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Positioning kindness and care at the centre of health services: A case study of an informal health and development programme oriented to surviving *well* collectively

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Abstract: *The mainstream development agenda highlights how important access to health care is for poorer regions of the world. In the area of maternal health, this is expressed in a concern to drive down rates of maternal morbidity and improve access to maternal health care services. While important, the focus on metrics misses the way that relations of care are fundamental to good health. This paper takes an example of a project which is offering a different approach to health and development in the resource scarce environment of Luang Prabang Province, in northern Laos. Here, a group of antipodean midwives has partnered with provincial health authorities to offer a midwifery training programme to health workers posted in remote rural health centres. Supported by the analytical tools of diverse economies, this paper explores how this programme centres relationality, collectivity and an ethic of kindness, and discusses the advantages of being relationship based, small and informal. The paper concludes that this training programme can be understood as an example of a community economy of care: based on global networks of care instead of formal development programmes built on global networks of bureaucracy.*

Keywords: *care, community economies, development, Laos, maternity*

Introduction and opening story

It is January 2020, and I am in the mountains of Luang Prabang Province, Laos, with a roomful of nurses and doctors laughing and dancing while they learn how to provide emergency care to a mother and child in a difficult labour. All the participants are having a turn pretending to be the birthing mother. Male and female nurses and doctors experiment with how it feels to lie down, or to squat or kneel, testing out the embodied experience of how the pelvis spreads. They explore how it feels to have carers use a rebozo scarf to support their legs, or provide comfort around their shoulders, and try out hanging from it in an imitation of a birthing position traditionally used in many Laos homes in which birthing women would hold on to a rope hung from the ceiling during childbirth – maximising the assistance of gravity while utilising the tension of the rope. The participants are also learning techniques for emergency management of shoulder dystocia, breech presentation, placenta praevia and postpartum haemorrhage (PPH), the latter representing the biggest cause of maternal death in the province. The steps of each technique are rendered in song and dance, to help participants create an embodied memory that they can rely on to inform their responses when a labour going wrong. Every song begins with a reminder to stay calm and centred (*jai yen yen*), and to treat the woman with gentle kindness (*khoi khoi*).

There is a lot of laughter in the room, but there have also been tears. Alongside the learning of new techniques, participants are frequently invited to share their stories. Everyone in the room can describe a time when something started to go wrong, and they did not know what to do – the labour was hard, the

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baby was breech, the woman began to bleed. For many health workers in the district clinics, expert obstetric support is only available by phone, and the equipment available to deal with emergencies is little more than would be available at a midwife-supported homebirth in minority world countries such as Australia or the UK.

The gatherings were part of a training programme for district health workers, doctors and nurses to learn basic emergency skills, and hands-on support for low-intervention, vaginal birth. The training programme, conducted by midwifery education collective 'Birthwork', looks very different to the usual scene for health and development interventions in northern Laos. The health system in Laos relies heavily on development investment and the technical support provided by international development organisations. In the province of Luang Prabang that technical assistance is divided by district, with different development agencies taking responsibility for supporting health services, including the Korean International Cooperation Agency (KOIKA), Save the Children International and Swiss Red Cross (SRC). The support provided ranges from provision of buildings and equipment, to training and capacity building, guided by the priorities set by the Ministry of Health in Vientiane and the dictates of the Lao People's Revolutionary Party. This contemporary regulatory environment is built on the foundations set by colonial authorities,[1] and the subsequent involvement of external agencies in shaping the health system from the late 1990s (Sweet, 2015). According to Sweet (2015) 'external assistance has exerted a powerful influence on modern Laos, and has played a formative role in shaping its health system' (p. 271), leading to an approach very much in tune with the biomedical and metrics-driven norms of the World Health Organization (WHO).

Globally, the inclusion of 'good health and well-being' objectives in the United Nations' (UN's) Sustainable Development Goal's signals how health care has become a focus for international development investment. It also reflects that health statistics have become one of the key metrics for measuring national development status (developed, developing, under-developed, etc.) used by the UN, WHO and other multilateral development organisations. As with other areas of international development, health and development investments are ostensibly intended to reduce global inequalities, working towards ensuring universal health coverage. The investment focuses on providing support for health care systems modelled on Western biomedicine,[2] usually ignoring the health care contributions of traditional medicine or indigenous and colloquial health care practices and knowledges. In other words, the metrics focus interest and attention on a narrow band of legible and measurable health care measures.

In Laos, inequities in access to health care remain a key concern. The Laos health care sector has historically been framed by an 'almost constant narrative of underachievement' (Sweet, 2015: 7). However, as High (2021) notes, the remarkably successful mobilisation in response to the COVID-19 pandemic has also demonstrated the strengths of the system and of a political culture that emphasises 'unity, solidarity, struggle, respect for science, guidance by a strong center, and the extension of the state into everyday life in the form of designated roles, committees, and organizations' (High, 2021: 144).

