his wife was no longer able to have children? How must it *be* to be a woman whose value—whose *survival*—depends on how many babies she can bear?

> *I remember this woman quite clearly. It was her sixth pregnancy; she had four live children and this was her first antenatal visit at 36 weeks. She only came for the blanket that we provided. Her blood pressure was high and there was protein in her urine. We told her that we would like to hospitalise her, start her on some medication to stabilise her. She agreed to that, seemingly understood it, and then that afternoon she discharged herself*

> *from the hospital. It makes sense; she had four other children at home to take care of. A few days later, one of the guards came to the compound and woke me up. A woman had come in bleeding. It was her. She was on the floor, she had blood coming from everywhere. She had a really tiny little baby boy beside her that she'd birthed at home and her family were around her. I couldn't stop the bleeding; none of the drugs were working. While we had a blood bank, we didn't have any blood in it and people didn't want to give their blood. Her husband was refusing that she go to theatre. I couldn't get him to understand or consent.* (Participant 4)

Again, we hear the anguish of a participant in their struggle to save a woman's life. While we are drawn to the statement regarding the husband not consenting to surgery, there are other factors equally failing this woman. We hear that the drugs were insufficient. We hear that the blood bank is empty. Yet the quietest, clearest factor of all was the woman's reluctance to save herself.

> *I remember trying to resuscitate her; she was still bleeding everywhere and her husband was still refusing for her to go to theatre… and she died. It was devastating for me. It was devastating because we didn't have any blood in the bank, it was devastating because her husband was refusing that his wife go to theatre, it was devastating because she hadn't stayed and taken some medication for a day or two. And the family was so sad, you know they were wailing, and it was just… ugh, God. It was awful.* (Participant 4)

Why did this woman choose not to stay? Did she not know the seriousness of her condition, or was she resigned to her fate at the hands of God or Allah? This is a question raised many times by the participants.

> *A woman came in with very high blood pressure and I pleaded with her to please stay, and we'd put her on medication and rest. She said, 'I can't, I can't.' Her husband was away working in the Middle East. She said 'Just let me go home and I'll come back this afternoon.' I said, 'You will?' She said, 'Yes, I promise you I'll come back.' So she went away and she didn't come back for nearly three days. She was brought in convulsing. When I looked at her pupils she was brain dead. I delivered the baby... I've never seen such steam coming out of the uterus. I just remember sitting next to this lady waiting for her heart to stop... the family didn't want to be near her. I thought, she's dying, she has four other children. It was so awful and I got really angry about the whole situation and the unfairness of it, you know, and she had gone home because they had just got a new house. Her husband was coming home, and she had gone to finish doing everything, and he arrived, and she died. I mean, her heart stopped beating that morning. He*

> *arrived in the afternoon from overseas; he just cried and cried and cried.* (Participant 11)

The tragedy of this story is not only that this woman died, but that she seemingly did so of her own volition. She was informed of the seriousness of her condition and was given the choice to return at her convenience to take the life-saving medication; yet, she followed her own path, choosing instead to have faith in her body and Allah. We hear that she was loved by her family and, indeed, by her husband. We also hear, so clearly, that with much support around her, she did not need to die. Is there, however, something underlying in this story that we are missing? What if everything is not as straightforward as it seems? We are reminded that in pondering this woman's story, we do so from the perspective of the participant and not the woman herself. Could it be that there were 'darker forces' at play as with this next participant's account?

> *A woman was brought in by her family. She had eclampsia and she'd been sitting at home for probably 24 hours, but they didn't bring her in because they thought that it was 'bad spirits' that was causing the problem. We stabilised her, and then I approached the family to discuss the urgency of a caesarean section. The woman wanted the operation, but we couldn't do it without the father's consent. It took me two days of negotiation, along with the local doctor in charge, to get permission to do the surgery – she had no power you know. Under international human rights law her consent should be enough to do the surgery, but the consequences to us if we had just performed the surgery was the high probability that the family would have come back and shot us. Fortunately this woman survived and the baby survived, miraculously, and the family were very grateful, but it was just the amount of negotiation that was involved to try to get the woman to the point where we were allowed to save her life.* (Participant 19)

This participant raises a very valid point—the question of human rights law and its efficacy and reach. The law was put in place for cases such as this; yet, this family is either unaware of such a law or chooses to ignore it. There is no accountability and no enforcement against human rights abuses in this country, and while this participant and their colleagues were well-versed in the law, we hear that to enforce it could well have led to their own demise.

The question of human rights abuses

Lack of human rights, particularly against women, is a common theme within the data and raises the question of just how relevant international policies are in these settings. Is the government aware of such wide-reaching lawlessness, or is it indeed turning a blind eye to

what is happening amongst its constituents? The following participant highlights another case where a woman's life appears to be of little consequence to those in power.

> *This 19-year old girl came in, she was pregnant, not at term but close enough, and she was dead on arrival. Her in-laws brought her in and said that she had drunk poison because her husband had taken a second wife, and she wanted to commit suicide, and so that's what happened. The relatives were never questioned, they just took the woman's body away. Whatever these in-laws said about this woman was taken as true. If it happened in a Western country there would be autopsies, there would be coronial inquiries, the police would be involved. There was none of that. The fact that this woman's life wasn't worth investigating as to why she died; it was just a shock and so awful.* (Participant 7)

Why was there no investigation? Why were this woman's in-laws taken at face value in their account of what happened to her, and what of her own family's wishes in these circumstances? The fact that this woman's death, and how it happened, was of little consequence to the medical professionals on duty too suggests this may be an altogether common scenario within this community. This participant grapples with the cultural shock they face as an expatriate aid worker in such a setting. Perusing the data, it becomes clear she is not alone.

> *I was working in a very challenging context, and there was a lot of rape occurring and a lot of underage sex that happened out of marriage as well, two big no-nos in this country. We had a young girl come in without a caretaker, she was 14 or 15, and announce that she was pregnant by her boyfriend. It was something that we didn't talk about, offering termination of pregnancy services; certainly we couldn't afford to in a country where we could get beaten or thrown out for doing so. It was something that in that context, we were not really in a position to offer support to her. The local midwife didn't dismiss it, but she said, 'Could you come back and see us tomorrow?'* (Participant 9)

It is clear from this participant's account that human rights law was not practiced in this setting either. With rape and underage sex commonplace, it appears that there are few laws to protect women and children in this country, or at the very least little policing of them. It is interesting too that the question of abortion was not raised amongst the staff nor with the young woman; the unsaid word, and the implied threat of violence against any health professional who performed it, suggesting it was altogether forbidden in this environment.

> *Later that night she came in with a facial trauma, and she was having difficulty breathing. When I saw her I could tell that it wasn't a standard*

> *trauma. She had angioedema, her tongue was very swollen and her lips were large, and she was with all of her family. They told me that she had fallen off the back of a donkey cart and hit her chin. It didn't make a lot of sense to me. I kept asking 'has she taken something, has she been drinking something?' I got a lot of 'No, no, no,' back to the donkey cart story. We take her into the procedure room and I give her a shot of adrenalin – she looked like she was having some kind of anaphylaxis, she was writhing around, looked very neurologically irritated. I palpated her uterus; she was definitely 11, 12 weeks pregnant. She continued to deteriorate, she wasn't responding to adrenalin or steroids or antihistamines that we were injecting. I spoke with the family as she had some black trace in her mouth which we couldn't quite figure out; I catheterised her and her urine was black, as black as I think I've ever seen. I couldn't quite piece it all together except I knew that this was poisoning; whether it was accidental or on purpose I didn't know. And I had discussed with the family, you know, 'This young girl is very, very sick and she's going to die if I don't figure out exactly what to do, and I need some more information from you,' and there was a lot of denial from the family.* (Participant 9)

Again, we are drawn to a family's secrecy surrounding the circumstances of a young pregnant woman's 'illness.' The family's story does not marry with the clinical picture, yet they remain stoic and unmoving in their account of what has happened. This time it is the young woman's own birth family that is proving obstructive to the participant's life-saving treatment for their daughter. Do they not believe that she will die? Would disclosing the circumstances of her 'predicament' bring shame upon the family? Or is it simply that they are scared to tell the truth?

> *We took her into theatre as her airway became increasingly compromised, and she bled out on the table as we did a tracheostomy to try and give her some airway. And her family were immensely grieved; I mean grieving is always difficult, but this was a very well-loved young daughter, one of only two children in the family. I spoke with the mother and she had her suspicions that her daughter was pregnant, but it really did give the history that this young girl had felt that there was no option to continue this pregnancy. She would be ostracised from the family, she would be harmed, in her mind, all these dreadful things would happen to her, and so she drank henna to try and terminate the pregnancy, but by doing so caused the end of her life. You know, this was something that was very hard for all of us who were involved... really tough. The truth is that that's the cultural, social and political situation that is a daily reality for many young women around the world – it's tragic.* (Participant 9)

This story sums up the complexity of the problem at hand. The social, cultural, and political situations in each of these stories highlights how precarious it is to be a childbearing woman in these settings.

Conclusion

I want to reiterate that this is a global study. These stories, and the ones that follow, do not reside in just one village, one town, one city, one country, or indeed one continent. The faces of these women do not hail from one ethnic or religious group. They are a global representation of childbearing women in some of the world's most over-researched and under-resourced countries.

The following data chapters seek to further unpack the issues brought to light in this introductory chapter; issues such as the abuse of human rights, the problem with aid, and the political quagmire are all examined in relation to what is shaping why women are still dying in such vast numbers in these settings. First, however, focus is placed on the participants and we hear what it is like to bear witness to these childbearing women losing their lives bringing their children into the world.

Chapter Seven: Bearing Witness

"Bearing witness", like "solidarity" and "compassion" is a term worth rehabilitating. It captures both ways of knowing, both forms of silence. Bearing witness is done on behalf of others, for their sake (even if those others are dead and forgotten). It needs to be done, but there is no point exaggerating the importance of the deed… no matter how great the pain of bearing witness, it will never be as great as the pain of those who endure.
(Farmer, 2005, p. 28)

Becoming a Witness

It is an unimaginable fate, yet the stories in the previous chapter bear testimony to the daily reality for many of the world's most vulnerable women. The adversity faced by these women, however, is not theirs alone. What of the health professional, the aid worker, who stands alongside these childbearing women at an often-crucial crossroad, bearing witness to her destiny?

There are more than quarter of a million people actively 'employed' in humanitarian aid organisations at any one time across the globe (Lopes Cardozo et al., 2012). It is both a rewarding and perilous industry with aid workers witnessing first-hand some of the worst atrocities known to humankind. Their daily routine often includes high-risk activities and almost always high stress, with workers facing everything from relentless exposure to human suffering, to prolonged brutality and war crimes (Comoretto et al., 2015; Eriksson et al., 2012; Gritti, 2015; Musa & Hamid, 2008; Shah et al., 2007; Veronese & Pepe, 2017). What draws a person to such a volatile industry, where their very health and safety is constantly in jeopardy?

> *I'm a very privileged spectator. Sometimes I get to make a difference, sometimes I get to share in a part of something that maybe is a flame that goes on and burns a little bit longer. You just have to know your place a little bit and respect that.* (Participant 9)

Knowing your place is admirable and often most wise, particularly in situations of conflict. However, to bear witness to a woman dying a preventable death is an unimaginable outcome for most health professionals in a Western setting. For the expatriate aid worker in a developing world setting, it is a precarious predicament:

> *I think about right now and making that the best I can offer, because I don't have any control over tomorrow, and I have to let that go a little bit. We take opportunity where we can, but working under conflict is utterly unpredictable, and a village that may be here today is not there tomorrow. You optimise what you can, you educate as much as you can, and you hope that some threads of that carry on in a person's future. We save a life today, and we keep saving as many lives as we can today, and through that experience and that exposure and that contact, you hope that there's something left over for them for tomorrow.* (Participant 9)

In interviewing these participants, and on occasion being privileged to witness their daily struggles, I became mindful of their unenviable predicament. As health professionals in the West, we are tireless advocates for our women and their babies. An expatriate aid worker often advocates at their emotional peril:

> *The males make the decisions, and caesarean section was not something that was looked upon, because if the woman died on the table it was the husband's fault, and the husband didn't want to take that responsibility; whereas if the husband took the woman home and she died at home, then it was no one's fault. I remember one woman, we wanted to do a caesarean section to get the baby out, and the husband said no, and took her home. We told him of the high probability that his wife and the baby could die. And that was okay. He was happy to accept that. He knew completely that what we were saying was true, but it was far more important for him to put his wife and his baby's life in the fate of Allah. We came across that scenario quite a few times, and as tragic as it is, you didn't want to undermine what they've hung their whole lives on.* (Participant 10)

This participant highlights the price of being a woman in many developing world settings. This cost is reserved both for the local childbearing woman and the aid worker. Gritti (2015) conducted research into aid worker resilience with 257 expatriate aid workers and uncovered a frank and interesting revelation from the participants involved—being a female aid worker was far more problematic than it was for her male counterparts. Working as a female aid worker in a patriarchal system was to prove challenging, as Participant 10 alludes to above, with men in those societies viewing the female aid worker as less qualified and with less respect than her male colleagues (Gritti, 2015). As well as gender bias and discrimination, female aid workers were often more likely to face unwanted sexual advances both at work and in the community, in which they live, and had very little recourse against such harassment when local laws did not support such a practice (Gritti, 2015). An interesting by-product was women were often torn as whether to act on their own conscience and follow their own tradition or adapt to the host culture or religion in

which they were living (Gritti, 2015). So, what draws a person to such a challenging vocation where the sanctity of life is at play with God's will? For some it would be an unthinkable, almost unbearable 'truth;' yet, Gadamer (2004) shed some light on how such a dynamic relationship with oneself can be better understood.

The act of witnessing

It is Gadamer's idea that understanding is always influenced by the tradition in which we are historically located, or rather the existing history, language, and culture into which we are thrown (Gadamer 2004; Phillips, 2007). For Gadamer, the idea that we can set aside our own cultural 'way-of-being' to embrace a timeless truth is pure modernist fiction (Lawn, 2006). New understanding, he suggested, is always tinged with the tradition that we bring forth with us, and we would be naïve to assume that we can fully embrace another's culture without drawing from our prior experiences (Gadamer, 2004). Gadamer takes tradition to be a part of our engagement with the world. It can never find a point outside it to test its validity (Lawn, 2006). Understanding is brought to the fore when we are attracted to something or it interests us (Gadamer, 2004). It is tradition that influences our attitudes towards this 'thing,' and it must be taken as a legacy which does not necessarily need to be analysed in advance, but just 'is' (Roy & Starosta, 2001). The question that begs answering is, just how does an aid worker fuse their tradition and understanding with that of the local people?

> *There are days, I won't deny, I get definitely hopeless and helpless. And there are times when I want to pull out my hair and start beating people with sticks just to get them to move faster or get them to value life a little more. And yet this is their world view and so I try to step out of my box and take a bigger picture of things.* (Participant 22)

This participant draws attention to their conflict with the local community's 'worldview'. It seems that their personal taken-for-granted expectation that when there is an urgent need for life-saving care things happen quickly, impacts on her afresh in this context. Her own tradition is embodied within her thinking and actions. To have to patiently wait amidst a seeming lack of care, or sense of trying to get help, draws her into a huge experience of personal conflict. Wanting to pull her hair out and beat people with sticks (behaviours outside of her own traditions norms) reveals the agony of such moments. She is engulfed in a feeling of being hopeless and helpless. It seems that as much as she yearns to act there is nothing she can do; yet the tension of inaction is almost more than she can bear.

Vicarious trauma

Paul Farmer (2005) reminded us there is little medical mystery to saving women in childbirth, "preventable diseases can be prevented, curable ailments can certainly be cured, and controllable maladies call out for control" (p. 28). What is in question is *why* women are continuing to face such adversity in their childbearing year. We could ask the women or the local staff themselves of course but, as Farmer also informed us, "the silence of the poor is conditioned. To describe it as stoic is not to be wrong but rather runs the risk of missing the great eloquence beneath the silence" (p. 26)—a fact echoed by my participants:

> *The sanctity of life wasn't there, the respect for life. The local staff were so deeply traumatised that they'd cut themselves off from it. They'd got so used to people dying and suffering, and they were suffering in their own way in their own families – everybody knew somebody else who'd died. It was quite a shock, being in an environment where seemingly there were health care professionals who cared, but actually that wasn't the reality for many different reasons.* (Participant 3)

This participant wrangles with the tension of perceived inaction amongst local communities; yet, as she explains, it is not through indifference but rather persistent exposure to the trauma of death during childbirth. What is now rare in the West is continuing as a 'normalised' event in many developing countries. Such is death's overwhelming presence in childbirth that they neither view it as preventable nor fixable—it just 'is.' What is perceived as lack of 'care' could, in fact, be the dehumanisation leitmotif woven through many of the participants' accounts. Common in many countries where conflict or death is a daily reality, dehumanisation could be, as this participant alludes to, a coping mechanism, a way to cut oneself off from the gruesome reality. Comoretto et al. (2015) agreed that mental disassociation or disengagement with trauma in the field can often be a coping strategy used by both local and expatriate aid workers alike. 'Vicarious trauma' and 'compassion fatigue' are widely used terms synonymous with humanitarian work, both occurring as a result of aid workers' relentless encounters with the pain, suffering, and grief of the community with whom they are working (Musa & Hamid, 2008; Veronese & Pepe, 2017; Vogel et al., 2011). Here, the aid worker, in empathising with the stories of those who have been traumatised, internalises the deep-rooted feelings of those experiencing such pain as if it was their own (Musa & Hamid, 2008; Perry, 2003; Veronese & Pepe, 2017). Another participant shed more light on the overwhelming conundrum:

> *It's too hard to show too much compassion because you just don't know where you're going to stop. You have to pull back and that's really challenging, because you'll be privately falling apart, but your team aren't, they're just getting on with the other 10 deliveries. They're far more matter of fact about a maternal death; that was that and we'll just push that one aside. But you know that it still affected them just as much as it affected me; I just had the luxury of being able to express my emotions a little bit more, because I could go back to my compound and talk amongst my expat colleagues and say, "What a dreadful day I've had." Those women couldn't because they were too busy delivering babies, then walking four hours home to look after their own kids and family. Life is pretty harsh for them.* (Participant 10)

What is clear from both participants' accounts is that the trauma of a woman dying in childbirth is not hers alone. The family, the local health professionals, and the expatriate aid workers are all witnesses to this sentinel event. Yet, how they deal with the vicarious trauma differs. It is here that Gadamer (2004) reminded us that as witnesses to life's tragedies, ours is only a partial account. He explained, "The person to my left can see further to the left horizon than I can see, but I can see further to the right. At no point do I step into her shoes and see what she sees" (Gadamer 2004, p. 303). Vogel et al. (2011), lamenting on their experience of working with aid workers, shared Gadamer's sentiment suggesting that an aid worker working in such a setting carries their share of the burden as they become intimately intertwined with the tragedy.

Experiencing thou as truly thou

Expatriate aid workers come to humanitarian work with their own prejudice of what should or should not happen when a woman is at risk of dying in childbirth. Similarly, the very people they are trying to care for have their own preconceptions; a history of trauma not experienced by the aid worker. Rather than assimilating to the point of view of the 'other', Gadamer (2004) suggested that by both parties interpreting each other's worldview, their horizons will extend, leading to a greater understanding of the world they both share. But how practical is Gadamer's philosophy in such a volatile setting?

> *This culture has a very complex view that you have obligations to your family and to certain people only. So, if someone that you've got an obligation to sends someone to you and says, 'This is my friend, look after them,' then you have an obligation to that person. But you have no obligation to someone that you don't know, and so when people came to the hospital, there was absolutely no empathy at all. Patients would die but the*

> *staff didn't care. It is an incredibly frustrating place to work.* (Participant 20)

This participant highlights an interesting conundrum. Those contemplating Gadamer's prose may argue that it is difficult to fuse horizons with another when the other party is unwilling to engage dialogically. With such deeply rooted traditions and prejudices held by many of the communities that the aid workers find themselves drawn to, many would believe a mutual understanding is unfeasible. Gadamer (1989) responded:

> In human relationships the important thing is… to experience the Thou as truly Thou… Without such openness to one another there is no genuine human bond… Openness to the other, then, involves recognizing that I myself must accept some things that are against me, even though no one else forces me to do so. (p. 360)

What Gadamer (1989) wrote points to the suggestion that is for aid workers to release themselves from the historically formed web that binds their view of the world and formulates the trajectory with which they navigate their way through. He asks, instead, that their horizons stay fluid and capricious. According to Gadamer (1989), by listening and really hearing what the other party is trying to say only then can the aid worker recognise that their horizon must shift in order to incorporate their newly expanded understanding of the other's culture, history, and current social plight. While Gadamer's dogma sounds all well and good, we are left to ponder how easy this is in practice when faced with an irrevocably broken system that does not value nor prioritise a woman and her unborn child's life. What is clear is that there is an undoubtable coming together, a sharing of the emotional burden, between an aid worker and a woman when she is subjected to a violent act. Vogel et al. (2011), on their experiences of working with aid workers returning from the field, surmised that it is not possible to be so intimately intertwined with another's suffering without sharing their hardship. A sentiment echoed by this participant.

> *I think it hurts everybody in a way, it's just not obvious. I dealt with horrific sexual violence in this country; a young girl tied over the fire, having her genitals burnt off, having been repeatedly raped. There was not a tear from her. It doesn't mean she's not hurt; it doesn't mean she's not broken inside; it doesn't mean she's not feeling. We make this kind of assumption that people actually don't feel the same – well they don't feel the same, not maybe as you or I would – but they feel. But how they understand that and that process for them is different.* (Participant 9)

This participant reminds us that the situation on the front line is, at best, complex. Here they describe a young woman severely brutalised yet, when presenting for treatment, seeming resilient and emotionless. This participant is experienced enough to recognise the stoicism for what it is, a survival mechanism of a woman so beaten down and broken by her horrific situation that she can longer function as one would 'expect.' Her trauma is so conditioned that she merely 'accepts' her fate. Masten (2001) believed resilience to be a kind of 'magic' resulting from our ability as humans to adapt to various stressors. Pearlin (1991), however, is wary; his study reveals that those who tried to lessen any emotional stress by not actively facing a stressor were, indeed, likely to experience the opposite effect – increased stress and less resilience. Shah et al. (2007), in their research into the prevalence of vicarious trauma in humanitarian aid workers, reported that it is this very predicament that aid workers struggle to reconcile with.

> It has been devastating the manner in which the women have been vandalised. It is almost as if we were the victims. I want to be honest and frank, at this moment we want to avoid people as our pain has hardened and we are feeling numb. (Aid worker, cited in Shah et al., 2007, p. 61)

Ehrenreich and Elliott (2004) agreed with the aid worker cited above, asserting that the kind of stress aid workers face in their daily working lives can take a heavy toll both on their emotional wellbeing and their ability to carry out the very mission with which they have been tasked. He further suggested that this type of stress can also have an adverse effect on the very people they are trying to assist (Ehrenreich & Elliott, 2004).

> *I had quite a few women who came in having eclamptic seizures; they actually didn't live that far away these women. They had access, they knew that the hospital was there, but they didn't come until right at the very final stages. Is that because they lived under plastic and they had no transport and life was really bloody miserable for them and they had five kids to look after and they didn't have any work so they couldn't actually go anywhere? And they never put themselves forward first, you know, they always put the rest of their family first. They die really, really quickly. And it was just heart-breaking that you knew that there was nothing that you could do to save them.* (Participant 10)

We are alerted to women actively choosing not to present themselves to a facility that is within their reach and that they know could be lifesaving. What prevents a woman from taking that crucial step towards help? How must it be to have the tools and the know-how to save a life yet be powerless to intervene and to witness a woman's last breath, knowing

all the while it could have been prevented, that she could have saved herself? What we do know is that stories such as this are the norm for those undertaking humanitarian aid work (Ehrenreich, 2015; Rubin, 2006; Vogel et al., 2011). Working extraordinarily long hours in physically challenging settings and in poor conditions, coupled with continuous exposure to horrific and tragic narratives and a very real threat to their own personal safety, can leave aid workers not only with compassion fatigue and vicarious trauma but showing signs of post-traumatic stress disorder (PTSD) and initiating self-destructive behaviours (Ehrenreich, 2015; Veronese & Pepe, 2017). This next participant explains the situation well:

> *On a political level most NGOs, in my experience, despite what it says on the internet and what you hear, do not go to the very remote areas. Most NGOs prefer to stay in the places of population, because when they can get away from the nightmare they might be dealing with, they can actually be involved in something relatively more civilized. When I went to a very remote place in this particular country, I lasted 10 days and I had to come back to the city, it was just so dreadful. That's where most of these horrible issues are going on, and there does not seem to be any money going towards these places. We're talking about places with no roads or no infrastructure. It was heart-breaking to me because I'm one of those people who thought they could handle it, but how you could actually live there for two or three years and make a difference, I have no idea.* (Participant 3)

It seems there are some places that in the very remoteness that 'needs help,' prove to be too hard for the aid worker to endure. It appears that what is perceived to be happening on the ground in these settings is being largely downplayed in popular media and amongst recruitment drives for aid organisations (Gritti, 2015; Veronese & Pepe, 2017). Rubin (2006) set the record straight. Life for expatriate and local humanitarian aid workers, he says, is fraught with danger.

> From 1992 to June 2001, over 200 UN field mission staff were killed and another 242 were taken hostage or kidnapped. In 1999 alone, 292 cases of robbery, rape and physical assault were reported. The bombing of UN headquarters in Baghdad in 2003 led to the loss of life of twenty-four UN personnel, including Sergio Viera de Mello of Brazil who, in the view of many at the UN, was poised to become the next Secretary General. (Rubin, 2006, p. 3)

What was once seen as a glorified profession by the masses has been eroded by the tales of these brutal killings now brought immediately into our living rooms, live as it happens,

in the age of social media. These killings include the horrific attack on a maternity hospital in Kabul, Afghanistan in May 2020, that killed 14 people including two newly born babies (BBC News, 2020). It is reported the terrorists caught women at their most vulnerable, during and immediately following giving birth, gunning them down in the NGO run maternity section where they lay. Two expatriate aid workers who were assisting childbearing women on that day, barely escaped with their lives (BBC News, 2020). This is the reality many aid workers believe those at the top of the larger aid organisations or research units fail to acknowledge.

