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THE MIDWIFE IN EL SALVADOR
AND
HER ROLE IN THE RURAL HEALTH SYSTEM
...Findings and Recommendations

Excerpts From
A Report Prepared By:

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Preface

The following is an English translation of three chapters (Chapters I, IV and V) of a report previously prepared by Polly F. Harrison and submitted in Spanish to the El Salvador Ministry of Health. The entire table of Contents is included here to illustrate the subject matter and data dealt with in the complete report.

Copies of the original report in Spanish have also been distributed to the AID Office of Population.

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What does the midwife do during the post-partum period?

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- Care of the newborn
- Care and counseling of the mother
 - Hygiene
 - Nutrition
- Other activities of the midwife
 - Help with infant illnesses
 - Role as confidante

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Would it be good for midwives to be salaried?

What do midwives do about family planning?

Could midwives promote family planning?

What is the midwife's personal experience with family planning?

What is the role of the midwife during pregnancy?

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CHAPTER I

INTRODUCTION

Purpose of the Study

The motivation for this study was the desire of the Salvadoran Ministry of Public Health and Social Service¹ to enhance the role and effectiveness of traditional² midwives in order to incorporate them into Rural Health Programs. The Ministry further wanted to explore the feasibility of midwife involvement in family planning promotion and distribution. This study was tailored to respond to those wishes.

In 1975 a detailed study,³ employing survey methodology, was carried out among 97 midwives throughout El Salvador; the perspective was that of the midwife. In order to avoid duplicating that excellent and useful work, and in order to see the other side of the coin, the present research was oriented toward: 1) more thorough investigation of certain aspects of midwives and midwifery that were of particular interest to the Ministry; 2) a deeper understanding of the midwife as an individual; and 3) the community view of the midwife, in other words, the perspective of her clientele.

The scope of work for the research encompassed the following emphases:⁴

- 1) What importance does the traditional midwife have in a rural community? When and with what frequency is she used? For what services other than childbirth does the community utilize her? Does she send patients to MSPAS clinics? Is she considered part of the rural health system? What qualities appear to affect her utilization, in her view and that of the community? What are the prevailing attitudes toward pregnancy, childbirth, the post-partum period, and hospital delivery? What are attitudes about family planning and its technology, especially with regard to the possible involvement of the midwife as family planning promoter and distributor?
- 2) What are the characteristics of a typical midwife population -- age, training, socioeconomic status, number of children, personality, and perception of her profession and its responsibilities?
- 3) What is the midwife's understanding of and attitude toward:
 - a) Family planning, its necessity, methods, and the best way of getting advice and services, as well as her own involvement in family planning
 - b) The rural health system
 - c) The importance of nutrition for infants and mothers in all stages of childbearing.
- 4) What is the feasibility of upgrading the traditional midwife in terms of her desire and capacity for further training, particularly in family planning and nutrition?

¹ Ministerio de Salud Pública y Asistencia Social, hereinafter MSPAS.

² Hereinafter "midwife," for brevity's sake. Customary Spanish terms are: partera, partera empírica, empírica, matrona, or natural, the last referring specifically to the midwife with no training whatsoever.

³ Claros, et al., 1975.

⁴ The scope of work was decided in conjunction with those Ministry of Health officials who had requested the study.

5) What is the midwife's attitude toward the possibility of becoming a trained member of a Rural Health Team with explicit ties to Rural Health Posts and Aides?

Methodology

The research site was a rural municipality where the investigator had carried out previous research, located in the Eastern Region of El Salvador, with a population of approximately 4100. The duration of the field stay was 24 days.

The methodology used combined the following techniques:

- 1) Collection of qualitative data through traditional anthropological approaches, i.e., participant observation, unstructured conversations with key informants, and analysis of interaction.
- 2) Collection of quantitative data through semi-structured interviews.
- 3) Group discussions.
- 4) Literature review.
- 5) Analysis of clinic records to confirm data given during interviews.

The study comprised, in effect, three basic samples, variously selected, and none of which were truly random:

- 1) A group of 12 midwives, residents of the municipality and of the cantons and hamlets dependent on the municipality. The sample was selected by identifying all the midwives in the catchment area of the municipality's health post and interviewing, as frequently and intensively as possible in unstructured fashion, as many of those midwives as could be located.
- 2) A group of 30 pregnant women or mothers of newborn infants, who were interviewed at the health post as they appeared for medical attention. The interview schedule for this sample was semi-structured.¹
- 3) A group of 167 housewives who belonged to the five Housewives' Clubs² in the same catchment area; one Club belonged to the municipality, the other four to cantons and hamlets. The methodology was open group discussion, using a list of core topics.

Unstructured interviews were also held with clinic personnel and key informants. Finally, five midwives were videotaped in a group discussion about needs and attitudes, the purpose of which was to clarify key issues revealed during the research period and to reiterate and relay those in more vivid fashion to the Ministry of Health.

¹ It had been hoped that it would be possible to have a "cleaner" sample of solely pregnant women, but it became apparent during the second week of the study that not enough pregnant women were going to appear at the clinic during the time available. Since the investigator wanted to keep constant the factor of clinic attendance, it was decided to include mothers of newborns whose recall and present experience could be assumed to be reliable.

² Organized by the home educators in the extension arm of the Salvadoran Ministry of Agriculture.

CHAPTER IV

SUMMARY OF FINDINGS

Characteristics of the Sample of Mothers

Of the total sample of 30 pregnant women and mothers of newborns, 13% came from the municipality, 60% from the cantons, and 27% from hamlets, an eminently rural sample. Average age was 26.9; the youngest woman was 16, the oldest 44. 27% were married, 70% were living in consensual union, and 3 were single. 77% lived with their husbands or companions. Average number of children per mother (incomplete fertility) was 3.5. The socioeconomic level of the sample as a whole was low; the majority of husbands and companions were small farmers. Average maximum schooling level was 1.5 grades.

As a group, these women had dealt with a total of 17 midwives, only some of whom were included in the sample of midwives interviewed. An ideal, and purer, design would have matched samples of midwives and clients; however, both midwives and mothers were quite mobile and the necessary search would have demanded an unjustifiable additional length of time.

What Facilities Are Used for Childbirth, and Why and How Is the Midwife Used?

67% of the sample of mothers had gone to a midwife for at least one childbirth, a figure representing 73% of all deliveries for the entire sample. In other words, the great majority of rural childbirths, if the study case is representative, are attended by midwives. 12% of the sample had given birth with the assistance of some member of the family, 12% had had a hospital delivery, 2% had given birth unattended, and less than 1% had had the services of someone who was neither a midwife nor a member of the family.

Viewed from another perspective, 65% of the sample had used a midwife for all their childbirths, 12% had used hospital facilities only, and 23% had given birth both at home and in the hospital. Of those who had used hospital facilities at all, the large majority had done so for medical reasons; more than half of these had sought sterilization.

The great majority of women who had used a midwife said they had done so for logistical or practical reasons; only a minority claimed motivations based on emotional ties or matters of belief. It would seem that the psychological and affective reasons often mentioned as essential to the survival of midwifery are diminishing.

Leaving the question of utilization and turning to the matter of preference, it was found that more than three-fourths of the sample preferred hospital births. Their reasons were primarily of a medical nature, better than half relating to the desire for sterilization. Other reasons offered for the hospital preference were reservations about the ability of the midwives available, and a miscellaneous combination of pragmatic and idiosyncratic justifications.

The other fourth of the sample preferred home deliveries attended by a midwife, half of these because of their positive attitudes toward the midwife concerned, the other half because of their negative attitudes toward the hospital.

Perhaps most interesting was that both groups, those who preferred hospital deliveries and those who preferred attendance at home by a midwife, expressed reservations about both options. It would seem that rural women in general feel that no environment available to them for childbirth is ideal.

There was neither statistical nor impressionistic correlation between reasons for selecting a given midwife and such explanatory variables as age and experience, training and/or educational level, or personality. The most common explanation, as suggested above, is simple accessibility. There is some indication that the younger midwives with some training are acquiring more clientele, but only where there is not much competition from older, experienced midwives. One might safely conclude that the midwife under age 50 can build up her clientele more easily where there is less competition from established midwives, simply because there is a need for her services. This, plus growing respect in the rural area for education and modern medicine, would suggest that the best place to concentrate forthcoming midwife training would be at the cantonal level, with younger women who have at least some experience, and where there are no other midwives or only older ones who are viewed, usually with regard, as being past their prime.

Where Are Midwives Located?