The programme discussed in this paper is an example of an initiative that worked with the quotidian realities of this socialist state system in unconventional ways. As a small scale, and largely unofficial initiative, the Birthwork programme exists in contrast to health development investments that have prioritised large scale technical investments globally (Gideon and Porter, 2016), as well as in Laos. While integrated with larger efforts to reduce maternal morbidity rates, the programme is demonstrating the potential of a different approach. Rather than more conventional health and development framings focused on metrics and the provision of technical support to health services, this programme emphasised informal and often unrecognised interpersonal relationships as its foundation, and an ethic of kindness and mutual respect as its core. To elaborate what is distinctive about this programme, in this paper I apply the thinking tools of diverse economies.

The diverse economies tradition provides analytical tools that centre the informal and often under-recognised sets of relationships and practices that make up the lived economy. The

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Figure 1. Diverse economies iceberg [Colour figure can be viewed at wileyonlinelibrary.com]

field of 'diverse economies' began with Gibson-Graham's *The End of Capitalism (As We Knew It)* (Gibson-Graham, 1996). The heart of this work is captured in the image of the 'diverse economies iceberg' (see Fig. 1). What the iceberg represents is the underlying claim of diverse economies analysis that what is seen as 'the economy' in mainstream and popular accounts is in fact only the 'tip of the iceberg': formal wage labour and capitalist enterprises. Below the water line is a vast array of formal and informal spaces of production, exchange and consumption, ways of stewarding common resources or investing in a shared future (Gibson-Graham and Dombroski, 2020).

This paper engages particularly with recent work in the diverse and community economies literature that highlights the importance of relations of care in a diverse economy. The work of care, that which reproduces and sustains life, is essential for all livelihoods and takes place largely below the waterline (Dombroski *et al.*, 2016; Dombroski *et al.*, 2019; Dombroski, 2020; McKinnon *et al.*, 2022). Engagements with care and care economies in the diverse economies literature has emphasised a need to rethink economic subjects. Werner's (2015) work, for example, discusses cases of actors in an economy of care that both delivers for basic needs, and 'cultivate a palpable sense of *we* through nonmarket and … nonmonetary processes of giving and receiving' (p. 72). She also emphasises the shifting sense of subjectivity that is bound up in participating in such economies of care, enabling an 'expanded sense of self, moving from I to we' (p. 73). This expanded sense of self stretches into recognition of interdependent caring subjects with Dombroski's (2020) recognition of the more-than-human caring work involved in the social enterprise Cultivate Christchurch. Dombroski (2020) argues that the interdependent care-giving exemplified in the work of this enterprise requires recognition of a new kind of economic subject: not the profit maximising *homoeconomicus*, nor the collective caring subject *homines curans*, but a 'hybrid caring collective that includes the more-than-human' (p. 159). This vision of the hybrid caring collective encompasses actors rarely recognised as actors in an economy. In the context of maternity care this can include mothers, babies, bodies, midwives, obstetricians, the tools and technologies for obstetric care, pharmaceuticals, institutions, blood and hormones, even the passing of time (McKinnon, 2021).

The open set of actors presents a confounding challenge for what gets measured, valued and ultimately managed in such an assemblage. Earlier diverse economies scholarship drew on insights from feminist economists to count 'the unpaid work that is conducted in the household, the family, and the neighbourhood, or the wider community' (Gibson-Graham, 2006: 62). Others, such as Barron and Hess (2020) have enlarged the circle to include caring relationships between humans and Earth Others vital for species survival – with the caution that these caring relationships are only partially captured by the language of ecosystem services (or indeed health services).

Miller (2019) offers a fuller accounting of the interdependent relationships through which care is given, received and reciprocated. Miller (2019) argues that all human livelihoods are a balance between making a livelihood for

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ourselves (autopoesis), accepting the livelihoods that are made for us by others (allopoesis), and the ways we compose a livelihood for others (alterpoesis). Embedded deeply in the process of balancing these three complementary practices is care, and the obligation to attend to questions around how to care for ourselves, give care for others and receive care from others. Care, as Fisher and Tronto helpfully outline, 'includes everything that we do to maintain, continue, and repair our "world" so that we can live in it as well as possible' (Fisher and Tronto, 1990: 40, emphasis in original, cited in Tronto, 2017: 31). From this perspective, an economy of care can be understood as being made up of the multiple relations of exchange that support the work of maintaining, continuing and repairing our 'world'. Miller's (2019) work helps elaborate how these relations of exchange involve making (for ourselves), receiving (from others) and giving (to others) across the array of practices that make up livelihoods.