> *I left a congress recently thinking, 'I could have stood up there and told them some stories that would have really been useful.' I took some of those researchers and bureaucrats off their pedestals and knew, as an aid worker, that I could speak out very loudly if I needed to and provide some invaluable information. As I sat there and listened, I wondered how many of them had ever knelt on a dirt floor with someone dying beside them or had a really long difficult labour where you have no idea how you're going to get the baby out. Where you can feel that sweat, it sort of starts from your heart and moves up and your face is all red and you're thinking, God, how am I going to get through this one.* (Participant 4)

It is disheartening to hear from this participant the wide chasm of knowledge that she believes exists between what is happening in the executive offices of Western aid organisations and the reality of life as an aid worker on the ground in the very developing world setting that organisation is promoting it assists.

Conclusion

Bearing witness is a heavy burden for aid workers, often leaving them feeling like they have failed dismally in the very mission to which they are deeply committed. Former UN Deputy General Mark Malloch Brown (cited in Moszynski, 2007) added to the conversation, stating his truth that politics is thwarting efforts to help or bear witness to these populations suffering the most and, by doing so is allowing the very hand that harms these populations to continue its oppression. Morten Rostrupp, former President of Doctors Without Borders International Council, concurred:

> It means going beyond providing medicine, shelter, and care to bearing witness and pointing to the cause of problems. We provoke political change by stating what we see in the field. It is a spontaneous action when you see misery and how politics is failing. (cited in Sheldon, 2004, p. 426)

What has become clear from this chapter is that bearing witness could be best described as akin to a fine balancing act. It is apparent, highlighted by the need for absolute and assured anonymity of the participants in this research study, that speaking out can have dire consequences leading to the endangering of aid workers in the field and stopping them from fulfilling their intended mission. However, a cone of silence is likely to be viewed as imprudent and maybe even immoral.

Chapters Nine will explore this issue further from a political and aid perspective but, first, Chapter Eight will address the question of maternal mortality and whether it is, indeed, a human rights abuse.

Chapter Eight: Maternal Mortality - A Human Rights Violation

The process of changing from a male-dominated culture to a culture of gender equality must be supported by a majority… including powerful men who come to understand that sharing power with women allows them to achieve goals they couldn't achieve if they relied on their power alone.

Melinda Gates (2019, p. 173)

Maternal Health is a Human Right

A woman dying in childbirth is, as the previous chapter informs us, a traumatic and life-altering event for all who bear witness; yet, the extraordinary numbers with which these women continue to die must surely be the greatest tragedy. Despite maternal mortality being widely recognised by the UN as a human rights issue, it appears little traction has been gained in combating it over the past 35 years. As mentioned previously, over a quarter of a million women and girls of childbearing age still die each year, with a further 10-15 million sustaining debilitating life-changing injuries during childbirth (Office of the High Commissioner for Human Rights [OHCHR], 2013). While gains have been made in some countries, documented targets, such as 5A and 5B of the Millennium Development Goals (MDGs); to reduce by three quarters the maternal mortality ratio and achieve universal access to reproductive health by 2015, have fallen far short (Miller et al., 2016).

The participants' voices in this study make it unanimously clear that little has improved for the women they are charged with caring for since the inception of the MDGs. The reasons behind this stagnation of improvement in maternal mortality outcomes are varied; yet one common theme remains constant amongst participants in the study—the current status of women in these societies.

> *Depending on where you are born gives you your chances and within the administration of human rights, we have to be able to go beyond that; every woman has to have a right.* (Participant 5)

This participant is clear that a woman's survival is, in the most part, due to 'luck'. Her chance of surviving depends largely on where she was born, and whether that country is a

party to the ICESCR. However, being a signatory to a human rights document does not ensure a mandate for change, especially in relation to women's health:

> *This country does not suffer from a lack of money, and if it were around a men's health issue, trust me they would have cured this problem by now, it would have been all solved. But there is simply an inability to get any buy-in to things that affect women. It's as simple as that.* (Participant 16)

Far from being dramatic, this participant is indeed stating a well-heeled fact. The global response to the HIV/AIDS epidemic, a largely, although not exclusively, male-dominated health issue, is a case in point. The global response and the cosmopolitan nature of the international community's commitment to realising the right to health for people afflicted by HIV have been termed "exceptional" (Hammond & Ooms, 2014). Yet, there is still incredible difficulty in obtaining equitable global buy-in when it comes to addressing the right to health for childbearing women.

> *We can't fix the reasons why women don't get access to care. Fundamentally the place of women in these societies is none. They have no capital, no economy. We can put more drugs into the system, build new health centres etc., and that will help some women, but once that support stops, most of these things will fall over because there's no buy-in here; it's not seen as important. And until you can get that traction then you're not going to be able to affect change here, no differently than you will in a similar country. While the context is different, it still revolves around the power and economy of women in society.* (Participant 16)

This participant brings to light one very key issue in regard to the response to this women's health crisis; the inability to address the heart of the problem—women's status. The response to-date has been practical in kind, supplying much needed drugs, building new health centres, and training new healthcare personnel. Yet, very few initiatives have addressed the fact that many women do not have the power to access such resources of their own free will:

> *I think the status of women generally in some of these societies impedes the ability to make the necessary changes. A woman was brought in by her family. She had eclampsia and had been sitting at home for 24 hours. They didn't bring her in because they thought bad spirits were causing the problem. We stabilised her, and I approached the family to discuss the urgent need for a caesarean section. The woman wanted the operation, but we couldn't do it without the father's consent. It took me two days of negotiation, with the local doctor in charge, to get permission to do the surgery. It's those sorts of aspects – I mean she had no power. Under*

> *international human rights law her consent should be enough to do the surgery, but it just wasn't possible. The consequence to us if we had gone ahead and done the surgery, was that the family would come back and have shot us.* (Participant 19)

Not only do women *not* have the power to save themselves, but this participant also informs us that neither do the health professionals charged with caring for her. To do so would be to risk their lives. Regardless of whether there is a mandated universal right to health care for this woman, and she is in a health care facility with lifesaving medicine and equipment being cared for by experienced health professionals, this woman's life is at the mercy of one man.

Patriarchal Influence

When it comes to power and control over women's reproductive rights, the participants voice that men are the principal offenders. Men, in these societies, are culturally conditioned to believe women are their possessions to be used at their whim.

> *One in three women report being raped in their lifetime in this country. In certain communities interviewed, 100% of women were in violent relationships and the levels of general abuse across the country have been known to be some of the highest in the world. Men are predominantly the perpetrators of violence here.* (Participant 9)

In much of the developed world, where human rights, indeed *women's* rights, are held as sacrosanct, the idea that every woman in a certain society is subjected to violence by the hand of her husband is abhorrent. What is it about a society that allows such behaviour to continue and what prevents women themselves taking a stand to change this behaviour? When it comes to domestic abuse, men are largely considered to be the main perpetrators of violence the world over (Dito, 2015; Omer et al., 2016; White et al., 2013). What is most disturbing is the familiarity with which violence against woman is normalised in some societies.

> *In a culture where violence is pervasive, it's in every home, on every corner and it's visible on the streets. You see it every day, when you're driving you see someone being beaten on the side of the road, or a child being dragged on its knees. Every day you see it, and every day in the clinics we would see women who were busted. They were broken on the outside and broken on the inside.* (Participant 9)

As this participant draws us into the 'normalness' of everyday violence for women in these societies, she inadvertently alerts us to conditioned exposure to violence that health professionals witness on a daily basis. What must it be to bear witness to such abuses, tend to the aftermath in the clinic and, despite being given a global mandate to do so, be unable to intervene?

> *We can't fix their problems, we can't make them go away, and we can't promise that it isn't going to happen again tomorrow, but the care and the support and that sort of extension of a hand to say, 'Look, we're beside you, and we can offer you this,' - I think that's huge. And you'd almost see women swell with that. I think it became a very safe place for them, and we would get frequent flyers, people that came in regularly who were in incredibly violent situations. We would get people who were coming in who had been repeatedly raped, sometimes not always in the marriage, but being raped by strangers or other members of the community.* (Participant 9)

While the barriers that forbid this expatriate health professional from reporting such abuses to the authorities remain elusive for now, we hear that what this participant and her colleagues offer women is a safe haven, a place to escape their abusers for a few hours.

> *We were just a real safe place where they could feel that they could talk with someone. In other countries that I work in there is a real sort of sisterhood and women supporting each other – that doesn't come as naturally in [this country], so this was an opportunity for them to have a bit of a selfish moment – where someone was all about them, listening to them and offering them support, offering them choices that they could make for themselves.* (Participant 9)

Is offering hope tantamount to offering sanctuary in situations where women cannot be free of their abusers? Does somehow having their voice heard and their feelings validated lend strength to women in an impossible situation? This participant talks about offering abused women choices in situations where they are unable to flee their abusers. This begs the question about the word 'choice'; why can women not free themselves from their abusers, and what cost to them if they attempt to do so?

> *We're still having horrific numbers of women burned, women harmed, women with acid thrown on them, and now with the young girls there are stalkers. Boys are stalking and really torturing these girls. They want this girl, she doesn't want them, but they keep coming. Often, either the girl commits suicide, or the boys throw acid on her or lights her on fire. It's a horrible attitude like, 'I'm a boy, I can have what I want.' And these girls are literally all covering up. More and more they're putting burqas on. They*

> *never did before; you really notice a lot more burqas in the city now.* (Participant 2)

This participant alludes to the danger of being a visible woman in these societies. While many in the West see burqas as a symbol of oppression, we hear that for countless women, in particular young women, donning a burqa is a means of control in an impossible situation in which she is otherwise powerless. Yet, what affect does becoming 'faceless' have on women's status in a community where her worth is not of equal value to men?

> *You have to understand that in these contexts, women have very little utility and the way to get utility for women is through men. People get philosophically opposed to that, saying, 'Well women should have this, and women should have that' and I'm not going to dispute that, but the reality is we won't actually get that changed without including men. I don't think it's possible for you or me to recreate development for someone else's country. I think what we can do is try to facilitate an enabling environment.* (Participant 16)

This participant brings to light an interesting paradox. While men are the predominant enablers of violence and the oppression of women, it is only with the cooperation of men that women's rights can be truly honoured. This participant highlights the fact that outsiders cannot change the situation for women; instead, their role is to create an environment for change to take place. Yet, how difficult is it to get buy-in from men in countries where women are considered nothing more than a cheap commodity.

> *Women are dispensable. This is what the guys tell me, or they say, 'It doesn't matter, if the woman dies, I'll get another wife.' It drives me nuts.* (Participant 21)

Patriarchal societies traditionally empower men and devalue women (Connell & Messerschmidt, 2005). The goal is for men to produce sons and heirs, with women merely the vessel through which this will occur. As this participant informs us, should the vessel be 'inadequate' or die, she is ultimately replaceable.

> *Women are definitely still seen as second class; the men still hold the dominant position in the family, although the women are the ones that do the majority of work. The lifespan here is very low. Child-bearing age is anywhere as an average from about 15 up to about 45. Every man expects their woman to have at least three children to them, of which at least one has to be a male, and that's because inheritance goes down the male line. If that husband leaves you and you get another partner, they will expect you to have three children as well. So, if you've got three, another man comes*

> *in, they want three. And they will not give consent to contraception or sterilisation. Then if their partner leaves them again or they leave for whatever reason, which is very common here, they'll have another three children, so the effects of nine children is very common*. (Participant 18)

Here we learn that multiple husbands or partners, through varying circumstances such as divorce or death, is commonplace for a woman in her lifetime. Without a husband, a woman in patriarchal societies will find herself vulnerable and socially unacceptable. This participant is clear that, despite already having birthed many children, the expectation from her new partner is that his wife will bear him more.

Dowry

One of the resounding themes extracted from the data was the everyday act of the buying and selling of women, an act normalised in many societies. Women are traded like vegetables and cattle. If they cannot fulfil their promise, the promise of children—most particularly a son—then they are of no worth.

> *The husband said, 'She'll stay here in this house until she has a baby – until she has a son. If she dies that's Allah's wish. Let her go.' It's so easy for men to get off the hook. One wife dies they go and get another one, and not only get another wife, but get another dowry. It's an advantage to have your wife die. And they're killing people for dowry years after they've been married.* (Participant 2)

The buying and selling of women carries with it terms such as honour, pride, status, and the promise of wealth. Men are paid, some handsomely, for taking the burden of women or girls from a family.

> *One woman, her husband started asking for dowry. He told her to go ask her mother and stepfather for dowry, and they'd been married seven years. I got hold of that guy and I said, 'How dare you ask! You should be paying her! She's borne you two children, she's the one who's doing most of the work, she's doing everything. You should be paying her'. So, he stopped talking about dowry and torturing her. But I think all these things take time and women have to empower other women. We have to first believe we're worth something.* (Participant 2)

However, the odds are stacked against women. Dowries are commonplace in patrilineal societies where women are expected to live with or near their husband's families. It is a transfer of wealth from the bride's family to the groom or his family, ostensibly for the bride although many do not benefit. It differs from bride price which is wealth paid by the

groom or his family to the parents of the women he is to marry. While attempts have and are being made to outlaw these patriarchal customs both are still widely practiced in many developing nations.

> *It's very prevalent here, this business of bride price. It's a bit like ownership; you're trading women for beads, pigs, and taro. That's how we see it, but how they see it is, because the woman goes to live in the man's community or in their village, they then become an income earner for that community, they are a valuable, able-bodied member of that community. That woman though has been taken out of her family, and so they have lost the income that she can generate. So, the transfer of shell money and pigs and things indicates the value that that woman has to the community and acknowledges one family's loss and one family's gain.* (Participant 14)

This participant, in her explanation, alerts us to the custom of a woman as a commodity. This time it is not her husband who is gaining from the marriage but her own family who are bargaining as to her worth. How must it be for women to be subjected to such practice? Does she see herself as valuable or as an item to be bought or sold at whim? And what if the marriage goes wrong?

> *It's difficult for the woman to go back to her family if shell price money has been paid, because then the family are supposed to give back the money that they had been given. So, if a woman is in a domestic violent relationship, she's sort of trapped.* (Participant 14)

Here we learn that even if it is seen as a positive practice for women, that bride price or dowry can trap women into situations they are not free to escape regardless of whether there is will on their part. For many women this is their fate. They not only belong to their husband, but his family long after he is gone.

> *Women are sometimes inherited as wives when their husbands die. Often women are shipped off to their brothers-in-law to get pregnant so that they can carry on having children, because my goodness, what else are they for? And so, there's a marriage bond between these brothers. And the inherited wives I think are the most problematic within the social structure because they are not wanted by anyone. They weren't chosen by their new husbands; they were sort of forced upon them and so it's an added burden for them financially. Then her children, he knows nothing about them, they're not even his kids, and so it's a little challenging.* (Participant 22)

Here the participant alerts us to the ties that bind women to their husbands' families and how difficult it is to break free. Their brother's family fulfils an obligation to his brother;

yet, neither the woman nor her children are wanted. They are an added burden. She is not free to remarry as she wishes, and he has an obligation to carry the burden of his brother's wife and children along with the wives and children for whom he already provides shelter. The woman, however, is not guaranteed solidarity and sanctity amongst her fellow wives.

> *There's plenty of jealousy. I think that in this community you want to be the first wife because every subsequent wife basically has to do what she says. And the next wife – especially if you live on the same compound – she's basically your maid service. I was delivering one baby of a first wife, and she passed a little stool; she pooped a little bit while she was pushing. And I gave her a bit of gauze and said, 'Oh, just wipe it away.' And she goes, 'I can't.' And I go, 'What are you talking about? Reach down, and just wipe it away!' And she said, 'No.' She called in the third wife who was the official poop wiper – nobody else wiped her butt.* (Participant 22)

We learn that violence against women is not only perpetrated by men but also by other women who themselves have most likely been the victims of such violence. What brings women to turn against other women? In a world where women have little control of what happens to them, is this their chance at control, their chance to feel special?

Women Against Themselves

It is not just sister wives who exert their power over women. Mothers-in-law can be equally abusive.

> *I do know that matriarchs, the mother-in-law, have a lot of clout with what happens with the daughters. Mothers get to exert influences over their sons, but in a very discreet way, and use their sons as a voice in their community and their clan. The sons are the decision-makers. When a family marries, it's a family marrying another family, it's really discussed for months on end, and everybody gets a say. When a new baby is born nobody gets to name their own child; they give that honour to the most important male in their family. And that person doesn't take that name lightly; he goes and asks everybody what they think, and then makes a decision. They make group decisions in this community, and the women have a voice – a limited voice through their children. And that's why the grandmothers and the matriarchs can make these sweeping decisions for the younger women of the community*. (Participant 22)

This participant brings to light an interesting point. Mothers-in-law have a lot of clout in decision-making in terms of her daughter-in-law's affairs. Is this because it is women's business and men's business is separate? Surely, she was a daughter-in-law once and had

the same power exerted over her. Would she not have empathy towards her daughter-in-law having been through the same thing, or is this considered to be a rite of passage?

> *There are so many factors that affect even the ability to make a decision in this setting. We had programmes to educate pregnant women about their needs, and we realised it was an absolute waste of time, because a pregnant woman never makes decisions about what she eats; it is her mother-in-law that tells her what she is allowed to eat or not eat, and what is to be done during delivery. So, we moved on to talking with that group of women instead. I say, 'Do you want an intelligent grandchild, or one that's a bit low in intelligence?' And they say, 'Oh, I want a very intelligent grandchild.' I tell them, 'Well if you feed your daughter-in-law, you'll have an intelligent grandchild. If you don't, it doesn't matter if you send the child to a good school later, 75% of brain development happens in utero and during the first two years.' Sometimes you have to oversimplify things, but it works.* (Participant 2)

This participant alludes to the fact that when it comes to women's business, matriarchs are in charge, that women are also the perpetrators of violence against other women. Once again, we hear that a young woman has no voice or ability to make decisions, but that an older matriarch can have almost equal power to that of a man. Yet, she does not use that power to empower women; rather, she engenders and supports cultural stereotypes.

> *In this village labouring women are put in huts where the cows are – that's where they go anyway when they menstruate, because they're dirty. But once they're pregnant that's where they go to birth, and they're shut there, and nobody goes with them and they're left on their own to labour. If they come out there's a celebration, and if they don't come out, by about four days someone will go and see if they're dead, and that's what's expected of them. It's these horrific stories about the way that women treat women. My reality is that that's more the norm; the cruelty to women that they would have been through themselves as mothers in labour; that they put other women through is unbelievable. Look, I don't know what the answer is, but women have lost the ability to look after women in some of these cultures, and I think it's because they've seen so much death and destruction and sadness, and the lack of their own autonomy, that they can't possibly have a heart for their sisters.* (Participant 24)

You can hear the frustration in this participant's voice. How can the status of women be changed for the better when women are themselves the perpetrators of violence against each other? What makes women believe it is acceptable to let another woman suffer or die alone? Is it their all-encompassing faith or doctrine that perpetuates this behaviour?

> *I got called to a birth that had gone wrong in a village. We walked about 25 minutes up and down mountains to get to this girl. It was clear that she'd been labouring for quite some time. She had about seven centimetres of oedematous cervix when we examined her, and a big head above the brim. And the mother-in-law and husband sat with us, listened to everything, us talking about it all. She was very young, and it was her first pregnancy, and she hadn't had any antenatal care. It was the scenario where you're called because she's 'not performing how she should have performed by now.' The mother-in-law was saying, 'She is no good; she is no good. We bought the wrong girl,' and she was talking the husband into not helping her. It was very hard to sit there. I looked at him a lot to see what his response would be. He was softer; it was the mother-in-law that was the hardest woman. And yet I know that she had probably herself been through some bad times, including the war. I don't know what was going through his head or her head.* (Participant 24)

Here we learn that while the husband may be the decision-maker, it is his mother who has the ultimate influence over his decisions in matters of women's business. How must it be for a woman who has been through a similar circumstance to be so critical towards a younger woman going through the same horror as she has? How is it that she can sit back and watch another woman die an avoidable death?

> *I think in the end the reason they allowed us to bring her with us was because of me, because I was there. I was the white woman sitting there going, 'I want to take her to hospital' – the authoritarian Anglo colonialist basically – the complete opposite of what I believe in coming to them and saying, 'She needs to come to the hospital now!' You know? That allowed it to happen. That's the frustrations of this sort of work, and what happens is I get a sense of fatalism that every woman I look after in these sorts of situations is probably going to die in the next pregnancy or the one after that.* (Participant 24)

This participant talks of the fatalism of these decisions and the tied cultural norms that bind such decisions. Rationality plays no part in decision making in this setting or scenario. The participant reminds us that once that 'colonising influence' is gone, the status quo will remain the same for the young woman.

> *They have a belief in this community that the first time a woman gets pregnant, the husband cannot be sure if it's his or not. Therefore, she has to go through a childbirth confession where she must deliver at home in her husband's hut, and while in transition or during the pushing stage, confess who she slept with other than her husband if she wants the pain to stop. Of course, no woman ever confesses – it's just a lot of hogwash. But they have*

> *some strange ideas that if she suffers too long, then she's cursed because she slept around, and therefore her husband rejects her and the baby dies. I think a lot of the reason is the cultural belief that the husband will not accept the child unless the child is delivered in his house, and he hears that she has not confessed to any infidelity, and the baby lives. Then of course it's his child, but other than that there's no guarantee he'll even recognise the child. So, she really has no option but to follow this particular protocol.* (Participant 22)

The horror of this scenario and the cultural ignorance surrounding childbirth is evident. The mere suggestion of a woman surviving childbirth based on whether she has been unfaithful in her marriage is absurd in the Western sense and, I would suggest, in many developing settings. How does one begin to break down these traditions and beliefs that are so deeply ingrained?

> *The husband decides whether she needs to be referred. If he knows that she's very weak and she is going to die, he won't sell his cattle to pay for her to go, because women are dispensable. They're like a second-class citizen and they'll find someone else to replace her. Unless we get to a point where we're empowering women, educating women, getting them to change their role in society, I don't think that's going to change.* (Participant 21)

Again, we are drawn into complexities. While the husband makes the decision, often at the advice of the matriarch, the act of arranged marriage and the subsequent buying and selling of women into marriage brings with it the idea of buying another wife and perhaps 'throwing out the trash.' She is treated much like a car, if she is unable to fulfil her duty and is costing her husband money, then she is not worth fixing and a new one is in order.

> *When you talk to men where their wife has been close to dying in childbirth, and you say to those men that, 'If this happens again, she will die,' they still won't agree to her having a tubal ligation. They're willing to accept that risk, because she's normally not the only wife – there's usually two or three or four, depending on how big a man you are. And even if you don't have other ones, you can just get another one to come look after the babies if she dies.* (Participant 16)

As we have learned, a man's status is determined in these patriarchal or patrilineal societies through his ability to bear sons. He cannot do that alone. Women, therefore, are his tool or vessel through which his desire of multiple sons is met. If his wife is unable to fulfil that role, his place in the community could be in jeopardy, and that too is true of his mother.

While having multiple wives ensures that that need is met, having a wife who is unable to meet the expectation of many sons is a burden from which the family must rid themselves.

> *If it were a boy, the men would go and call it out from the mosque; if it was a girl they'd look the other way. And even if that mother fed the baby she wouldn't look at it. I thought this was so awful from the mothers, but when I got to know them they told me, 'I can't get close to her because I know what she's going to suffer. I can't love her too much because I know what she's in for.'* (Participant 2)

We learn here that it is not the act of giving birth that women fear most, but the fear of not producing a son that is most fervent. We learn that the fear is not actually what their husbands or mothers-in-law may do to *them*, but the fear of what will become of their daughters. What must it be like to fear loving your own child, or to feel guilt that you are responsible for her fate? And why is that mothers-in-law perpetuate that fate?

> *I remember one young girl; she came in with her family. She was sitting under a tree when I came out, and she was tiny, and she was very young. I couldn't quite work out what was going on except that she had an incredible fever. It turned out that she had puerperal sepsis and had had the baby four days earlier. She was grossly unwell, she hardly spoke at all really, but she also just had that sense of, 'I don't have any choice.' I had to deal with her mother-in-law and her husband. I gave her all my usual management of puerperal sepsis, but she didn't get better and continued to lose lots of blood and muck. I needed to transfer her – we were a mud hut hospital, we had no anaesthetics, and we had no blood. The sad thing was her identity was not there, there was no self in her. And it was such a weird experience; I said to the family, I needed to get their permission to get her to hospital, so that she could have a review and potentially an evacuation of the products left in her uterus. I thought that she would die if she stayed with me too long, because I could only manage her for so long with her infection. But the response of the family was that no she couldn't go; the baby, a boy was okay, and she needed to stay here to breastfeed the baby, and that it didn't matter really about her. And I asked her what she thought about that, and she just shrugged her shoulders. She was the sweetest little thing, about 14 years old, and she basically just went, 'Well it's up to them; I'll do what my family says.'* (Participant 24)

Here, we are led to assume that it is the baby who is most important to the family, not the mother. Whether she eventually lived or died was of no consequence, as long as she fulfilled her duty of producing a son and continued to feed him. Why was it that they brought her to the clinic if not to save her life? Was the fear in the further transfer?

> *I continued to bug them for a few days. But I just remember that feeling of sitting there with this lovely young girl, who had just got through death through coming to us really; she would have died within a few days I imagine. That's life for women; that whole sense of self is not there. She was not alone. In many other countries I've worked in, in remote places around the world where women still live with a life that says you will be married off, you have a bride price and that's your job, they actually don't have a sense of anything other than, 'This is my job.' Families say no they can't go to hospital, they can't take them, they don't want to spend the money, because they're a little bit like a commodity.* (Participant 24)

Reflecting on the views shared by the participants above, we learn that men are the main perpetrators of violence against women, men see women as nothing more than a cheap commodity, and a women's worth is measured by men in her ability to bear sons. What is perhaps worse, is that women, who themselves were subjected to such harsh conditions, often perpetuate the cultural norms instead of supporting their daughters-in-law to achieve a safe pregnancy and birth.