Clear consensus emerged among the mothers interviewed that the number of available midwives is decreasing and that "replacements" are not forthcoming, a consensus confirmed by the investigator's own perceptions. There are more midwives available per capita at the level of the municipality, but their sphere of action is limited by preference and logistics to the municipality itself. The cantons and hamlets in the catchment area studied had only one or two midwives each, for a relatively large and scattered population. In several sites there were no midwives at all, a condition which generated considerable anxiety.

In sum it can be said that the demand for hospital delivery is growing, and that interest in the services of midwives increasingly depends less on faith and shared belief than on necessity. The feeling prevalent in more remote areas is that prospective mothers are without options: midwives are disappearing and hospitals are just as inaccessible as ever. Midwives are valued because they are there.

What Is the Midwife's Image?

The traits considered most desirable in a midwife are basically related to quality of service: either some training and experience or considerable experience, thorough attention, and courteous treatment. The traits considered undesirable are tied to essentially pragmatic considerations -- old age, high cost, lack of knowledge -- but roughness and impatience are deemed utterly unacceptable. The most important personal quality for a midwife is valor, which subsumes courage, willingness to take risks, a combination of emotional toughness and compassion, and sheer physical strength. The last component is frequently and explicitly tied to relative youthfulness, a relevant point for the recruitment of midwifery trainees.

What Status Does the Midwife Occupy and How Much Prestige Does She Have?

The status of the Salvadoran midwife is quite different from that of the midwife in many other countries where that status is quite distinct, where the role is often ritualized, and where the midwife is ascribed high prestige due to her advanced age, her religiosity, and her special knowledge and skills. In such countries the midwife's role is also far broader; in El Salvador her role is quite limited. Furthermore, it has little ritual content and is not expanded into other community responsibilities. As rural health services have expanded in El Salvador and communications improved, even given their limitations, the midwife's role has become increasingly limited. At present her standard responsibilities involve as few as one consultation during pregnancy for massage, the delivery itself, and few visits or none during the post-partum period. One mother summed up the appraisal of the majority by describing the midwife as noone very special.

Is a Midwife Who Has Been a Mother Better?

The consensus was that a midwife who had had children was preferable. Nevertheless, some women indicated that, when all was said and done, they would give more weight to the level of training, availability, and a demonstrated quality of vigor and/or valor.

Is There a Need for Better-Trained Midwives?

Three-fourths of the sample of clients agreed with the need to train existing midwives and to train new ones for sites where none were presently operating. A very clear distinction was made between the midwife with some kind of training and the natural, that is, the midwife who was self-trained or introduced to the profession by a relative or friend. However, no distinction was perceived among types of training, nor was any preference shown for one kind of training over another. A midwife who had attended a few classes at a Health Post was considered just as trained as a midwife with intensive and broader training elsewhere.

Is It Important for a Midwife To Be Licensed?

The women interviewed considered the license, diploma, carnet, or patente, of great value. They indicated that, between a known midwife with a license and another known midwife without one, they would choose the former.

Would It Be Good for Midwives To Be Salaried?

The interviewees had difficulty grasping the idea of a salaried midwife. They tended to conclude that, if midwives were salaried, they would not have to pay for their childbirths. They did not comprehend the possibility of the midwife as a paramedic under the aegis of the Ministry of Health. This may have been partly due to lack of familiarity with the role of the Rural Health Aide and should be considered only as interesting, rather than as conclusive.

What Do Midwives Do About Family Planning?

According to their clients, the overwhelming majority of midwives are not promoting family planning. A few midwives are known to be opposed to family planning on principle but do not apparently actively proselytize. In any case their opinions on the subject, whether positive or negative, do not seem to weigh heavily in the decision-making process of their clients. Among midwives who do have a positive attitude toward the concept of family planning, promotional activities are nevertheless lukewarm, primarily because of reservations about the possible negative impact on health of the available technology. Those who have a negative view of family planning in general are the older midwives who are not taken seriously in this regard, particularly by the younger mothers.

The prevailing pattern with regard to family planning is one of scant or unenthusiastic involvement, and little either negative or positive influence by midwives upon their clientele.

Could Midwives Promote Family Planning?

Despite the poor record of midwives in family planning promotion, the great majority of mothers were favorable toward the idea of special training in family planning for midwives and toward the idea of midwives as promoters and distributors of contraceptive materials. Their rationale was that midwives were accessible, more so than the health post, not only in geographical terms but from the standpoint of intimacy and trust. Still, one-fourth of the sample was opposed to any major involvement of midwives in family planning activity and thought that such matters were best left to the clinics and in the hands of those better prepared.

What Is the Client's Experience with Family Planning?

Of the sample, three women had been sterilized at the time of their recent delivery, 10 were going to be sterilized with the next childbirth if they could get to the hospital in time and, if not, then later. Two were going to start using birth control methods, three wanted no more children but did not know what to do about it, and the rest were women who had borne only one child and/or wanted more children.

What Is the Role of the Midwife During Pregnancy?

Referrals for Clinic Checkups

Only a small minority of the midwives used by the women in the client sample had referred them to a clinic or health post for pre- or post-natal checkups. Approximately a third of the sample had gone to the clinic because they did not feel well, an essentially curative rather than preventive motivation. Another third had gone to the clinic in order to get the referral card for hospital sterilization at the time of childbirth. The rest went because their infants were ill. The midwife's influence on any decisions for clinic attention seems to have been minimal, although there were some indications of more influence with regard to post-natal care, for reasons that are not clear.

Month in Which Pregnant Women Seek Out a Midwife

Half of the sample had sought a midwife in the sixth or seventh month of pregnancy. The average number of consultations between midwife and client before childbirth was two. The pre-natal visits took place either at the client's or the midwife's home, with roughly equal frequency.

When patient-midwife and patient-clinic contacts are compared from the standpoints of timing and frequency, an important difference emerges. Whereas the customary first visit to the midwife is in the sixth month of pregnancy, the pregnant woman who goes to the clinic customarily goes in the fourth month. The earliest reported visit to a midwife was in the third month of pregnancy; the earliest report for the clinic was the second month.

The difference in number of visits is even more striking. The average number of visits to a midwife is 1.65; the average number of clinic visits is 4.7 for completed pregnancies and 2.9 for women still-pregnant.¹

The data suggest that rural women typically go to a clinic or health post for diagnosis or confirmation of pregnancy, as well as for the other care and counselling offered there. The midwife role thus appears to be losing two of its traditional components, diagnosis of pregnancy and counselling; what remains of that role, in any generalized and consistent way, is the pre-natal massage or the sobada.

Massage

100% of the women in the client sample stated that their principal reason for pre-natal visit(s) to a midwife was the sobada, a special massage whose supposed purpose is to adjust the position of the fetus in the uterus. 100% also reported satisfaction with the experience, claiming that they had received relief from their discomfort. Obviously, some of these women were also getting pre-natal clinic care as well, but only one interviewee noted that there might be some contradiction in the simultaneous involvement in the two medical systems.

Advisory Role of the Midwife During Pregnancy

Nutrition

Only a quarter of the midwives patronized by the interviewees had given any advice about nutrition and in all cases the advice was far from thorough. There is a perceptible reluctance on the part of midwives, according to their clients, to be vigorous in nutritional recommendations, simply because both patient and practitioner come from the same socioeconomic stratum in which eating better may seem impossible because economic resources remain limited, even if one is pregnant. There was no indication of awareness among midwives of ways to eat better within those same resources; if such awareness did exist, it was not communicated to any of the clients interviewed. This regrettable fact was reflected in the clinic records which showed a significant proportion of low

¹ It must be recalled that the sample included both pregnant women and women who had recently delivered.

weight gains during pregnancy among the women in the sample. Among first-time mothers, this may have been due in part to a frequently stated desire for small babies to make delivery easier, but not all the women were mothers for the first time and the percentage was significant.

Hygiene

According to the interviewees, midwives generally say nothing about either home or personal hygiene during pregnancy or prior to childbirth.

Sexual Relations

No interviewee reported having received advice from a midwife about the proper time to cease having sexual relations during pregnancy.

Danger Signals

No midwife was reported by the client sample as having advised them explicitly about danger signals during pregnancy and how these should be dealt with. The interviewees suggested three possible explanations for this silence: 1) midwives primarily concern themselves with counselling women who are pregnant for the first time, assuming that women who have already borne children know all there is to know; 2) some danger signals are so obvious (for example, hemorrhaging) that it is felt that any woman could recognize them herself; 3) such problems are automatically taken care of at the clinic. There is strong evidence of a lack of awareness on the part of most rural women of what constitute the chief dangers during pregnancy; for the most part, women go to the clinic for pre-natal care when they do not feel well in general. Malaise, rather than menace, appears to be their main rationale.

