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ORIGINAL RESEARCH – QUALITATIVE

Village midwives and their changing roles in Brunei Darussalam: A qualitative study

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ABSTRACT

Background: There are lay midwives worldwide, interchangeably and universally called traditional birth attendants or traditional midwives by organisations such as the World Health Organization and the International Confederation of Midwives.
Aim: This study aimed to explore the history of lay midwives (village midwives) in Brunei, describe the evolution from their previous to current roles and determine if they are still needed by women today.
Methods: This qualitative, descriptive study included in-depth, semi-structured interviews with eight women who had received care from village midwives. Data analysis was based on the principles underpinning thematic analysis and used a constant comparative method.
Findings: Village midwives have been popular in Brunei since the 1900s, with their major role being to assist women with childbirth. However, since the 1960s, their roles and practices have changed to focus on pre-conception, antenatal, postnatal and women's general healthcare. Traditional practices were influenced by religion, culture and the social context of and within Brunei.
Discussion: The major changes in village midwives' roles and practices resulted from the enforcement of the Brunei Midwives' Act in 1956. Village midwives' traditional practices became juxtaposed with modern complementary alternative medicine practices, and they began charging a fee for their services.
Conclusion: Brunei village midwives are trusted by women, and their practices may still be widely accepted in Brunei. Further research is necessary to confirm their existence, determine the detailed scope and appropriateness of their practices and verify the feasibility of them working together with healthcare professionals.

Summary of Relevance

Issue
Traditional midwives play important roles in childbirth, but the safety of their practices must be determined.

What is Already Known
Traditional midwives exist in the rural areas of many developing, developed and industrialised countries. In some countries, they are integrated in the mainstream healthcare system; in others, they undergo training based on scientific knowledge and technology.

What this Paper Adds
Some women in rural and urban areas may still need traditional midwives for their general health, including childbirth. Today, the practices of traditional midwives are integrated with contemporary ideas and modern trends in complementary alternative health care.

1. Introduction

Lay midwives still exist in many parts of the world. In addition to developing countries such as Africa,[1] India, China,[2] Indonesia,[3]

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Malaysia[4] and Brunei Darussalam (henceforth: Brunei),[5] lay midwives are found in industrialised and developed countries such as Canada[6] and the United States.[7] They are usually present in rural areas, because of the inaccessibility of registered midwives to women's homes[8] or the inaccessibility of healthcare centres to women.[9] These midwives are called different names in different countries, such as lay midwives,[6] bidan kampong (village midwives)[3–5] and traditional midwives.[7] However, they are universally and interchangeably addressed as traditional birth attendants (TBAs) and traditional midwives by international organisations such as the World Health Organization (WHO) and the International Confederation of Midwives.[10] The significance of their existence and the safety of their practices are debated, especially in the present era of organised and modern healthcare systems. This debate arises from the perception that their midwifery practice is based on culture, beliefs and traditions,[11] compared with trained midwives whose practices are based on scientific knowledge and modern technology.[5]

2. Literature review

Initially, TBAs did not receive formal training, as it was believed that they acquired their knowledge and skills from their own experiences and apprenticeship with their predecessors,[5,11] or their ancestors' spirits.[1] TBAs are viewed as unskilled and lacking knowledge; they are not trained according to the principles of modern medicine and technology, do not have modern equipment to manage complicated childbirth cases and their practices are considered unsafe and risky to women.[5,11] Despite these views, TBAs still practise worldwide, especially in isolated rural areas, and are regarded as a sustainable and distinctive labour force serving mothers and children.[12–14] Traditional midwives remain in demand by women and their families because they share the same culture, and are trusted and respected in their communities.[15] Global initiatives continue to be implemented to improve their knowledge and enhance their skills. In some countries, traditional midwives still practise with limited or no intervention from healthcare professionals. Formal training of traditional midwives, in collaboration with organisations including the WHO and the United Nations International Children's Emergency Fund, has occurred in some parts of the world such as Africa and Asia.[16] In China and India, TBAs are part of complementary and alternative medicine and are integrated into the mainstream healthcare system.[2]

In 2013, the Brunei population was estimated at around 406,200 people.[17] During that year, there were 450 legally-practising midwives, 6680 childbirths, two maternal deaths and an infant mortality rate of 7.6 per 1000 live births.[17,18] In addition, 99.9% of births had skilled attendance.[18] Unlike other countries, there is limited published evidence available in Brunei documenting the existence of traditional midwives, whether they still practise in the community and if their practices are harmful to women and infants. There is also no documentation regarding maternal and infant mortality and morbidity owing to traditional midwives' practices. Village midwives were popular in the early 1900s, but their popularity decreased from the 1930s, when the Government of Brunei established a legal requirement for compulsory childbirth attendance by a registered nurse/midwife, and fined unregistered midwives for attending childbirth.[5] This was followed by the enforcement of the Midwives' Act in 1956, with penalties ranging from BND $400 to $16,000 (approximately USD $280 to $11,400) for illegal practice as a midwife in Brunei (Clauses 5, 9, 11, 12 and 14).[19]

A previous study on traditional midwives in Brunei, who are commonly known as *bidan kampong* (tr. village midwife/midwives), highlighted their existence and that they were still needed by some women.[11] Village midwives progressively regained popularity because of the expansion of their scope beyond a focus only on childbirth, and the gradual transformation and modernisation of their practices consistent with contemporary healthcare trends.[11] However, this study was conducted with village midwives themselves, and therefore may be biased. Further study with the women cared for by village midwives is needed to confirm their previous and current existence, describe their previous and current roles in Brunei and verify if they are still needed by women today.

3. Methods

3.1. Operational definitions

Unless otherwise stated, the term childbirth is defined as the antenatal period through to the end of 6 weeks postpartum. The terms 'lay midwives', 'traditional midwives' and 'village midwives' are used interchangeably to denote untrained midwives who exist in a community and serve women and families for their general health, including childbirth.

3.2. Research design

A qualitative, descriptive research design was determined to be appropriate to investigate village midwives and their practices in Brunei. This method facilitates description of the study topic through discovering or uncovering new insights, meanings and understanding,[20] especially when little is known about the subject under investigation.

3.3. Participants

The first two potential participants in this study were encountered at a women's health clinic. These women coincidentally mentioned that they received care from Brunei village midwives to the researcher's colleague who worked at the clinic. This colleague gave the two women information about the present study, and enquired if they were interested in participating. On expression of their interest, permission was obtained from the women to mention them to the researcher and pass on their contact details. Consequently, the two women were introduced to the researcher who formally invited them to participate in the study through personal meetings and telephone communications. The women were provided full information about the study through these face-to-face meetings and telephone conversations. They were informed that participation in the study was voluntary and that they could decline the invitation if they did not wish to participate, and were given an information sheet that provided details about the study, participation and consent. The women were given 3 days (72 h) to process the information before deciding whether or not to participate in the study. One of the women refused to participate, but the other agreed. This woman introduced the researcher to another woman, who in turn led the researcher to another woman. These women led the researcher to more women who had received care from Brunei village midwives. In total, eight women were selected via a purposive and chain referral sampling strategy and agreed to participate in this study. Purposive sampling refers to the selection of participants who may provide information relevant to the study.[21] A chain referral sampling strategy is when a participant purposefully leads the researcher to another participant.[20] The inclusion criterion was women who had experience of being cared for during childbirth by a village midwife at some point during their life. The women's age was not a factor considered for inclusion because the main aim was to explore the existence of village midwives in Brunei, describe the evolution of their role and determine whether they were still needed by women.

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