Politics, Culture and Religion

So how and why do these cultural and political norms remain so embedded in the everyday lives of childbearing women? With governments committing to honour women's rights, how is it that very little has changed?

> *The decision makers in these settings are frequently men. Don't get me wrong, I love men, but these men haven't watched a woman die; they don't know what it feels like to be pregnant; they haven't looked after a pregnant woman; they don't get it. They don't get the impact on a society. It's not just the women dying, it's the children they leave behind, it's the economy; it's everything. It's a fact that the key decision makers in [the big agencies] are predominantly men, and in governments they are too. They don't care. We need to infiltrate more women at the decision-making level.* (Participant 4)

Yet, this next participant alerts us to the complexities involved with such a proposal.

> *Women's business and men's business is very divided, and so what is done in the women's world is not shared with the men. Yet the men make all the decisions, and the men actually didn't know that there was evidence to prove that the women should perhaps go to the hospital, and they could save their women's and their babies' lives if they brought them in, they were quite ignorant to that information.* (Participant 10)

Has one vital part of this jigsaw been ignored? This participant suggests it may indeed be the case, with men not being truly educated or informed that if a woman is struggling in childbirth, a hospital could give her life-saving care. Yet, overwhelming evidence to the contrary appears to suggest otherwise; it is male indifference rather than ignorance which is putting childbearing lives at risk.

> *In my view it's not just a power issue, an anti-women issue; it's also what's happening politically. If you dampen down women in this regard, all of a sudden what's happening is domestic violence and violence against women. Historically, that was very much unheard of in this country, but because they have lost their status, women are getting subjected to more and more.* (Participant 6)

With an issue such as maternal mortality being on the global health agenda for the past three decades, and women's rights also being mandated for a similar length of time, how is it that life for a childbearing woman is extraordinarily challenging in many developing countries. This participant suggests that it is not just a cultural or religious bias affecting women, but what is happening politically within a country that can shape how women access lifesaving care.

> *In a protracted crisis, as opposed to a sudden civil war, how it affects women is that they ended up losing any opportunity to get an education. So you've got at least one or maybe two generations of women who are birthing who have no knowledge about their bodies at all apart from superstitions. In that situation, the only time women access health services is when something goes wrong. They are the ones that come because there's an arm hanging out and no one knows what to do with it, or they come because the baby's delivered but the placenta's still in and everyone's had a pull, and nobody can get it out. I saw lots of horrible, horrible things.* (Participant 24)

Certainly, in any conflict, protracted or otherwise, childbearing women often bear the brunt of a fractured health system. It is interesting how this participant reflects on the long-term effects they have on the generations to come, not just the effect it has during the conflict. In unsafe times, women do what they can to keep themselves safe. We also hear that women become even less of a priority during times of crisis.

> *In a war, often health facilities are destroyed and even if the health facility is there they may not be getting supplies anymore. The staff may be gone, or they may be engaged with caring for people who are wounded and therefore don't have the time or energy to spend with pregnant women. Women who are displaced are in a very risky situation during the time that they're*

> *moving too, and also possibly wherever they resettle afterwards so conflict affects them in that sense. Certainly using gender and race as weapons of war is a factor in many modern conflicts.* (Participant 17)

Women are not only casualties of war but are so often used as weapons; raped and pillaged in front of their husbands and families by the very soldiers sent to protect them. For women it is often too dangerous to leave the only sanctuary they may have left—their home.

> *They know that the hospital is there, but they'll only come if they think it is safe to leave the village. When I worked in [Pacific country], even though the war had ended two years before, people wouldn't travel out of their own area for safety reasons because they feared attack. In parts of Africa, people were always fearful that if they were alone or if it was two women together that they might be attacked and raped. It greatly affected women's access to the hospital. There was also the fact that if the husband didn't give permission for them to travel then they couldn't move anyway. I've had women dragged out of hospital; one woman came in with an incomplete abortion bleeding profusely. Her husband dragged her out drip and all. She would have, at the very least, been badly beaten; perhaps even killed.* (Participant 19)

This participant opens us up to the paradox of what it is to be safe in such a context. We learn that women may not access care for fear of attack by strangers, and yet we hear that even when reaching the sanctuary of the health centre, a woman is attacked by her own husband. Once again we are led to question the efficacy of human rights laws when no one, not even the health professionals, can intervene to save the woman.

What is not in question, however, is the part religion plays in determining a woman's path to safe maternal health care. To delve deeply into this area would require a thesis in itself; however, the participants in this study clearly allude to religious ideals contributing to maternal and infant mortality.

> *The church is so powerful here that sex outside of marriage is definitely frowned upon, yet it happens. There have been cases here of infanticide, where babies have been born and died early or have been killed. I've heard of four suicides in the last two months, which is something I've never heard of before and these are young females as well. You don't see it in the paper or anything like that, it's not discussed, but you hear it through the grapevine that these things are happening.* (Participant 14)

This participant alerts us to the expectations of religious practice, and the absolute need to practice to its ideals. The shame and stigma of not meeting these ideals or practicing outside

of religion is a risk many women, particularly young women, are not prepared to take; preferring to kill themselves or their babies to avoid being cast out.

Health Professionals

If women are not able to speak for themselves nor garner support from their families, what role does the health professional play in assuring women receive timely and life sustaining care? As well as individual countries assuming their own medical code of ethics, there are many universal documents relating to the ethical practice of health care professionals. Two such documents are The Hippocratic Oath and the International Medical Code of Ethics, which states that, "A physician shall give emergency care as a humanitarian duty unless he/she is assured that others are willing and able to give such care" (World Medical Association, 2006).

> *The concept of a nurse or a midwife in this country is that she is a servant of the doctor, so there is no importance given to her. People who go into these occupations are from poor families, they are looked down on, and I think that's where you have to look at all the cultural things. They're really looked down on because they live together in a nurses' home; it means they are away from their fathers and their brothers and God knows what they're doing; they become impure. They are not under the supervision all the time of the men. And that is why historically it is really difficult for a nurse to get a husband. They've married men who can't do anything or who were a bit sick or something like that. This is how society views them.* (Participant 11)

In countries where the majority of maternal health care professionals are women, it is often difficult for them to gain traction. This is true of many Western societies still to this day. The premise of 'women caring for women' is not a priority on many government agendas, as is highlighted by this participant. Rather than being a revered profession, a midwife is seen as someone with low status, who is afforded little autonomy.

> *The biggest problem in this country is that once you are qualified the government sends you back to the place you were born. If you're married, your husband has to accompany you. They come into the profession knowing that that's going to happen, and so their husbands and their family accept that that's what they'll do. Quite often some of the husbands have a good job and they don't move, so that nurse or midwife might live separated from her husband for five years. It's a bizarre thing to be doing.* (Participant 18)

Here we learn that becoming a midwife can pose challenges for women. For some, it can create strain on their marital relationships. Despite a woman, once married, becoming part

of her husband's family and community, after qualifying as a midwife, we learn that she is sent back to her place of birth to ensure her community does not lose her expertise to the city. Her husband is expected to accompany her; yet, this may be impossible for him. Such a lengthy separation surely would prevent many women from applying to become midwives or health professionals and may explain why many rural health centres remain understaffed or, in some cases, empty.

> *For women in a remote rural setting, it's life threatening to be pregnant. Most women think, 'Now how can I get to that health centre when I come to deliver because my village is three and a half hour's walk up that hill. And so, when I come to labour, especially if the waters break before dawn, I can't get there.' And then if you do manage to get there at night, the health centre might be closed! That would be the worse option, wouldn't it, you're right at the health centre and no lights on and the doors closed. So, then you might have to have the baby on the veranda by yourself or something. So, most women don't come, and our supervised birth proportion has dropped from high 60s, to 37% last year.* (Interview 15)

The reality of birthing in remote rural areas is such that a woman often faces an impossible choice. She is expected, often by her government and by propaganda, to birth at her local health centre, yet the health centre may be some distance away. It may also be logistically challenging or dangerous for her to travel to, and once there, the health centre may be understaffed or worse still, closed.

> *It's those rural women that often come to the greatest harm. A midwife, who was trying to deal with a woman in the community, was told by the higher authority that as a midwife she shouldn't be doing breech births in the community. So, she transferred that woman in against the woman's better judgment, and what she got exposed to was about 15 health professionals and a white western woman who doesn't speak her language mucking around with her genital area and her body, with her husband locked outside.* (Participant 3)

This participant alerts us to the complexity of birthing women in remote rural areas. Many of these women would never have set foot in a large town or city. They would have watched their sisters and friends birth in their own village, surrounded by family, and with the community midwife. There is no doubt they would have witnessed some of these women dying. In this particular country, a large number of the population may live in remote areas not easily accessible to health centres; hence a greater maternal mortality ratio. Yet, the UN directive to this country's government is to reduce that ratio by up to 75 percent: that directive is sent down the chain of command all the way to the community midwife and

she is no longer permitted to deliver breech births. Despite having delivered hundreds of breech babies successfully in the past, she is told that it is too risky, and she MUST transfer the woman to the nearest health centre. Against the woman's wishes, she is sent to an unfamiliar place, unable to understand what is happening to her, without the support of her family, and promptly delivered OF her baby.

> *It must have been awful. No wonder these rural women don't want to go in... It's like they kind of get medically raped by a system that doesn't acknowledge them as human. But the thing that really got me is she accepted it; she actually perceived herself as being of less value than people in the urban areas.* (Participant 3)

Despite the experience being a terrifying one for the woman, this participant suggests that there is a large divide between the treatment of urban and rural women in relation to health care treatment. She hints at prejudice against rural women based on their lower status, cultural practices, and/or poverty.

> *As well as being bombarded by cultural obligations, which are really strong in this country, women are told how to birth, and where to birth and we're going to cut you before you have your baby, so they're less and less empowered in a nation that traditionally had women as so privileged socially*. (Participant 6)

And herein lies the paradox. Women once revered by their society have now become beaten down by a system that affords them no ability to make autonomous decisions regarding their childbearing practices. On one hand, they are expected to uphold the traditional birth practices defined by their culture; on the other hand, they must obey the directives of the local and international health authorities.

> *The women here go to the clinic because they know they have to, not because they want to. They would wait all day, they would not be greeted, and they would not be treated with any respect. They would be given a name or a number card, they would be looked down upon because hierarchically, a woman or a nurse doing the antenatal care is absolutely way above them; they are at the bottom of the barrel, they accepted that, but they didn't like it.* (Participant 24)

Far from being a welcoming and uplifting experience designed to encourage women to return to the health centre and deliver their babies there, the clinic experience can be quite dehumanising for many women. We have learned that a midwife is afforded little status in

society and, as this participant suggests, the only way to gain themselves a little power or status is to enforce with women who are perceived as lesser value than themselves.

> *So, the women would have their antenatal check-up, they'd be given their tablets, they would be told they had to take them without any explanation about side effects or why folate was so important. They would be measured, they would be poked, they would be prodded; the baby would be listened to, but no one would be told, 'Isn't that great, your baby is healthy,' big or small or otherwise. And then they would be sent off up the hill to walk another four hours home with their antenatal card without any enjoyment of the experience. And that's what they talk about; they say, 'I don't really understand why I went. I didn't enjoy it; I had to leave all my chores which means I had to stay up late, I had to work hard the next day. What did it give me?' To them, it's a bit of a waste of time.* (Participant 15)

If a rural woman's burdens are many; a *pregnant* rural woman's load is even more so. Now required to attend regular antenatal clinics far from their home, women are further hampered by the need to catch up on all of the duties they missed whilst taking the day to attend the clinic. Rather than embrace the clinic as a potentially life-saving opportunity, women see it as a negative experience, adding further stress to their already burgeoning workload.

> *From that came discussions from everybody else about why would I bother going to the clinic to have my baby? And people's stories were that if they did go, they actually only ever heard about either abusive behaviour, terrible pain, and being yelled at or hit or bashed or screamed at or something like that, so terrible abuses. And on top of that, when they'd finally been bashed and screamed and yelled at and lying on their backs with their legs in the air and no privacy, they would have an episiotomy and then would be sutured with no local anaesthetic, and they would be screaming and being told to shut up.* (Participant 24)

With horror stories of being abused while giving birth at the health centre being spread amongst the community, is it any wonder women are reluctant to transfer there when in labour? Birth, for them, has suddenly shifted from being 'private women's business in the home' to a free-for-all outdated medical model where women are cut and abused if they do not progress fast enough. It is clear from the low uptake by women in some countries that they would rather die than be subjected to such a degrading experience.

> *The local midwives are not taking care of the women, they've still got this kind of attitude where they hit and abuse the mothers. And we're expecting the mothers to come to us; we don't go to them and they do get upset about*

> *that. Can you imagine walking six hours, you know, at nine months? No way! You wouldn't do it! I wouldn't do it. Okay, if it was going to save my life, maybe, but can I find an easy way to get there? And if nobody's going to help me, well then, I might as well stay at home and deliver with the traditional birth attendant that has managed my other deliveries, and I was fine.* (Participant 21)

This participant raises an interesting question. Why are the antenatal clinics not mobile? And other than asserting their authority, what reason can be given as to why these health professionals, charged with caring for the women are so abusive? If the goal is to ensure women receive quality antenatal care and have a safe labour and delivery, why is this system not seen as the gold standard and up-scaled across many nations? Clearly, from the participants in this study, and the scholarship on this issue, it is a system with serious flaws.

> *I've seen women hit for not pushing when they're fully dilated and meant to be pushing, and that is skilled birth attendants saying things like 'You are so lazy… this baby will never be born… this baby deserves a good mother, you are a terrible mother, why are you not pushing?' and hitting the woman in the face, and telling her that she's lazy.* (Participant 7)

It is abhorrent to hear from so many participants during this study that this abuse of childbearing women by health professionals is so prevalent. It is worth noting that the participants in this study had vast experience working with childbearing women from developing nations from a range of countries across the globe. It is not just happening in one town, in one country, or on one continent. During my time as a researcher during this study, I too witnessed this behaviour in multiple settings and countries.

> *If you watch the midwives, the nurses, or anyone looking after women here it is just appalling. They scream at women, they slap them, it's sort of very reminiscent of 1960s in the western world; the old midwife with a veil on screaming at someone from one end of the ward to the other. They show women no respect. That is one reason women fail to access care, and if you look at the drop off rate from first antenatal visit to the fourth, it is quite significant. A lot of that is around the way they treat the women. I've seen women get to health centres, like maybe the health centre did its antenatal clinics on Tuesday. The woman showed up on a Monday, so the nurses berated her for turning up on the wrong day – of course that woman never comes back. It's not like they say, 'Look, you know, thanks for coming, I'll see you this time, but you know we have clinics on Tuesdays so when you come back for your next visit could you come on a Tuesday?' That would be the way of dealing with that I would have thought. But instead, they just treat them abominably. And it is that sense that it's often groups who are*

> *persecuted who are the worst perpetrators of violence against the same group. It becomes like a psyche thing.* (Participant 16)

The final comment by this participant is most telling. As we learned earlier, midwives or nurses working in rural clinics are most likely to be women who originated from those areas. They have gone to the city to train; to better themselves and to lift themselves out of poverty, only to be seconded by the government back to their own area. Do these women feel like they have paid their dues, that they suffered at the hands of health professionals through the hardship of being pregnant, and that it is a rite of passage that all women must go through? Are they full of resentment that they thought they were escaping the poverty of their home, only to find themselves back there again, or is it simply an ingrained psyche that says, "I am more important and powerful than you and don't you forget it?" The following participant believes so.

> *As soon as she went to that state hospital, the poverty just took over – and the resentment and the oppression which had probably been there for years. Things like privacy, which is very important to traditional women – gone; self-autonomy of the woman – gone. Politically she was less than nothing.* (Participant 3)

Herein lies the dilemma. Women are encouraged, and in some instances expected, to birth in clinics with qualified health professionals. They are told their baby will be at less risk and that they themselves will have a better chance of survival. Yet, having a baby is so much more than just "giving birth". There is so much at stake for women. Politically they are not recognised; in the city they are belittled for their poverty and, at times, face prejudice because of their religious affiliation; and in their own home region, the women, who once stood beside them or that they grew up with, are now beating them, screaming at them and telling them they are no good. Could it be, for the many women who stay at home despite the risk to their life, that there is seemingly a fate worse than death?

> *At the end of the day, you can train midwives, you can put in clinics, you can actually have equipment and stuff, but if that midwife is an absolute horrible, bitchy, aggressive, abusive woman, then it's unlikely that the women from her local region will come to her*. (Participant 24)

The above statement is a sentiment strongly echoed by all study participants in relation to their experience of local health professionals' relationships with childbearing women. To have included a quote from each participant would have overwhelmed this thesis; therefore, the musings above are a representation of the issues most prevalent. Simply training new

health professionals and building new clinics is not, and has not been, the answer to reducing maternal mortality in these developing nations.

Women Themselves

With the above reflection in mind, it is not surprising that women themselves have a defeatist attitude when it comes to surviving childbirth. If their husbands do not value them; their mothers-in-law wield power over them; their country, religion, or culture either does not acknowledge them as a valuable members of society; and when obeying the rules set for their survival during childbirth they are berated and abused, what pillar does a woman have left to stand on and fight.

> *Women's expectations of what will come out of life are exceptionally low. When you talk to pregnant women you ask them do, they ever think about dying in childbirth. And some women will say they do, and then others say that they don't, they just accept that there's nothing they can do about it, so they don't worry about it.* (Participant 16)

So why do women have such low expectations? What prevents them from making a stand and saying enough is enough? Are the circumstances in which they find themselves in so oppressive, that even their own death is acceptable?

> *I think you can't make a sweeping comment that women are oppressed in a certain culture. There are very big aspects of this particular culture where women are oppressed, but you can't tar everyone with the same brush. They're not educated; they're married off when they're very young to have children, to work in the fields, but they hold a lot of power within the family unit. They are the decision makers. There's not much money in the family unit, but whatever money is there, they dictate where it goes. So, there is a balance of power, but it's really hard to see, and you don't see it until you're sort of sitting and living within that particular environment, because looking from the outside you see that they are an oppressed gender. And it's true, they're not given the opportunities of education, so that does give them a certain degree of oppression, but it doesn't mean to say that every part of their makeup and activities of daily living are subservient to the male gender. Women are definitely a more vulnerable group than men, so of course there's oppression, because they don't get to eat as much; they're vulnerable because they aren't as healthy; they're vulnerable because their fertility is abused; they're vulnerable because they're not educated.* (Participant 10)

For childbearing women in developing nations, there are so many present-day pressures, that worrying about the future is a luxury not afforded to many. They are so overburdened with responsibility that each day must be about survival—mentally and physically.

> *These women, they are the workers, they get everything done. They walk hours a day for water, they walk and work in the fields, they cultivate the plants, they do all of the cooking, they do all of the tending. The husbands sit under the trees and chat and smoke, and then make babies at night. They have no right to refuse their husband sexually, even if their husband has STDs and refuses to be treated. And these women therefore have to deal with the consequences of these STDs, because that comes into the play of not being able to have children, carry to term or suffer many miscarriages.* (Participant 22)

As this participant reminds us, women have little to no control over their sexual health as they cannot refuse their husbands; to do so would result in an almost certain death sentence. They cannot question his sexual practices and must accept his advances regardless of the serious health and fertility consequences that could materialise as a result of that sexual encounter.

> *There is an acceptance that this is their reality, like it's their lot in life. If you talk to the women themselves, they will often say there's some violence from men against women that is justified. Even women believe that because they've been socialised into accepting that as being the way of life. So if you don't do what your husband wants or you don't service his needs in the right way, then their belief is that it's reasonable that he should beat you.* (Participant 16)

What must it be like to believe, truly believe, that it is okay for another human being to beat you senseless? It is hard to comprehend from our Western perspective, and yet it is commonplace in these patriarchal societies. Women, in these situations, have been conditioned to believe they are the lowest priority in their societies that they must honour and obey their husbands, forsaking all others, including themselves.

> *The women here are remarkably strong, and yet fatalistic, in the sense where they know they have no options, and so they'll fight to live if they can live; but if not, they will accept dying, because that's what happens, and it's not hidden from them. They watch their friends, they watch their sisters, and their mothers die in childbirth, and they cry, they grieve, and they weep, but they also realise that their only way of moving up in the world is by having babies. They have no social clout, there's no value in them whatsoever unless they can be pregnant and carry a child to term and keep that child alive. Their husbands won't love them. They'll maybe even face divorce or*

> *estrangement or be cut off financially from their husbands unless they produce these children. They are desperate to be pregnant, even though it brings a terrible risk. And they recognise the risk, but that's the only commodity they have – their baby-making ability.* (Participant 15)

While these women may appear resigned to their fate, they are neither weak nor unwise. They understand that bearing children, particularly male heirs, is also their role to a better life. Children are currency, pure and simple. Without them, it is unlikely a woman will survive. Die giving birth or be killed or abandoned for not bearing a son, the odds do not look good; therefore, most, if not all, will take their chances in childbirth.

> *Women live in a bit of denial, or they're very fatalistic about dying, because they don't have a choice not to have children. We always had contraception in the clinics, but people didn't use it very much. We advertise that we had contraception, and I never found a way to promote it without getting into trouble, which used to happen when I tried to give out condoms in the waiting room. The staff would beg me not to do it anymore because they would be lectured at the mosque for three hours on a Friday about how bad it was.* (Participant 20)

If bearing many sons is akin to a better quality of life for women, then offering contraception would prove fruitless. Despite the medical necessity in terms of allowing better birth spacing, and, therefore, ensuring better survival rates for women and their babies, this participant reminds us that for many women contraception is not an option. Religion plays an important and extremely influential part of these women's lives, and the issue of contraception goes against many religious teachings. Once again, these women's childbearing years are not theirs to control.

> *There was an incredible fatalism; an acceptance that none of this was in their control and acceptance that this was their job – their life was meant to be this way; and a fatalism that entered labour and delivery with the knowledge that people die. One in eight die, that's exactly their experience, so it's not hidden from them. You'd meet some women, and you could tell that their husbands cared for them; then there were other women that were so sad, and the look on their faces. When you got them to open up about their life with their husbands and their mothers-in-law, it was very clear that they had absolutely no control over anything, and their husband didn't love them for who they were, that they were just a possession, and their role to be fulfilled was to be a mother and produce a child. I suppose I got a sense from that about how tough these women were, but also how they didn't have a sense of self at all.* (Participant 24)

The word ‘fatalism’ appears in many of the participants’ stories; this idea that women believe that their life is in the hands of Allah, that death is very real. Far from weak, these women’s strength of character is such that they make the only choice that is open to them, despite it coming with unbearable risk. Yet, in one area, there are signs of a sisterhood fighting back.

> *The ladies were telling me, ‘We agree that we’ll have five children; we just don’t want to have five children in a row.’ So secretly in this village they were using IUDs, and none of their husbands knew they had one. It was an absolute agreement between the midwife and the women, their sisters, and their mothers together, that they would have five children, but they would have them every three years. The men would never be allowed to know about this decision, so you had to have a kind of a real agreement among women that ‘we will trick our husbands, but we will still give them what they want too.’* (Participant 5)

This participant informs us of a secret society of women who have found a way to take some control back in their lives, while still giving their husbands the children that they desire. This silent empowerment by women shows a respectful pushback against societal norms in a way that gives these women a sense of self and ensures that she maintains her cultural and familial duties as a wife and mother.

> *This country was classic for the reason that women actually liked to be pregnant, because when they were pregnant, they didn’t have to have sex. So, birth spacing went out the window – and that would just be so challenging. You’d get a woman who’s just delivered, she’s got a one-year-old, and that baby then is weaned rapidly. We’d then see malnutrition, and the whole cycle would begin again, because then she’s busy with this new baby and hasn’t got any time to feed this little one who still needs a lot of support It seems that women are using pregnancy as a tool to get away from sex, to reclaim that kind of power and control back in their lives. It’s just very, very difficult, and they’re not interested in contraception because they’d like to get pregnant again. So, you know, it’s like trying to flog a dead horse that one.* (Participant 9)

Here we are shown another, perhaps more dangerous, scenario of women attempting to take control of their fertility. This time, instead of wishing to space their births, these women desire to be continually pregnant so as to avoid having sex with their husbands. In some societies, it is frowned upon for men to have sex with pregnant women. Often men will have multiple wives for this very reason. As this participant tells us, there is very little

success in convincing these women to take contraception to help space their pregnancies and ultimately help save their lives.

> *I think we're going to need at least 20 years for these women to be educated. I don't think they're going to take their health seriously until somebody teaches them that they are of value. A friend of mine did a fascinating study, basically her conclusion was if a woman were educated to the fifth-grade level – she can read and write – there would be an 80% decrease family sicknesses, because she can read her prescription bottles, she can follow directions on food packages, she can read a container and learn that that's a toxic chemical and she shouldn't gather water with that container. When a woman is educated, she learns how to learn; when a woman is educated, she realises that she can think and that her ideas are world changing. When a woman is educated, she can look at the world from a new perspective and realise that she has something to offer and something to gain, and therefore becomes a mover and a shaker. We can do mass campaigns, but until these women start thinking for themselves, there's not going to be a significant change.* (Participant 22)

While education is the key to ensuring better survival rates for women during pregnancy and childbirth, cultural pull and familial responsibility are, in many developing country settings, too great a barrier to overcome. A groundswell of women with the bravery and courage to take a stand against their own cultural norms is needed; yet, how do women who themselves believe they are unworthy, begin this process?