What is required in order to live in the world 'as well as possible' is, however, a separate question. In diverse economies lexicon, this question is posed as what it takes to 'survive well together': how do human and Earth Others work together not just for survival, but to survive well? Taken together the phrases 'as well as possible' and 'surviving well' suggest that care does always take place under ideal conditions or circumstances of our choosing. Indeed, the capacity to care may hinge upon apprehending the concrete circumstances in which care given, reciprocated and received. Making room for caring as well as possible, as well as circumstances allow, requires letting go of the fantasy that care-delivery can be 'optimised.' Healy (2008), writing in the context of the United States, describes how the extension of market-logics to a still largely non-profit health care sector promises the efficient allocation of resources and optimization of care. In the United States and elsewhere such 'optimised' health care systems radically undermine the health and well-being of care workers, and threaten maternal health outcomes for sectors of the population, especially Black and Latinx women (Siden *et al.*, 2022). Prudent use of resources, or the reduction of maternal mortality in Laos, are laudable goals. What is concerning, however, is that the drive towards optimization threatens to obscure the way care is always relational, and that relations of care must always negotiate particularities of context and circumstance (Mol, 2008). This fails to recognise that economies of care are made up of the relations which care is given, reciprocated and received, and the particular circumstances that enable it. Diverse economies scholarship of care helps to highlight that health needs and solutions are inherently variable, and that a deliberative ethical response is appropriate even when it might not meet the criteria of an (unrealistic) singular solution. As my discussion below will elaborate, there are many aspects of Healy's analysis that are also relevant to the Laos context: a bureaucratic response that recommends a one-size-fits-all approach to improving health outcomes; a narrative that orients efforts towards 'fixing the problem' rather than an ethical commitment to sufficient caregiving; and the failure to recognise the indeterminacy of particular circumstances of caregiving.

In this paper I bring a diverse economies lens to the space of health development to explore what might be learned about economies of care from the example of the Birthwork training programme in northern Laos. I experiment with applying Miller's livelihoods triad (making–receiving–giving) through an elaboration of how the Birthwork training programme was situated both above and below the waterline of a diverse care economy. Alongside this exploration, I reflect also on the implicit ethical negotiations taking place around the role of maternity care in supporting efforts to survive well together, pointing out tensions around sufficiency in the delivery of health development programmes.

Research approach

The Birthwork childbirth education programmes in Luang Prabang Province were conducted by midwifery education collective 'Birthwork', at the invitation of, and in close collaboration with the Luang Prabang Department of Health. The team running the training programme included three Australian and New Zealand based volunteers (midwife, midwife educator and birth educator); and Luang Prabang Department of Health staff, including lead midwifery trainers,

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and members of the Maternal and Child Health programme. The team was also accompanied by a translator, to facilitate communication during the training sessions, and during the discussions and conversations that took place over meals and during journeys.

Two training programmes were run in Luang Prabang Province, in January–February 2019 and 2020. These followed the delivery of an initial programme delivered by the Birthwork team under the auspices of the SRC in 2017. I was invited to accompany the team to investigate how participants in the training programme perceived the relevance and impacts of training on their own clinical practice, and whether community needs were being met. The training sessions themselves required effective communication between Australian and New Zealand team members, their Lao counterparts and the Lao health workers who were participating in the programme. In addition, most health workers were providing care to community members who were from diverse cultural groups, so an additional component of the research was to consider how well the programme was meeting these complex challenges of cross-cultural learning and communication. An ethnographic approach was taken to the evaluation of the training programme, using participant observation during the two- to three-week training periods in 2019 and 2020, with informal and open-ended interviews conducted with key stakeholders involved in delivery of maternity care in Luang Prabang Province. Observations took place during formal training sessions held at two district hospitals (DHs) in 2019 and 2020, and one Provincial Health Clinic in 2019.

My work was also supported by the team translator, especially during formal training sessions. But after hours and during less formal conversations, my knowledge of spoken Thai[3] (a language closely related to Lao), with the English language skills of Lao team members and some participants, enabled me to continue to learn about their experiences and knowledge of the contexts in which we were working.[4] Participants in the workshops included DH staff, Provincial Health Centre staff and Village Health Workers, with a wide range of medical expertise and prior knowledge and experience in supporting women through childbirth. Village Health Workers, for example, had received six months training in Luang Prabang and offer basic health care in their home communities. Present also were fully qualified nurses, midwives, doctors and also medical assistants and nursing assistants who had completed a proportion of the requirements for a nursing or medical degree, but had further study to complete.[5]

Delivering maternity care in Laos PDR

In Laos, maternal and child health has been a central focus of development investment and a featured component of Five-Year National Socio-economic Development Plans. The most recent Five-Year Plan (2016–2020) included the aim of more than halving the maternal morbidity rate (from 357 per 1000 live births in 2011 to 160 by 2020) and dramatically increasing the proportion of births attended by trained health personnel (from only 58% in 2009) (Ministry of Planning and Investment, Laos PDR, 2016). The plan outlined an intention to train more midwives, with the aim of reaching one trained midwife per village by 2020. It also set targets for the proportion of mothers who are attending at least four antenatal visits, and who are birthing at regional clinics and hospitals (80%). Provincial health authorities are meant to report on these targets, and are supported by technical support from international aid organisations operating under strict memorandum of understanding (MoU) with the central Laos Ministry of Health located in Vientiane.