Medication

Over half the midwives were reported to have prescribed traditional medicines during pregnancy, primarily for the cure or prevention of aire.¹ Few medicines were prescribed as specifics for any danger signals; however, the rather amorphous category covered by the term aire subsumes symptoms of distress which could also be symptoms of potentially grave conditions. Thus, while none of the primarily herbal remedies seem in themselves perilous, their use may in some cases postpone the seeking of medical assistance for very real and dangerous problems.

Preparations for Childbirth

This was the matter most discussed by midwives with their clients, although counselling in this regard was generally erratic, incomplete, and infrequent. One might hypothesize that the concern with preparations for childbirth is rooted in economic reality, that is, the midwife's inability to absorb all the costs of the deliveries at which she assists.

¹ Aire is a rather shifting and shapeless category of complaint, varying in its content according to age and condition of the patient. For pregnant women, its cardinal symptom is gastric discomfort or a sense of internal pressure; it is considered almost endemic to pregnancy, but may be exacerbated by certain events such as chilling or fright.

What Does the Midwife Do During Childbirth?

Clients in general had no complaints about midwife behavior during childbirth. Only one mother made a clearly negative comment, criticizing an impatient midwife who had, in quite irritable fashion, demanded expulsive efforts inappropriately soon.

For the most part, midwives are seen as willing to take the parturient with labor problems to the hospital, but only after it has become clear that the problem is irresolvable and some rather extreme manipulations may have been tried. Such manipulations might include: heavy massage, with the goal of manipulation of fetal position; the administration of herbal and commercial oxytocic preparations; exaggerated delivery positions such as suspension; introduction of the hand into the birth canal; and the probably innocuous measure of applications of warm compresses. The impression given is that such techniques are not employed because they are believed to be correct; they seem to arise rather from a condition of emergency and a sense of desperation.

More than half of the mothers reported that their husbands or companions were in the house or in the delivery room during childbirth and that midwives were generally appreciative of their presence and assistance.

More than half also reported that the midwife had used scissors to cut the umbilical cord and antiseptics on the stump. The rest reported use of home remedies such as camphorated oil and beef tallow, the latter by a small minority only.

No interviewee freely noted any special treatment for the newborn's eyes; several women added, however, that in the period immediately after delivery, they were not particularly alert to events around them. Thus even mothers who know what hygienic procedures ought to be followed are not normally in condition to see that they are carried out; the responsibility becomes largely the midwife's.

There was great variety in the sequence of procedures after delivery, indicating that there is little systematic perception of what constitutes routine procedure and priorities in the order of infant- and mother-care.

The majority of midwives performed the apretada, a special massage supposed to close the pelvic bones which are said to have opened during childbirth. A few midwives gave the mother a body rub with some sort of refresher liquid, simply to relieve aches and pains.

Bathing of the mother is erratic in frequency, depending rather on the mother's wishes than on hygienic considerations. No interviewee said that the midwife had insisted on bathing her or washing the vulvar area, although they were in all cases willing to do it if the mother requested it.

Lactation Management

The use of the chupón¹ and/or cathartics for newborns were overwhelmingly common. The stated purpose was the cleansing of the baby's stomach and as a pacifier during the period before nursing is begun, at times up to three days after childbirth. Bottles of sugar water are also used for the latter purpose. None of these

¹ A clean bit of cloth soaked in various liquids of home manufacture, given to the infant to suck on.

techniques is desirable from the standpoint of either hygiene or infant health; the risk of infant diarrhea is not inconsiderable and the loss of maternal colostrum is a major detriment. The belief that the first liquid from the mother's breasts is not real milk or is bad milk is quite widespread; the usual procedure is to express it. Nonetheless, mothers who had nursed their babies the first day and given them the colostrum were conscious that they had healthier babies and no gastroenteritic problems in their infants.

Client commentaries make it quite clear that midwives do not regularly give advice about lactation management. Ironically and somewhat sadly, the advice of midwives in this regard is generally heeded, so that midwives who say nothing are in effect a lost health resource. At the same time, the potential exists for useful interventions if midwives are appropriately trained.

There does exist, at least in this rural area, a still favorable attitude toward lactation: mother's milk is still perceived as better and the impact of the milk products industry is negligible. Furthermore, lactation is viewed, perhaps with dangerous certainty, as a contraceptive. In sum, the lactation complex for rural El Salvador is still in a stage of constituting a health advantage; however, this advantage could be enhanced through proper midwife training.

What Does the Midwife Do During the Post-Partum Period?

Number of Visits

More than half the client sample reported that the midwife had visited them during the post-partum period. Those who made fewer visits were the older midwives. In other words, older midwives are not a major health resource during this quite crucial period when mothers cannot easily travel to seek medical care. The average number of post-partum visits was two; no midwife made more than five visits and this was clearly an extreme case.

Care of the Newborn

All of the midwives who made post-partum home visits attended to the healing of the newborn's umbilicus and this is considered the raison d'être for such visits. In fact, the healing of the umbilicus signals the end of the midwife's responsibilities to a given client. Few midwives concern themselves with more general infant hygiene, in accordance with maternal preference and the belief shared by many midwives and mothers that water is dangerous for a newborn, if only because there is the risk of wetting the navel.

Care and Counselling of the Mother

Hygiene

A tiny minority of the midwives bathed the mother; a third gave advice about hygiene. Midwives do seem to be gradually abandoning the position that maternal hygiene is a maternal responsibility and are more willing to address the issue with mothers. However, their advice appears timid and erratic and is not translated into action.

One aspect of post-partum maternal hygiene about which both mothers and midwives share belief is the use of cathartics for mother as well as child. The purpose is to relieve discomfort in the gastric or uterine zones; no one mentioned the relief of constipation, a common post-partum problem. This would not appear to be a disadvantageous intervention, except in cases of the use of castor oil.

Nutrition

The great majority of midwives were accustomed to make some comment about appropriate diet for the post-partum mother but, except for a small minority, this advice was traditional or, at best, conservative. Traditional dietary recommendations are quite restrictive and constitute a net health disadvantage.

Other Activities of the Midwife

Help with Infant Illnesses

Rural families appear to turn to the midwife fairly frequently to cure such infant diseases as mollera caída,¹ ojo,² and empacho.³ The first two categories describe truly severe cases of diarrhea with attendant dehydration, and the traditional treatment provided by midwives or other indigenous practitioners neither comprehend the nature and severity of the condition nor address it adequately in a medical sense. The delays in seeking appropriate assistance can be fatal.

Role as Confidante

Interviewees as a group did not rank midwives at the top of their coteries of confidantes, unless they were related by blood or marriage. This is not because midwives are not considered trustworthy; they are. It is simply because family members have prior ranking and are generally sufficient. For ethical reasons, clients were not asked if they had turned to midwives for help in terminating pregnancies.

¹ Mollera caída, fallen fontanelle, is a symptom which describes an illness category. Perceived causes are various but in no respect is the folk explanation for the condition reflective of the true cause, an infection producing severe diarrhea, subsequent dehydration, and deleterious effect on body tissues, inter alia. The traditional cure centers on pulling out the fontanelle through a variety of interventions and, most crucially, withdrawal of liquids.

² Ojo, "eye" or "evil eye," again has a mixed etiology, perhaps reflecting a transitional stage in folk medical beliefs. The symptoms somewhat overlap with mollera caída without, however, the fallen fontanelle. While this has not been adequately analyzed, ojo may simply correspond to an earlier stage on the way to the extreme condition characterized by fallen fontanelle.

³ Empacho occurs mainly in older infants who are consuming some solid foods and is believed to derive from the blockage of an overly large piece of food somewhere in the gastric system.

Characteristics of the Sample of Midwives

A little less than half of the midwives lived in the municipality, the rest in cantons and hamlets. In other words, over half the midwives interviewed lived in relatively remote areas serving a population whose access to modern health services ranged from possible to quite difficult.

The average age of the midwives was 59. If the one 100-year-old midwife interviewed is eliminated from the calculation, average age was 55.6. A fourth of the sample was married, two were living in consensual union, three were widows, and four were previously married or living in consensual union but were presently living apart. In total, 58% lived without a male companion, although all lived with other family members and had some responsibility for them.

The average number of living children per midwife was 6.3 (completed fertility), a higher rate than the national average of 5.1 for the rural area. Their socio-economic level was low; the great majority of their companions or husbands were small farmers.

Levels of hygiene in midwife homes was in general low; the level of personal hygiene ranged from medium to high. Understanding of disease pathways was incomplete and based on rote memory rather than conviction.