> *It's a matter of circumstance and some sort of perfect storm of enough women who are motivated. I think that comes from the grassroots though, it's not something that's imposed from the outside. So, you have to have enough women in the setting who have reached a point where they say, okay, enough is enough, we need some change.* (Participant 17)

It is clear that while the international community can shine a light on women's rights, advocating and writing global policy for change, it is fruitless if the women at the very heart of this thesis do not fight for their right to be prioritised. For that to occur, women need to first believe they are worth fighting for.

The following chapter, Chapter Nine, further unpacks how aid and politics can perpetuate the toxic environment that adds to the continuation of childbearing women losing their lives during childbirth.

Chapter Nine: The Problem with Aid and A Political Quagmire

The notion that aid can alleviate systemic poverty, and has done so, is a myth. Millions in Africa are poorer today because of aid; misery and poverty have not ended but increased. Aid has been, and continues to be, an unmitigated political, economic, and humanitarian disaster for most parts of the developing world.

(Moyo, 2009, p. xix)

The multi-billion-dollar industry that is foreign aid has proven a contentious topic of research for decades. As European colonisation extended its reach across the globe in the early 20th century, aid revealed its many faces (Phillips, 2013). The most prevalent is that of humanitarian relief. With 'Western' media saturated by images and stories of the starving and the poor, we were told it took just a 'dollar-a-day' to feed a starving child. That same 'dollar-a day' also provided medicine to protect said child's future. Media advertisements morphed into celebrity-endorsed rock concerts streamed worldwide with millions of dollars donated to 'save the children.' Hunger can be fixed, albeit in a non-sustainable manner, but what of the women who give birth in such fragile contexts with minimal access to appropriate health care? That the rates of maternal mortality have been so slow to diminish suggests this is an issue for which there is no easy fix. Aid, in itself, is complex and multi-faceted with a political and economic mandate arguably, at times, seen to benefit those 'Western' or developed world donors, much more so than it has to those in developing nations for which the aid was intended.

My own observation of the trouble with aid was highlighted during my midwifery journey in Senegal, as outlined in Chapter One. An ambulance gifted by a US agency to a maternity hospital sat idle and covered in sand. The local sage-femmes (midwives) explaining that it was too expensive to run, and women were not seen as enough of a priority to warrant the expense. In the neighbouring town, a row of state-of-the art incubators gifted by a church group from France sat abandoned in a storeroom. A thoughtful gift; yet, there was no reliable electricity source to run them. It was a sobering moment as I replayed in my mind the many donations I had blindly given, without a thought for what was actually needed on the ground.

It was to be the year following my African visit, when I stumbled across a book that was to cement my doctoral journey—*Dead Aid* by Dambisa Moyo, a Zambian-born, American educated economist and author, was the first voice that frankly spoke to my observations. Moyo, a former consultant with the World Bank and co-author of their World Development Report in the 1990s, spoke to the inefficacy of aid and debunked the great myth that the billions of dollars sent from affluent donor nations assisted in growing those developing countries' economies and saving the lives of its people.

Subsequent scholarship has backed up Moyo's claim. Doucouliagos and Paldam's (2009) article, *The Aid Effectiveness Literature: The Sad Results of 40 Years of Research*, published the same year as Moyo's book, reiterated similar findings in that they were unable to conclude any meaningful positive overall outcome associated with development aid. Williamson (2008) agreed, surmising that while international aid could indeed be a formidable weapon against poverty, that weapon is underutilised and clearly off target.
Armed with my own preunderstandings and a literary bias, I was curious to uncover what those working on the frontline, the aid workers charged with implementing the very aid projects targeted at the populations they served, thought. Again, I would like to reiterate that this is a global study and as such all references to specific countries have been removed from participants' stories. Many participants spoke freely against the very aid organisation they were working for, on condition that they would not be identifiable. It is to be noted that while they criticised the systems of aid in which they were enmeshed, in their humility they did not give voice to their own commitment to 'make a difference'.

Lack of Cooperation by Leading Agencies

For the majority of participants, particularly those working in the larger global agencies, this was their first opportunity to speak freely and openly about the frustrations of life on the frontline as an aid worker charged with saving women's lives. Their exasperation is, at times, clearly palpable.

> *The UN, they're so far removed from what's going on in the field. They're not implementing actors. They work with ministries; they help to influence. It's all political, and it's about who's who. I was hoping the MDGs would have more of an impact at a grassroots level, and that we would see changes, but they end up talking about lots of bureaucracy, paper shuffling, everything takes too long to be able to make any difference.* (Participant 21)

This participant articulates the frustration of those on the frontline of this crisis. They believe the UN, who with their MDGs have set the gold standard of expectation and intervention in maternal health care in developing nations, has more of a political agenda than one actually intended to make a marked difference to those in the field trying to save women's lives.

> *WHO, UNFPA, they should be more practically approached, or more clinical; they just don't seem to be able to bridge that pushing around the paperwork to getting the care out on the field.* (Participant 5)

Echoing the previous participant, we hear again the strong sentiment that the UN agencies seem unable or unwilling to translate their commitment on paper into active and necessary work on the ground. This participant alerts us to the idea that those writing and publishing the UN policies seem to have little practical experience either in maternal health or in the developing country for which they are charged with implementing policy.

> *Most of the UN agencies, the vast majority of them, are not implementing agencies. They're not providing any services on the ground; therefore, they don't have people on the ground. They take data and storage from those of us who are implementing and pull it together in a report and use it, but they don't have any sort of contextual feeling for what's happening in the remote locations, where that information's coming from.* (Participant 17)

This participant perhaps highlights the root cause of the aid worker's frustrations. All the participants interviewed in this study stated that they had never been consulted about the relevance of work they have been asked to carry out. Policies are being implemented by key agencies without context, and little consultation with their own frontline staff. Instead, this aid worker feels like they are just a necessary cog in a larger wheel being used as data collectors for reports that will show no context and be of little value to those in the field.

> *I just feel quite angry when I think about UNFPA, WHO, all the UN salaries going on, and all this money that's spent on experts, but equally again just doesn't get filtered down to the ground. I think their policies are probably really sound but again, they hit that stumbling block when it comes to rolling it out, and they don't roll it out. And all this money gets served into pockets of people so they can buy more suits and I struggle with that!* (Participant 5)

It is interesting that this participant, in venting their frustration, brings up the subject of the inequity of aid money and whether it is spent in the right places. Once aid is in a country do donors have much say on how and where it is dispersed? While the UN agencies appear

to not have a shortage of money to spend, this aid worker believes they implement a top-down approach to spending, with a negligible amount of that money being used where it is needed the most—at the grassroots.

> *I'm going to take off my UN hat, and I'm going to say I think they're often a pain in the neck, because every year a slightly different message comes out from Geneva or comes out from New York. They should say, 'This is our strategy for the next five years, just work on it, okay? Please make it happen.' But often it comes out, 'This year we want to concentrate on this; this year we want to concentrate on that.' There's nothing magical about 12 months; they should really let countries just get on with it. That would give them the best return for their investment in terms of saving women's lives.* (Participant 8)

This UN worker shares their frustration at the lack of a clear message and direction from the central offices of the UN and WHO. They suggest that these agencies would do better to allow those in-country to be in charge of their own agenda if they wish to see their goal of a reduction in maternal mortality come to fruition.

> *You need those people sitting in Washington working for UNDP and UNFPA and all of these organisations and you need the specialists and the in-country offices in developing countries to be looking at having higher standards, you do, but actually you also need grassroot organisations who are going to come up the other way, and that's where the vacuum is.* (Participant 9)

This participant backs the agenda of the UN agencies to ensure that a higher level of care is being sought for childbearing women in developing countries. They do, however, clearly endorse the mandate from the other participants to ensure firm support for action from the ground up rather than the top-down approach that is currently offered. They speak to the important role of the grassroot organisations who have a richer view of what is happening on the ground yet cannot seem to garner the attention of the leading development agencies.

> *We had the UN, who was highly inefficient and useless and who had protected themselves with armed guards, and all I ever experienced from the UN was meeting after meeting to get nowhere. We had WHO, who asked for nothing but reports from us, and we saw them not come out of their compound hardly at all. So those reports – maybe they were being filtered back into the international environment and maybe they were making some changes that were required to be made; I don't know, because the information never came back to us. We had WFP, who never seemed to have enough food to go around, who was always telling us that they didn't have*

> *enough food to do anything, so I'm not quite sure why they were there. We had a French organisation where they had men on the ground who were actually working alongside the local people to build bridges and to plant crops. They had an incredible reputation; they were very much loved by the population. We had the Red Cross, who was also loved but kind of held a little bit out there by the population because they came in with all the equipment, with all the money, with everything, and they locked themselves in a little compound at the end of the day. They had their own little expat township, and they came out to the hospital to do their work, so their work was certainly respected because it was seen, it was evident, the population could see what they were doing.* (Participant 10)

Here this participant introduces us to a wider perspective of how the larger aid agencies interact with the communities they are serving when in-country. From this participant's account, there seems to be a lack of cohesion, with some foreign agencies both living and working amongst the community and others sheltering themselves in highly guarded expatriate compounds once off duty. What is interesting is that this diversity in approach to serving the local people is happening within the same community of people. What must those communities think when some organisations arrive and hide themselves away, while others feel safe enough to live freely amongst them?

> *World Vision is big, it's organised, and it has organisational clout. It is quite overt with its agenda. It does waste enormous amounts of funds on its Christian beliefs, but it also has an enormous amount of money so it can put a lot of that into action on the ground. Other organisations come over with their odd practices, and the population gets really confused as to what's right and what's wrong. They're coming in with money and they're coming in with new clothes and everything, so they believe that it's got to be good. But it turns them upside down often, and I think that's a real shame.* (Participant 10)

This participant highlights the confusion amongst the local people by the different approaches and practices that foreign agencies bring to bear on the population they are assisting. While that population may appreciate the help being offered, that help can be often short-term, ever-changing, and unsustainable.

> *A few years ago, the WHO said, 'TBAs, they've made no difference to maternal mortality, we should stop training,' and the government stopped training rural TBAs. Some NGOs continued updating them. We didn't in the beginning, but now we do because we realised they're still a really important group.* (Participant 11)

The training of TBAs, has been the subject of much debate as shown in the earlier literature review. What this aid worker reminds us is that these TBAs are an important link to particularly hard-to-reach communities. They are also valuable as an extra resource in bridging the gap between the expatriate workforce and the local communities when it comes to caring for childbearing women.

> *I think most of the big organisations really underestimate the resources required fundamentally, because they think about the technical fix and they don't think about the system and how the system needs to be resourced.* (Participant 13)

A common criticism throughout this thread has been the inability of the larger aid organisations to fundamentally understand the crucial needs of the communities they are charged with serving. Once again, we hear about the quick fixes that are proposed by these organisations to be implemented in-country, but with little thought to the long-term sustainability of these solutions.

> *We were all there at this crisis, there were all these other NGOs, the UN left, right, and centre, people everywhere, and no one was talking to each other! You know, we talk about these coordination meetings, and everyone agrees 'Yes we're going to do X, Y, and Z' but then they walk out the door and do something completely different.* (Participant 5)

This thread is both disheartening and equally disturbing. We are alerted to aid organisations responding to an urgent need on the ground and yet arriving with their own agendas, and with agreements in principle but not in practice. Why is it that these organisations, all with a common goal in voice and on paper, fail to come together in a seamless and harmonised way when it comes to the implementation of a crisis response?

> *The health sector is full of vertical programmes that don't talk to each other, and funders that don't talk to each other. And I think the countries that may have done a bit better are where they had sector-wide approaches. The answers to improving maternal mortality are not rocket science.* (Participant 13)

While the answers to improving the chances of women surviving childbirth may not be rocket science, this participant underscores that gaining a consensus amongst aid organisations as to the best approach to tackle the problem is, at best, a challenge.

> *People have sector approaches and geographic approaches, so we say we're going to do this kind of service, and someone else says okay well if*

> *you're doing that we'll do this, and some else says well we'll do that, and you end up most of the time with hopefully not too much overlap and no gaps. It does depend a lot on the level of coordination though, and that is something that I know different UN agencies get criticised a lot for; they're meant to be coordinating but the extent to which that is actually experienced – a positive synergy of the agencies – is not always there.* (Participant 17)

This participant underscores the issue of a lack of coordination by the UN and between the larger agencies when responding to a humanitarian crisis. Agencies appear to have their own 'patch' for which they believe they are responsible, and it is evident that while there is cooperation in spirit, there is little in kind.

A Question of Power

So why is it that those who work for the world's leading humanitarian agency, the UN, are so disparaging about the very umbrella organisation they work under?

> *The UN don't see the real picture. They don't have that ownership; they have that attitude that they have the power, and they know the knowledge and they treat the national staff very badly, because they're expats, so they know better than the national staff. They fail automatically because of their attitude.* (Participant 21)

The sentiment and disdain shared by this aid worker was clearly and articulately echoed by their counterparts on the ground.

> *It is a bandwagon, it is an industry, and it is a money-making opportunity.* (Participant 5)

We are alerted by this participant to a new and more disconcerting discourse, that aid is more about controlling people's lives rather than saving them.

> *Things like the MDGs and the WHO, they may have been well-meaning, but they become these vehicles of power. And with the evidence-based medicine movement as well, it's fabulous and it's this and it's that, but it's so good at ignoring human experience.* (Participant 6)

That aid could be motivated by anything other than helping the lives of the less fortunate seems abhorrent; yet, the reality appears to be quite different.

> *This nation is desperate for money. They've got loans from the World Bank, so they've had to adhere to the MDGs and there's a complex form of politics and economics playing out, complete with power games. At the same time,*

> *this is just in one little country, they must have it in every country in different ways.* (Participant 6)

The criticism for the world's top humanitarian agencies continues by the participants in this research, many of whom work for or in partnership with these very organisations.

> *When I look at WHO, they seem to sit in their offices or in their big hotel that they're staying in here, they're not understanding the coal face, they're not listening to women's organisations. I've never seen them active in any way, they're just there as figureheads to be seen. The locals pander to all these people as well. They hold them up as being gurus or whatever, but they're not. They're just getting good wages and sitting in these countries, and basically doing what Geneva says rather than what the country really wants.* (Participant 14)

The participants appear to suggest that these larger aid organisations are not up to date with what is happening in many of these developing nations, that they are focused instead on their own political interests.

Out of Touch With What is Happening on the Front Line

The idea that many of the world's leading aid agencies are immensely out of touch with what is happening on the front line of this maternal mortality crisis is supported by scholarship. Despite the Muskoka Initiative on Maternal, Newborn and Child Health adopted in 2010 at the G8 Summit, and the resulting commitment of US$7.3 billion dedicated to improving maternal and child health in developing nations over the ensuing five years, little changed during that time (Banchani & Swiss, 2019). Indeed Banchani and Swiss (2019) reiterated the very presumption that aid can ensure the survival of childbearing women has, to date, not been backed by evidence. Despite an estimated US$11.6 billion of aid being devoted to saving the lives of these women between 1990 and 2017, maternal mortality is still prevalent in many of the world's poorest nations (Banchani & Swiss, 2019). Banchani and Swiss admitted to being surprised by the lack of empirical evidence connecting aid and a maternal mortality reduction based on the substantial attention paid by the international donor aid community in recent years. It does, however, come as no surprise to those at the forefront of this crisis.

> *I'm not against anything if it works. For me, the frustration is they're not looking at why these things are happening. These people who go to meetings and run things haven't got a clue about what's happening at the grassroots level. It's simple, first you go to the place where the mothers are dying, and really find out why they are they dying. You've got to start here, but they*

> *don't. They just look at the statistics, and then tell us what we should be doing.* (Participant 2)

Here we are left to ponder whether this participant is alone in their frustration, or if the issue is more widespread. With such a substantial amount of money and focus being dedicated by the international community to reduce maternal mortality, surely there must be evidence on the ground that the aid is getting through to where it is needed most.

> *My experience with working for fairly big organisations on the ground was that I felt like they were very disconnected from what was actually going on. I felt that huge disconnect from the offices in Manhattan to the villages in this country. I think it's natural that there will be some disconnect, but I feel like there's got to be a way to link them in a stronger way.* (Participant 25)

Martinez-Alvarez et al.'s (2017) study into the effectiveness of aid from 2008 to 2013 concluded that less than half of all aid funding for maternal child health from donors to recipient countries was distributed through governments. They also concluded that "projects delivered outside the government are the least coordinated with or aligned to country strategies" (Martinez-Alvarez et al., 2017, p. 1884); findings mirrored in a similar study out of Uganda four years earlier by Stierman et al. (2013).

> *Agencies need to look at each place individually and really find out the cause of why these things happen, work on the cause, and then work up to the good policies. But you've got these high-powered people running from country to country saying, 'This is what research says, and this is proved.' And then they wonder why our maternal mortality is not going down a great deal.* (Participant 2)

It also appears that the aid assistance that is making it through can be somewhat misguided. This next participant highlights a clear lack of communication between donor and recipient.

> *Someone was showing me around and they said, 'Come and take a look at this in the maternity' and there were about a dozen incubators, pristine in this room, unused, and they'd been donated by a large NGO. The irony was there was no electricity to operate any of this equipment. So those are the kind of follies and mismanagement of money that are occurring every day at a really basic level in projects in developing areas. It's crazy.* (Participant 5)

There is a clear lack of local consultation when international aid agencies and donor organisations are 'gifting' to areas they believe are in need. Here, incubators were given to assist in saving babies lives; yet, it is a very Western method that does not translate as a

suitable option for many developing nation settings. There appears to be little research or conversation from the Western donor about what is needed most by the recipient community and, indeed, what resources that community has to sustainably use such aid.

> *I tried to follow the protocol by the WHO for prenatal care for this community, and I looked over it and realised that it wasn't giving enough, and I could give more. I don't use it at all. I don't go by their guidelines – I give more. You can't uniformly say this is the way it should be done. Each culture, each sub-tribe, is unique and different. There are a few tribes in this area, and they handle things very differently; how I have to deal with them is very different to what the WHO suggests.* (Participant 22)

This is the first we are hearing of formal guidelines and a uniform approach to maternal health care being inappropriate and even irrelevant to many situations on the ground. We are reminded that childbirth is not simply a medical condition but simply a normal life event, despite its many dangers; that life differs culture to culture, tribe to tribe and indeed woman to woman.

> *I just don't think we talk. If there's something that's missing it is some kind of international coordination of all of the activities. I just don't think that people have gone to those places before they start rolling out this care, to stop for even a week or two weeks to take a look at what is there, what is needed, and to talk to the people on the ground.* (Participant 5)

It is a theme that runs through the heart of this thesis—a clear lack of communication between donor and recipient. What shocked me most when interviewing the participants for this research, was that not one of them had been formally asked by the organisation they worked for what they believed was most appropriate action to assist in the fight to reduce maternal mortality in the region they were working.

> *When the government was being difficult and not cooperative with lots of the work that we were trying to do, the person who was in charge of the overall project said, 'Well you know, if the government's not cooperative here, we'll just pick another community.' And I remember feeling this sense of, 'But what about the people who we've already been working with for the past several months? Don't we have some level of accountability to them to follow through on this even if the government is difficult?' To me it just seemed like it wasn't about the people anymore, it was about, 'We have the money from the foundation, and we have this goal of reducing maternal mortality in this state by this much by this time, and we'll do it however we can,' as opposed to a personal relationship with a place and with the population of that place.* (Participant 25)

In a goal-oriented, hypothesis-driven industry, such as the aid during the era of the MDGs, there is a danger that the woman at the centre of this predicament becomes even more invisible. If her very community is being ignored, how then does the woman's voice get heard? The exasperation of the participants in this thesis is clearly palpable.

Lack of Community Consultation

Nowhere are those participants' frustrations illustrated more than when talking about the lack of *community* consultation by donors and aid agencies. Not only were the agencies they were working for ignoring the views of their own staff, but little was being done to explore the sentiments of the very communities they were trying to assist. It was as if all voices in-country were muted.

> *Every day we get vast numbers of electronic documents, also hard copies sent to us, and the local community would just look at them and say, 'Well, I can't really see where this is really going to help us.' In the end we choose whether or not to tell people about it. We need to go to countries and listen to them tell us what works and what they want us to help them with, rather than imposing sort of global checklists.* (Participant 8)

How easy is it to navigate a pathway forward when the donor organisation and recipient country agendas are in conflict? One participant highlights the complexity of the issue, particularly when it pertains to the health of women and children.

> *There's also going to be mixed agendas, because I think as much as we say we're very much proximate to the population and we try to assess and address their needs and provide interventions that meet them, in some cultures and societies women and children wouldn't be their top priority and actually that's the intervention we want to put in place, and so sometimes it's really working with local leaders to re-educate and support.* (Participant 9)

Again, we are brought back to the previous chapter where the status of women, and their perceived value within their communities, determines what level of care is afforded them. It appears, at least in some developing country settings, that the aid organisation's agenda can often be at odds with the local communities' priorities, particularly when women and children's health are involved.

> *I don't really see a lot of local consultation, and when there is local consultation, I'm not sure that it's true consultation. In some cultures, people will always say what they think you want to hear; they won't*

> *necessarily say what they want in that situation. We have to explore, other ways of trying to get more community involvement and perhaps different ways of consultation according to the community. I think people have tried various things over the years; first of all, people would get the community leaders involved, but then you might discover down the track that some of the tribal leaders were in fact involved with channelling money off. It was quite difficult to implement some of what was suggested. There are lots of issues and frustrations that you come across.* (Participant 19)

This participant also suggests that consultation can, at times, be likened to a double-edged sword, with communities in these settings often using donor money for uses other than what was intended. With women and children at the bottom of the consultation chain, a broken link can lead to their voices remaining silenced as this next participant highlights.

> *One of the things that I found was that it seemed like nobody ever talked to the women – or really the community health workers for that matter either. Simply just going to their homes and asking about their experiences.* (Participant 25)

To date very few studies have been conducted to examine the effect of aid on reducing maternal mortality. A study by Greco et al. (2008) observed the flow of health-related aid over a four-year period from 2003 to 2006. They uncovered that aid primarily set aside for maternal health did not always go to the most needed nations. This lack of empirical evidence is indeed both alarming and thought-provoking given the large amount of international attention given to maternal mortality by international aid and research organisations over the years.

> *I have to believe that some of these big organisations do talk to women and do talk to families and talk to the health workers and do those things. But my experience so far is that it's been the small, grassroots, mom and pop organisations that have that level of commitment and accountability to communities, and the big ones somehow seem to be losing that and focusing so much on big picture targets. It's left me in a position now where I'm sort of like, 'Ugh, I don't even know what I want to do next!' because I found it so troubling to work for the last project that I worked for.* (Participant 25)

It is interesting to hear this participant's observation that the smaller the donor organisation the greater the community input. Could it be that these expatriate aid organisations that commit to living and working amongst the community are more respectful and committed to success than the larger agencies coming in and out on a project basis purely to test out a hypothesis?

> *With this population, you never arrive and say, 'This is our meeting, this is our agenda, this is what we want to discuss.' You sit down, and I quite honestly would have meetings that would last for a whole day, and we wouldn't actually get to what I wanted to talk about. First of all, you meet the person, and then you find out about how the person's family is, and how everyone in the room's family is, including your own. You go through all of that, and then you actually get to know these people before you can be trusted to introduce your topic. And so long as you respect that process – it's a beautiful process, you know, it works really, really well for them.* (Participant 10)

This participant stresses the importance of a culturally appropriate, community-led approach when first working with a local population. The following participant agrees, stating that imposing their own agenda at the outset would have proven fruitless.

> *My agenda was to get a hospital up and running as soon as I could, but it wasn't their agenda at all. They wanted to get a hospital up and running, for sure, but it was going to happen when they were ready for it to happen. You don't rush. You go in and you speak to the right people, respect the culture, make sure that you speak to the leader first to make sure it`s okay to talk to the women.* (Participant 10)

So, what of those projects born out of New York and Geneva, tested in one country only to be scaled up in another? How does this marry with a culturally safe and community consultative approach?

One Size Does Not Fit All

What has become clear from speaking with the participants is that the smaller donor organisations, much like the aid workers themselves, are those closest to getting it 'right'. Yet, as the following participant heeds, they do not always gain the credit they deserve.

> *Some of the fellows were working for very small organisations that were run by a husband and wife, for example, who had committed their entire lives to a certain region, a certain couple of villages, and had dedicated their lives to improving – whether it be education or livelihoods or farming or public health or whatever, in those few communities. And then people are just bashing the organisation saying, 'But it's not scalable, it's not realistic, other people aren't going to commit their whole lives to a project like that.' And I just find it so frustrating because I feel like oftentimes those are the projects that we should be celebrating and saying, 'Wow, look how successful that is.' Maybe it's not going to work on a large scale, but maybe somebody else could do it on a small scale somewhere.* (Participant 25)

The need for a project to be scalable is indeed a priority of many large donor organisations (Spicer et al., 2018), the perceived benefits being a wider geographical reach and the ability to assist a larger number of people. The following participant is not so sure it is the right approach.

> *This 'Is it scalable?' mentality has become this like weird sick obsession. I get the idea that if a project works and it's addressing an actual serious problem, then let's think about how we can scale it up and have a larger impact; that makes sense to me. But this idea of it's not even worth doing a project if it's not scalable, I think is so upsetting, because I think there are projects that can work in certain places and might not be scalable. I think that's okay, because if they're improving the lives of that community great. That should be enough.* (Participant 25)

Has the pressure to meet targets like the UN MGDs proven to be a hindrance rather than a help? Has taking a 'one size fits all' approach rather than one tailored to each individual community meant wasted money, time, and resource if the community it is awarded to are reluctant to cooperate?