If we were to draw a diverse economies iceberg for the health and development industry in Laos PDR, the activities undertaken through such MoUs by international aid organisations to meet and report on the objectives set by the Five-Year Plan would constitute what exists ‘above the waterline’. What is reported against the official targets is what is most visible to aid organisations and health authorities, and informs decisions made about where to allocate resources and what issues to prioritise. Certainly, progress has been made against the formal targets, with a drop in the maternal morbidity rate and a rise in the proportion of births attended by a skilled birth attendant (SBA) (World Health Organization, 2019).[6] The emphasis on the formal training of ‘skilled birth attendants’ sidelines both the existence and skills of traditional birth attendants (TBAs). The

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option to be attended by a TBA is not available in many communities, and even their existence is seldom recognised by health officials. Yet midwives who may only have received limited training (sometimes only nine weeks on top of their nursing training) are counted as SBAs. As a result the reporting against the proportion of birth attended by SBAs may not be an accurate reflection of the presence of strong midwifery skills, and there are few opportunities for ongoing training outside urban centres in Luang Prabang Province, whether sourced in traditional medicine or formal training in Western biomedicine.

The network of regional clinics and hospitals carry the burden of meeting the goals of the Five-Year Plan, which was established as part of investments in extending a primary health care network to provide health care across the country. This has included district health centres (*souksala*), linked to district hospitals, and provincial hospitals. The *souksala* provide basic health care services, with basic pharmaceutical supplies and medical equipment. The particular circumstances of providing care in these regional clinics and hospitals vary. Most *souksala* and district hospitalss we visited had only basic medication and equipment available. While these regional health workers are charged with providing medical support during pregnancy and childbirth, many have very limited background in maternal health and childbirth. The target-driven approach gives little recognition to the varying conditions for delivering health services across the country, or the particular challenges in place for clinics operating in the mountains of northern districts, where transport and infrastructure networks, cultural diversity and resource distributions all present a unique set of circumstances for maternal health care.

The clinic context is often characterised by discomfort. The small district hospitals and *souksala* spaces have little in the way of comfort or privacy. At the centre of the birthing rooms is usually a bed with plastic coverings and lithotomy stirrups. Often these rooms open on to a recovery room through an open doorway (usually covered with a thin curtain) where there may be two to three beds for women to stay following birth. The birth space is often quite small, with little space for a birthing mother to choose her birth position. Sychareun *et al*. (2012) report that relatively low rates of Lao women attend antenatal care, and one significant reason was that the women in their study felt clinics were uncomfortable, not allowing freedom of movement or providing space for family members to support women.

Another contextual challenge was that in Luang Prabang Province, villages are sometimes a great distance from clinics and district hostpials. Not all families have access to motorised transport, and some villages may be reached only on foot. Participants in the training programmes reported that it was not uncommon for the journey from village to *souksala* to take 4–5 hours on a motorbike, with the prospect of transferring to a district hospital needing another 3–4 hours, and if an additional transfer for surgery was required that would mean transferring again to the provincial hospital in Luang Prabang, with the only available operating theatre. In addition, when it rains unpaved roads in the mountains become dangerously slippery or outright impassable. Cost was an additional barrier. While maternity care is meant to be free for all Lao women, in practice many families in rural areas struggle to cover the costs of travel and of providing food for the mother while she is in hospital (Marsden, 2011; Sychareun *et al*., 2016), on top of missed earnings while family members remain at the hospital.

Finally, Sychareun *et al*. (2012) noted in their study that one reason women were reluctant to go to clinics was because they were unable to communicate with health staff due to language barriers. Laos PDR is one of the most ethnically diverse countries in the world, with 86 documented languages spoken. Although the Vientiane Lao dialect is the official language of the country, many ethnic minority people cannot speak or understand Lao, with men being more likely than women to speak the language. Officially there is no distinction made between majority Lao Lum and other groups, all are officially classified as 'ethnic groups' (Badenoch and Shinsuke, 2013). However, minority groups are often still looked upon as 'backward' or 'undeveloped' and are not always treated with respect. Sychareun *et al*. (2012, 2016) found that in addition to transport difficulties and discomfort in clinics, women also felt afraid, and many had experienced bullying and mistreatment, and felt spiritually and physically vulnerable in

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hospital, being unable to receive the traditional spiritual or medicinal treatments that they need for a safe and healthy birth, while also having to submit to intrusive examinations by medical staff (Sychareun *et al.*, 2012; Sychareun *et al.*, 2016). At every hospital and clinic we visited in 2019 and 2020, staff reported that they often needed to care for women with whom they did not share a common language. In these cases they would call on health workers who did speak the language (usually Hmong or Khmu), but more often communicated through family members who spoke Lao.

