

A photograph of a woman wearing a purple headscarf and a purple patterned top, holding a baby wrapped in a white cloth. The background is slightly blurred, showing some greenery and a pink object.

By Kay Torrance

One professor teaches life-saving skills while respecting local culture

Making Childbirth Safer in the Developing World

Somewhere in Ethiopia or Haiti or any other impoverished country in the world, in a small village without the luxuries of running water or electricity, a woman gives birth. By her side is a local woman who's attended many births but who has no formal medical training. The mother begins to bleed heavily and eventually dies. Unfortunately, this scenario plays out every day.

In fact, a woman dies every minute from causes related to pregnancy and birth, making childbirth the leading cause of death and disability for women of reproductive age, according to the World Health Organization. Those women who live in the poorest countries are at the most risk. In sub-Saharan Africa, the lifetime risk of maternal death is 1 in 16, in developed countries, 1 in 2,800.

One faculty member at the nursing school at Emory is trying to change those numbers.

Lynn Sibley, a nurse-midwife and anthropologist, has been teaching midwives and health care workers in the developing world some simple steps that can greatly increase a woman's chances of survival should an emergency occur. Along with colleagues from the American College of Nurse-Midwives (ACNM), she has created a program, Home Based Life-Saving Skills (HBLSS), that focuses on educating women and traditional birth attendants about basic life-saving techniques they can use without expensive tools or technology.

The program was first tested in India and has worked so well that it has branched out to six other countries. The ACNM recently has gotten requests from a number of U.S. universities

For two years, she lived in two rural communities in Belize for her dissertation research on traditional birth attendants and maternal health.

"It was amazing," she says. "I had been a midwife at the University of Colorado for six years before becoming a doctoral student in anthropology. I knew I would have professional biases as to how things should be done and that I would be learning different ways in Belize. What I didn't realize was how strong my own beliefs would be."

Birth attendants in Belize did things midwives in this country were trained never to do. "It took me awhile to become comfortable sitting quietly and observing," she says. She watched as they pushed and pulled the cervix vigorously, seeing the womb as a passive vehicle to birth. Although she cringed inside sometimes, she was there to



The nursing school's Lynn Sibley joined a medical anthropologist and two midwives in Matlab, Bangladesh, to introduce the HBLSS program. With support from Emory's Global Health Institute, she is beginning a project to help birth attendants recognize danger signs during birth that can lead to an emergency.

to come and teach the program to their nurse-midwifery faculty and students.

"Though midwifery in the United States is wonderful and important, there is such a need elsewhere," Sibley says. "It's been an interesting journey. I did clinical nursing for five years, and then I had a child. In becoming a mother, I realized I wanted to do something much more hands on and challenging in maternal and newborn health."

That journey began when she began graduate studies in nurse-midwifery at the University of Colorado, stayed on as faculty there, and decided to get her doctorate in anthropology.

observe and made it clear to the women that she wouldn't interfere unless she was asked to help, and in a couple of emergencies, she was.

After she earned her PhD, she worked as a senior technical adviser at the ACNM in Silver Spring, Md., from 1995 to 2003. It was then that she and three of her colleagues, who today remain some of her closest friends, began to develop HBLSS after they talked with the college's head of global outreach, based in Washington. She still remembers the exact date of that meeting: December 6, 1996.

Sandy Tebben Buffington, one of those ACNM colleagues, remembers Sibley saying



at the time, “These women and newborns are so valuable, we must find something that will help them—there must be some way to stop the suffering.”

At the time, there was a debate within the field of midwifery. Foreign aid was going toward the training of traditional birth attendants overseas, but after more than two decades there was little evidence that maternal mortality was decreasing. The problem was one that Sibley thought about numerous times.

“My experience in Belize was the seed for the home-based program,” she says. “I remember dreaming about this: How can we train birth attendants and midwives in other countries while still respecting their cultural norms and beliefs?”

She and her colleagues designed HBLSS to respect local practices and to help families plan how to safely transfer a mother and newborn to a health facility, if such a place is available. The approach was different, Sibley says, because the medical problem of maternal and newborn death was framed in a context of cultural and economic realities.