> *I've been victim, like everyone else. I went up there with my 60 boxes of WHO things and went back a year later and they hadn't used them. But I know on some WHO report, there will be, 'Such & such distributed and taught how to use 60 birth boxes.' Tick. It makes you feel really resentful. That's a lot of work. Of course, the TBAs have this sense of pride; they have this wonderful box that this western midwife gave them. They didn't open it. Well, they did open it; it was for toys for the kids.* (Participant 3)

I witnessed this practice by local TBAs first-hand upon visiting a Maternal/Child Health Programme as a guest of a large aid organisation in one such developing nation. As I was introduced to the women and their shiny new boxes, I noted, like the participant above, that they too had never been opened. Together, the women and I undid a box, and when I asked them to demonstrate how to use what was inside, I was met with blank stares. One woman eventually took out the bar of soap and mimicked washing her hands. It was evident these birth kits were more for show and to "tick off boxes" as the participant above describes. The TBAs had no intention of using them in this village. Herein lies the problem, as this participant describes.

> *You have to acknowledge that there are huge culture differences, even within one country. In this country there's like seven different languages going on, you know one size doesn't fit all. And that's the problem with a*

> *lot of the WHO stuff. I know there's a lot of sensitive people there, but their voices don't seem to be heard and it doesn't seem to spread, it's all about statistics and, well I'm sorry that's not my take on how it should be.* (Participant 3)

My eyes were further opened when I went on a two-day field visit with one of the participants. She wanted to show me first-hand the issue of scaling up in one small area, let alone a country. She took me to a vast tea garden where three separate villages of workers spanned over a 10-mile radius. The Christian village had a clear maternal health plan. Here, a government trained midwife would oversee all pregnancies with wonderful support by the qualified doctor in the village. They had adequate equipment and a referral plan for complications and emergencies to the nearest government hospital. The Muslim village had a community trained midwife who tended to most childbearing women and without medical support. Her equipment was stark in comparison and there was no referral policy. The final village was the one that shocked me the most. Here, the local untrained TBA was treated with disdain. She was considered low in status and gained little respect from the hierarchy of the village. Women called her only in desperate times and the local community leaders would often ignore her advice. There had been an abundance of girls born during the past few months prior to my visit, and the local men blamed the TBA suggesting she was cursed. That day, the participant I was visiting with called a meeting of those local men and leaders in the village and, speaking fluently and passionately in their local language, proceeded to put them right on the science behind whose fault it really was that female babies were being born. To this day, I remember the shocked looks on those men's faces. The reason for this account is to highlight that when all factors are considered, scaling up a maternal health intervention can be problematic in just one small geographical area, let alone from one country to the next.

Research is Skewed

The scaling up of maternal health programmes is based wholly on empirical evidence; yet, there was much consternation from many of the participants as to how reliable that evidence was.

> *All the research is skewed. It's skewed because half of what they say has happened hasn't actually happened. So, I would say if you're basing everything on all this wonderful quantitative research just be aware. In this country, any kind of research, most of it is false. It's just filled in by people who never did the work. I've seen it in our own projects when we did*

> *evaluations of things. We collect these nice clean, tidy papers, with all of the boxes ticked with the same pen sitting neatly on a desk. We knew they hadn't been out in the field.* (Participant 2)

The organisation this participant is referring to is regarded as one of the most reputable and reliable aid organisations in the world. Much of their research is published in the world's finest medical journals and their recommendations are not only considered best practice, but the gold standard of care when it comes to caring for childbearing women in developing nations. I sought to uncover whether this participant was a lone wolf, a disgruntled employee wishing to bring an organisation into disrepute. It appears they were not.

> *Because our data is so inaccurate, WHO always estimates. They said, 'We estimate what developing countries are doing. We estimate it because there is no true data.' And the data is very skewed; the maternal mortality and morbidity is so incorrect because nobody collects correct data, nobody's got consistent definitions.* (Participant 18)

Could it be a misunderstanding? Is it a lack of resource or pressure from on high to show that the aid and research dollar is being well spent? Once again, we question whether a mandate like the MDGs place organisations under such intense scrutiny to be seen to 'performing' that they succumb to whatever it takes to look good on paper?

> *A bureaucrat from an aid organisation came to our hospital for a meeting with a report she had published and stated, 'Did you know that maternity is only 45% occupancy?' And I said, 'Oh, what rubbish is that? Where did that information come from?' She said, she had asked somebody on the ward – she hadn't asked the sister in charge, she hadn't asked me, she hadn't asked any medical person, she had asked one person there – 'What are your total beds here?' So, they counted absolutely every single bed that was in the unit that we don't use and said that it was 41. We actually only have 29 beds, so the occupancy rate of 45% immediately went up. And then she had written there that our caesarean rate for last year was only 22 caesareans. And I said to her, 'Where did we get that number from?' I went back and looked at our numbers – it was 171 caesareans last year. She was literally here showing this to the Ministry of Health, WHO, and many other large organisations and donor groups who were at the meeting. And in fact, today at the workshop, the WHO coordinator came to me and she said, 'Gosh, did you get a draft report of that budget that was done?' I said, 'That is so incorrect.' She said, 'No, we were all there, we heard it, we saw the stats!' And I said, 'But they're incorrect statistics.'* (Participant 18)

The notion of incorrect and sloppy data and making statistics 'fit' is yet another disturbing theme that has emerged from the study. Many participants believe that the research and practice did not match.

> *Realistically I think for countries here based on a population of 200 000, its pointless talking about the maternal mortality ratio [MMR], because one or two deaths makes such a big difference. For small countries, I think the MMR adds no strength or meaning to the day-to-day work of midwives and obstetricians.* (Participant 8)

What could possibly be behind the need of these major organisations to publish such inaccurate numbers? What and whose agenda does it best serve? Certainly not that of childbearing women whose very lives are relying on the accuracy of such research.

> *That's another reason why a lot of this research is meaningless and doesn't work is because the context is so wrong; no one buys into it, because it's just a supply-drive thing. They invented their own need for it.* (Participant 16)

William Easterly's controversial book, published in 2007, *The White Man's Burden: Why the West's Efforts to Aid the Rest Have Done So Much Ill and So Little Good*, addresses this notion of the 'invention of need'. While Easterly (2007) introduced the idea, it is Nancy Birdsall in the 2008 publication *Reinventing Foreign Aid*, edited by Easterly, that sums it up best:

> recipient countries now cope with dozens of official creditors, bilateral donors, UN and public agencies and international NGOs. All of these in turn operate in dozens of countries. In each country, donors also typically operate in many sectors with many projects. Managing their "own" projects increases donor visibility and doing so in many countries maximises donor countries' abilities to leverage the diplomatic support of small countries for their objectives in the United Nations and other international settings. (Easterly, 2008, p. 523)

The very idea of aid being used as anything other than an attempt to ensure those who desperately need help to survive receive it is indeed abhorrent to most. However, it appears what Birdsall intimated back in 2008 rings true today.

Corruption and Incompetence

Much has been written about both the ineffectiveness and the corruption of aid and its related activities (Banchani & Swiss, 2019; Easterly, 2007; Farmer, 2008; Mekasha &

Tarp, 2019; Moyo, 2009; Ogbuoji & Yamey, 2019; Teshome & Hoebink, 2018); so much so, that to relay just a small portion of the issues reported would dominate this thesis. It comes as no surprise then, that research itself should be brought into question. Rebecca Chopp in Farmer (2010) reminded us that the dominant and substantive quantitative nature of aid research may in fact seek to hide the truth rather than reveal it.

> Events of massive, public suffering defy quantitative analysis. How can one really understand statistics citing the death of six million Jews or graphs of third-world starvation? Do numbers really reveal the agony, the interruption, the questions that these victims put to the meaning and nature of our individual lives and life as a whole? (Farmer, 2010, p. 337)

That agony and interruption is witnessed daily by those on the frontline, the aid workers implementing the quantitative research-led policies of the international aid agencies, coupled with government mandates. Despite the abundance of scholarship favouring the negative, I was keen to uncover the 'truth' as seen by those charged with saving the lives of childbearing women.

> *The corruption is blatant, even one of the biggest and most successful NGOs in the world; the government's using them to get their policies through. When misoprostol [a drug that can be used to stem rapid blood loss but can have terrible side effects] came in, we found out the government wasn't giving it themselves, they were saying that the NGO had to instead. The NGO had no choice if they wanted to continue working in the country. They didn't want to; the midwives especially, because the midwives found out the outcomes were better when they didn't give misoprostol how they were instructed to. I just said to the midwives, 'You make your own decision.' They came back to me and said, 'It's alright. We don't give it, but we're telling them we do,' so the research is all going to be wrong. They say what they've got to say for the statistics, but they'll just not do it if they don't think it will benefit the women.* (Participant 2)

Why is it that these local midwives feel that they cannot speak up against a Western practice that they feel has no right to be used in their community, and further still could be detrimental? Could it be they feel powerless to speak out unless they get thrown out, believing it is better to stay and try and make a difference no matter how slight? The NGO, too, seems to be at the mercy of the local government. Why would they be complicit to something that in their mind would not aid the very population they had flown in to assist?

> *I think if you look at the financing of a lot of aid agencies it's built into agendas. If you're dependent on governments then you absolutely are sucked into their agendas. You only have to talk to NGOs about working in this region; basically, they get funded or not as to whether or not they follow the government's agenda, because they rely on government funding. And certainly, a lot of the British organisations are like that and the Americans pretty much the same. They weren't doing abortions when Bush was around, that kind of stuff. You know, that's how it all works.* (Participant 13)

Surely, regardless of the various government mandates, 'best practice' guidelines are still adhered to where life and death is concerned? The following participant disagrees.

> *You have to look at each country's situation first. And the big problem in this country is all the training, the decision-making, has been by doctors who have never done a normal delivery. They've told me. Even the numbers they needed to pass medical school, they got the nurses to do it and made them sign to say it was them. They've certainly never done a home delivery, or a village clinic delivery without backup.* (Participant 2)

The image of 'window-dressing' comes to mind when listening to these participants talk of both their local and expatriate counterparts. As long as boxes were ticked and the reports written, it seemed what actually was happening on the ground was of little consequence to those bureaucrats whose job it was to set the agenda.

> *When the expatriate government health advisors arrive, you know they've just done an MPH [Master of Public Health] or something a few years ago, and that's about it, they've never been on the ground, so they haven't got a clue. When you tell them about stuff, they hear just snippets. They get a few bright ideas, and next thing there's a new project that's being formulated, because this is what you said you needed. And about six months later, at the end of their first year, you get to see the project which is going to cost 36 million dollars, and then you look at it and think, 'I didn't say that!' or 'What's that all about?'* (Participant 15)

What say do these aid workers have when it comes to standing their ground in an effort to best serve the very population, on whose behalf they are working?

> *We look at the project and say, 'We don't really want that, that would be pretty useless.' And we get tiny modifications at that point; and then bang, there arrives the project, and there's all these advisors that arrive. Suddenly all the good people are sucked out of the health sector and now start working on the project for double the money, so the health system goes down the tube more because all the good people have gone to sitting in desks working for the project. And the project usually produces very little. At the*

> *end of the 30, 40, 50-million-dollar project, after three or four years you look at and think, 'Now what on earth did the women's and children's project do? What have we got out of that?' And it's very little.* (Participant 15)

What we are hearing from these participants is that even when they speak their truth against a project destined for the community they are assisting, it is little more than lip-service. In the end the political agenda prevails.

> *I think the governments themselves are not free in those countries. You know, we blame them a lot and say they're corrupt but in fact they are so under the control of the World Bank, that really they don't run their countries. Pressure is put on them all the time to do things.* (Participant 2)

This participant alludes to the fact that many of the world's developing nations do not have free will when it comes to the development agenda. How then can these governments work in the best interest of their people if they have so little control?

> *It is such an unstable government. You never know who's going to be in power. People don't earn the position they get into, quite often it's, 'you're my brother's cousin's daughter, you could be in that position… your father's the chief, you'd be really good, and you've got year 12 so I think you could be the helper of the Director General of Health. The manager of our whole province is a registered nurse who has never ever worked in a hospital. I have no idea how he got that, but he now runs the whole of our province, and he's just an idiot! He has no understanding of the clinical situation.* (Participant 18)

Here we come to the crux of the issue. In countries where women are most at risk of dying in childbirth, the government has little free will of its own for reasons expressed by the participants above. Leadership is non-existent, breeding corruption, and, as this next participant tells us, the women are left to shoulder the burden.

> *They have a patient care fund, so when somebody comes into the antenatal clinic, they have to pay money which is equivalent to US$2 dollars and that goes into a care fund which buys food for the patient. It's an illegal care fund, and quite often what happens is the patients have to pay to stay. If you come in and have a baby, you have to pay the equivalent of $7 dollars a night, and you pay a maximum of five nights, I mean, that could almost be two weeks wages for somebody. And that goes into the fund as well. Then you have the CEO who borrows from the fund and doesn't replace it. It's the corruptness of even our local management, but also the same happens throughout government as well.* (Participant 18)

How do women have any chance of beating the odds when they cannot trust the very help that is sent their way, when such systemic corruption and dishonesty freely runs rife?

> *I think it's all promise; it's all hope. We all say in about three to five years we should be seeing the maternal mortality rate going down, provided all the other things that the government's promised, happen. But the logistics and the culture of crime, have been significant barriers.* (Participant 23)

'Aid' and 'corruption' have been synonymous for many years. The UN Development Programme's 1994 Human Development Report highlighted criticism from donors who believed that their aid money was being used to fund corrupt spending. Ten years later, Senator Richard Lugar, at a hearing of the US Senate Committee on Foreign Relations, claimed that the World Bank was also complicit in 100 million dollars of US funds earmarked for development being misused or corrupted (Moyo, 2009). In fact, it has been alleged that the problem with aid is that it provides a natural breeding ground for corruption, with an estimated quarter of all development money lent to countries in need between 1946 and 2009 (an estimated US$130 billion) being misappropriated (Moyo, 2009). With lack of accountability and thorough checks, foreign aid programmes are susceptible to brazen manipulation (Moyo, 2009).

Inducements to Local Staff

Manipulation by government officials does not just lend itself to currency, but also to the corruption of the local community on the ground. While visiting developing nations during the interviewing stage of this study, I was struck by the numbers of empty buildings set aside for clinics and hospitals, particularly in the rural areas. I was told local staff were being lured to more lucrative positions, many working for donor organisations.

> *You've got these silos that suck out anybody in-country to work with them, anybody with any knowledge here is key to making a department work. A big agency will take that person and say, 'Right, come and work with us because we need you in-country,' and it leaves everybody else floundering because they haven't got that leadership. There's so little capacity of highly skilled people here that these big agencies that come in and offer good money will suck out any capacity.* (Participant 14)

It seems counterintuitive for aid organisations coming into a local community with a view to improving the maternal health service to hire the most experienced local clinical staff who are most needed on the frontline.

> *We find our skilled ones, the skilled midwife or nurse becoming a desk job person; they go and get a job at the Ministry, which pays more, so it takes the skill away. You're taking a skill based on the clinical situation, into a management or a desk job. That is really hard, I can tell you that's the most frustrating part.* (Participant 18)

Having seen for myself just how hard those local midwives work and how little they are remunerated; it is not difficult to see why they leap at the opportunity to work with Western aid organisations.

> *Lots of people just go for the ride of course because there are lots of lollies. The project starts; if you're a good health worker, you can put a good CV together and can interview well, speak English clearly, you can get a job in the project, and you've got double the salary. You don't have to be a midwife anymore; you don't have to deliver babies or get your hands dirty. You're the project officer in the donor organisation's project, and answer the phone, meet them at the airport, ride around in air-conditioned four-wheel drive vehicles, have coffee breaks and go to workshops and meetings.* (Participant 15)

Who could blame the local staff for accepting such an offer? For many it would mean the difference between sending their children to school or not, or feeding a large family. Once again, what looks good on paper for the donor organisation, local staff as part of a foreign-led programme, is compounding the very heart of the problem—a lack of skilled workers on the ground. The local staff, however, are far from unhappy with the status quo.

> *They see NGOs as a source of money and material goods rather than technical expertise. Even though that's there as well, it's not the primary reason that people are interested to have that intervention.* (Participant 19)

I experienced this perception first-hand as. Prior to leaving New Zealand, to visit these developing nations, I was given a list of 'urgent supplies' needed for the health clinics I was visiting. It was an unwritten rule that you never turned up empty-handed.

> *When a volunteer comes, the midwife in charge loves that the volunteers will bring free medical supplies. It's not needed, we've got plenty of the stuff, but they still take it, because if she doesn't take it, or says I'll give it to another hospital, they won't bring it next time. It's all about take, because if I didn't take, 1) I'd seem ungrateful, you've given me something free, and free is a big thing; and 2) you won't bring me something if I say I don't actually need anything. And when the volunteer comes in, if they haven't brought something they're almost frowned upon that they haven't brought anything free.* (Participant 18)

These participants bring light to a dichotomy—to give or not to give? By offering money to aid organisations are we helping or hindering the situation on the ground? Could our Western drive to 'save the developing world' be inadvertently hurting it?

> *One of my professors in graduate school he taught this class that most students who were focusing on global health took. He said to us, 'Many of you will find yourselves within a year after you graduate in a position in a nice office working on a global health issue and fooling yourselves into believing that you are actually making a difference to people's lives – but you're actually just maintaining the status quo.' And honestly, that's how I felt when I was working in New York. Every day I would ask myself, 'Have I actually improved anyone's life today? Have I improved maternal health in a developing country today? No, I haven't.' And it was so frustrating. And I think that that's just how the system is set up right now, so something has to change.* (Participant 25)

Herein lies a further the dilemma. As health professionals we enter this domain with our western construction of right and wrong, good and evil, and, most poignantly, life and death. Once again, in this thesis, we face the question, "Is the West the best?" when it comes to caring for childbearing women in a developing world setting.

First Do No Harm

As health professionals, we are bound by the unofficial mantra of 'First Do No Harm.' While not officially part of the Hippocratic Oath, it is a reminder that we should refrain from practicing a 'save at all costs' mentality; that there are, indeed, moments when doing nothing may be more appropriate than intervening and causing further harm (Harvard Medical School, 2015). We enter our various health professions with the primary goal to make lives better for those who are suffering. Expatriate aid workers, in particular, are considered the most selfless of them all, endangering their lives by working in places most would not dare to go.

> *For me, expats have caused so many problems. They come in with this ideology that they can make huge difference; you know that they are the most important people and they're going to be able to change everything. And you're like, 'No, no you're not!' You're one person! Do you think you can change a health system that's been like this for 20, 40 years? Forget it! They end up getting really frustrated, crying, and I end up saying, 'Well you should go home; we're better off without you. You're causing more harm than good.' The local staff, okay they have their limitations, but let's build up on that, because in the end, the staff are staying. You are just here for six*

> *months; you will do what you want, and then you're out of here. And then somebody else comes, and they have another way of working, and then somebody else comes. It causes a big mess.* (Participant 21)

This participant has seen it all, as a very experienced long-term aid worker who has worked in many and varied developing world settings. They talk of the frustration about the new and unseasoned aid workers who bring with them high hopes, big egos, and, sometimes, bad practice.

> *You walk into the delivery room, and see vaginas staring at you. And you're like, 'What the hell? Why isn't there a curtain?' They just seem to think, 'Oh but its Africa/India/Papua New Guinea, it doesn't matter.' That attitude you hear a lot, and it stinks. I always say to them, 'Imagine your sister's here, you give her the same care you would anybody.' I say it to the national staff too, 'Would you deliver here?' If they say no, then you've got to do something about it. We really do have to change the attitude of our expats, and also sometimes our national staff.* (Participant 21)

I experienced similar practice by first-time expatriate interns while working in a US-led midwifery practice programme in Africa. I thought I was attending the month-long programme as a newly graduated midwife to extend my learning and discover whether aid work was an option for me. Little did I know that this programme was designed for American midwives to get their birthing numbers up as they were not able to do so in their own country.

Split into two teams, working 24-hour shifts, I was the most experienced by far. I had attended well over 100 births in my time as a midwifery student, just one other intern had had any real hands-on birthing experience. We were told to wear white laboratory coats as apparently we would not be respected by the locals otherwise. Then we were placed in an office next to the birthing room and only called in to 'catch' the baby once the woman was pushing. There was no labour care, no after care, our job was to just deliver the baby and leave the room. The local midwives would do the rest. I was shocked. It went against all of my training. I tried to ensure I connected in some way with the birthing woman in those few minutes; yet, the local women did not seem to want my kindness when it was offered. Was it that they resented me being there? Did they feel violated by my very presence? I began to feel uncomfortable for them and wondered if my being there was somehow making the experience more difficult.

> *You need to be constantly aware and remain critical of your own practice, and question what it is that you're doing and why it is that you're doing it. Is there a better way to do it, and is there somebody else who can do it? If you just keep hold of those principles, and whenever anyone asks you the question as to why you're there you have to believe in the real principles that are holding you there. You need to remain aware and critical of things that are not going well and speak about them.* (Participant 10)

Participants in this research demonstrated strong principles that keep them soldiering on in difficult contexts. At the same time, as the participant declares, they need to bring a courageous spirit of critical appraisal. To speak about tensions may sound easy but it is likely that such an act brings vulnerability. Many participants valued the safety of this research as a means of sharing their concerns.

> *Because they know their women, they know their culture; they're in a better position to be able to provide the care than we are. I get really mad that expats come in and say, 'Well we should do this and this.' I just think, 'Would you accept that in your own country? No way!' A foreigner coming in and telling you what to do? It's like, 'Get lost!'* (Participant 21)

This participant reiterates the importance of aid workers acknowledging both local staff and the culture with which they are working.

> *I've seen a lot of aid workers do a lot of damage, and I've seen a lot of NGOs do a lot of damage. A lot of these populations have been downtrodden and have gone through enormous hardships for a long, long time and it's hard enough for them to get through every single day let alone expatriates coming in and making it more difficult.* (Participant 10)

There appears little, if no, directive for expatriate aid workers to pass any sort of mandatory test nor to educate themselves about the community they are to work amongst, prior to their arrival. How can these organisations have such freedom to come and go, with no expectation to ensure they have a clear understanding of the culture, religion, or lives the very people for whom they are charged with caring?

> *Just because there is the UN or WHO or WFP or whatever, doesn't mean to say that they're beyond having to explain themselves, and having to sort of demonstrate that what they're doing is quality service of care or provision of care. I think everyone needs to be questioned, and as soon as you're a little bit frightened to be questioned, then it gives you an indication that you're heading towards a failure mark.* (Participant 10)

Where much of the conflict lies is when military peacekeeping and aid work combine. This participant alludes to the issues that occur when the lines are blurred.

> *An army force came in to protect the population against a militant group, to fleece out this group, but also to do humanitarian work at the same time. Basically, they would frighten the population into providing information for them, and then when the population provided the information for them they would do a good deed like fix up a school or fix up a bridge. That really screwed the heads of these people, and it has done so for the last 10 years, so I'll be incredibly happy when the army gets out of there. There're heaps of organisations that just were disastrous all around you, but you only can fight your battle.* (Participant 10)

Here, this participant illustrates the price of aid on the local population which is often conditional and comes with a hefty price tag. How must it be for a community to feel torn between protecting their own lives from the militia and helping the aid community whose very agenda is supposed to be protecting them from harm?

War and Unrest

As Farmer (2010) reminded us "war remains a major interest of societies rich and poor; war remains a major source not only of death and conquest but of profit… war remains a growth industry" (p. 405). Within this structure health systems fall victim, with women and children often paying the ultimate price (Farmer, 2010).

> *You can't try and improve a health structure when the country is on its knees, when the country's not being run properly, when there's no money or there's war or there's all these other huge influencing factors, which all come back onto the mortality rates of the population.* (Participant 10)

And while those mounting mortality rates seem unfathomable to those in the West, not all countries facing war and unrest are keen to prioritise the health and wellbeing of their population.

> *If you've got a country that's not being run properly, or is at war, there are other things that are given precedence over the health and well-being of the population. Often with war, it suits countries to have certain parts of their race or population in a vulnerable state, in an unhealthy state. It suits a lot of people with a lot of power to have populations that are vulnerable.* (Participant 10)

This participant alerts us to a dichotomy. How effective can healthcare aid be if a country is set on keeping its population in a vulnerable state, and does the West have any right to intervene?

> *Usually when conflict happens, people flee, and health workers often have the ability to flee first, often because they're better trained they know they can get work other places. It's hard to attract people to work in zones where there is conflict. Certainly, what we've found, is that maternal health access for women is difficult because there's a conflict going on. Most places people won't move at night, even if there's not conflict, and if there is conflict, they certainly won't, and so that becomes quite difficult as well.* (Participant 13)

This participant alerts us to the need to intervene, particularly when it comes to childbearing women. As trained health workers flee to safer towns or cities, women are often left with an unthinkable dilemma, whether to fend for themselves at home or risk their life to seek medical care.

> *Twenty of the last 30 years this country's been at war, and so you have a whole generation that hasn't been educated. I'm looking forward to the day, that we become redundant, and we can just make sure that everybody gets to the government hospital and gets cared for that way. But the reality is the government hospital isn't doing it, and until they start doing it, we're going to continue to do it, because we're tired of watching people suffer and die.* (Participant 22)

Just as we can't force women to seek healthcare for themselves and their unborn child, so too is it impossible to force governments to care for their own. The only lifeline for many populations of countries at war is the aid organisations that risk condemnation, as well as life and limb to ensure these women can birth safely.

Can't Get Local Staff to Work

So, what responsibility do the local healthcare workers feel for ensuring the safety of their own compatriots?

> *Particularly the doctors come from well-to-do families. They are not going to go to the village areas where there are not good schools for their children, where there are no facilities, or electricity and nothing is there. Why would they go? The government doesn't pay them much. And you see most of them earn their money by private practice, so they want to be where people are who can pay you. Even if you've become a qualified midwife, you're not going to work in a little rural area where you haven't got backup because*

> *the doctor hasn't come, and where if something goes wrong it will be your fault, and then they'll beat you up.* (Participant 2)

This participant raises a good point. While the international maternal health focus is on training more health workers to ensure adequate care of childbearing women, many of these workers do not wish to return to their rural roots.

> *A lot of people are trained at capital level, but they don't want to go to the rural zone. They go for the six-month placement and then they leave, so we're back to square one.* (Participant 21)

It seems even with a contracted placement, there is little commitment by these doctors to help the very community in which they were raised.