The challenges faced by health workers and the mothers they care for were amply illustrated by the stories shared by midwives during 2019 and 2020 trainings. Many of these stories were shared during training sessions as participants debriefed about their experiences with breech delivery, PPH or other emergencies. The senior Luang Prabang Health Department (LPDH) staff who accompanied the team also shared their stories. During conversations over the long drives to district hospitals and health centres, and over meals shared outside of the training sessions, these senior mother and child health officials also used the opportunity to debrief, sharing stories of when things had gone wrong. Lack of knowledge about how to deal with emergency situations, alongside the remoteness of many of the clinics, were central features of these stories. PPH is the primary cause of maternal morbidity and in these cases it was often the distance away from medical care that was the biggest concern. The following story, recorded in my field notes following conversation with one of the LPDH midwives on the team, exemplifies a common challenge:

> [She] told us the story of a woman who had birthed at a Health Centre but suffered PPH following breech delivery. The mother was transported by boat to Nambak, where there is a large district hospital. The journey by boat took 4 hours, and staff had called ahead to make sure that blood was available for transfusion when they arrived. Duang received a call at home to ask if she could help them find the right blood type to send up to Nambak from Luang Prabang as they had none available. It would take 2.5 hours to get the blood up to the hospital, but none was available in Luang Prabang either. The woman died on the way to Nambak, but the baby survived. In another case, a woman had a retained placenta following birth at a health centre and had to travel for 10 hours: by two boats and then a 2 hour road journey to get to Nambak hospital, and from there transferred again 2.5 hours to Luang Prabang for surgery. She survived.

In my conversations with the Lao members of the training team, and with the medical workers we engaged with, it was clear that there was widespread awareness that the goals clinics were striving to reach were inappropriate in many cases. To reach the antenatal visit and birth in clinic targets meant persuading pregnant women to take long journeys of sometimes one to two days to get to a clinic which may itself be an 8 hour journey from the nearest hospital, which would in turn be a 4–8-hour journey from the nearest facility with an operating theatre. Most of the health workers taking part in the training sessions reported that they had access to basic supplies, such as oxygen, Syntocinon (a synthetic oxytocin to stimulate contractions) and blankets. Many did not have infant resuscitation equipment or tools for monitoring infant heart rates. Many clinics had received Dopplers, a handheld electronic monitoring device, and the district hospitals has cardiotocography (CTG) machines for monitoring infant heart rates, but it was common that this equipment had broken or could not be used due to unreliable electricity supplies. Knowledge of how to use simpler tools, such a Pinard,[7] was not common.

The staff we met were usually passionate and dedicated, doing the best they could with the skills and resources they had at hand. Many though, simply did not know how to deal with common emergencies, especially when they had nothing but their hands, their mobile phone and a supply of Syntocinon and, not always, oxygen. Our participants also reported that it is rare for women to come to more than one antenatal visit, and in the majority of cases would not come to clinic unless something was going wrong with the pregnancy or the birth.

The kinds of challenges made evident during fieldwork fall easily into a narrative of chronic deficiency in the Laos health system (as mentioned earlier). The response from the Laos Ministry of Health and the international development sector has been to put in place standard measures and targets, with

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the goal of meeting these supported by enormous international development investment. Such a response is akin to the health care reforms critiqued by Healy (2008) in which a singular (and bureaucratic) solution is proposed for complex and highly contingent particularities. As I elaborate below, the Birthwork training programme was driven by a different agenda and sought to begin from an apprehension of the strengths, rather than the deficiencies, of the health workers that participated. Supporting health workers to attend to the particularities of the women they care for, and attuning to an ethic of kindness and of sufficiency came before the imperative to meet prescribed targets. According to Birthwork team leader Jenny, the programme sought to instil confidence in communication and hands-on skills, and to help boost morale by acknowledging that working with birth can be scary and challenging, as well as rewarding. She noted that when working in isolation, feelings of fear and disempowerment can easily come to the fore. Thus the programme sought to foster confidence alongside the skills to act, enabling health workers to do what is necessary to act in the interests of mother and baby. The Birthwork programme aimed to make the most of the strengths brought by participants, adopting what could be called a post-development approach building on place-based strengths (Dombroski, 2015) and perhaps enabling, in Healy's terms, an ethical fidelity to good care over prescribed outcomes. In this case, the approach was to build the programme around participants' existing knowledge and motivation, and their expertise in social, cultural and political contexts of the places in which they live and work.