Average level of schooling was 1.1 grades, lower than that of the client group interviewees. 67% were clearly illiterate, a rate higher than the 1971 rate of 57.2% for the Salvadoran rural area as a whole.

The training of the midwives had been erratic and variable; none of them was licensed. 50% considered themselves naturales, since they had had no training outside their own experience and/or apprenticeship or training by another midwife or paramedic. There was palpable disappointment at the premature termination of the midwife-training course which had been begun at the local health post.

The great majority of midwives had begun their careers in response to some emergency, at the prodding of some relative who was a midwife, through motivation by a medical or paramedical person, or had been simply inspired by their own experience to engage in the profession. The average number of years of experience was 25.7. The least experienced midwife had begun seven years prior to the study period and was 40 years old; the most experienced had had 50 years of practice and was said to be 100 years old. The average age at which these midwives had started their professional activity was 31.7. In other words, the large majority had begun to assist at childbirths when they were relatively young, with children or infants of their own at home, and when they were still in fertile age themselves.

Only one midwife was training another, in this case her daughter. The reasons given for not training other women as midwives were that they had no daughters who wanted to learn, their daughters were too young or too busy, or they themselves were too busy. Several of the daughters had explained their resistance to undertaking the career of midwife as deriving from the belief that it required a valor which they did not possess; there was no evidence of disdain for the profession itself.

How Much Does a Midwife Earn?

Number of Cases

There was a great variation in the number of cases attended by the midwives in the sample, from 4 to 36 a year. Average caseloads are very hard to calculate since demand appears quite erratic. The overall impression is that the 36 cases a year claimed by the most active midwife is a somewhat unlikely high and that a maximum rate would be on the order of 24 cases per year attended by relatively active midwives. The data gathered in this area were unsatisfactory, although necessarily so, but they did serve to support an impression that midwifery in El Salvador is not a full-time activity.

Earnings from Midwifery

There is also great variation in what the midwife charges. Some midwives charge nothing or help without expecting compensation. The highest fee recorded was ¢25.00,¹ but that was charged only to those who were capable of paying it. All the midwives charged by scale, that is, in accordance with the economic capacity of the mother and/or the family. Similarly, all midwives permitted payment by installments, a consideration frequently abused by clients who did not pay up.

The average earnings per childbirth was ¢6.50, with no notable difference between municipality and canton or hamlet. A calculation of an average 12 cases per year at an average fee per childbirth of ¢6.50, produces an average gross yearly income of ¢78.00 (US\$31.20) from the practice of midwifery. Detailed calculations of a midwife's expenses per childbirth produced an average expense per case of ¢5.30. Thus net profit per childbirth is approximately ¢1.20 per birth or, at an average 12 childbirths attended per annum, an annual net profit from midwifery of ¢14.40 (US\$5.76).

Going further and calculating consultation time before and after childbirth, plus the time spent on the delivery itself, gross earnings per hour from midwifery come out to about ¢.34, or ¢.06 net. Minimum wage for a female farm laborer (1977 figures) is ¢3.15 per day.

There is certainly considerable range in the figures which provided the base for these calculations, but even construing context and reality most generously and allowing for every advantage to the midwife, it is quite obvious that midwives in El Salvador do not get rich from midwifery, a fact they themselves realize. The commonly heard argument that midwives oppose family planning because it implies potential income loss does not hold up very well in the Salvadoran context. The rural Salvadoran midwife is rather a servant of her community, with the corresponding motivation and orientation.

What Is the Midwife's Self-Image?

Midwives, although they frequently define themselves primarily as housewives, also consider themselves as professionals. They do identify in a broad way with other midwives; at the same time, there was some evidence of competition expressed in the delicate criticism of the quality of service and training levels of other midwives. A feeling of sisterhood was reported by midwives from different areas

¹ ¢1.00 is equivalent to US\$.40.

who had participated in a special short course under private auspices, indicating that midwives involved in training of a certain type can form a concept of team membership. This may, of course, occur only when there is no competition between midwives in a given geographical area.

Midwives further see themselves as possessing a special technical capability, accompanied by such personal qualities as valor, a sense of duty, of service, and of dedication. She also sees herself as industrious and, at times, exploited and mistreated by her clientele.

The great majority of midwives were fully prepared to respond to emergency requests for help with childbirth. There was, nevertheless, some ambivalence on this score due to resentment at being considered a last resort, or due to irritation with people who displayed no foresight or who were unwilling to pay for complete care.¹

Midwives, in summary, see themselves as women with more knowledge and more dedication, as well as more competence in a given area of expertise. They recognize, however, the reality reflected in the comments of their clientele, which is that these qualities and achievements do not earn them any noteworthy status or prestige in the community.

Is a Midwife Who Has Been a Mother Better?

The great majority of midwives thought it better that midwives themselves had had the experience of childbearing, a reaction consistent with that of the client sample.

Is There a Need for Better-Trained Midwives?

Personal Desire for More Training

Only the two oldest midwives did not want more training.

Reasons for Wanting More Training

Midwives simply wanted to know more in order to do their jobs better and to thereby inspire more confidence in their clientele. The naturales felt particularly strongly in both respects.

Is It Important for a Midwife To Be Licensed?

All the midwives interviewed, except for the oldest, were firm in their wishes to acquire a license or be legitimated in a very explicit, documented way. They said, in fact, that they would not attend any training course that would not offer them such legitimation.

¹ It is not uncommon for a midwife to be called in just to cut and treat the umbilical cord, with no other attention to mother or child before, during, or after childbirth. Payment is correspondingly reduced and the strategy is viewed by midwives as a rather cheap one.

Type of Training

There was a noteworthy preference for an intensive course of adequate duration to permit several visits to a hospital and time for supervised practicum. It was suggested that limited economic assistance be given mothers with small children at home so that they could pay someone to care for them while they attended the course. Midwives also felt a need for financial support for transportation and lodging. No midwife mentioned an expectation of payment for attending the course; the course itself was seen as adequate reward.

Would It Be Good for Midwives To Be Salaried?

Midwives had the same problem in contemplating being salaried as the clients interviewed. Some asked how a salary could be adjusted to the variation in the number of cases attended, to the difference in experience and/or training among midwives, et cetera. It was obvious that the idea had never occurred to them and that it was hard for them to understand. The generalized response was a rather bemused murmur that it would be nice.

What Do Midwives Do About Family Planning?

Most midwives favored the idea of family planning, but only one-third were promoting it in any way among their clients; more than half said that they had referred members of their family to the health post for enrollment in family planning. In all cases, even the most enthusiastic, there was concern about the deleterious effects of all contraceptive methods, a concern which must have been relayed to clients since only 10% of the client sample reported that a midwife had counseled them positively about family planning.

Consequently, there was great interest in learning more about contraceptive methodology in order to be able to answer the questions of interested clients and to dispel the midwives' own doubts. There was not the slightest interest in hearing more about the philosophy or theory of family planning.

Could Midwives Promote Family Planning?

The midwives contacted were willing to promote family planning only if they received more training in contraceptive methodology. Only 55% were willing to get involved in the distribution of contraceptives and half of those would not do so except among women who had had a prior medical examination and the appropriate contraceptive prescription. It cannot be stated emphatically enough that midwives, if the group interviewed is at all representative, would have serious reservations about accepting the responsibility for contraceptive distribution.

What Is the Midwife's Personal Experience with Family Planning?

The youngest midwife contacted was 41 and under clinic care preparatory to sterilization. The others were no longer in fertile age and none had used a high-efficiency contraceptive method because, for most of their childbearing span, such methods had not been readily available to them. Almost half the sample had daughters who were planning to use birth control methods or who had already been sterilized.

What Is the Role of the Midwife During Pregnancy?

Referrals for Clinic Care

The majority of midwives said that it was their custom to refer their patients to the health post for pre- and post-natal checkups, but this does not coincide with the low percentage reported by the patients themselves. As a group the midwives had very tenuous ties with the clinic, at least at the time of the present study; when the clinic had first been established, clinic-midwife contact was more frequent and more mutually enthusiastic, but personnel changes had had a negative effect on that early, satisfactory relationship.

While there may have been an element of self-deception on the part of the midwives or an effort to gratify the investigator, this does not seem sufficient to explain the discrepancy between client and practitioner perspectives on referral activity. It seems more likely that both samples were just only partially correct: the midwives, when they were on friendlier terms with the clinic, did refer patients there; at the time of the study they had more or less stopped doing so, resulting in the more negative picture presented by the mothers. The conclusion can only be that her personal relations with the clinic profoundly influence the midwife's willingness to refer her clients to it, a crucial point for any plan aimed at involving the midwife more actively in the rural health system.