> *A lot of these doctors, they're actually assigned to the rural areas and they only go on pay day to collect their pay. Now the government's trying to go around and check up on these doctors and they're finding there's hardly anybody there.* (Participant 2)

We are reminded of the clinics and hospitals previously spoken about sitting empty in rural towns and villages; much is now making sense as to why they remain abandoned.

> *The government hospital was built about two years ago, but it sat empty for a year. They slowly started stocking it these last few months, but the staff never shows up, so the patients will go there and wait for eight hours and never be seen. We are doing the job of the government hospital because the government hospital won't or can't get it together.* (Participant 22)

How are these health professionals to remain committed to their community when the government itself shows lethargy and cannot guarantee their wellbeing?

> *The government built all these centres in the rural areas, even putting in solar power, but they couldn't get the nurses or the midwives to actually live in them because they were really scared for their safety. So, they just moved away, and when they moved back into the main centres, people would descend on the health centres and take away the water tank, help themselves to the solar panels and stuff like this.* (Participant 8)

It is understandable why a community would do such a thing when they feel the government and the very health professionals they relied on have let them down. Once again, we question the sustainability of many of the aid initiatives that governments, in support of the MDGS, feel obligated to implement.

Bad Practice

With no government support and trained health professionals to care for them, what support do childbearing women have in these communities to ensure a safe birth?

> *We had a midwife in each clinic who was supposedly looking after the women coming in and having babies, but in fact it was very dodgy. Their practice was unbelievably bad, and it was really hard to influence it because I was supervising four clinics, and it was a very restricted place security-wise, so I had very limited time in each place. When I was there, they weren't so bad, but as soon as I went away, I know they just did what they did before.* (Participant 20)

Even with expatriate aid workers in support, this participant shows us that cultural attitudes and teachings are deeply ingrained in the local staff and practice is difficult to change.

> *Many of the local staff definitely don't want to listen, and I think there's so many reasons for that. We're paying them money, they're happy to take the money, but they don't want to do anything else; they'll show up for work but that's it. Another aspect is that every expat that comes tells them a different thing, so I'm sure they get expat fatigue. And that's partly because every expat has their own idea and no idea of what's appropriate in these settings, and they implement what they think, which may be completely wrong.* (Participant 20)

This idea of expat fatigue is an interesting one. With so many differing aid organisations descending on them month after month, each with their conflicting teachings and protocols, what must the local community think of these expatriate aid workers and how difficult must it be to trust them when these expatriates show little respect for their cultural values?

> *A lot of the time there's a lot of lack of motivation amongst the locals to do the job, so they do the minimum. They don't go that extra mile, there's no ownership, because they're left on their own and nobody cares about them, so why the hell should they care about what they're doing? These have been the challenges when we enter, of motivating the staff, of getting them to really work effectively, doing long hours, attending all the shifts that they have to. They must make choices for that job; they might have to leave their family behind and stay away for three months, which is tough. For economic reasons they need the job, so they do it, but they're not happy to do it.* (Participant 21)

With so many sacrifices, long hours, low pay, and a revolving expatriate community that changes the guidelines with each transition, is it any wonder that buy in from the local staff is so difficult to procure?

> *I don't know whether it's education or just general fatigue or whatever, but there's a lot of cultural differences around time management and completion of tasks that can hinder progress. There is that expectation that these expats will do it, and then there will be some more after they go – more will come. Things will slip back, and there's so much money available that they literally just have to ask now, and it'll come.* (Participant 23)

Has this lack of local responsibility and lethargy been born as a result of expatriate intervention? Has aid caused more harm than good by disempowering the local population so they no longer feel a sense of ownership when it comes to their own healthcare?

> *I think in countries where there's been conflict or a failing system, people take the opportunity to get the best they can. For example, staff would try to find a way to steal drugs and set up their own private business to make some money, because their salary is crap. We've had staff steal tyres off the wheels, take fuel out of the cars, all sorts of things. They just think that it's normal. For them it's a survival mechanism, we see it as stealing, but they're just trying to make the most of a situation. They know we have money, and they're like, well why not? We'll go and get another replacement, so no harm done.* (Participant 21)

This participant highlights that with lack of ownership nor a feeling of being valued the local staff see aid organisations as a means to an end, a way to improve their own personal situation with no thought nor responsibility for the greater good. This begs the question, is Western intervention unintentionally aiding in the dissolution of deeply rooted cultural systems? Is aid in fact doing more harm than good?

Millennium Development Goal 5A

This brings us full circle to the UN MDGs, in particular MDG 5A and its aim to reduce the MMR by 75% by 2015. Here we acknowledge its good intention and its overwhelming path to failure (Kyei-Nimakoh et al., 2016).

> *Some countries, their denominator is so low that every time they have a maternal death their MMR goes up a couple of hundred and that's just one death a year. So, although they meet the level of MDG 5, they won't actually meet MDG 5 itself, because MDG 5 calls for a 75% reduction. Statistics don't add up to saving women's lives here.* (Participant 8)

This participant echoes previous participants' concerns that statistics alone are not only unreliable, but they do not reveal the full story of what is happening on the ground.

> *We don't talk about MDGs – it's nothing that we're driven by. I mention it and they're like, 'Okay but yeah, that doesn't interest us, that's just at political and international level, not at where we are at.'* (Participant 21)

When talking with the participants, expatriate aid workers who have previously or are currently working closely with childbearing women across multiple developing nations, the question of the MDG 5A and its relevance to their day-to day practice on the ground, was met unanimously with a negative response.

> *I think that the fact that they keep moving the goalposts all the time on the Millennium goals gives you a strong indication that whatever we're doing is not working. I'm completely exasperated by and I don't understand why the maternal mortality rate is still as high as it is in many of these countries. When you look at this country for example, the maternal mortality rate here is astronomical, but the amount of money and work that's being pumped into that country is just ridiculous really. So why is that? I ask myself that question all the time. And all the time it comes down to politics.* (Participant 10)

Once again, we hear that those at the very coal face of this issue, the participants, see the MDGs as a purely political issue, something that is neither applicable nor translatable to the settings in which they work.

> *The MDGs are political and they're not on the agenda for many of the countries that they should be on. It's just an ongoing battle because it's not a priority. Money is not being given to really focus and implement all the things that the MDGs are saying.* (Participant 21)

The following participant, working on a completely different continent, agrees.

> *Those goals will not be attained any time soon. I think what we need is more grassroots development so that some of those goals will be realised. I guess it's about picking out key goals which are more realistic, because I think if they're always distant goals that you never reach, then there's going to be a huge amount of 'Well we're never going to get there, so why bother?'* (Participant 9)

The aid workers, themselves, felt that while having a benchmark to work towards was commendable, the lack of consultation from those working daily with women dying in childbirth as to what those goals should look like, enhanced the lack of buy-in.

> *We're still saying the same stuff, and yet there's no improvement – well it doesn't feel like there's an improvement when we look at the numbers and we look at the progress. And now they're freaking out, 'Oh, we're not going to make it.' Whoopee doo! I could have told you that 10 years ago, you're not going to make it!* (Participant 21)

Others also felt that the gross failure of such a politically driven goal could lead to a negative response and less assistance towards women's health in the future.

> *You can sign onto anything you like, that doesn't necessarily translate from it being a good idea to a practical reality. I worry that when our time ends, people will just see it as, 'Well we tried that and that failed' and I worry that we will lose once again the traction on women's health I don't know that there has necessarily been a lot of thought around how we safeguard that, so that the traction we have managed to get is not actually lost.* (Participant 16)

As this thesis draws to a close, 2015 has come and gone. The gross failure of MDG 5A, and many of the other MDGs, has been widely documented and in its place the Sustainable Development Goals have been birthed. Tucked away under Goal 3 – *Ensure healthy lives and promote well-being for all at all ages* – is Target 3.1: to reduce the maternal mortality ratio to less than 70 per 100,000 live births by 2030. What relevance this target has to aid workers on the ground in 2021 remains to be seen.

Conclusion

There are many people and organisations who care about reducing maternal mortality. How to achieve that remains deeply challenging and complex—a policy written by 'experts' in a foreign country is unlikely to work. That is because, first, there needs to be understanding of 'these people' in 'this place'. Such an understanding only comes by being there, winning trust, and working with the local people. Yet, even the participants in my study who had worked for sustained periods in one place knew that encouraging the local people towards change often felt impossible. Cultural traditions, war, corruption, and the low status given to women time and again, undermined progress towards reducing maternal mortality. There are no easy ready-made answers.

Chapter Ten: Discussion

When you're down and out
When you're on the street
When evening falls so hard
I will comfort you
I'll take your part
When darkness comes
And pain is all around
Like a bridge over troubled water
I will lay me down

Paul Simon & Art Garfunkel (1970)

Introduction

The vision of this thesis has been to uncover what is shaping why women are still needlessly dying in childbirth, and in such large numbers, in many of the world's developing nations. It was indeed a complex question, and has proven to be an even more difficult task to unpack.

As explained earlier in the thesis, due to ethics and language constraints I was unable to interview the women most affected, the women in developing countries who watch their mothers, sisters, daughters, and friends die almost daily in their struggle to bear a child. Instead, it was the voices of the 28 aid workers who I challenged to bring to light the circumstances that these childbearing women face.

The data were compelling, heart-breaking, frustrating, and, at times, overwhelming. On occasion, during my first reading through a purely hermeneutic lens, I found myself furious at the women, irritated with the aid worker, and mad at the world for allowing these senseless and needless deaths to occur. With clear political mandates in place, health professionals and NGOs, whose tradition was to save at all costs and whose oath was to 'Do No Harm,' were, at first glance, seemingly failing at their task; and my white Western tradition struggled to accept that a woman would not fight with all that she had to save her and her unborn baby's life.

My second reading of the data required a more critical eye. Why did I feel so triggered by these stories? Was it my own feeling of inadequacy, my preunderstandings and background during my time in Senegal that was clouding my judgement? What were the hidden

influences at play in these stories that shaped why these women were unable to be saved? It was here I leaned heavily on the work of Hans Herbert Kögler and his critical interpretation. He reminded me that, far from delivering a harsh critique, this thesis was indeed an act of unearthing, that I needed to truly come to understand the influences at play that were preventing the very survival of these women.

The Emergence of an Empathetic Intercultural Hermeneutics

Hans Herbert Kögler is a working philosopher most known for his theory of critical interpretation. During the tenure of this thesis, and since the methodology chapter was created, Kögler (2014) has added to his body of work, most notably introducing a self-distanciating critical intercultural hermeneutics. As a reminder, in his earlier work, Kögler (1999) stated that the core focus of his critical interpretation and, indeed, its methodological grounding should come by way of reflexive self-distanciation. His new work is an expansion of that project.

Kögler's critical intercultural hermeneutics is purely non-ethnocentric in its approach but makes room for a power critical edge. Its purpose is primarily to encourage, "a practice of dialogical understanding that does not merely accept or fuse beliefs into acceptable truth but makes explicit the underlying mechanisms of constraint and oppression, of exclusion and domination, without employing entirely context-foreign and therefore symbolically violent means" (Kögler, 2014, p. 277). Implied is a carefully orchestrated balancing act whereby, by way of example, the interpreter avoids being triggered by, and therefore admonishing, what may seem a heinous cultural or religious practice, and instead encourages being a mere observer to the power structures this act uncovers, acknowledging its subsequent importance of meaning to the agent (Kögler, 2014).

Throughout the analysis of the data in this thesis, I found myself on this methodological and moral 'tightrope.' It felt so easy to succumb to the horror that was presented before me; husbands and mothers-in-law not allowing their wives or daughters-in-law to receive medical care that could save their lives, women themselves seemingly not valuing their own lives enough to seek life-saving care, and a well-meaning, but what could be interpreted as an ostensibly naïve, aid industry that uses childbearing women as pawns in political point-scoring or vice-versa. To self-distanciate from an act that sees a woman accepting the fate of absolute death bestowed upon her by her family, while health

professionals remain powerless to intervene, seemed improbable. Kögler (2014) then brought forth the notion of *empathetic understanding*.

Empathetic understanding is about protecting the authenticity of the agent's experience; and while the act of empathetic interpretation may seem like we are expected to place ourselves in the woman's position, to do so would be an oversimplification (Kögler, 2014). What Kögler (2014) asks us to do, is to understand the event by way of re-experiencing it through the perspective of the woman with regard to how this practice may "be indispensable to her female identity" (Kögler, 2014, p. 278). It is the coming together, a fusion of shared perspectives that brings about the 'truth' and meaning of the practice. While it does seem far-fetched that I could ever be at peace with a woman not accepting life-saving medical care, Kögler reassured me that I do no need to. Instead, he suggested that:

> the project of critical intercultural interpretation implies that we get hermeneutically acquainted with others' perspectives in order to see ourselves from their perspectives as well… It is just such an unfamiliar gaze upon the other that allows us to see aspects and facets of the other's being that are usually too well hidden for his or her own self-understanding. The position of the interpretive outsider thus offers a special epistemic opportunity. (Kögler, 2014, pp. 282-283)

This opportunity that Kögler (2014) alludes to is the fact that as an interpreter I will never have prior knowledge as to which of my many backgrounds assumptions are likely to be tested at any given time. As such, interpretation must be observed as a dialogic occurrence that neither party can anticipate nor control. Kögler explained that a "fusion of horizons" will arise during that dialogic moment when our differing or opposing hermeneutic points of view become relatable (yet not necessarily agreeable) to one another, "that brings into play the background knowledge of both sides in order to create a new meaning. The meaning of texts is thereby permanently deepened and transformed by an ongoing dialogic process in which multiple viewpoints concerning the subject matter merge into new understandings" (p. 286).

As I pondered this new perspective from Kögler (2014) and perused the data with fresh eyes, I was reminded that as an interpreter I was deeply embedded in my tradition and its subsequent assumptions and beliefs, that I needed to be open-minded and reflexive with every dialogic encounter, and that at no time should I claim, "normative or epistemic

superiority over another culture, social or historical agent" (Kögler, 2014, p. 289). Kögler also alerted me to the question of social power and how I was to be mindful of "how power relations shape and construct the epistemic and ethical perspectives of situated agents" (p. 289). Such analysis highlighting the fact that critical reflexivity is at risk of being eroded by social and, most pertinent to this thesis, cultural factors at play (Kögler, 2014).

What Kögler's (2014) new scholarship most had me dwelling on was the notion of 'free choice.' As a white childbearing woman in my taken-for-granted Western tradition, I had both the freedom and choice as to when I began my childbearing journey, what that journey would look like and, when I most needed it, the freedom to choose and accept life-saving treatment for myself and my child. Such a choice was never in question. Were their social and medical powers at play? Of course. I did not think to ask my male obstetrician if the many interventions I received were entirely warranted—I had been socially constructed to accept his every word as 'true.' While it would seem that the childbearing women in this thesis had little choice or decision-making power, that is not altogether 'true' either. Kögler reminded me that their choices (or silence) were constrained by forms of deep social, symbolic, and cultural power. That what I may view as oppressive, a woman in this setting may take great comfort in as the social and cultural norms that have played out in her family and community for generations. Like me with my obstetrician, she would not think to question those deeply held beliefs and assumptions that the decisions being made for her were as it should be. For her to go against these norms could, as Kögler alerted me, be a form of 'social suicide.' For both of us, as childbearing women, "the need to be recognised as acceptable in order to avoid social exclusion prevails and shapes the self-understanding in both contexts" (Kögler, 2014, p. 297). So how could I make sense of these contrasting worldviews? In attempting to do so, I touched on the work of McAra-Couper (2007) and her thesis regarding what was shaping intervention in childbirth. An admirer of Kögler's work on critical interpretation, McAra-Couper used tables as a form of analysis to present the worldviews of her participants and their interplay with discursive orders and social practices.

The following are tables brought to life during the second round of analysis of my data, with Kögler's empathetic intercultural hermeneutics in mind. They present the three differing worldviews at play; that of the Western perspective expressed as the legal statute shaped by law, and the perspectives of both the aid worker and the woman they are caring for, both being shaped by their lived experience. Five key themes were to emerge: The

Right to Maternal Care; Gender Equality in Reproductive Healthcare; Women's Decision-making Power; Intrafamilial Power; and the importance of Skilled Health Professionals. Once each worldview had been unpacked, I moved to uncover the social practices and discursive orders that were at play in helping shape those worldviews.

The Right to Maternal Care

The right to maternal care, as was established in Chapters Two and Eight, is a basic human right that has been clearly mandated in international law for decades. What has shaped that law is a Western-led social system that views life as sacred, with every attempt to save that life being the paramount objective. Inherent in this discourse is that women are entitled to the same quality of life-saving health care as men. When we look across to the childbearing women's perspective (as interpreted through the data analysis process) we see that her lived experience is entirely different to that of what is written in law (refer to Table 1). For a childbearing woman, her survival depends very much on how physically strong and healthy she is and, most importantly, on the strength of her faith. As the aid worker living and working in this woman's environment alerts us, women are of little consequence to the societies they are born into; their healthcare is not considered a priority, and they are seen as adding little value to society unless they bear children. The aid worker's perspective is an amalgamation of the two. Born, educated, and trained in Western society, their worldview is tested in such an environment. To assimilate to the society in which they are now residing and caring for childbearing women, would be too great a leap. Instead, the aid worker self-distantiates from their Western prejudice and tradition and becomes hermeneutically acquainted with their new environment whilst identifying the powers at play. As such, their worldview becomes much more circumspect—a bridge, as it were, between the opposing worldviews on either side of them.

Table 1. The contrasting political worldviews in relation to the Right to Maternal Care

	The legal statute (shaped by law)	***The aid worker's perspective (shaped by lived experience)***	***The woman's perspective (shaped by lived experience)***
Worldview (the shaped)	Maternal health is a human right	Maternal health relies on the status of women	Maternal health is survival of the fittest
Social Practices (the shaping)	A social system in which every life is sacrosanct and maternal mortality is rare	A social system in which women are not prioritised and a women's life has little value	A social system in which a woman has no voice
Discursive symbolic orders (the shaping)	Women are equal to men and deserve the same right to quality healthcare	Depending on where a woman is born determines her chances at life. The place of a woman in these societies is non-existent	A woman's survival is determined by God's will

Gender Equality in Reproductive Healthcare

When it comes to gender equality in reproductive healthcare it is clear from Table 2 below that the gap between Western-led humanitarian law and the woman's lived experience in her own society is cavernous. What is stark is the reality that, despite being written into law and ratified by many governments overseeing the very societies these women live in, choice is absolutely not afforded to childbearing women. Men, instead, have that power, becoming one of the key determinants of a woman's survival during childbirth. The aid worker, as the bridge between these two worldviews, is able to add some perspective as to why women accept their fate without question. This, in turn, gives the aid worker the ability to work more effectively within these societies, knowing where the power lies and how to carefully negotiate and advocate for life-saving treatment on the women's behalf, whilst carefully honouring the social system in which they are working.

Table 2. The contrasting political worldviews in relation to Gender Equality in Reproductive Healthcare

	The legal statue (shaped by law)	***The aid worker's perspective (shaped by lived experience)***	***The woman's perspective (shaped by lived experience)***
Worldview (the shaped)	Men and women have equal rights to make their own informed decisions	Women need the permission of their husbands to seek health care	It is my husband's decision whether I live or die
Social Practices (the shaping)	A social system in which women have control over their own bodies and their own decisions regarding pregnancy and childbirth	A patriarchal or patrilineal social system in which women are not free to make their own choices regarding pregnancy and childbirth	A social system in which women are the 'property' of their husbands and as such make few autonomous decisions around pregnancy and childbirth
Discursive symbolic orders (the shaping)	Women have the freedom to make informed choices regarding their own maternal health care	A woman's access to life-saving medical care is determined by her husband	Whether a woman lives or dies during childbirth is at the mercy of her husband

Women's Decision-making Power

Perhaps the most challenging of tables was the one around women's decision-making power (see Table 3). Though we have been reminded of the lack of decision-making ability of childbearing women in the earlier tables, here we are faced with the notion of childbirth being a form of currency. That a woman's status in her community is very much determined by the number of live children she bears. This is a vast contrast to the Western mandate where it is a woman's choice whether or not she bears children. While we choose to believe in Western societies that whether or not a woman has a child does not determine her worth, there are subtle signs of an underlying power discourse that has much in common with that of many developing nations. As a woman struggling with infertility, I spent many years and thousands of dollars in the quest to have a child; the more I failed, the more obsessed I became, feeling the guilt and shame associated of not fulfilling my 'womanly duties.'

Today, the prolific availability of fertility clinics and 'wombs for hire,' add to the societal implication that being a woman is synonymous with becoming a mother.

Table 3. The contrasting political worldviews in relation to Women's Decision-Making Power

	The legal statue (shaped by law)	***The aid worker's perspective (shaped by lived experience)***	***The woman's perspective (shaped by lived experience)***
Worldview (the shaped)	Women have the same right to life and quality healthcare as men, and motherhood is a choice	Women are less valuable than a man in society and, as such, have less access and little right to quality healthcare	A woman must produce live children (preferably sons), or they are no worth to their husband or society
Social Practices (the shaping)	A social system in which women's healthcare is prioritised and she has access to essential lifesaving care	A social system in which cultural practices and beliefs are valued more than a woman's life	A social system in which childbirth is a form of currency and determines a woman's value in her society
Discursive symbolic orders (the shaping)	A healthy mother and baby are imperative, and both must be saved at all costs	How well a woman observes her cultural beliefs and obeys her husband will determine her fate	How many live children a woman bears, particularly in her home, determines how valuable she is to her community

The aid worker adds a compelling layer, illuminating the fact that it is how connected a woman is to her cultural beliefs that is most prized when it comes to pregnancy and childbirth. This has important implications for all in the West who wish to advocate on behalf of these childbearing women, whether it be writing new policy, assisting on the ground with aid intervention, educating the women's communities, or, indeed, leading their maternal healthcare.

Intrafamilial Power

Table 4 below highlights another circumstance where Western views, and those in the developing world setting in which these aid workers work, are distinctly different. As the

Western world becomes more liberal in its views of marriage, the same cannot be said for many of the world's developing nations. Marriage, in the majority of the Western world, is mostly celebrated as a mutually agreed contract between two consenting partners. Increasingly, in many Western countries, that right extends to same-sex couples; yet, in the developing world, such progression is still a very distant prospect, with marriage rights afforded solely to a man and a woman. As the participants in this research highlighted in Chapter Eight, marriage in many developing countries is very much a contract between two families rather than between the couple themselves. In fact, all participants reported marriage, in the settings they were involved, to be parentally arranged. To delve deeper into this phenomenon is beyond the scope of this thesis; however, the aid worker's insights make sense of why a woman is furthermore powerless to make life-saving decisions regarding her own reproductive health. If a woman, once married, is deemed to be the full property of others, choice becomes non-existent. However, as Chapter Eight reveals, women do not always remain without power. The participants revealed that once women have raised healthy boys, these mothers become their son's advisor, leading marriage negotiations and often taking full control of her daughter-in-law's childbearing journey. Once again, for the aid worker to understand the woman's worldview in this situation is key. Rather than pressuring her into an informed choice scenario, it is important to involve key family members in any decision-making around her childbearing journey. This will both aid the woman to feel safe and may lead to better buy in from the family to any life-saving decisions.

Skilled Health Professionals

While the Western ideal for any childbearing woman in a developing world setting is to birth their baby with the help of a skilled midwife and nearby a fully equipped and well-staffed hospital, this is not always the view of the community. As the participants in this research allude, having skilled staff and a life-saving facility is not the miracle cure to saving these women's lives as it was once thought to be. These aid workers remind us that in the majority of these settings birth is so culturally and socially bound that birthing with a skilled health professional means very little. Many women would rather risk their lives and follow traditional and social norms, than birth in an institution with staff that do not value or respect their cultural birthing practices. The aid worker also highlights the user pays systems that are rife in many developing world settings. I remember in Senegal, during the birth highlighted in Chapter One, the health clinic was not stocked with life-saving

drugs. Instead, I was told to instruct a family member to run to the local shop and buy them, along with the tools with which the drug would be administered. For many families this is out of reach financially and creates a situation where women would rather refuse treatment than be a burden on her family.

Table 4. The contrasting political worldviews in relation to Intrafamilial Power

	The legal statue (shaped by law)	***The aid worker's perspective (shaped by lived experience)***	***The woman's perspective (shaped by lived experience)***
Worldview (the shaped)	Marriage is a mutually agreed contractual partnership based on love and respect, where each party has equal rights and status	A woman's marriage is a lifelong binding agreement between two families. She is not free to marry for love, nor has the ability to refuse a marriage arrangement	A woman must obey her family and respect their cultural practices. She is nothing without a husband and sons
Social Practices (the shaping)	A social system in which women are free to marry (or not), choose their life partner and dissolve the marriage should it become unsafe, or it no longer meets her needs	A social system in which marriage is negotiated between families, not between husband and wife	A social system in which women are considered commodities to be bought and sold without their consent
Discursive symbolic orders (the shaping)	Marriage is a mutually agreed partnership between two people	Marriage is a mutually agreed partnership between two families, irrespective of the wishes of the woman	Marriage is inevitable for a woman, not to be refused or questioned

Table 5. The contrasting political worldviews in relation to Health Professionals

	The legal statue (shaped by law)	***The aid worker's perspective (shaped by lived experience)***	***The woman's perspective (shaped by lived experience)***
Worldview (the shaped)	Health professionals give high quality, culturally safe, respectful, and timely care; regardless of race, creed, gender, or socioeconomic status	Health workers treat their women as patients with little privacy and few resources. The quality of care is dependent on her socioeconomic status, religion, and caste or tribal affiliations	Women feel safer and more respected with their local TBA or clinic who knows their culture and birth customs
Social Practices (the shaping)	A social system which values and respects childbearing women having informed choice and quality care	A social system in which healthcare is not free and, as a consequence, the wealthy receive good quality healthcare and the poor do not	A social system in which the woman can fulfil her cultural norms and familial obligations and give birth, albeit not always safely, within her home and community
Discursive symbolic orders (the shaping)	Quality and respectful maternal healthcare is accessible to all	Quality, affordable maternal healthcare is predominantly only accessible to the wealthy	Women feel safer, more respected, and less of a burden on their family if they birth at home or in their local community

The Bridge Over Troubled Waters

It is no coincidence that my interpretation of the worldview of the aid worker sits between that of the Western construct and the childbearing women for whom they are caring. Just as Kögler (2014) eluded, the expatriate aid workers in this thesis have all been born, raised, and educated in the Western construct. Before beginning their journey as an aid worker, they, too, sat firmly to the left of the tables where gender equity and informed choice are hallmarks of this Western worldview. To make the leap to the right and assimilate to the worldview of the community they are working in would not have been possible and likely

detrimental to success of saving women's lives. Instead, the aid worker gently bridges their own background and preunderstandings, and that of the woman for whom they are caring, with a worldview that pays homage to both sides. Heidegger (1993) explained,

> The bridge swings over the stream "with ease and power." It does not just connect banks that are already there. The banks emerge as banks only as the bridge crosses the stream. The bridge expressly causes them to lie across from each other. One side is set off against the other by the bridge… With the banks, the bridge brings to the stream the one and the other expanse of the landscape lying behind them. It brings stream and bank and land into each other's neighbourhood. (p. 354)

Much more than just a conduit delivering the mandate of donor agencies to the community for which they are caring, the aid worker, as the bridge, can enable a fusion of meaning and relationship between the two opposing worldviews, allowing a fluid pathway towards open dialogue and true understanding between the donor and the community; yet, allowing each to still stand firm in their own worldview.