The Birthwork programme: Dialogue, collectivity and kindness

Feedback from the health workers taking part in training sessions confirmed that the skills the programme was teaching were felt to be much needed, but these skills did not fit neatly with the 'above the waterline' priorities for maternal health investments. The official contributions of international agencies governed by MoUs between the operating agency and the central Ministry of Health constitute the 'above the waterline' of health and development operations in Laos: They are visible and accountable to the Ministry, and must focus explicitly on achieving progress towards the objectives set by the Five-Year Plan. The Birthwork programme, in contrast, was undertaken almost entirely as a 'below the waterline' health development intervention.

In this section I outline the background to the programme, highlighting seven characteristics of a below the waterline economy of care that were exemplified in it. I explore how such 'below the waterline' qualities opened space for what Healy terms 'ethical fidelity' in care, aimed towards a sufficiency in tune with surviving well together.

First, the programme placed personal and professional relationships at the centre of its design. The midwifery training programme grew out of a dialogue between an Australian midwife and birth educator and a Lao health and development professional. Jenny leads a small collective of midwives and natural birth advocates based in Australia and New Zealand, offering training programmes worldwide in gentle techniques for supporting pregnancy and birth. Vannaly worked for the Lao SRC Maternal Newborn and Child Health (MNCH) programme in Luang Prabang and the Department of Health. When they met in Luang Prabang in 2005, the pair discovered a shared concern for the knowledge and skills of regional health workers. The pair noted the lack of working modern equipment available in the region, and a concomitant lack of low-tech skills for listening to babies' heartbeats or feeling their positions. Building on their shared concern, and their friendship, Vannaly invited Jenny to return to teach the kind of hands-on skills that midwives needed.

Second, a free and reciprocal exchange of knowledge and skills characterised the programme. Jenny brought together a team of midwives, midwife trainers and birth educators, who returned to run the first training session in 2017. The teaching programme was put together through a collaborative approach between Jenny and Vannaly, based on matching the greatest training needs with the skills of the team that Jenny could bring together. On the Australian side, the programme was informed by the knowledge and skills for supporting low-intervention birth offered by the Birthwork collective. The midwives, childbirth educators and doulas in the collective often

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support at home births, and are passionate about 'celebrating, sustaining, safeguarding and growing natural birth wisdom' (Birthwork Collective, 2022). From the Laos side, however, the programme needed to be shaped to meet the needs of clinical staff on the ground. The programme thus took shape with reference to the midwifery skills training protocols recently developed by the SRC , and separate protocols developed by Save the Children, Laos – both developed as part of the formal technical support provided for government health services in Luang Prabang. During sessions the content was also revised and added to by the Lao team members, who contributed their knowledge to ensure the content complemented the clinical training participants had already received. Through this dialogue with existing capacities and resources, a programme was designed that simplified essential elements of emergency skills needed and was shaped around the circumstances under which health staff are operating in villages, district hospitals and health centres. The collaboration was driven by an interest in both giving and receiving knowledge, in order to shape an outcome that could be held in common.

Third, the Birthwork trainers undertook their work as unpaid volunteers, with the approval of the Director of the Provincial Health Department. Because it was established as a volunteer programme the team did not have to set up an independent MoU with the central Lao Ministry of Health in Vientiane, as is usually required of external agencies operating in Laos. A Health Department official noted that one of the great benefits of the approach, and why they did not want to pursue the formal MoU, is that it allowed the programme to be focused on people, 'what they feel they need and what skills they already have', rather than being driven by external criteria. This perception that a formal MoU agreement would not allow such a programme to take place was also reinforced by comments made by staff of INGOs delivering health programmes elsewhere in Laos. The informality of the programme, and its orientation to the gifting of time and know-how, was evidently important to both Laos and Australian members of the team.

Fourth, the hospitality of local families and participants was a valued part of the exchange. In addition to paying the team of two to three LPDH midwives who helped deliver the training, the department offered vehicles and drivers, and helped organise the logistics of the visit and facilitate connections with local community members who offered meals, beds and hospitality to the team. The warm reception, and shared meals hosted in their homes by district health workers, provided a context of reciprocity, and the opportunity to build friendship.