Month in Which Pregnant Women Seek Out a Midwife

The time at which clients usually sought a midwife's assistance varied from a visit in the third month to confirm a pregnancy, to a last-minute call to cut an umbilical cord. Most clients appeared during the sixth month for the sobada; most midwives were unwilling to perform the sobada earlier than that, in any case, because the fetus was still believed not adequately formed.

The number of visits per pregnancy varied from none to 5; the average number reported by both patients and midwives was 2. The site of the visit depended on the patient's condition, distance, and whether it was a first contact or a subsequent one. All the midwives were willing to make home visits when circumstances required.

Massage

All midwives but one performed the sobada and expressed the same faith in this activity as had their clients. Only one commented that she knew doctors opposed the practice; this opposition had produced no change in her behavior.

Advisory Role of the Midwife During Pregnancy

Nutrition

The large majority of midwives stated that they counselled their patients about what to eat during pregnancy and they all said that they advised them to eat a balanced diet or, as they termed it, something of everything. Still, it is apparent that midwives as a group do not have a consistent grasp of the theory of adequate nutrition and of advisable and feasible strategies appropriate to the demands of pregnancy. Nor is there any awareness of different strategies which are suitable and necessary for each trimester. Midwives know that some pregnant

women, especially first-time mothers, eat little in order to have smaller babies and easier childbirths, but they do not know how to oppose this practice. They have some idea of the constituents of a balanced diet but no practical ideas about to achieve such a diet in the context of the harsh rural reality, and they are very sensitive to the economic limitations of the environment that they share with their clients.

Hygiene

Almost half the midwives said that they gave advice on hygiene during pregnancy, in contrast to the minority of clients who reported that they had received such counselling. It appears that the midwife's handling of this area is erratic and does not have much impact on her clientele.

Sexual relations

Only one midwife said she had given advice on this subject, to a member of her family; this coincides with the behavior described by clients. Both groups seem to consider this a subject not mutually discussed.

Danger Signals

The midwife deals with danger signals during pregnancy in one of two ways: treats symptoms herself or avoids the responsibility. If she opts for the latter, she refers the client to the clinic or, more likely, concludes that the complaint will be taken care of in the normal course of a clinic checkup. There is not a full understanding of the range of danger signals, their etiology, their implications, or their management.

Preparations for Childbirth

Most midwives said that they discussed with their patients what they should do to prepare for delivery, a claim that accords with the behavior noted by the client sample. Nevertheless, there is no consistent notion of the appropriate materials or of which of these should be provided by the prospective mother and which by the midwife. Only two midwives carried anything that could be considered a midwifery kit, although all perceived the necessity of such a kit. They also expressed the logistical and economic need for resupply of expendable materials at the clinic, either free or at low cost.

What Is the Role of the Midwife During Childbirth?

Hygiene

Less than half the midwives insisted that their patients bathe before delivery or that they at least wash the vulvar area. Midwives also indicated that they often found resistance to these hygienic procedures, particularly the latter, but only two refused to attend a patient who was unwilling to comply with even minimal hygiene requirements. Midwives as a whole did not feel influential enough to demand an adequate level of personal or home hygiene for delivery. No midwife made any attempt to shave the patient; the practice was seen as silly, offensive, and impossible.

Position for Delivery

Half the midwives preferred to have the mother lying down on a bed, but all accepted whatever position the mother preferred, a flexibility which accords with the most modern thinking about childbirth management.

Midwives reported that it was very common for the husband or companion to be present or nearby during childbirth, and for him to be helpful in a number of ways, all of them appreciated.

Medication and Techniques

The majority of midwives gave medicines, either commercial or of home manufacture, and performed other ministrations to hasten birth, behaviors which contradict the frequently expressed belief that childbirth brings its own force. The impression given by midwives is that they are under pressure to speed up the birth because of the parturient's distress which, given the midwife's essentially compassionate nature, is difficult to ignore. According to mothers, only one midwife in their experience had demonstrated a basically selfish impatience; it is reasonable to conclude that the more extreme and sometimes inappropriate things that midwives do during childbirth are very far from the ignorant brutality sometimes ascribed to them, but are instead born of desperation and true concern for the patient.

Hospital Referrals

Without exception, midwives were willing to take or send a patient to the hospital, but only when they were unable to complete the delivery themselves. This coincides with the appraisal offered by the client sample. Taking a patient to the hospital deprives the midwife of all or most of her earnings, notwithstanding the time she may have spent on the delivery itself and on previous visits: not infrequently a midwife will also pay her own transportation to and from the hospital when she is brave enough to accompany a patient there. Also, on occasion, her reception at the hospital is somewhat less than courteous and the family of the parturient may criticize her for having, in effect, failed.

The same loss of earnings applies if the midwife recommends high- or medium-risk patients for hospital delivery. Thus the roots of the apparent resistance to referring a patient to a hospital either before or during delivery are practical, economic, cultural, and deep.

Counselling and Support During Delivery

Midwives excel in their disposition to offer words of sympathy and encouragement to the parturient, who is generally described as "the sufferer." The majority did not permit or demand exertions too early in labor, but there was no precise idea of what "too early" really meant. Midwives were generally relaxed about behavior permitted the mother during childbirth; small amounts of food and liquid were permitted, especially in the course of long labors, and any noises the parturient chose to make were in general considerable and even useful.

Treatment of the New Infant

All midwives said that it was their custom to clean the baby, though methods differed. Treatment of the navel varied as well, but over half the midwives used antiseptic techniques, indicating that public health efforts in this regard have had their impact. A quarter of the midwives utilized a mixture of modern and traditional techniques, sometimes in counterproductive fashion.

More than half mentioned the use of medication for the newborn infant's eyes, in contradiction to client reports. The discrepancy suggests an area for training concentration, for both mothers and midwives, although as indicated earlier, this is a point during childbirth where much of the responsibility rests by necessity with the midwife.

The sequence of treatment immediately post-partum is quite inconsistent from midwife to midwife, suggesting a lack of systematic incorporation of such procedures into regular behavior patterns.

Treatment of the Mother After Delivery

The sequence followed in attending the mother is even more inconsistent than that followed in infant care. Nevertheless, the content of such care varies little and includes different degrees of cleaning, change of clothing, and the apretada. Midwives share the belief with mothers that the post-partum state is a delicate, dangerous, and "cold" condition in which the body is particularly weak and vulnerable.

Lactation Management

Almost half the midwives said that they suggested to their patients that they begin to breastfeed the first day, but did so without full awareness of the rationale for their recommendation. The others advised waiting until the third day or until the milk let down, using in the interim period a bottle of sugar water, a cathartic, a chupón (pacifier), or a combination of these. All were in favor of breastfeeding but displayed a need for more complete understanding to be fully effective. Knowledge of infant nutrition, particularly the timing and content of weaning, is quite lacking.

What Does the Midwife Do During the Post-Partum Period?

Number of Visits

All the midwives, 100% compared to the 59% reported by the mothers interviewed, said they visited their patients after childbirth. The number of visits ranged from none to five, the average number being three. Lack of time, problems of distance, and economic factors were cited as an explanation for not making many, or any, visits. Several midwives noted that they used to make more visits than they do now, due to the factors mentioned, which may explain at least some of the differential between practitioner and client reports of behavior.

Care of the Newborn Infant

The view of the midwives is that their primordial obligation to mother and child is the care and vigilance of the umbilical cord. There is awareness of the high potential for infection of the cord and the relationship with tetanus, but curative procedures do not always respond to that awareness.

Only a few midwives bathed the baby, changed its clothing, or gave the mother advice on proper infant care.

Care and Counselling of the Post-Partum Mother

Hygiene

A small minority, the same proportion noted by the client sample, cleaned the mother's vulvar area; only one cleaned the breasts or instructed the mother on proper procedures. In the main, the midwife's attitude was one of resignation to most mothers' unwillingness, rooted in persistent cultural considerations, to bathe or be bathed during a rather well-defined period.

Midwives concurred with their clients that the use of cathartics during this period was appropriate. None made an exception of strong cathartics such as castor oil.

Other Responsibilities

A few midwives on occasion had performed uterine massage to restore tone and eliminate clots.

Other Advice

Recommendations for post-partum bedrest varied widely. The most common prescription, when it was given, was three days in bed; the most extreme recommendation was that eight days of bedrest was appropriate. No midwife recommended the traditional 40-day confinement, the cuarentena.

Only two midwives had discussed with any patient the proper time for resumption of sexual relations after childbirth. That advice ranged from 40 days to six months of abstinence, the last from an old and not very popular midwife. As with the subject of sexual relations during pregnancy, there was a tacit assumption among clients and practitioners that this was not an appropriate area for midwife advice.