Always and ever differently the bridge initiates the lingering and hastening ways of men to and fro, so that they may get to other banks and in the end, as mortals, to the other side (Heidegger, 1993, p. 354). Why donor agencies and those creating policies for and researching developing world communities have seemingly not sensed this vital link is extraordinary. As a crucial connection between the aid agencies and the communities they are serving, it is my belief, and that of the participants in this research, that expatriate aid workers are not being acknowledged as an all-important voice in the maternal health discourse.

During the tenure of this thesis, I attended many global maternal health conferences led by various donor agencies. It was my hope that I would glean some insight as to a way forward for addressing and reducing maternal mortality. Instead, I was presented with numbers and graphs and talks of 'scaling up' by quantitative researchers, most of whom had never set foot in the very communities they were discussing. Stories of the plight of childbearing women in these communities were left to well-meaning celebrities whose job it was to encourage more donations to the agency they were representing. While I enjoyed perusing the past 20 years of The Lancet, I am frustrated by the lack of qualitative articles that appear, by their absence, to be regarded as much less relevant. If my literature review, and the voices of my participants, has shown anything, it is that it appears that purely

quantitative research has proven less reliable when it comes to solving the issues most pertinent to the survival of childbearing women.

Comparing Findings with Literature

This research is believed to be original insomuch that it has uncovered what is shaping why women are still dying in childbirth so prolifically in many developing country settings through the voices of the very people charged with saving their lives—the humanitarian aid workers. This group of health care workers remains a largely untapped source of vital information. As expressed earlier, aid workers are a critical bridge to the very survival of childbearing women and children in some of the harshest conditions imaginable. This very sentiment is echoed in research published in the past few months. It is research that backs up my findings that aid workers too are a vulnerable population that need better regulation, better training, and, above all else, far better support from the agencies that enlist them.

Increased Support for Childbearing Women and Children

Following on from the literature earlier reviewed throughout the data collection and analysis period of this research, I once again turned to The Lancet to see what, if anything, they had to say in regard to my findings. I was encouraged to discover a four-part series published in January 2021 that focuses on scholarship from a new enterprise the *Bridging Research & Action in Conflict Settings for Health of Women and Children (BRANCH)* Consortium. The BRANCH Consortium is an international academic research initiative with the goal of "improving evidence and guidance for effective action on women's and children's health and nutrition in conflict settings" (BRANCH, 2021 p. 1). As well as a large group of international co-investigators, BRANCH collaborates with local researchers based in areas of conflict, as well as local and international humanitarian agencies (BRANCH, 2021). The aim of The Lancet series was to investigate and build on the knowledge led by BRANCH in an attempt to provide new insight and help fill gaps in understanding and action regarding the health care of women and children living in conflict settings. While the papers centre around women and children affected by armed conflict, I was heartened to discover that their findings echoed much of what my participants had espoused across the majority of developing world settings, not just those in areas of conflict.

Dying to Help

It is a fact that aid workers working in health settings in areas of conflict stare death in the face almost as frequently as the childbearing women they are trying to save. In the first nine months of 2019, it is reported that 171 health workers lost their lives and some 700 were injured in a total of 825 attacks on health workers in highly volatile environments (Wise et al., 2021). Another study looking at violent incidents that greatly affected the provision of health care in 22 conflict-ridden countries, found that healthcare workers were the prime target in over 90 percent of reported cases (Elnakib et al., 2021). Many facilities they were working in were deliberately targeted. Childbearing women and their infants, and those that help care for them, are not immune as highlighted by the deadly May 2020 attack on an international medical charity *Médecins Sans Frontières (MSF)* maternity clinic in the heart of Kabul, Afghanistan (BBC News, 2020). Twenty-four women and children were killed, including three women in the process of delivering their babies in the birthing room. The attack led to the forced closing of the Dasht-e-Barchi hospital as it was determined that the mothers, their babies, and the health workers caring for them were deliberately targeted by the gunmen (BBC News, 2020). Wise and colleagues (2021) explained the many political and security challenges that have become more contemporary in their approach. No longer is it faction against faction; rather, the global face of war is changing with prolific groups of armed non-state actors cementing their interests with ever-changing patterns of violence, the like not often seen before in humanitarian settings (Wise et al., 2021). Add to that, new initiatives in the provision of medical and public health care providing its own minefield for aid workers to negotiate. All these factors combine to confirm the findings of this thesis that a more intensive spotlight needs to be placed on what services are provided, contextualised by the setting they are in, with the emphasis being much more proximal to the frontlines (Wise et al., 2021).

The second paper in The Lancet series focuses largely on the direct (caused by violence done to them) and indirect issues (the lack of the essentials of life due to the devastation) pertaining to the health of women and children in areas of armed conflict (Bendavid et al., 2021). It is estimated that 265 million women and 368 million children live within 50 kilometres of areas of chronic armed unrest. That is, 10 percent of women and 15 percent of children across the world living in areas where their lives are consistently at risk on a daily basis (Bendavid et al., 2021). In this article, Bendavid and colleagues (2021) confirmed the gravity of the situation brought forth by the participants in this study—that war and unrest is a major component to a static or climbing maternal mortality rate. They

go a step further by suggesting that childbearing women and those of reproductive age have triple the mortality rate of those living in peaceful surroundings (Bendavid et al., 2021).

Donor Inadequacy

Neha Singh (2021) heads the research of the third paper in The Lancet series. Here, she and her colleagues add further weight to the argument presented by the participants in Chapter Nine—that donors, while well-meaning, can often add to the chaos and confusion around the implementation of lifesaving care for women and children, particularly when working in areas of conflict (Singh et al., 2021). Singh and her team (2021) conducted 10 case studies of countries around the world affected by war and unrest. They uncovered that prioritised healthcare was, in the majority, donor-driven according to a predefined agenda. Often this agenda did not reach a consensus with other donor agencies or those implementing the health care on the ground; and much were not implemented (Singh et al., 2021). The authors also reported a distinct lack of comprehensive data coming out of these settings, and the quality of that data being questionable (Singh et al., 2021). They emphasised the importance of context-driven initiatives rather than a one-size fits all approach given that the "dynamic nature of modern conflict and the expanding role of armed non-state actors in large geographical areas pose new challenges to delivering health… to women and children and assessing outcomes" (Singh et al., 2021, p. 1). This sentiment was to be echoed in the final paper in the series.

Context Specific

Many international policies and donor interventions related to women's health, most specifically reproductive health, have been generic in its approach and implementation (Gaffey et al., 2021). Michelle Gaffey (2021) and fellow researchers highlighted this fact in the fourth paper in The Lancet series, calling on the need to be context specific when deciding on health intervention priorities for women of reproductive age, particularly in areas of conflict. Much like the participants in my study, they call for an assessment at grassroots level both of what intervention is likely to be successful and what is most feasible in contexts that are dynamic in nature, such as those involved in conflict (Gaffey et al., 2021). In an associated comment, Bhutta et al. (2021) illuminated the many calls, also echoed by the participants in the current study, for reform of the humanitarian health sector to optimise local engagement and provide more flexibility in delivery of women's health programmes in such settings.

The last word was given to former New Zealand Prime Minister, former Administrator of the United Nations Development Programme, and now Chair of the Board of Partnership for Maternal, Newborn and Child Health, Helen Clark, who reflected on the series and its consequences. Clark (2021) made special mention of the plight of childbearing women in areas of unrest, acknowledging that in such settings maternal mortality is up to 28 percent higher than that of areas of no conflict. Clark also acknowledged the plight of young women of childbearing age in humanitarian settings, conceding that gender-based violence was too prevalent. It is reported that as many as a third of all adolescent girls in such settings experience violence in the form of rape as their first sexual encounter (Clark, 2021).

While Clark (2021) talks of an integrated and multisectoral approach to maternal health care intervention, one that appears at odds with the views of the participants in this research, what Clark and they agree on is that that intervention should be informed by local actors at the grassroots level. Furthermore, a move to decolonise global health must be a priority for all actors working across the humanitarian setting.

Aid Workers are the "Forgotten First Responders".

While the aim of this thesis was to uncover what was shaping why women are dying in childbirth in developing world settings, there has proven to be a gentle undertow that has pulled me consistently back to both the importance and the precariousness of the aid worker. Their work is somewhat of a dichotomy, with these health workers often putting themselves in harm's way in an attempt to save the lives of the childbearing women for whom they are caring. I was struck by the nature of their work and, while not originally planned, a chapter dedicated to the congruent plight of the aid worker to those they care for—Bearing Witness—was born. Upon completion of data analysis, I was keen to compare my accidental findings with current literature.

MacPherson and Burkle (2020) underscore my finding that the aid worker is often an overlooked and undervalued resource in a humanitarian setting. Labelled "The Forgotten First Responders", MacPherson and Burkle suggested an industry-wide lack of accountability for the health and wellbeing of the aid worker, particularly pertaining to post traumatic stress disorder and its effects. There are close to half a million humanitarian aid workers in emergency settings spread across the world at any one time. A 2015 survey into

the health and wellbeing of such aid workers found that close to 80 percent admitted to serious mental health issues, with 50 percent declaring they had been clinically diagnosed with depression (MacPherson & Burkle, 2020). The survey also concluded that just *one* short-term mission could lead an aid worker to return home, subsequently isolating from family and friends and struggling to reconnect with their former life (MacPherson & Burkle, 2020). For some, the need to quickly return to a humanitarian setting is overbearing, and they return finding relief amongst the familiar, and to those that share comparable experiences (MacPherson & Burkle, 2020). As reported earlier, it is not just declining mental health that is on the rise amongst aid workers; their physical health (disease and injury) and safety has become increasingly unstable. Aid workers lives can be placed in jeopardy as a result of violent assaults and even kidnapping (MacPherson & Burkle, 2020).

Turner et al. (2021) support MacPherson and Burkle's (2020) claims, reiterating that aid workers "experience continuous, episodic, personal, communal and vicarious trauma" (p. 1). While that trauma can be in the form of physical and mental trauma, other stressors such as needing to perform arduous tasks for which they were not specifically trained, can prove overwhelming (Turner et al., 2021). One of the findings that really stood out was that donor policies, in-country infrastructure, and, indeed, some of the practices of the various aid agencies they were working for was often a major contributor of stress for the humanitarian worker (Turner et al., 2021). These findings were further backed Elnakib and colleagues (2021) who stated, "We found that the complex security situation – characterized by multiple parties to the conflict, politicization of humanitarian aid and constraints in humanitarian access – was coupled with everyday stressors that prevented health workers from carrying out their work" (p. 1).

Sexual violence against female aid workers committed by local actors within the aid organisations themselves is a constant danger (Turner et al., 2021), as is sexual exploitation and abuse conducted by humanitarian aid workers and peacekeepers against the very population for whom they are charged with caring (Javed et al., 2021). While the UN has a zero-tolerance policy against sexual exploitation and abuse, the issue remains widespread. Many such cases were exposed in relation to sex trafficking rings connected to United Nations peacekeepers in the 1990s; but, recent reports during the Ebola virus outbreak have revealed upwards of 50 women accusing UN aid workers of sexual offences from 2018 to 2020 (Javed et al., 2021). This is, in part, due to the large numbers of men occupying positions of power and women desperate to get jobs in a type of 'blackmail-for-

hire' situation that often involved sexual favours being demanded of women (Javed et al., 2021). To this end, the call has gone out for an increase in the number and visibility of female humanitarian aid workers on the ground, particularly for those in key decision making positions (Paul, 2019).

Recommendations for Change

The call for more visibility of female humanitarian aid workers is crucial in ensuring that women in conflict settings can feel safe to seek help. Of course, this must be done with the aid worker's safety at the forefront. So too, is finding a safe and neutral space for aid workers to have their voices heard. This would need to be an independent body, with no ties to any one particular aid agency, to ensure the utmost confidentiality. I would also like to see greater regulation around the aid industry. A regular audit on NGOs looking at the value they have added to the communities in which they are working, how sustainable their projects are, and what the local buy-in is like, should be mandatory. It is essential to ensure that all expatriate agencies are working under the 'First Do No Harm' ethos.

I would like to see mandated that all policymakers, including those at the highest echelon, must have had experience in, and received input from, the ground, in the country for which they are charged with making new policy. No longer should a purely top down approach be tolerated.

Change is always context specific. The participants in this research are clear that 'scaling up' an intervention and transferring it to another developing world setting does not often work. There should be no global 5-step method for anything related to the health and wellbeing of childbearing women. It has been clearly proven in the literature review of this thesis, that the past 20 years of statistical research has had little effect in reducing maternal mortality. Instead, more voices from within these settings need to be heard and valued as important and significant information sources.

One of the changes I would also like to see happen is more support for aid workers. I would like to see a limit on how long an aid worker can be in-country before they must take a self-care break. After interviewing these aid workers, I was left unsure as to who was monitoring their wellbeing, and whether any debriefing, both by their agency and with an independent source, was happening. There appears to be no mandatory supervision or

regular counselling required of, or offered to, these aid workers, despite them working in extraordinarily stressful and often life-threatening circumstances.

Lastly, I would like to see an end to the many undergraduate training programmes where students fly into a country for a month, gain skills, and leave again; adding little to no value to the population on the ground. I was horrified upon my arrival in Senegal that the interns, with whom I was to be working 24 hour shifts in the local birthing centre, were trainee midwives trying to gain the required number of hands-on births that they were not able to, nor regulated to, obtain in their home country. I arrived in Senegal as a new graduate midwife having conducted 86 hands-on births and attended a total of 122 labours. Of the other nine interns I was with, only one had attended more than four births and none had conducted any hands-on, let alone knew maternal or neonatal resuscitation. I was horrified that this programme existed and, from what I have heard, may still exist today.

Recommendations for Education

Most humanitarian workers who operate at the level of these participants have a formal medical or public health qualification. Most participants had achieved their current (at the time of interview) humanitarian postings through vast previous experience working in developing nations. Some acquired additional postgraduate qualifications in public health or global studies. None had received formal training in how to deal with vicarious trauma, cultural safety, or negotiation skills; nor indeed on the effects of colonisation on the indigenous population. While some agencies held short courses on dealing with conflict and emergency scenarios, most aid workers had learned what they needed to through experience in the field.

Today, undergraduate students can apply for experience abroad in developing countries through unregulated internship programmes. Their universities or medical training programmes do not need to have given these students any prior training around the social, cultural, and political nuances of the country they will be visiting. Nor is it a requirement that they receive 24/7 support from their educators. What is lacking in many medical or health science degrees is the aspect of self-care and how to manage working in a setting where they are frequently caring for patients they are unable to save, as well as dealing with those who have been brutally raped and abused by their families, communities, or as a result of war and conflict.

As a result of listening to the aid workers in this research and hearing their stories, I would like to propose that working in a developing world setting becomes solely a postgraduate opportunity for medical and health science students, and not offered at undergraduate level. While there are postgraduate offerings for experienced aid workers, I would like to see a new graduate internship qualification proposed. This qualification would be country specific and designed to prepare students for their first developing world experience rather than focusing on generic teaching. It would include the following, tailored to each person in relation to their country of destination:

- History of the country; its people, their values, beliefs and practices; and the effect of colonisation on the indigenous population.
- The major health determinants of the population and what is or is not working in relation to achieving sustainable positive health outcomes.
- Political history and stability of the country, including any obligations to the World Bank. Is the government in control of its own affairs?
- Aid organisations that are currently working with the country and the success (or not) of their programmes.
- Ascertain any pharmaceutical drug trials within that community, who they are led by, and whether they are deemed helpful for the local population.
- Unlearning of Western practices that would be detrimental to, or ineffective for, the current population.
- Cultural safety and the need to approach each patient as a unique individual with familial practices vital to their mental health and wellbeing, and the success of their treatment.
- Vicarious trauma. Dealing with patients that put their health in the faith of their God rather than the medical profession. What to do when they will not let you save their life.
- Vicarious trauma. Dealing with patients who are recurrently brutally assaulted and there is no option of reporting to authorities or intervening.
- Negotiation skills and relationship building. How to negotiate and build better relationships with patients and their families, when there is resistance, to ensure the best outcome for all.
- Negotiation skills and relationship building. How to negotiate and build relationships with the local community leaders when preparing to introduce a life-benefitting health practice.

- Emergency scenarios when there is no emergency equipment, power, or clean water.
- Self-care. How to keep safe in an unfamiliar and fragile environment. How to recognise when one is not coping and needs to ask for help or remove oneself from the environment.

Recommendations for Future Research

Much research on the health of populations in a developing world setting is conducted each year. Some would say medical related research on developing nations is an entire industry in itself. The research is predominantly quantitative in nature with major publications such as The Lancet and the British Medical Journal rarely publishing qualitative research. With qualitative research not valued to the same extent as quantitative research, crucial voices, such as the participants in this study, in both the maternal health and developing world discourses, will continue to be unheard by those who need to listen to them the most. So, herein lies my first recommendation; that qualitative research (much like verbal autopsies are now seen as significant data) be given the credibility by leading publications that it deserves, and that the crucial stories on the frontline are not just left to journalists to tell.

During the interview process a question that was asked of the participants was "What is working well?" Unfortunately, I was met with so few positive answers that I was unable to put a paragraph together. As an extension of this thesis, I would like to see an action research project, using an appreciative lens, take place; once again, on a global scale. Many years on, I would like to interview another cohort of long-term expatriate aid workers as to what they believe is working well, how to make it even better, and to what extent that intervention or assistance is sustainable in the long-term for the betterment of the community in which they are working.

What concerned me the most during the analysis of this data was the mental health of the aid worker working in such a setting, for a sustained length of time. Often, their trauma was palpable. There are a few psychology studies regarding aid workers and post traumatic stress disorder after working in conflict settings. There were many statistics presented in those studies, but I wanted to hear from the aid workers themselves. I did not just want to read the percentage of aid workers suffering from flashbacks and night terrors, coupled with the inability to reintegrate successfully back into Western society. I wanted to know what those flashbacks involved, how that affected both their mental and physical health

and, most importantly, how that affected their ability to work within the community they were assisting. What was it about integrating back into Western society that made it so difficult to sustain a return? This, in turn, could give agencies a stronger mandate to support their workers in the field.

I would also like to see more grassroots led research conducted in-country. Here the local community could use the expertise of experienced researchers to investigate issues that are important to them. This could lead to better buy-in by the local community to any recommendations made.

Strengths and Limitations of this Study

The strength of this study is that it is a true global reflection of the expatriate aid workers' experience of working in the many diverse developing world settings. This is not a thesis about one community, one country, or one continent. I am grateful for the AUT University Vice Chancellor's Scholarship I received prior to embarking on my data gathering journey. Along with a New Zealand Ministry of Foreign Affairs and Trade Field Research Scholarship, I was enabled to travel and interview some of the most experienced expatriate aid workers in the world. These aid workers took an enormous risk speaking out about the very agencies they represented. To be on the ground in person and reassure them they could trust that I would keep their identity confidential, added hugely to the quality of data in this research.

A limitation of this study could be seen to be the length of time between interviewing and thesis submission; however, with 776 pages of data to unpack and 28 extraordinary voices to be heard, the data analysis process was lengthy. Their stories too were about maternal death. Some raw and uncut versions were even more heart-breaking than what has been presented in this thesis. As a working midwife and a mother who experienced life-saving treatment, I had to balance my own mental health against the amount of data analysis I could undertake at any given time. There were times when I needed to step away for months to ensure that when I sat with this data I was giving it the very best of me.

Some might also view as a limitation that this research is somewhat generic, that they would have preferred more country specific outcomes. I would argue that this thesis proves that there are over-arching themes dominant across most developing nations. These issues,

by being highlighted as a global problem, could not be easily explained away by detractors as just occurring in one community or country setting.

Concluding Thinking

It is April 2021. As I sit at my desk pondering how to end what has become the dominant discourse in my life these past years, my phone alerts me to another freshly published and extraordinary article led by Helen Clark in *Foreign Policy* magazine. The article, titled *In Tigray, Sexual Violence Has Become a Weapon of War,* is a call to end the violence against women in conflict settings and to prosecute the perpetrators. Clark and Kyte (2021) call on the UN to act on resolutions passed just three short years ago, to protect these women, and to see their rape by soldiers for what it is—a war crime. What struck me most about the article was a story shared by the UN emergency relief coordinator Mark Lowcock. It is an all too familiar story:

> An internally displaced woman… explained that when conflict began in her town, she fled and hid in the forest for six days with her family. She gave birth while in hiding, but her baby dies a few days later – at the same time that her husband was also killed. When she resumed her journey, she met four Eritrean soldiers who raped her in front of the rest of her children throughout the night and into the following day.

This recount should have shocked me; yet I just feel numb. I am reminded, yet again, that agencies charged with keeping these women and children safe are having little to no effect. What use is a Global Security Council that is largely ineffective? One of the very first interviews I conducted for this thesis was with a participant who was late to the satellite call because they were suturing a seven year old girl who had been brought in after being raped by soldiers that very day. Years later, the narrative is the same.

The question at the very beginning of this thesis was "What is the lived experience of aid workers actively involved in seeking to reduce maternal mortality in the developing world?". The primary objective was to uncover what is shaping why childbearing women are dying in such large numbers in developing countries. There is no doubt from the data presented and further questions raised during the writing of this thesis, that the answer is complex. We know that, medically, sepsis and haemorrhage are the main physical causes of why women are dying; yet, the political, social, and cultural reasons appear the most crippling. What we can ascertain from this research is that a top-down approach is not

working. It is also clear that while agencies such as the UN have clear mandates to keep these women safe and well, little is being done to enforce them. They are in effect powerless, as alluded to in Clark and Kyte's (2021) article. Until there is sustained action against governments who blatantly choose to turn a blind eye to human rights abuses, childbearing women will continue to die in extraordinary numbers for many years to come.

Simply put, a tree cannot bear fruit without first a seed being firmly embedded into the earth. From there its roots must spread deeper and wider before that seedling can burst through the darkness and into the light. But even then, it is not safe. It needs light and warmth and careful nurturing if it is to first bloom and ultimately bear fruit. It also needs careful protection from the creatures that seek to devour it. Once separated from its rooted source that tree begins to wilt within minutes. No amount of light, water, or care can save it. Even if we seek to transplant it to a more favourable environment, that tree has been separated from its deepest roots and, without a solid foundation, it can take years for it to recover. Weakened, it is more susceptible than ever to succumb to anything that seeks to overpower it. Yet there is hope. Some trees when planted next to two different subspecies rather than their own kind, have been known to produce both the sweetest and largest fruit, proving that a fusion of like-minded life-forms all standing firm in their own horizons—yet holding a safe space for each other—can, indeed, produce something more glorious than if they all stood alone. What the participants in this thesis have shown us is, that to be successful in saving the lives of childbearing women we cannot separate them from their roots, nor transplant them to an unfamiliar environment, albeit with the best of conditions. It requires instead, a complex human eco-system to 'stand alongside' and 'work with' these women so they can remain grounded and bear the healthiest and most beautiful 'fruit'.

When you're weary, feeling small,
When tears are in your eyes
I will dry them all
I'm on your side
Oh when times get rough
And friends just can't be found
Like a bridge over troubled water
I will lay me down

Bridge Over Troubled Water – Paul Simon & Art Garfunkel (1970)

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Appendices

Appendix A: Ethical Approval

MEMORANDUM

Auckland University of Technology Ethics Committee (AUTEC)

To: Liz Smythe
From: **Madeline Banda** Executive Secretary, AUTEC
Date: 3 June 2010
Subject: Ethics Application Number 10/85 **Insights related to the experience of being actively involved in seeking to reduce maternal mortality in the developing world.**

Dear Liz

Thank you for providing written evidence as requested. I am pleased to advise that it satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC) at their meeting on 10 May 2010 and that on 1 June 2010, I approved your ethics application including an amendment to the title from "Uncovering complexity in the delivery of maternal-child health services in the developing world". This delegated approval is made in accordance with section 5.3.2.3 of AUTEC's *Applying for Ethics Approval: Guidelines and Procedures* and is subject to endorsement at AUTEC's meeting on 12 July 2010.

Your ethics application is approved for a period of three years until 1 June 2013.

I advise that as part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/research/research-ethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 1 June 2013;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/research/research-ethics. This report is to be submitted either when the approval expires on 1 June 2013 or on completion of the project, whichever comes sooner;

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are reminded that, as applicant, you are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

Please note that AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to make the arrangements necessary to obtain this. Also, if your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply within that jurisdiction.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact Charles Grinter, Ethics Coordinator, by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 8860.