Fifth, the programme could not have operated without the gifting of time, money and materials. The training programme is backed by individual donations, as well as financial contributions from two Australian based nonprofits whose work aims to reduce the rates of maternal and infant mortality. The team from Birthwork raised funds to support the programme:

> We have to provide financially for every aspect of the venture, other than a vehicle which is provided for us. Each participant receives an allowance to enable them to travel, eat and stay close to the training. We provide each participant with a bag of essential supplies – nail brush, nail scissors, disposable gloves, scourers, cotton twine, torch, fetoscope, lubricant, tape measure, notepad, pens, etc. And we take much needed supplies to give out such as infant bag/masks, dolls for education, posters and hot water bottles for comfort. We also buy blankets, pillows, towels, vinyl mats, basins, batteries and other essentials. (Blythe, 2022)

In addition to the supplies given to health workers, *Days for Girls* contributed washable cloth menstrual kits for the Birthwork team to distribute to mothers and women in villages. Disposable menstrual pads are not easily available, whereas most villages are located near a water supply for washing, so the kits provide women with an alternative to rags for postpartum bleeding, as well as monthly menstruation. The kits are sewn by volunteers in Australia, and donated to the programme. These supplies weighed down the vehicles that transported the team into the mountains for training sessions, becoming enrolled as part of the collective effort of maternity care.

Sixth, the programme focused consciously on enrolling low-tech tools, and embodied and

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affective methods of care. The training focused on providing the kind of care that can optimise the chances of women delivering safely, focusing on making the most of the resources that all health workers will have available. Rather than relying on medical equipment that may not work, the techniques taught focused on use of body position, touch and commonly available tools such as a sarong or scarf, a Pinard and the presence of family to support a woman's body to relax and to birth. As part of this, the team enrolled traditional practices and low-tech tools into the economy of care they were supporting – emphasising skills that can support safe and effective birth in the absence of modern equipment (or the reliable electricity supply needed to operate such equipment). The body itself was thus enrolled as an active participant in both providing and receiving care.

Finally, the programme as a whole is built around an ethic of kindness as the foundation of respectful care. Each workshop began with a discussion of the importance of kind words and kind actions, reinforced throughout the programme with the reminder to be calm (*jai yen yen*) and be kind and gentle (*khoi khoi*) with every emergency response. Jenny's introduction in every training session outlined how good care comes with the practice of 'Three Kindnesses'. The first is to be kind by sharing knowledge with others, being open with explanations about what is happening, what carers are doing and seeking to increase everyone's understanding with a 'kind heart' (Jenny, Phou Khoun, 28 January 2020). The second is to be kind to mothers and their families by treating them with respect, treating the mother always as a 'dear sister' even when the care relation is difficult:

> Even if you have some problem with the woman or some judgement about her try to treat her as a dear sister. And she will always remember your kindness, and she will be less afraid. (Jenny, Phou Khoun, 28 January 2020)

The third kindness is about being kind to yourself:

> Take kind care of yourself so that you can do a good job. This means things like: always have your phone charged in case you need to call, have two backup numbers, make sure you drink and eat, and sleep well, and always be prepared, have your equipment ready. We want health workers to be well, we want communities to be well, and we want mothers and children to be well. (Jenny, Phonthong DH, 2020).

The mention of self-care caused a hum of surprise during some workshops, usually followed by nods of acknowledgement. Kindness for the self and care for one's own capacity to do the job (what Miller might term autopoesis), was thus placed alongside kindness in the giving of care to others and the open sharing of knowledge (alterpoesis).

Enacting a community of care

The focus on kindness as the foundations of a programme intended to support better and safer maternity care runs counter to the logics of mainstream health development assistance. The emphasis on technical support means that the key organisations supporting maternal health in Luang Prabang are focused on improved service delivery, biomedical training and the provision of medical equipment to hospitals and clinics. The imperative to shape programmes around priorities set by the Ministry of Health means that there are few opportunities to build interventions through dialogue and collaboration with people who live and work in the places where help is needed. Additionally, a strong focus on health metrics to reveal areas of need and measure progress towards improved health services, means that areas of care that are not visible in the metrics are unlikely to attract investment.

In contrast, the Birthwork programme emerged in response to locally identified needs and took shape in conversation with existing strengths and capacities. The programme focused on issues that do not count in the metrics, such as the prevalence of hands-on midwifery skills for supporting natural birth. Through its emphasis on skilled touch, an ethic of kindness and respect and the encouragement for health workers to welcome families into the labour room, the programme may well be offering a way to offer care across cultural and linguistic boundaries, addressing some of the reasons that Lao women do not want to attend

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clinics (Sychareun *et al*., 2012). Because of the dialogic, and ad hoc nature of the programme and the strength of the relationships upon which it is built, it is has also enabled space for compromise between the bureaucratic imperatives that health workers in Laos must work with, and the natural birth ethic brought by the Birthwork team. The teaching programme was developed with a careful and considerate attention to the needs of health workers in context, the policy structures in which they work, and a commitment to an ethic of women centred care. Largely because the programme takes place 'under the radar' it has been able to focus on teaching respectful care, democratising knowledge and low-tech, hands-on skills that are not part of (but do complement) current midwifery curriculum in Laos – making space in the process for health workers to shape care to the woman in the room, rather than to the target they are under pressure to meet.