Nutrition Counselling

Half the midwives recommended to their patients a more extensive diet than the traditional prescription of dry cheese, toasted tortilla, and hot chocolate. Only one midwife advised her clients to eat everything; the rest all imposed at least some sort of dietary restrictions. The most frequent prohibitions were against "cold" foods (alimentos helados), acid and spicy foods, and virtually all fruits

¹ Such prohibitions accord with traditional hot-cold food and body-state theories common in much of the traditional world, and the importance of maintaining a corporal balance between the two.

and vegetables. The core belief is that the post-partum period is a most dangerous time for mother and infant, a belief that is quite stubborn and persistent and which must—and can be—integrated into health education for both mothers and midwives.

With regard to infant nutrition, particularly with regard to the timing and strategy of weaning, midwives are quite weak in knowledge, inactive from an educational perspective, and do not see this area as one of their present responsibilities.

Other Activities of the Midwife

Help with Infant Illnesses

Close to half the midwives, less than that reported by clients, said that their assistance was sought when a child suffered from mollera caida. There was less demand for assistance in cases of ojo and still less in cases of entacho. The difference between the samples was not significant and the role of the midwife with regard to the first two syndromes must continue to be considered meaningful.

Help with Health Problems of Adults

Almost half of the midwives stated that at some point they had been sought out to perform an abortion or to salvage an induced abortion. All stated that they had refused to do so, partly out of fear and partly out of distaste for the task. This line of investigation was not pursued with vigor.

What Sort of Personality Does the Midwife Have?

The following words serve to describe the midwife's personality: independent, shy, warm, firm, responsible, uninhibited, candid, open, generous, talkative, tale-bearing, patient, professionally proud, domineering, generally intelligent, hard-working, sensitive about lack of preparation, exceedingly proud of little training, convinced of the value of practical experience, not perceiving lack of schooling as an impediment to improvement, having leadership qualities, irritable with slovenly or stubborn patients, stubborn, and utterly simpática.

CCDA

El Salvador and its midwives have reached a crossroads on the way to delivery of adequate rural health services. If the samples covered in this study are at all representative, the large majority of traditional midwives are old, are not training others, are decreasing in number, and their roles are becoming more and more limited. At the same time, desire for hospital births and clinic care, and the perception of the midwife as only an emergency resource, are growing in the client population. The role of the midwife prior to childbirth centers on a technique which is opposed by the medical establishment: her role after childbirth has been constantly diminishing in quantity and quality for complicated and somewhat cloudy reasons. If the Ministry of Public Health wishes to salvage this health resource for areas where there will be a need for it for some years to come, haste must be made to effect the rescue or the crossroads will become a cul-de-sac.

CHAPTER V

RECOMMENDATIONS

The recommendations which follow flow from the combined perspectives of the populations represented in the samples interviewed. Those perspectives were described in detail and summarized in preceding chapters. Yet the recommendations also flow from the discrepancies between those perspectives, which serve to mark the missing links in the chain of health service and education.

General Recommendations

1. The MSPAF must decide if it is going to salvage the role of the traditional midwife, whose number and level of preparation do not adequately respond to the needs of the Salvadoran rural population. This inadequacy can only become more acute as numbers of midwives continue to dwindle and rural expectations for services rise.
2. If the decision is made to salvage the midwife role, the midwife must be retrained and the pedagogical model used in the past modified.
3. The decision will also have to be made concerning what midwives should be trained, where, and for what purpose.

Recommendations for Recruitment

Geographical Focus

1. It is recommended that recruitment be concentrated on the cantons and hamlets where the profession of midwifery seems to be disappearing fastest and where the need is, and will continue to be, greatest. A satellite model is suggested for recruitment, structured on the selection of four or five midwives resident in key sites around a rural municipality with a health post. Such a model would respond to the needs of the cantons and hamlets, decrease the possibility of competition among midwives, and take advantage of the service and supervisory resources of the post. It does not seem advisable for the MSPAF to try to train all practising midwives; an optimum expenditure of funds and training competence would be directed toward a select trainee population in key, remote areas where there are few or no midwives.

Method of Identification

1. Experience has indicated that a mode of recruitment based on identification of trainees by community leaders has its limitations. Identification of practising or potential midwives through several modalities seems advisable; informal surveys might be combined with the recommendations of Rural Health Aides, clinic personnel, and group discussions with Housewives' Clubs.

Manner of Selection

1. Suggested methods of selection, after initial identification has been made, are: a) home visits to the midwife; b) examination of clinic records to see use of services by the potential trainee and her family, as well as health problems she has had, particularly those resulting from poor hygiene; c) interviews with potential trainees, focussed on their use of and attitude toward the clinic, their level of awareness of hygiene and preventive medicine, their personality and sense of service, their level of interest in training and in midwifery as a profession, and their present level of activity.
2. The Rural Health Aide should not have all the responsibility for the final selection. His or her recommendation should be weighed in the light of comments by members of Housewives Clubs, clinic staff, and community leaders.

Trainee Profile

1. Residence: canton or hamlet.
2. Age: under 60, above 20, but with priority given to those in their 30's and 40's.
3. Education: functional literacy would be optimal, but a candidate who fulfilled most other criteria should not be disqualified for illiteracy.
4. Condition: basically good health and willingness to have a complete medical examination.
5. Experience: has had or has delivered children and is seen by the community as someone with the appropriate motivation. The number of births assisted in the past need not be high, since rates of assistance seem low in any case. Younger women who have actually assisted at relatively few births and are in the process of acquiring their reputation would constitute an ideal target population.
5. Attitudes: in favor of family planning in terms of its philosophy and theory, and willing to distribute contraceptives pending adequate training. She should also be willing to maintain strong regularized ties with the health post.

Parameters of the Midwife Role

Clinic Referrals During the Period of Pregnancy

1. A decision should be made concerning the respective responsibilities of the midwife and of the health post during pregnancy. It must be determined whether the midwife's role will be to refer all pregnant women for medical care, limiting her own activity to such referrals and to ad hoc and essentially marginal promotion of MFPAS policies; or, whether her role will be more extensive, including consultation service for low-risk pregnant women and clinic referrals only of those women she has learned to define as medium- or high-risk cases or those who have been so designated by a doctor. An intermediate position would be to reduce clinic contact for low-risk women to one or two consultations, leaving interim routine checkups to the midwife. If the first route is selected, pressures on health post resources could become excessive, at the same time the role of the midwife continues marginal.

¹ The issue of clinic relations clearly must be weighed in the light of the quality of the clinic staff and their relations with other members of the community. If those relations are generally poor, the midwife can hardly be criticized.

Hospital Referrals

1. Current MSPAS policy is to refer any pregnant woman to the hospital for childbirth, a policy which, sooner or later, will create a deluge of demand which present facilities and those projected for the near future will probably not be able to satisfy. Furthermore, such a policy will not foster the creation of a corps of trained, functioning midwives. It is suggested that a policy be adopted that will restrict referrals for hospital delivery to medium- and high-risk cases and to those women who wish to be sterilized.

Relationship with the Health Post

1. The nature of the relationship between midwife and health post should be made quite clear. If the midwife is to be an explicit member of a Rural Health Team, administrative and ideological steps should be taken to assure her position. These steps would include: a) legitimizing the midwife within the medical establishment, using tactics such as involvement of the corresponding clinic personnel at some point in the midwife's training; b) assuring special treatment in the clinic for the midwife, her patients, and the midwife's immediate family; c) formal introductions to the new staff of the clinic as it turns over, and accompanying mutual orientation; d) explicit legitimization of the midwife by MSPAS personnel in relation to key people and institutions in her geographical area of operation; e) additions to the educational component of maternal-child health care at the clinic level which would include information on the role of the midwife, her services, her responsibilities, and a declaration of clinic support of her efforts; and f) the provision of a bed at the health post for the use of such midwives in cases that require that facility.

Midwife Responsibilities During the Post-Partum Period

1. Boundaries must be fixed on the responsibilities of the midwife after childbirth. It must be decided whether the midwife finishes her activities at the traditional termination point of the curing of the umbilicus, or whether she continues with other rural health tasks such as the nutritional education of the mother and the care of children under one year of age. These two activities would be very compatible with the traditional role of the midwife, even in its limited form. However, there is the possibility of conflict with the duties of the Rural Health Aide and the new group of nurses with expanded responsibilities. This does not have to be an insoluble conflict but it could become one if limits are not established at the outset.