On behalf of the AUTEC and myself, I wish you success with your research and look forward to reading about it in your reports.

Yours sincerely

Madeline Banda
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Kate Heard kheard@xtra.co.nz, Peggy Fairbairn-Dunlop

From the desk of …
Madeline Banda
Executive Secretary
AUTEC

Private Bag 92006, Auckland 1142
New Zealand
E-mail: ethics@aut.ac.nz

Tel: 64 9 921 9999
ext 8044
Fax: 64 9 921 9925

Appendix B: Participant Information Sheet

Participant Information Sheet

AUT UNIVERSITY
TE WĀNANGA ARONUI O TAMAKI MAKAU RAU

Date Information Sheet Produced:

01 June 2010

Project Title

Insights related to the experience of being actively involved in seeking to reduce maternal mortality in the developing world.

An Invitation

My name is Kate Heard and I am a registered midwife from New Zealand. I will be undertaking this research as a fulltime PhD student at the Auckland University of Technology in New Zealand. My current research interest is in helping uncover what is working well and what challenges aid workers face in their efforts to develop a robust maternal-child health service in the developing world.

I would like to invite you to participate in this research by sharing your experience of working in the area of maternal-child health in a developing country.

Participation in this research is purely voluntary and you may withdraw yourself or any information that you have provided at any time prior to the completion of data collection, without being disadvantaged in any way.

What is the purpose of this research?

It is expected that the information provided by participants in this research will be of great benefit to international governments, aid agencies, NGO's and health workers as it will bring to light the areas that are working well in terms of reducing maternal and infant mortality and highlight those areas that are not. This qualitative research is intended to complement and add value to the vast quantitative research being undertaken globally on maternal and infant mortality and the reality of achieving the United Nations Millennium Development Goals by 2015.

The final research will be published as a PhD thesis, which will be available in the Auckland University of Technology library and online. Short articles relating to the study will be published in relevant professional journals and presented at conferences and seminars. Your identity will not be revealed in any of these contexts.

How was I identified and why am I being invited to participate in this research?

You were chosen to participate in this research because you have the experience of working as an expatriate aid worker in the field of maternal-child health in one or more developing countries, and the knowledge, interest and experience that could assist in further developing the emerging knowing around the delivery of robust maternal-child health services in the developing world.

Participants in this research will be selected through the social and professional networks of the researcher and through advertisements. Participants will, therefore, self-select or be identified as a potential participant by someone who knows of their interest, experience or involvement in maternal-child health in developing countries.

What will happen in this research?

After agreeing to participate in this research, the following process will be undertaken:

1. You will be asked whether you wish to participate in a face-to-face interview or be interviewed via Skype.

2. Prior to the consent form being signed, further consultation will take place to ensure any questions or concerns have been addressed.

3. You will be contacted by phone or email and a preferred time and venue will be discussed. This is to ensure you are not inconvenienced in any way and feel comfortable throughout the interview process.

4. Should you so request, a question outline will be sent to you in advance no later than 48 hours before the interview takes place.

5. The interview will take place at a time and place mutually agreed by you and the researcher.

6. At the completion of the interview the audiotape will be transcribed and the written information returned to you for your review and discussion. You will be signed a pseudonym and only the researcher and her supervisors will have access to your information.

7. You participation is purely voluntary and you may withdraw your participation during any stage of this research. No explanation will be sought.

What are the discomforts and risks?

As a participant in this research you will be asked to discuss your experience of working as an aid worker specialising in maternal-child health. Due to the subject content of this research, there is a possibility that you may disclose information of a sensitive nature, especially pertaining to maternal mortality. It is acknowledged that this could be potentially troubling for you.

There is also a possibility that you may feel uncomfortable about discussing the political or organisational complexities of your work for fear of being identified by your employer, colleagues or other stakeholders. These may include governmental initiatives or organisational policies that you have been asked to implement during the course of your work, but have proven troublesome. You can be assured that all efforts will be made to ensure your privacy is protected at all times.

I do not anticipate any physical risks to you from participating in this research.

How will these discomforts and risks be alleviated?

You do not have to answer all of the questions put to you, and you will have the opportunity to stop and start the interview at your discretion. If you feel, on reflection, that you are unhappy with something you have said, you may withdraw yourself or any of the information you have provided prior to the completion of data collection. If you withdraw yourself you do not have to give a reason. You will also be offered the opportunity to debrief the interview session at a later date.

Due to the sensitive nature of this research, your confidentiality will be a priority. To protect your identity you will be provided with a pseudonym. Your employer will not be informed as to your participation, nor will any identifiable information be revealed in any research reports, unless it is your wish to do so. Any direct quotes used in the reporting of this research will also be free of any information that can lead to your identification.

Counselling services will be freely available to provide support during and after the interview process, should you feel you require help. The Auckland University of Technology has a free online counselling service, and a private counsellor with experience of working in developing countries will also be offered, at no cost to you. Information on how to access these services will be made available with the Consent Form.

What are the benefits?

The major benefit of your participation in this research is that the information you provide will aid in helping create a more robust maternal-child health service for those who are most vulnerable. Ultimately, by participating in this research it is predicted that you will be helping to save lives.

How will my privacy be protected?

All identifying features of your person will remain confidential to the researcher unless you have agreed to publicly acknowledge your participation in this research. A pseudonym, used on all material such as tapes and transcripts will protect your identity. Audiotapes of interviews and the typed transcripts will be kept in a locked cabinet that only the researcher and her supervisors will be able to access. They will be destroyed 10 years after the study's completion.

What are the costs of participating in this research?

The cost of your participation in this research is time. You will be asked to take part in one interview lasting no more than 90 minutes. A second interview of lesser duration may be requested. You will also be offered the opportunity to review the information you have contributed and make any necessary changes. This will be done at your discretion, but is anticipated to take no longer than two hours.

What opportunity do I have to consider this invitation?

You will have two weeks from the receipt of this form to consider this invitation.

How do I agree to participate in this research?

Should you wish to participate in this study, you will be asked to sign a consent form that will be provided by the researcher.

Will I receive feedback on the results of this research?

Yes. Once the thesis has been completed, you will be contacted and provided with information on how to view the thesis and a summary of the findings online.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Associate Professor Liz Smythe, *lizsmythe@aut.ac.nz* 0064 9 921 9999 ext 7196

Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEC, Madeline Banda, *madeline.banda@aut.ac.nz*, 0064 9 921 9999 ext 8044

Whom do I contact for further information about this research?

Researcher Contact Details:

Kate Heard, *kheard@xtra.co.nz* 0064 21 996644

Project Supervisor Contact Details:

Associate Professor Liz Smythe, *lizsmythe@aut.ac.nz* 0064 9 921 9999 ext 7196

Approved by the Auckland University of Technology Ethics Committee on ***type the date final ethics approval was granted*****, AUTEC Reference number** ***type the reference number*****.**

This version was last edited on 15 February 2010

Appendix C: Consent Form

Consent Form

Project title: *Insights related to the experience of being actively involved in seeking to reduce maternal mortality in the developing world.*

Project Supervisor: *Associate Professor Liz Smythe*

Researcher: *Kate Heard*

- O I have read and understood the information provided about this research project in the Information Sheet dated 01 June 2010.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- O If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- O I agree to take part in this research.
- O I wish to receive a copy of the report from the research (please tick one): YesO NoO

Participant's signature: .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

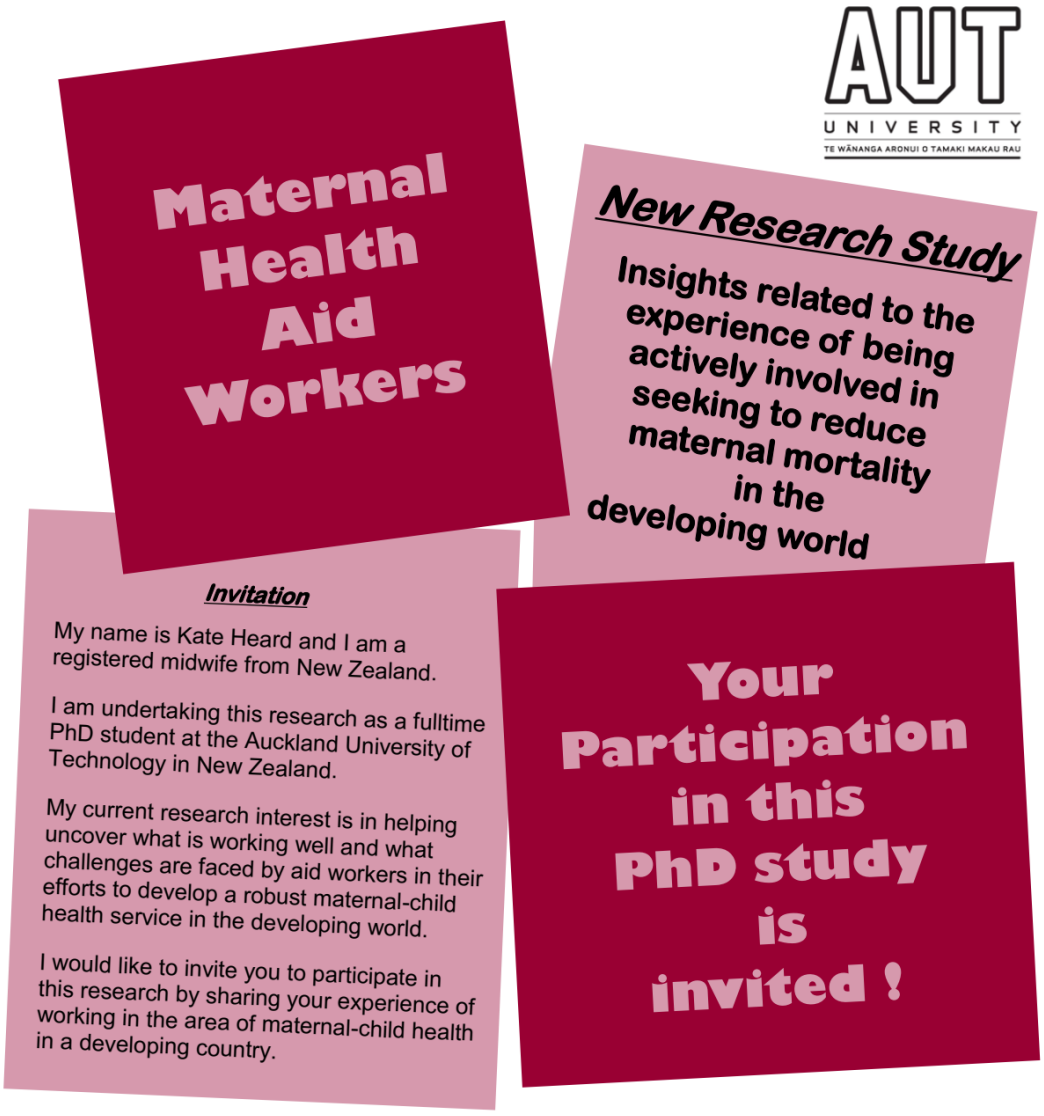
.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy of this form.

Appendix D: Advertisement

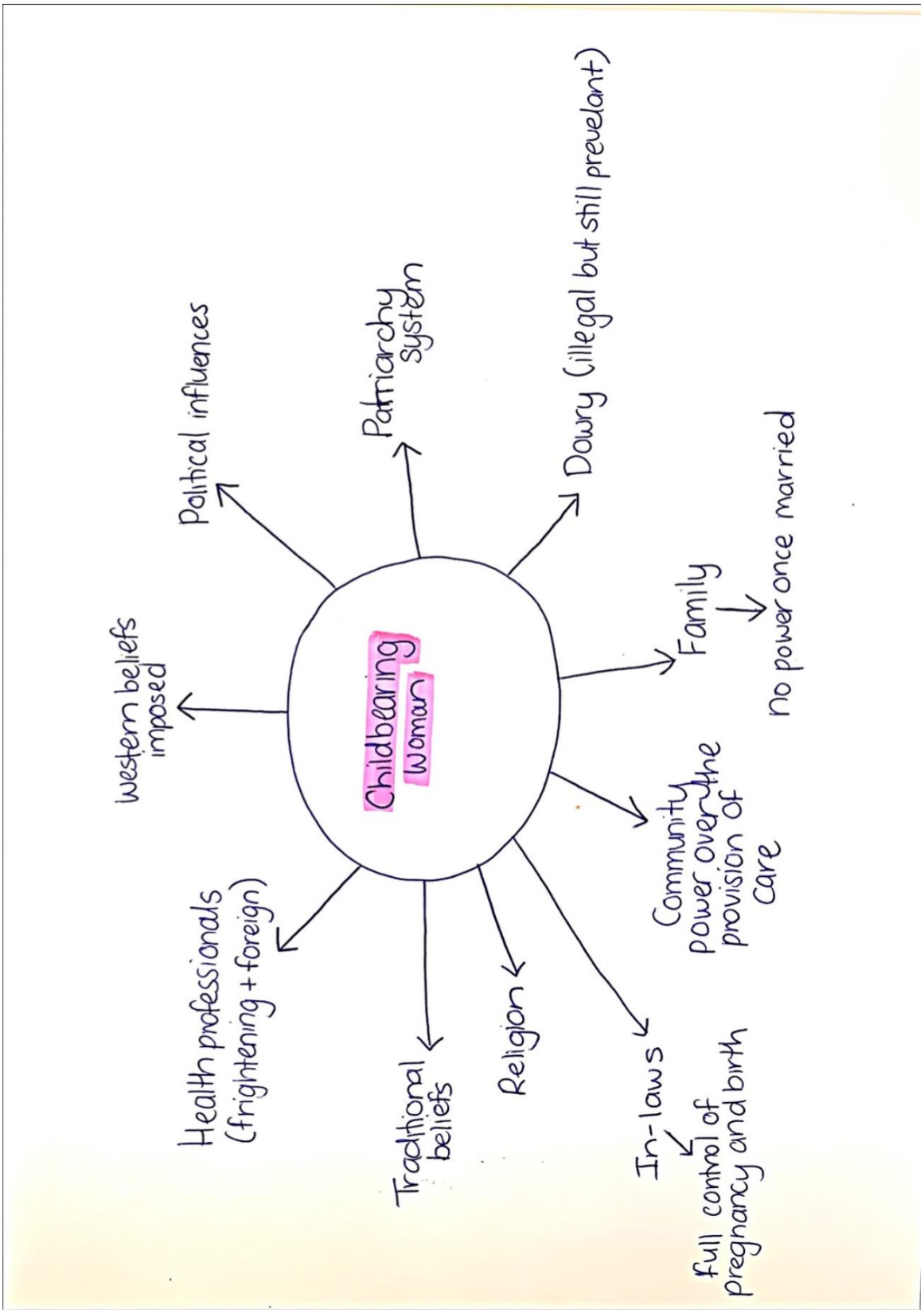


Are you interested?

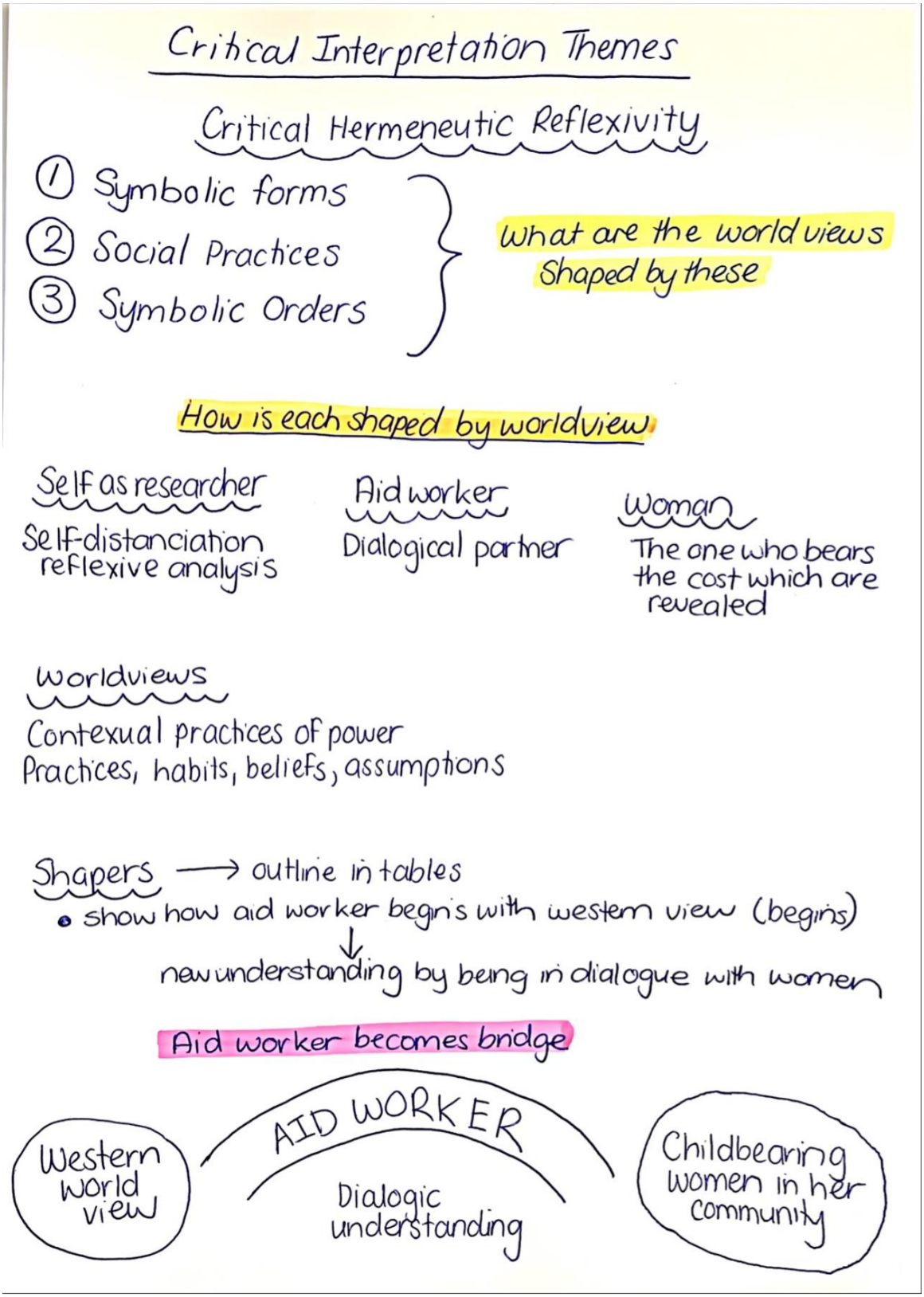
If you are interested in participating in this research, please contact the researcher Kate Heard at kheard@xtra.co.nz and an information sheet will be forwarded to you.

Interviews may be conducted via Skype!

Appendix E: Critical Interpretation and Workings of World Views: Example 1



Appendix F: Critical Interpretation and Workings of World Views: Example 2



Appendix G: Critical Interpretation and Workings of World Views: Example 3

Political

Worldview (the shaped)

1. Maternal health is a human right – (the legal statue that is shaped by law)
2. Maternal health relies on the status of women – (the aid worker's perspective shaped by lived experience)
3. Maternal health is survival of the fittest (the woman's perspective shaped by lived experience)

Social Practices (the shaping)

1. A Western social system in which every life is sacrosanct and maternal mortality is rare
2. A social system in which women are not prioritised and a woman's life has little value
3. A social system in which a woman has no voice

Discursive Symbolic Orders (the shaping)

1. Women are equal to men and deserve the same right to quality healthcare.
2. Depending on where a woman is born determines her chances in life. The place of women in these societies is non-existent.
3. A woman's survival is determined by God's will.

The unacceptable (for all three) - a woman dies in childbirth

I

From here, I discuss and reveal the shapers of these three worldviews by:

1. Reviewing literature around the history of women's rights movements and human rights law.
2. Discussion around how aid workers are socialised to practice in the Western way or 'save at all costs', yet must honour the cultural practices of the setting they are in and watch women die.
3. Discussion around why women are so fatalistic. Who or what is shaping that way of thinking?

Appendix H: Critical Interpretation and Workings of World Views: Example 4

Patriarchy

Worldview (the shaped)

4. Men and women have equal rights to make their own informed decisions– (the legal statue that is shaped by law)

5. Women need the permission of their husbands to seek health care – (the aid worker's perspective shaped by lived experience)

6. It is my husband's decision whether I live or die (the woman's perspective shaped by social practices).

Social Practices (the shaping)

4. A social system in which women have control over their own bodies and their own decisions regarding pregnancy and childbirth.

5. A patrilineal society in which women are not free to make their own choices regarding pregnancy and childbirth.

6. A social system in which women are the 'property' of their husbands and as such make few autonomous decisions around pregnancy and childbirth.

Discursive Symbolic Orders (the shaping)

4. Women are equal to men and deserve the same right to quality healthcare.

5. Depending on where a woman is born determines her chances in life. The place of women in these societies is non-existent.

6. A woman's survival is determined by God's will.

The unacceptable (for all three) - a woman dies in childbirth

From here, I discuss and reveal the shapers of these three worldviews by:

4. Reviewing literature around the history of women's rights movements and human rights law.

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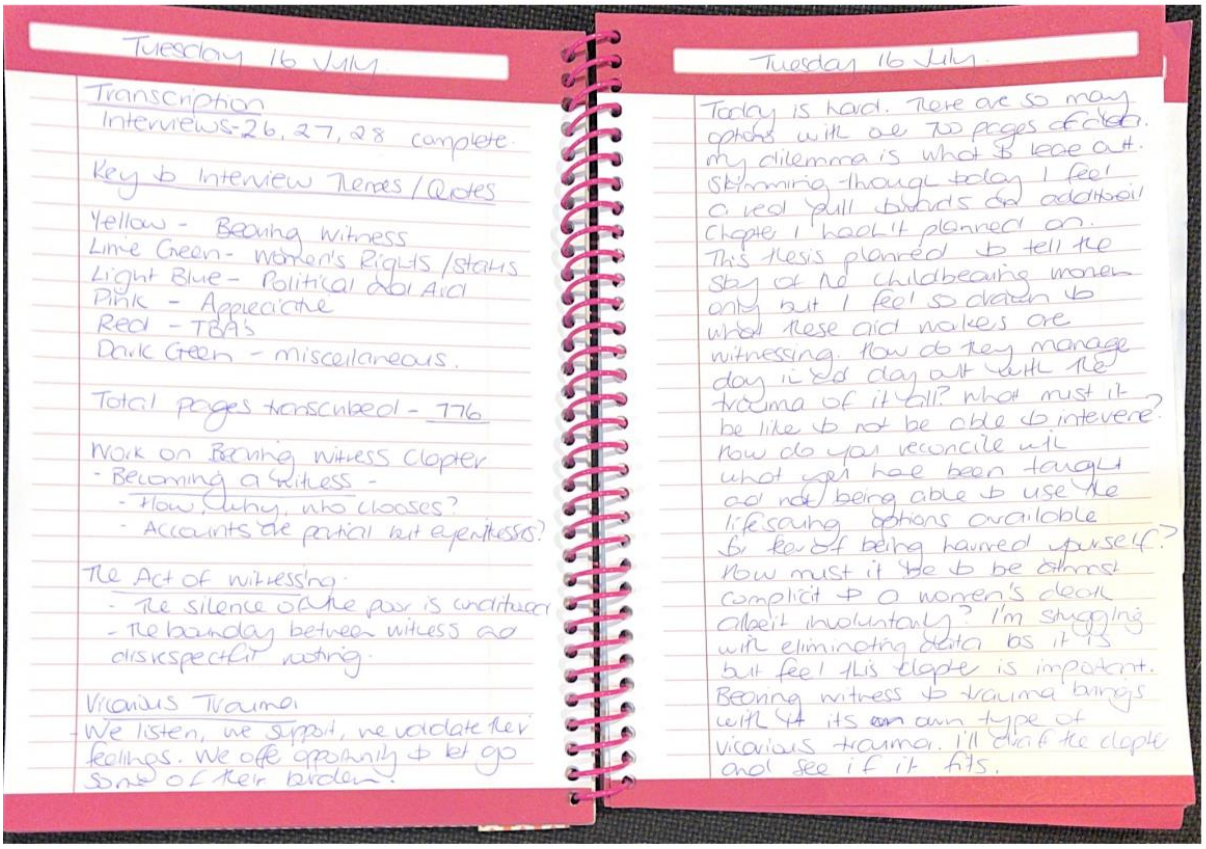
6. Discussion around why women are so fatalistic. Who or what is shaping that way of thinking?

Appendix I: Example of a Journal Entry



Tuesday 16 July

Transcription
Interviews-26, 27, 28 complete.

Key to Interview Themes / Quotes

Yellow - Bearing Witness
Lime Green - Women's Rights / Status
Light Blue - Political abi Aid
Pink - Appreciative
Red - TBA's
Dark Green - miscellaneous.

Total pages transcribed - 776

Work on Bearing Witness Chapter
- Becoming a Witness -
  - How, Why, who chooses?
  - Accounts the partial but eyewitness?

The Act of witnessing
- The silence of the poor is unattributed
- The boundary between witness and disrespectful noting.

Vicarious Trauma
- We listen, we support, we validate her feelings. We offer opportunity to let go some of their burden.

Tuesday 16 July

Today is hard. There are so many options with the 700 pages of data. My dilemma is what to leave out. Skimming through today I feel a real pull towards the additional chapter I hadn't planned on. This thesis planned to tell the story of NI childbearing women only but I feel so drawn to what these old makes are witnessing. How do they manage day in day out with the trauma of it all? What must it be like to not be able to intervene? How do you reconcile with what you have been taught and not being able to use the life saving options available to fear of being harmed yourself? How must it be to be almost complicit to a women's death albeit involuntary? I'm struggling with eliminating data as it is but feel this chapter is important. Bearing witness to trauma brings with it its own own type of vicarious trauma. I'll draft the chapter and see if it fits.