PUTTING THE PLAN INTO ACTION

Sibley and her colleagues first field-tested the program in India, with the help of a local nongovernment organization. They set about gauging what medical facilities were available for emergency maternal and newborn care and drafted teaching materials—picture cards for the mostly illiterate population in the poor villages in which they worked.

The picture cards depict the steps to take to help ensure a problem-free birth, such as massaging the womb and nipple, making sure the mother-to-be stays hydrated, and not rushing the exit of the placenta. To reach the most people possible and to ensure the program’s longevity, they teach the selected women to be trainers, who, in turn, train women in the community to implement the program on a regular basis.

The program, though, does not teach birth attendants or families to handle serious complications all on their own. In such an event, families are encouraged to seek professional help, though for many people in developing countries, help is hours away on foot to the capital city.

In India, villagers eagerly picked women to go to the training after Sibley and her team shared with them the statistics of high maternal mortality in their own area—nine maternal deaths in one year out of a population of only 22,000.

The village-level HBLSS trainers adjusted the sessions because of issues surrounding gender and economic status. Some women from one caste wouldn’t sit with those from another, so one-on-one sessions were organized. Men wouldn’t attend any meeting with the women. A separate male-only meeting on referrals to medical facilities and organizing transportation to them was held.

Sibley found a more open and engaged society in Ethiopia, where 90% of births take place at home and 25,000 women die each year of complications. What was supposed to be a two-hour session with village elders turned into two days. The community leaders were so interested in the program that they wanted help in setting up their own data-collection system.

“It was really incredible to see the initiative there take root so vigorously and the idea Ethiopians have that you haven’t done your duty until you’ve told someone about this in the next village,” she says.

Sibley was so touched by the experience in Ethiopia, Buffington recalls, that she called Buffington from Africa to read her the evaluations of the training “with joy and tears in her voice.”

“People who work in child and maternal health are deeply committed,” Sibley says. “The real joy is joining hands with someone to make a difference. Even small differences are important.”

The program is also in Haiti, Liberia, Afghanistan, Ghana, and Bangladesh and is gearing up in Tanzania and the Peruvian Amazon River basin.

“Lynn is willing to look at what is learned each day during training, make adjustments, be transparent with trainees and donors, and document experiences to make the program the best it can be in the place it is being implemented,” says Buffington. “Her style is ‘respect’ and ‘acceptance’ with every birth attendant she approaches.”

GETTING STUDENTS INVOLVED

Most recently, Sibley worked in Bangladesh, and since coming to Emory in 2003, she has been able to engage students in the project. “I find Bangladesh challenging because of women’s roles in a predominantly Muslim country, density of population, and the level of congestion and filth in Dhaka,” she says. “I had one student in Bangladesh last summer. The student is a nurse and had done a lot of world

I remember dreaming about this: How can we train birth attendants and midwives in other countries while still respecting their cultural norms and beliefs? —LYNN SIBLEY



travel, but Bangladesh was still a shock to her. We had a discussion before she left the states about the need to prepare herself for such a difficult environment and how to keep doing this kind of work despite the challenges.”

Still, the experience proved so gratifying for one student in nursing/public health who worked in Liberia that she decided to extend her studies to become a certified nurse-midwife and family nurse practitioner. “Even something as small as sitting in a hot room training 10 midwives in the HBLSS model has the potential to change the health of a nation,” says Kelly McNatt, 05MPH, 07MN. “HBLSS is great in providing a forum for discussing all the traditional practices that midwives do, allowing them to express their

experiences and thoughts and as a group agree on new skills or practices that they are going to use.”

With HBLSS under way for almost a decade, questions have arisen from the traditional birth attendants and midwives that have led Sibley to another project. They wanted to know how much is too much bleeding and how long is too long of a labor duration. They knew the methods to deal with an emergency but didn’t have a firm grasp on when an emergency started, so Sibley will soon start a study in Bangladesh on improving recognition and response to prolonged labor and birth asphyxia after recently receiving a three-year grant from Emory’s Global Health Institute. [EN](#)

Sibley stands in a field of mustard flowers in Matlab, Bangladesh.