Midwife Potential in Family Planning

1. There is evidence from other countries that the traditional midwife can function as a valuable agent of family planning, as promoter and/or distributor. Most Salvadoran midwives agree with the need for family planning. With a more thorough and focussed training, with a well supervised practicum in active promotion, they could become effective distributors and promoters. The decision that has to be made is whether the MSPAS is willing to respect the current resistance of midwives to contraceptive distribution and accede to a gradual expansion of this component of their role.

Training Model

Site

1. Departmental capitals offer more prestige, easier access to a hospital for observation and practicum, and a separation of the midwife from her domestic concerns.

Schedule

1. Midwives prefer that training be given in a single time block. In any case, the strategy of one day a month, or some similar arrangement, has been discredited in a number of ways. Periods of pure lecture should be brief and punctuated by short breaks: periods of high visual content or of participation can be longer.

Financing

1. Per diem should be provided to cover transportation costs, child care according to need, and perhaps a small additional sum as incentive and compensation for any work the midwife may have missed. Lodging should also be provided.

Teachers

1. Experience in other countries indicates that the best person for training midwives is a nurse-midwife of somewhat advanced age and considerable experience. If this category of personnel is not available in El Salvador, something close to those qualities should be sought. Doctors have high status among the rural population in general and are excellent for training in delivery procedures, assuming attitudes of understanding and interest.

Pedagogical Techniques

1. Ample use of audio-visual materials such as: plastic or rubber models; films; posters; videotape to provide feedback on practica; microscopes for showing the realities of germ theory; raw material for midwifery kits, such as cloth for making binders, bandages, receiving sheets, etc., so that these could be made at one classroom session. The MSPAS might also consider the preparation of slide-tape units on such subjects as correct delivery and hygiene procedures, danger signals during pregnancy and the post-partum period, diagnosis of undernourished or dehydrated children, preparation of emergency rehydration fluids, and how to eat better with limited resources.

2. Problem-solving, such as: "What do you do if...?"; the in-class design of a good, culturally acceptable diet; handling of delivery crises; et cetera.

3. Role-playing: acting out interviews and crucial actions, such as, the mother who is afraid of the pill, hygiene before childbirth and maternal resistance, etc.

4. Brief daily oral tests to catch errors and misunderstandings before they become embedded.

5. Oral repetition.

6. Discussion groups, particularly at the outset of the course, to give participants the opportunity to clarify the areas in which they feel weakest and to give the trainer the opportunity to better focus her presentations.

7. Demonstration and practice. These training nodes were at the top of the midwives' list of priorities. Examples: seeing hospital births and medical examinations, assisting the doctor, and finally handling a delivery, perhaps in pairs, under the supervision of a doctor or obstetrical nurse.

The pedagogical structure should be one of two-way communication between participant and trainer, elimination of non-essential details, and an emphasis on practical experience.

Philosophy

There are certain basic principles that seem to be integral to the training of what is hoped will be a new breed of midwives:

1. The midwife is a member of a rural health team.
2. Her involvement in the work of the clinic is central to her training.
3. The midwife is also an educator, and perhaps the only educator, for many rural women who go neither to hospital nor clinic; thus she is the only health link with those women.
4. Traditional attitudes and practices are not in themselves something to be eliminated or wiped out; only those attitudes and practices which are clearly harmful ought to be opposed. All others should be honored, with a courteous silence when they are harmless, and with open respect when they are beneficial. Areas in which knowledge is lacking about traditional healing relating to the child/birth complex, such as the use of herbal preparations, should be investigated scientifically before they are attacked, except for known oxytocics.

Training Content

The purpose of the following set of recommendations is not to present the entire content of a training manual for midwives. Its aim is to point out special areas of interest which emerged from this study. No order of priority is suggested.

However, it is recommended that any new manual depart from the traditional sequence. Instead of beginning with extensive periods of general orientation, general hygiene, the rules of midwifery, et cetera, it is proposed here that any new manual, or at least the new training sequence, begin directly with pregnancy, proceed to delivery, and thence to the post-partum period. Key issues such as hygiene and nutrition are introduced according to their relevance to the stage under consideration. With such a model, participant interest might be captured from the outset: if there are dropouts, at least they will have been exposed to applied and applicable material instead of mere theoretical generalizations.

Pregnancy

1. The structure of the interview with the pregnant woman, especially the first interview (questions about general health, danger signals, nutrition, worries or concerns), with the main purpose of identifying high- or medium-risk women.
2. Danger signals during pregnancy, symptoms and syndromes, compared to what are only the discomforts of pregnancy. How to treat the latter. When to refer.
3. Mental health of the pregnant woman. Frequency of states of anxiety, insomnia, anorexia, and the importance of the midwife as an understanding person and confidante.
4. The process of referring patients to the clinic, especially high-risk cases. Handling of referral cards.
5. Signs of anemia.
6. Details of her clinic role -- helping with weighing patients; taking temperatures; the content of the pre-natal examination, the consultation with the graduate or auxiliary nurse, immunizations, et cetera.
7. The socada. How to substitute a gentle massage to relieve the mother without harming the fetus. Explanation of the process of "lightening" in the seventh month, which often gives relief naturally without heavy manipulation. The psychological and physiological value of the massage when correctly done and the risks when mishandled.
8. Dangers of very restrictive diets for the purpose of keeping fetal weight low to facilitate delivery. Special danger in the third trimester and the vulnerability of the fetal brain.
9. Strategies for eating better during the entire pregnancy, with emphasis on problems and needs of each trimester. Emphasis on the third trimester for women whose economic resources do not permit major dietary modifications throughout an entire pregnancy.
10. Danger of a diet high in starches and fats, the importance of liquids (herbal teas may be promoted here), danger of strong cathartics.
11. Preparations for childbirth. The midwife's and the family's responsibilities. Preparation of materials for the midwifery kit.
11. Lactation. Specific details about its value, adding to customary considerations of temperature, convenience, and cleanliness, the value of colostrum (stimulus to milk production, restoration of uterine tone, infant cathartic, protection of infant from gastroenteritic infections, contraceptive effect); breast hygiene; breastfeeding shortly after childbirth; the dangers of the churón, cathartics, and substitution liquids; solid food introduction; weaning.
12. Sexual relations and how to handle a preliminary discussion about family planning.

Childbirth

1. How to recognize, as early as possible, births which may be problematic.
2. The structure and sequence of the practitioner-patient interview at the onset of childbirth: priority questions about childbirth history, onset and frequency of pains; elimination during the day, last meal, medicine taken.
3. Markers of each birth stage and the proper timing of expulsive efforts.
4. Danger signals during labor. Ways of handling delivery emergencies when it is absolutely impossible to get a doctor's help, mandatory referrals and how to anticipate.
5. Hygienic preparations of birth site; minimal and optimal conditions.
6. How to perform gentle massage to reduce tension and why heavy massage should be avoided.
7. How to teach the mother to breathe during the first and second stages, especially during the painful transition period.
8. Positions for delivery. Legitimizing use of other positions than the reclining mode. Scientific and practical benefits of semi-seated positions for the moment of childbirth. Psychological importance of flexible attitudes.
9. Motivation of the midwife to refuse assistance unless mother will accede to at least minimal levels of hygiene.
10. Correct use of oxytocics.
11. Correct use of ergotrate.¹
12. Management of the placenta, including related problems; uterine massage.
13. Respiratory problems of the newborn and how to handle.
14. Strategies and preparations for the premature infant.
15. Ritualization of routine steps to be followed in mother and infant care right after childbirth.

The Post-Partum Period

1. Danger signals in the mother, how to handle, when and how to refer.
2. Materials for the post-partum visits, required number of visits, prescribed content of visits. Importance of the midwife as the only source of medical assistance. Termination of her responsibility.
3. Content of post-partum interviews with mother and key questions and observations (presence of fever, excessive bleeding, genital odor, disuria).

¹ These recommendations obviously tread quite heavily on medical territory and their ultimate determination is equally obviously in the hands of the M.F.A.S. They emerged, however, in the research as problem areas which need decision and definition.