The relationships of exchange that make the programme possible encompass a range of practices that can best be described as 'under the waterline' activities, seldom visible in accounts of how a care economy might function. These include the work undertaken to build personal and professional relationships; share skills and knowledge; compromise; undertake fundraising; gift time, materials and/or money; offer reciprocation in hospitality; and undertake the emotional work needed to care with kindness. Seen as a collective effort, the Birthwork Lao programme can be understood to bring together many different types of resources – from the cash contributions of non-profits and other donors, to the skills and knowledge offered for free, to the material contributions of vehicles, food, menstrual kits. It also brought together many different people and organisations. This network of collaborators comes together around the delivery of the programme, and in doing so forms a community of care, constituted by 'the conjoined actions of collectives, the living and non-living things that assemble in order to enable … care' (Dombroski *et al.*, 2019: 103).

Through the Birthwork programme, Australian and Lao midwives and health workers had the opportunity to learn from each other as the programme was developed, delivered and modified: in the process both giving and receiving knowledge and know-how. In many development contexts, 'training' is usually posed as the transfer of expertise and knowledge from trainers to participants. In this case, the dialogic nature of the programme design process gave a different feel to the encounter. As did the deliberate effort to provide a strengths based approach to learning, driven (as the LPHD official noted above) by a desire to work with what participants 'feel they need and what skills they already have'. Furthermore, operating outside the usual formal MoU structures, the programme as a whole was able to sidestep the requirement to focus support on meeting the targets of the Lao PDR Five-Year Plan. Instead of being enrolled into the singular solution to maternal health represented by morbidity and antenatal consultation targets, this programme was able to orient to building skills for sufficient care, with an ethic of kindness, in circumstances which are unlikely to be ideal. Supporting health workers to care well, and to be well, was the aim.

Concluding comments

In this paper I explored how the Birthwork training programme is enacted through relationships, and activates a collective that is caring for safe and gentle birthing practices in Luang Prabang Province. The story of 'Birthwork' that I tell is shown through the lens of diverse economies. A diverse economies analysis provides a way to foreground how practices that create and maintain human lives and livelihoods, are always already, entangled with relationships of care. In this case, it provides a way of viewing the ecology of the Birthwork training programme as both built on, and performing, a community economy of care.

In the face of a heavily regulated, and deeply bureaucratised international development industry, this small effort is demonstrating what can be achieved at an interpersonal scale. Without the usual scaffolding of MoU's and Ministry approvals, the Birthwork programme brings homebirth midwives from Australia and New Zealand into partnership with local health officials to work together on building the skills of health workers in the most remote districts of the province. It is a programme built on interpersonal relationships of mutual respect, an ethic of knowledge sharing, and a belief that low-tech, hands-on skills and kind and respectful care for mothers are the best tools for improving maternity care. The programme introduces the possibility that health care can be about

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more than service delivery and patient outcomes, and shows an alternative pathway for development assistance based in relational and collective acts of care in low-tech environments. In contrast to formal development programmes built on global networks of development bureaucracy, this programme is based on direct relationships, intentionally remains small and informal, and is possible because it activates a global network – a community – that comes into existence in the giving, the receiving, and the doing of care. In the process it offers an example of a health and development programme oriented towards finding ways for distant communities, in Australia and in Laos, to help each other survive well together.

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Notes

[1] The territory of the contemporary Lao People's Democratic Republic was formed from three kingdoms when the French established colonial rule in 1893. Independence was won in 1953, and the current socialist state was established in 1975 following a brutal civil war.

[2] The term 'Western biomedicine' is shorthand for the practice of health care shaped by medical sciences that originated in Western Europe and are now dominant in most health care systems globally.

[3] My Thai language comes from learning Thai as a child living in northern Thailand, and further study during my PhD research in the early 2000s.

[4] Like the other Australian and New Zealand team members, I am a woman of European descent, but also had spent many years living in northern Thailand as a child and an adult. My language skills were quite rusty, but a familiarity with aspect of the cultural context were very helpful in forging cordial and trusting relationships in Luang Prabang.

[5] All observations were recorded using hand written field notes and later analysed for key themes. Research was conducted with clearance from the La Trobe University human ethics committee and all data was anonymised to protect the identity of individuals, except where explicit permission has been given for individuals to be identified.

[6] It is also important to note that the quality of record keeping in Lao PDR is variable: in more remote communities many births still go unrecorded, and it is likely that improvements for minority ethno-linguistic groups have not been as strong (Durham *et al*., 2016).

[7] A Pinard is a simple stethoscope, made from wood or plastic, which allows a carer to monitor the infant's heartbeat in utero. The Pinard was invented in the nineteenth century and does not require batteries or electricity; however, it does take some skill to place it well.

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