4. How to judge normal and excessive bleeding.
5. Danger signals in the newborn.
6. Special care of the premature infant.
7. When and how to talk to the family about mother and child care, danger signs in both and what to do if they appear; diet, consumption of liquids, etc.
8. Correct use of simple analgesics for the mother.
9. Possible problems with breastfeeding and how to handle them; lactation management, especially for the first-time mother.
10. Sponge-bathing of the mother, educating her to keep her breasts, genitals, and hands clean; sponge-bathing the newborn; how to maintain acceptable hygiene levels for mother and infant while respecting firm, culturally-based resistance.
11. How and when to talk with the couple, as soon as possible after birth, about family planning.
12. How to handle referrals for sterilization.
13. Crucial illnesses in infants (malnutrition, dehydration, diarrhea, tetanus, eye infections), how to recognize them early in their career and how to deal with them. How to make hygienic emergency rehydration fluids. Mandatory referrals. What really causes cholera, ojo, and erracho. Feeding mild and severe diarrheas. What constitutes mild and severe diarrheas.
14. Nutrition education, with emphasis on mother's post-partum diet. Core philosophy should be that cultural restrictions on diet endure because of belief that period is a dangerous one for mother and infant and that dangerous substances pass from mother to child through the milk supply. Strategies: 1) observation that babies do not die as often as they used to; 2) that diet can be expanded to be compatible with traditional prohibitions (e.g., adding "hot" foods and neutralizing agents such as spices to "cold" foods important for health). How to emphasize culturally-acceptable foods and their use earlier in the post-partum period. The concept of "addition" instead of substitution. Importance of ample liquids for mother's milk and how to make nutritious drinks.
15. Administration of vitamins in the first month post-partum, especially the careful management of Vitamin A.
16. The value of post-natal checkups and the handling of referrals.

Equipment

The essential part of the midwife's equipment is the license or carnet awarded at the conclusion of training. Its renewal and the restocking of her kit should depend on her fulfilling her clinic-related duties and her assistance at any retraining. Next in importance is the kit, which she should receive at the conclusion of training, during which she has been responsible for making and assembling its contents. Items which were mentioned by the midwives as seeming to them crucial are listed below; this list is not to be considered complete, but only as reflective of midwives' ideas on their needs:

1. Apron and cap or kerchief with a special pin or embroidered emblem indicating status.

2. A sign for her home.
3. The following medicines, all in coded boxes with different colors for each medication: ergotamine/ergotrate; analgesics; vitamin/mineral supplement (high in iron and folic acid); oxytocics¹.
4. Battery lantern and clock or watch².
5. Syringe to remove mucous from newborn's airways.
6. Referral cards for pre- and post-natal checkups, family planning, hospital delivery, and sterilization, all color-coded.

The midwife should have the right to get replacements of disposable materials at the clinic, gratis or at low cost according to the remunerative arrangement that is decided on. Restocking could take place on the days that the midwife comes with her patients for their pre-natal checkups (see Activities as Member of Health Team below).

The Midwife and Family Planning

The training of the midwife as a promoter of family planning and distributor of the relevant technology should be conceived of as a two-stage design. The first should be a detailed and very practical training sequence on how to promote family planning; the second should be concerned with the distribution of the methods decided upon by the MPAF. The first stage would be an integral part of the retraining course for selected midwives; the second would be the focus of a short refresher course six months later.

The content of the first stage would be the following:

1. Contraceptive methods: kinds; advantages/disadvantages; relative risks compared to risks of pregnancy or childbirth, especially in certain categories of women; possible side-effects, their meaning, gravity, and handling
2. Strategies for promotion of family planning (how and when)
3. How to answer questions about family planning and, in particular, methods.
4. How to recognize baseless complaints and problems that do require medical attention.
5. Handling of referrals.

The content of the second stage should be the following:

1. A review of the crucial points of the first training and discussion of any problems midwives might have encountered in the interim.
2. Handling of the distribution of selected contraceptives.
3. Practicum in a family planning clinic.
4. Explanation of goals: seeking enrollments, remotivation of dropouts after followup, provision of contraceptives for women already enrolled in a program and who have had a prior medical examination.

¹ The curative orientation that prevails in Salvadoran rural areas toward medicine, in addition to real needs, results in the ascription of prestige to those who can provide medicines. The midwife should have the same access to this source of prestige as the Rural Health Aide. Furthermore, the medicines mentioned here constitute a basic minimum for treatment under circumstances where the midwife is the only resource. The key is the training in how these should be used; many midwives already use them in any case.

² These are obviously high-cost items and did not seem to be considered as highest priority by the midwives.

The rationale for a two-stage model should be reiterated here. As previously stated, midwives without exception currently entertain serious doubts about contraceptive methods and the midwife's preparation for accepting the responsibility of distributing them. This attitude should be respected not only for ethical but for very practical reasons: if a distribution responsibility is thrust upon midwives, cultural patterning is such that they will probably accept it and then proceed to do nothing, in a sort of passive resistance.

The two-stage model would reduce the possibility of this response, it would show the MSPAS's respect for the midwives' position, it avoids the likelihood of the midwife's reacting as if she were being exploited rather than utilized as a health resource, and it would give the midwife the opportunity to learn how to deal with both the mythology and the facts relating to problems with individual methods, before she has the responsibility for distributing them. The second stage would also be built upon established cooperative ties between the MSPAS and the midwife, with the corresponding entailments of reciprocity.

Financing

The possibility of a salaried midwife has been discussed in El Salvador. The findings of the present study and experience with such a model in other countries (see Rogers and Solomon) point to real problems in a plan to salary midwives. First, as midwives themselves have observed, there is the problem of adjusting salaries to the number of cases attended, degree of experience, traditional systems of remuneration, and so forth. It has also been discovered in other countries that the cost-benefit ratio involved in the use of the salaried midwife for the distribution of contraceptive technology is unfavorable.

The model offered here is based on pay for activity, handled through an account for each midwife held in the clinic; the monies earned by the midwife in her various activities would be accumulated in that account and disbursed to her monthly. The paid activities would be the following:

1. Delivery. The patient would pay \$10 and the clinic another \$10.¹
2. Referrals of various types for clinic pre- and post-natal program enrollment.
3. Referrals of problematic childbirths to the hospital, to compensate for the midwife's loss of earnings.
4. Referrals for enrollments in family planning programs and for follow-ups. Incentive payments would be based on a rising scale for continuance in use of oral contraceptives, and on a descending scale for the IUD.

It is worth pointing out here another advantage of a paid-activity system, that is, it confronts the central problem of many family planning programs—dropouts. If the midwife is paid specifically to seek out dropouts and re motivate them, thus becoming a key to continuance in the program, her motivation will be higher than if she were salaried and continuation rates will be higher than is presently the case. There is the possibility of fraud and this will add to the supervisory tasks of the clinic; however, fraud is implicit in the salary system as well when midwives, or any other paramedic for that matter, simply do not perform.

¹ The sum is not an arbitrary one. \$10 is coming to be a more or less standardized rate in rural areas, when it is paid at all.

A compromise system would be a combination of salary for routine midwife activity and incentives for family planning activities. This would be complicated logistically and open the midwife up to charges that she did family planning promotion for money, labelling her as perhaps somewhat exploitative. If all her activity were incentive- and fee-based, she would, in fact, be paid like most private doctors, curanderos, and traditional midwives.

Activities as a Member of the Rural Health Team

As a member of the rural health team, the midwife would have a day set aside for bringing her patients to the clinic for pre- or post-natal checkups, taking advantage of the visit to refill her kit. These visits would occur once a month, except in cases of emergency, and would also allow the midwife to collect the money accumulated in her account. Since there is a tendency for women in distant cantons and hamlets to go to the clinic together on certain days, this procedure would not entail a great change in existing cultural patterns.

At that time, the midwife would be present during the patients' consultations with the doctor and the graduate nurse. She would also help weigh the patients, take their temperatures, and perform any other appropriate task, including the maintenance of the mother's weight chart.

Other activities that would make the midwife a part of the health team were discussed at the beginning of this section. In addition to this, the MSPAS might wish to contemplate the possibility in the future of stronger and more structured ties between the midwife's activity and that of the Rural Health Aide in the form of collaboration in community health promotion programs.

Evaluation and Supervision

The difficulty of supervising the midwife's work has been frequently noted; this derives mainly from the environment in which she works and corresponding problems of accessibility and transportation, as well as from babies' age-old skill in circumventing adult attempts to plan. Nevertheless, the following supervisory strategies might be considered:

1. The resident, roving supervisor in the midwife's area of responsibility.
2. The auxiliary nurse, with some additional training, as an ad hoc supervisor.
3. Periodic refresher training with role-playing and supervised practicums.
4. Checking condition and degree of utilization of the kit when the midwife appears for restocking.
5. Interviews at random with clients.
6. Systematic analysis of the various referral cards.
7. Utilization rates of trained midwives compared with untrained ones.
8. Level of community awareness of the new paramedic.
9. Changes in morbidity and mortality rates.

None of these strategies will involve the gathering of baseline data and periodic small structured and unstructured surveys. These need not be costly if they are carefully designed and use existing regional and local personnel. They are, however, important strategies: the evaluation element has been missing in many midwife training programs and those programs have suffered as a result.